Compensation Issue

AOC REPORT

Leadership teams such as Sandy Emery's at West Virginia must work collaboratively across borders to manage the big business of Orthopaedic Departments.

West Virginia University Department of Orthopaedics

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This is the annual release of our Compensation & Clinical Productivity national benchmark information. As you will read in the data, despite the many challenges we face in academic Orthopaedics today, this is a thriving profession that has an increasing impact across constituencies within institutions and beyond. It is clearly "big business" and as we detailed in our Leadership Issue of the AOC Report, these are heady times that call for strong cabinets in support of the Chair and Chief Administrative Officers.

Contribute to the *AOC Report* on Research and Education

We will be releasing a **Special Issue focused on Research & Education in coming months** … The AOC was contacted by OMeGA leadership and held a conference call to discuss our assistance in surveying academic departments to get a national biopsy/read on how fellowships and related are being managed and funded. Stay tuned for this release and thank you in advance for participating in this questionnaire designed by OMeGA leadership. We will also reach out to national thought leaders in education and also research to gather energizing/challenging commentaries on these matters.

Please contact the AOC if you are interested in contributing.

Is Your Portfolio Diversified … Enough?

Increased diversification of Departmental revenue portfolios needs to be embraced, in a compliant way, in order for Departments to survive the next phase of our new normal and what follows. Historically, academic Departments have been able to support themselves and the missions (at least at baseline level) via clinical receipts, salary support from VA Hospitals, and endowment income. In the 90's we began to see medical directorships; financial support from hospitals for services such as trauma and pediatrics; and some proliferation of coverage agreements (i.e. with community hospitals) coming into vogue. Collectively, these valuable new sources of revenue began to increase the number of slices on Departmental revenue pie charts. Relying too much on any one or two slices comes with risk and adds vulnerability to Departments who are trying fund academic missions and retain faculty. Clinical receipts are trending downward.Costs of new EMRs have added expenses to Departments. Health exchanges are having an impact (and employers have yet to really get aggressive so their impact has not been felt yet). And many Departments haven't been able to organize/capitalize on philanthropy. It's a slippery slope and there are some who have done well to navigate all of this; programs such as Emory and Washington University stand out as being ahead of their time and effective in negotiating funds flows and partnerships for their services.

More recently some programs have begun to negotiate co-management agreements with their health systems (who have much deeper resources and who need our partnership to effect system wide change). These agreements provide a baseline of financial support in exchange for faculty who will be truly engaged in the process of examining quality metrics, costs, care pathways, discharge planning, and numerous other variables that impact financial and clinical metrics associated with the musculoskeltal service line. These agreements also have an incentive component that is additive to the baseline support. It makes sense for all involved; and beyond the financial funds flow, it provides the faculty with an opportunity to effect positive change to his/her work environment and associated productivity (i.e. Peri-operative efficiencies that reach a level where a joint surgeon can do 10 surgeries and be walking out the door at 4 pm). Co-management is a smart new revenue source for departments and the scale can be significant.

As we heard last year at the AOC Annual meeting in Chicago with the Columbia and Midwest Rush presentations, a number of Departments (32% of programs have a DME program in place) are now getting in to supply side management. It is smart for Departments to think entrepreneurially. Specifically, entering the DME business to take responsibility for acquiring, dispensing product and providing patient education in clinic and peri-operative environment. For those who can manage the details effectively, there is a significant opportunity that can add yet another important slice to a Department's revenue portfolio. This is basically partnering with a vendor to establish this as a business within the Department. The vendor can offer critical expertise during the early stages of development (and this will take time to develop … 12 months to begin to reach scale).

Related, over the past 3 months I have been in discussions with several DME companies about the constructs that some Departments are exploring as described above. There is great interest from lthe companies part to demonstrate how this might work, as a partner to the Department(s). Between now and early fall, I am going to begin to map out how such a construct could be developed and adapted for those Departments who may be interested. I will bring that construct directly to the Chairs and the Chief Administrative Officers to decide if this is something consider and to perhaps put some numbers around with a vendor.

Are there any other opportunities? Yes.

The implant/device companies are in process of examining their business models and how they relate to faculty and the health systems within which the faculty work. The dollars that used to flow to surgeons who were paid consultants and/or who were able to receive academic/educational grants from these companies is shrinking… stemming primarily from Department of

Justice restrictions of such and also as reflection for the realties that their product margins are coming down as the companies come in line with pricing controls exacted by the hospitals/health systems. Some Departments rely heavily on this valuable support (revenue slice) from industry and are having to think longer term about how to fund fellowships and the academic missions absent such funds flows. Hence the need to manage the Department revenue portfolio wisely.

As you read this, I am at work organizing a national level consulting engagement comprised of 3 Chief Administrative Officers and 3 Senior faculty from among the AOC to examine how a compliant model could be developed to focus on how to take the costs out of our musculoskeletal care, in partnership with industry, while also establishing an academic funds flow of significance for the Departments who adapted such constructs. This would have to exist in such a way that SOM compliance officers would endorse. There are many ways that compliant academic partnerships with industry could be accomplished. I shared these concepts with 4 or 5 Chairs recently who each said that "yes" they would like to see such a construct, at least to consider. We will also examine how we can do a better job with outcomes research and truly taking this to scale. Frankly, it has been very difficult to find a way to do this within the EMR products that are be operationalized now (i.e. Epic) though some are doing better than others with this (i.e. Wisconsin). I shared these concepts with 4 or 5 Chairs recently who each said that "yes" they would like to see such a construct, at least to consider.

If we are going to continue to exist as academics – who truly are academic – we will need to find a way to embrace a more complete, compliant, and diversified revenue portfolio. As always, please feel free to reach out to me to share your thoughts.

Happy Summer!

Michael R. Gagnon

Founder & CEO, AOC
Chief Administrative Officer, Duke Orthopaedics

ACADEMIC ORTHOPAEDIC CONSORTIUM MEMBERSHIP

Academic Affiliation	Chief Administrative Officer	Chair
Baylor College Of Medicine	Gayleen Breeding	Thomas Hunt
Boston University	Melissa Poleo	Scott Duncan
Brown University	Weber Shill	Michael Ehrlich
Cleveland Clinic	Brian Thomas	Joseph Iannotti
Columbia University Medical Center	Barbara Hewson	Bill Levine
Drexel University	Stuart Van Kirk	Patrick DeMeo
Duke University	Michael Gagnon	Ben Alman
Emory University	Merideth Cooper	James Roberson
Georgia Health Sciences University	Mark Lewis	Monte Hunter
Harvard Medical School	David Gaynor	Harry Rubash
Hofstra University	Janice Vetrano	Nicholas Sgaglione
Howard University	Frederick Peal	Terry Thompson
Houston Methodist	Todd Griffith	Kevin Varner
Johns Hopkins University	Jo Jennings	James Ficke
Maimonides Medical Center	Viktoriya Furina	Jack Choueka
Medstar Orthopaedics	Michaele Morrison	Leslie S. Matthews
Mount Sinai School of Medicine	Lisa Grossman	VACANT
MUSC	VACANT	Vincent Pellegrini
NEOMED	Kathy Walsh	Thomas Thompson
St. Luke's University Health Network	Natalie Gould	William DeLong
Northwestern University	Christopher Kubychek	Terrance Peabody
New York University	Steven DeBrocky	Joseph Zuckerman
Ochsner Medical Center	Amy Chauffe	George Chimento
Oregon Health & Science University	Heidi Snyder	Jung Yoo
Penn State University	Tiffany Gibbons	Kevin Black
Rush	Dennis Viellieu	Joshua Jacobs
Southern Illinois University School of Medicine	Marla Beatty	Khaled J. Saleh
Stanford University	Morisa Guy	William Maloney
The Children's Hospital of Philadelphia	Ellen Feinstein	John Flynn
The Ohio State University	Mike O'Brien	Andrew Glassman
The University of Chicago	Amy Burklund	Douglas Dirschl
Thomas Jefferson University	Michael West	Alex Vaccaro
Tulane University	Ed Leonard	Raoul P. Rodriguez
UC SAN DIEGO	Lisa Rhodes	Steven R. Garfin
UCSF Orthopaedic Surgery	Richard Capra	Tad Vail
UCSF Fresno	Joyce Fields-Keene	Eric Lindvall
Univeristy of Colorado	David Kaplan	Robert D'Ambrosia

Academic Affiliation	Chief Administrative Officer	Chair
Univerity of Missouri	Ann Juengermann	James Stannard
University Hospitals Case Medical Center	Diane DeRubertis	Randall Marcus
University of Arizona	Amy Van Hoesen	John Ruth
University of Arkansas for Medical Sciences	Paul Stover	Charles Lowry Barnes
University of California Los Angeles	Tonya Allen	Jeffrey Eckardt
University of Cincinnati	Ian Smith	Mike Archdeacon
University of Cincinnati, Children's hospital	Sandy Singleton	James McCarthy
University of Florida	Andrew Duncan	Mark T. Scarborough
University of Illinois at Chicago	Jonathan Bode	Mark Gonzalez
University of Iowa	John Swenning	Lawrence Marsh
University of Maryland	Lawrence Thompson	Andrew Pollak
University of Massachusetts Medical School	Mary Lammi	David Ayers
Rutgers University	Steve Schmidt	Joseph Benevenia
University of Miami	Terry Deochand	Frank Eismont
University of Michigan	Carolyn Cole-Brown	James Carpenter
University of Minnesota	Erica Stangeland	Dennis Clohisy
University of Nebraska Medica Center	David Staiert	Kevin Garvin
University of North Carolina at Chapel Hill	Philip Clark	Edmund Campion
University of Pennsylvania	Lori Gustave	Scott Levin
University of Rochester	James Hoefen	VACANT
University of South Alabama	Anne Norton	VACANT
University of Texas at San Antonio	Brian Petter	Robert Quinn
University of Utah	David Quinn	Charles Saltzman
University of Vermont	Bradley Krompf	Claude Nichols
University of Virginia	Michael Boblitz	A. Bobby Chhabra
University of Washington	Kenneth Karbowski	Howard A. Chansky
Upstate Medical University	Lisa DaRin	Stephen A. Albanese
Vanderbilt University	Lisa Raines	Herb Schwartz
Virginia Commonwealth University	Kevin O'Keefe	Robert Adelaar
Wake Forest Baptist Health	Amy Goodman	L. Andrew Koman
Washington University	Ronald Faulbaum	Regis O'Keefe
Wayne State University	John Elliott	Lawrence G. Morawa
Weill Cornell Medical College	Laura Robbins	Todd Albert
West Virginia University	Antoinette Summers	Sanford Emery

The AOC is Celebrating 10 Years : : Thank You!

2014 ANALYSIS SURVEY

PURPOSE/GOALS OF SURVEY

To provide AOC with a "biopsy" that we can consequently use as a platform to advance critical understanding and dialogue specific to American Academic Orthopaedic Departments.

Accordingly, we hope to use this valuable context to deepen our individual and collective understanding to improve the national landscape for academic orthopaedics. Likewise, this data also provides private practice Orthopaedists with information that improves their own context in relation to academics/trends.

- Understanding where your program exists in relation to your peers
- Learning points that can be used as discussion points within your institutions
- Utilizing the information to make adjustments and to improve your program
- Empower you with information

SURVEY METHODOLOGY

- An email was sent to all 75 Executive Directors with an excel attachment and survey monkey link to communicate the goals of the survey and to request program participation. Periodic notifications were subsequently sent by AOC to encourage full participation.
- Programs were requested to invest the 90 minutes required to complete the data.
- All data emailed directly to Michael R. Gagnon at Duke Medical Center as he coordinated the survey and was responsible for the confidentiality of the participants as well as the integrity of the final analysis and the de-identification. The survey monkey results herein are as directly provided by the program participants.
- All data are de-identified in the report.
- The data were collected over a 3 month period and are more than 3 months old.
- Legal Counsel was involved to be sure that the study and the structure of this report were not in violation of anti-trust regulation.
- The benchmark analysis herein has been updated to reflect all programs that participated through June 2015.

DATA REVIEW AND AUDITING

Mr. Gagnon reviewed all data as provided by the programs and communicated directly with programs where there were questions with any data points as submitted by participating programs.

Typical questions/issues that prompted follow up included:

- Clarification and follow up to obtain any missing data
- Investigation of any unusual correlation within a reporting program (i.e. high receipts and low WRVU; Average compensation figures that mathematically seemed implausible given reported salary ranges)
- Investigation of data significantly above/below the threshold for norms, not only among the group but in larger context.

SURVEY PARTICIPATION

*The survey results are based on data reported by 35 distinct Academic Orthopaedic Surgery programs, which is a **47% programmatic response rate within the AOC.***

The directions below were given to clarify how to record the data specific to productivity and compensation and exclusions.

PLEASE NOTE:

1. INCLUDE SURGEONS ONLY IN ALL ANALYIS (EXCLUDE NON-OPERATIVE PERSONNEL)
2. NO DATA SHOULD INCLUDE ANY MIDLEVEL RELATED INFORMATION (I.E. PHYSICIAN ASSISTANT RECEIPTS, WRVUS GENERATED BY FELLOWS)
3. DO NOT INCLUDE STATISTICS ASSOCIATED WITH THE CHAIRMAN OF DEPARTMENT IN ANALYSIS.
4. DO NOT INCLUDE NEW HIRES WHO ARE STILL ON GUARANTEE.
5. BE SURE TO NORMALIZE ANY PART-TIME STATISTICS FOR THOSE WHO YOU INCLUDE IN YOUR AVERAGES. FOR EXAMPLE, IF YOU HAVE A GME PROGRAM DIRECTOR INCLUDED

   WHO IS 50% CLINICAL EFFORT, YOU SHOULD DOUBLE HIS RECEIPTS AND WRVUS BEFORE ADDING IN TO THE CALCULATIONS FOR AVERAGES.

SURVEY PARTICIPANTS

Case Western Reserve
Drexel University
Duke University
Johns Hopkins University
Medstar Health
Midwest Rush
New York University
Northwestern University
Ohio State University
Pennsylvania State University
Southern Illinois University
Stanford University
Tulane University
University Hospitals Case Medical Center
University of California at Los Angeles
University of California at San Diego
University of California at San Francisco
University of Chicago
University of Cincinnatti
University of Colorado
University of Florida
University of Iowa
University of Maryland
University of Missouri
University of Nebraska
University of Pennsylvania
University of Rochester
University of Utah
University of Virginia
University of Vermont
Upstate Medical University
Virginia Commonwealth University
Wake Forest University
Washington University
West Virginia University

2014 Survey Results: **Department Level Statistics**

The data below represents the aggregate of all subspecialty data across all reporting Departments.

DEPARTMENT LEVEL STATISTICS	FY 14 RANGE	FY 14 AVERAGE	FY 14 MEDIAN
Average Collections per surgeon	$561,244 - $1,226,217	$939,869	$962,175
Average WRVUs (modifier adjusted) per surgeon	5,114 - 13,385	9,863	10,034
Collections/WRVU	$68 - $139	$98	$95
Average TOTAL Compensation of surgeons including bonus (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$389,396 - $967,783	$568,330	$560,158
Compensation as % of Receipts	44% - 84%	61%	58%
Comp/WRVU	$39 - $81	$59	$57
What is the typical starting base salary that you offer to these hires for someone right out of fellowship?	$240,000 - $400,000	$320,007	$326,901
How many years has your Chairman been serving as Chairman of your Department?	Interim - 20 years	8.3	6.5
How many WRVU did your Chairman do last year?	1,035 - 10,682	5,270	5,090
How many years have you served as Chief Administrative Officer of your Department?	1 - 34	10.7	7.0

2014 Survey Results: **Foot and Ankle**

FOOT AND ANKLE	FY 14 RANGE	FY 14 AVERAGE	FY 14 MEDIAN
Average Collections per surgeon	$446,885 - $1,184,725	$750,474	$745,356
Average operative cases per surgeon	184 - 525	312	295
Average WRVUs (modifier adjusted) per surgeon	4,905 - 14,000	7,977	7,689
Collections/WRVU	$63 - $143	$100	$96
Average TOTAL Compensation of surgeons including bonus (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$348,483 - $762,405	$465,733	$402,908
Compensation as % of Receipts	44% - 88%	62%	61%
Comp/WRVU	$45 - $91	$60	$54
What is the typical starting base salary that you offer to these hires for someone right out of fellowship?	$200,000 - $404,845	$301,603	$303,000

2014 Survey Results: **Hand**

HAND	FY 14 RANGE	FY 14 AVERAGE	FY 14 MEDIAN
Average Collections per surgeon	$506,071 - $1,370,946	$850,873	$821,604
Average operative cases per surgeon	224 - 777	447	435
Average WRVUs (modifier adjusted) per surgeon	3,177 - 14,613	8,294	7,713
Collections/WRVU		$109	$95
Average TOTAL Compensation of surgeons including bonus (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$325,000 - $927,740	$514,546	$466,930
Compensation as % of Receipts	39% - 88%	60%	60%
Comp/WRVU	$36 - $128	$65	$56
What is the typical starting base salary that you offer to these hires for someone right out of fellowship?	$220,000 - $370,000	$308,216	$300,750

2014 Survey Results: **Oncology**

ONCOLOGY	FY 14 RANGE	FY 14 AVERAGE	FY 14 MEDIAN
Average Collections per surgeon	$318,357 - $1,170,497	$614,198	$560,703
Average operative cases per surgeon	128 - 525	257	220
Average WRVUs (modifier adjusted) per surgeon	3,683 - 14,436	6,894	6,747
Collections/WRVU	$59 - $129	$94	$91
Average TOTAL Compensation of surgeons including bonus (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$315,000 - $596,512	$415,957	$392,650
Compensation as % of Receipts	44% - 109%	72%	71%
Comp/WRVU	$41 - $91	$64	$58
What is the typical starting base salary that you offer to these hires for someone right out of fellowship?	$250,000 - $407,398	$325,600	$325,000

2014 Survey Results: **Pediatric**

PEDIATRIC	FY 14 RANGE	FY 14 AVERAGE	FY 14 MEDIAN
Average Collections per surgeon	$373,019 - $1,105,182	$645,127	$614,469
Average operative cases per surgeon	106 - 615	241	217
Average WRVUs (modifier adjusted) per surgeon	2,893 - 16,474	7,262	6,887
Collections/WRVU	$67 - $130	$95	$91
Average TOTAL Compensation of surgeons including bonus (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$359,488 - $586,141	$482,448	$473,415
Compensation as % of Receipts	49% - 97%	74%	75%
Comp/WRVU	$33 - $104	$69	$67
What is the typical starting base salary that you offer to these hires for someone right out of fellowship?	$220,000 - $382,000	$311,032	$312,500

2014 Survey Results: **Spine**

SPINE	FY 14 RANGE	FY 14 AVERAGE	FY 14 MEDIAN
Average Collections per surgeon	$570,568 - $1,649,490	$1,193,476	$1,214,506
Average operative cases per surgeon	94 - 394	241	244
Average WRVUs (modifier adjusted) per surgeon	6,131 - 19,483	13,650	13,824
Collections/WRVU	$61 - $114	$89	$89
Average TOTAL Compensation of surgeons including bonus (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$386,947 - $1,111,381	$685,885	$700,000
Compensation as % of Receipts	34% - 88%	58%	54%
Comp/WRVU	$30 - $66	$52	$54
What is the typical starting base salary that you offer to these hires for someone right out of fellowship?	$260,000 - $415,000	$334,353	$337,500

2014 Survey Results: **Sports**

SPORTS	FY 14 RANGE	FY 14 AVERAGE	FY 14 MEDIAN
Average Collections per surgeon	$630,934 - $1,737,435	$1,051,192	$974,351
Average operative cases per surgeon	236 - 622	437	416
Average WRVUs (modifier adjusted) per surgeon	5,803 - 16,335	9,795	9,462
Collections/WRVU	$76 - $171	$110	$102
Average TOTAL Compensation of surgeons including bonus (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$381,900 - $931,713	$582,148	$526,264
Compensation as % of Receipts	31% - 78%	56%	54%
Comp/WRVU	$35 - $91	$61	$59
What is the typical starting base salary that you offer to these hires for someone right out of fellowship?	$175,000 - $370,000	$305,964	$310,000

2014 Survey Results: **Joint Reconstruction**

JOINT RECONSTRUCTION	FY 14 RANGE	FY 14 AVERAGE	FY 14 MEDIAN
Average Collections per surgeon	$569,495 - $1,684,593	$1,011,803	$1,008,763
Average operative cases per surgeon	219 - 721	438	441
Average WRVUs (modifier adjusted) per surgeon	5,074 - 18,617	11,223	11,029
Collections/WRVU	$66 - $126	$91	$90
Average TOTAL Compensation of surgeons including bonus (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$382,607 -$1,302,134	$599,877	$544,090
Compensation as % of Receipts	42% - 83%	61%	60%
Comp/WRVU	$36 - $85	$55	$51
What is the typical starting base salary that you offer to these hires for someone right out of fellowship?	$220,000 - $407,399	$324,025	$317,500

2014 Survey Results: **Trauma**

TRAUMA	FY 14 RANGE	FY 14 AVERAGE	FY 14 MEDIAN
Average Collections per surgeon	$488,818 - $1,470,540	$844,887	$789,017
Average operative cases per surgeon	228 - 753	448	455
Average WRVUs (modifier adjusted) per surgeon	5,787 - 12,732	9,448	9,379
Collections/WRVU	$55 - $147	$89	$86
Average TOTAL Compensation of surgeons including bonus (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$332,384 - $734,004	$542,674	$556,315
Compensation as % of Receipts	37% - 112%	68%	69%
Comp/WRVU	$38 - $89	$59	$58
What is the typical starting base salary that you offer to these hires for someone right out of fellowship?	$220,000 - $396,289	$313,753	$310,000

2014 Survey Results: **Non-Ortho Surgeon Faculty & Midlevel**

NON-ORTHO SURGEON FACULTY & MIDLEVEL	FY 14 AVERAGE	FY 14 MEDIAN
PM&R		
How many PM&R do you have?	3	3
Average Collections per PM&R	$567,503	$553,667
Average WRVUs per PM&R	5,744	5,798
Average TOTAL COMPENSATION per PM&R	$274,847	$245,601
PODIATRISTS		
How many PODIATRISTS do you have?	2	2
Average Collections per PODIATRIST	$325,501	$316,504
Average WRVUs per PODIATRIST	4,166	4,523
Average TOTAL COMPENSATION per PODIATRIST	$154,241	$160,000

2014 Survey Results: **Non-Ortho Surgeon Faculty & Midlevel (continued)**

NON-ORTHO SURGEON FACULTY & MIDLEVEL	FY 14 AVERAGE	FY 14 MEDIAN
PRIMARY CARE DOCTORS/INTERNISTS		
How many PRIMARY CARE DOCTORS/INTERNISTS do you have?	2	2
Average Collections per PRIMARY CARE DOCTOR/INTERNIST	$471,017	$342,249
Average WRVUs per PRIMARY CARE DOCTOR/INTERNIST	4,402	4,875
Average TOTAL COMPNESATION per PRIMARY CARE DOCTOR/ INTERNIST	$225,803	$225,000
MIDLEVELS (PA OR NP)		
How many MIDLEVELS (PA OR NP) do you have?	12	10
Average Collections per MIDLEVEL	$125,755	$126,196
Average WRVUs per MIDLEVEL	1,478	1,441
Average TOTAL COMPENSATION per MIDLEVEL	$107,073	$98,979

2014 AOC Annual Benchmark Survey

Beyond the raw data, a total of 31 Departments provided responses to various questions associated with their programmatic characteristics and definitions.

2014 AOC Annual Benchmark Survey

Regarding CFTE)"clinical full-time equivalent"), the most commonly used definitions center around how much time you spend in a billing capacity. Many academic Orthopaedic Departments define a "full time" CFTE as someone who is 80% clinical. Which of the definitions below best describes how your Department defines a CLINICAL full time equivalent?

Answer Choices	Responses	
A person who spends 80% of their time in clinical functions (ie works 4 full days per week in clinic and/or OR in total)	**58.06%**	**18**
A person who spends 85% of their time in clinical functions (ie works 4 full days per week in clinic and/or OR in total plus some occassional work obn a 5th day	**12.90%**	**4**
A person who spends 100% of their time doing clinical work	**6.45%**	**2**
Other	**22.58%**	**7**
Total		**31**

Other (please specify)
90%
We look at a typical month, listing all of the responsibilities and then calculate the clinical portion.
90% cFTE unless funding received to buy time away from Clinical duties
We are looking at a definition based on percent of compensation fuding. ie. if 100% of compensation is from clinical activity, then faculty would be 1.00 of 100% CFTE.
95% clinical
Spends 90% of their time in clinical work.
The eternally challenging question! In completing a UHC survey this year we are using .9 for a "full-time" faculty clinician.

2014 AOC Annual Benchmark Survey

What type of EMR system do you use?

Answer Choices	Responses	
Epic	**80.65%**	**25**
Cerner	**6.45%**	**2**
Nextgen	**3.23%**	**1**
Allscripts	**6.45%**	**2**
None right now	**0.00%**	**0**
Other	**3.23%**	**1**
Total		**31**

Other (please specify)
eClinicalWorks

2014 AOC Annual Benchmark Survey

If you have an EMR, how many years have you now had this system in place?

Answer Choices	Responses	
1 year	**9.68%**	**3**
2 years	**22.58%**	**7**
3 years	**19.35%**	**6**
4 years	**12.90%**	**4**
5 years	**6.45%**	**2**
> 5 years	**29.03%**	**9**
Total		**31**

Other (please specify)
2 and 1/2 years
1.5 years

2014 AOC Annual Benchmark Survey

Please select one response from below:

Answer Choices	Responses	
Our Department has a DME program that generates money (profit) for our Department	**32.26%**	**10**
Our Department has a DME program that loses money for our Department	**0.00%**	**0**
Our Department has no financial ties to DME	**67.74%**	**21**
Total		**31**

Which DME company? Please also feel free to comment on this question.
Currently evaluating
We are just starting our DME program and have some barriers with the HMO payers
We lease space to an external DME provider
Don Joy
In the next 6 months we are moving from contract to our facilty running
American Prosthetics
We now outsource to Orthocare after losing money in the DME business.
DJO Global
Synergy

2014 AOC Annual Benchmark Survey

Please select one response from below:

Answer Choices	Responses	
Our Department has ties to XRAY revenue that generates money (profit) for our Department	**41.94%**	**13**
Our Department has ties to XRAY revenue but we ultimately lose money on XRAY (costs are more than revenue)	**0.00%**	**0**
Our Department has no financial ties to XRAY	**58.06%**	**18**
Total		**31**

Please also feel free to comment on this question.
The Health System owns/operates all imaging.
Our pediatric orthopaedic division operates as a SOS 11. The Department ownes all the imaging equipment used in those clinics and retains the revenue.
We have invested in one MRI machine at network location and are opening another clinic with Rad. services.
Our department has a productivity based comp plan that recognizes the entire orthopaedic service line, which includes ortho radiology

2014 AOC Annual Benchmark Survey

Please select one response from below:

Answer Choices	Responses	
Our Department has ties to PT/OT revenue that generates money (profit) for our Department	**9.68%**	**3**
Our Department has ties to PT/OT revenue but we ultimately lose money on PT/OT (costs are more than revenue)	**3.23%**	**1**
Our Department has no financial ties to PT/OT	**87.10%**	**27**
Total		**31**

Please also feel free to comment on this question.
We looked at this in the past, but the PT Dept runs an academic model (one to one, one pt to one PT for one hour). If they could not change to a more clinical model we were not interested.)
The Health System owns/operates all PT/OT.
PT/OT is a Hospital entity separate from our Department.
Our department has a agreement with the hospital that recognizes our ortho PT/OT production
Our Dept oversees the Hospital PT program as part of a service line, but virtually none of the “profit” comes the the Dept

2014 AOC Annual Benchmark Survey

Affiliated Practices in the community for which Your Department receives some revenue

Answer Choices	Responses	
Our Department does not have any affiliated practices.	**77.42%**	**24**
Our Department has affiliated practices (private practice type groups) who are also tied to us and we receive revenue from this arrangement.	**9.68%**	**3**
Our Department has affiliated practices (private practice type groups) who are also tied to us and we do NOT receive revenue from this arrangement	**12.90%**	**4**
Total		**31**

Please also feel free to comment on this question.
We do have contracts for professional services at external sites that do provide revenue
All outreach currently are either under being a contractor service are we own physicians
Affiliated with another hospital, Department gets lump sum annual dollars for affiliation.

2014 AOC Annual Benchmark Survey

Specific to clinical fellows, please select the sentence below that best describes how the bulk of your fellows are funded.

Answer Choices	Responses	
They are primarily funded by industry (pharma/device/Omega)	**6.45%**	**2**
They are billing fellows and pay for themselves via receipts they generate	**22.58%**	**7**
The hospital funds the fellows	**41.94%**	**13**
We do not have fellows	**9.68%**	**3**
Other	**19.35%**	**6**
Total		**31**

Other (please specify)
all of the above options
We have both hospital funded and billing fellows
Our only fellows at the moment are part of a rotation via Mississippi Sports medicine and Orthopaedics in Jackson
Our hand fellows and spine fellows are supported by their billing efforts, but the sports fellows are supported by industry
we also have ACGME Fellows that are funded by industry and/or other grants
we have some that pay for themselves and others that the hospital pays for
Combination of industry grants and self generated clinical receipts.
half of our ACGME Fellows are funded by hospital other half funded by divisions
the majority of our fellowship programs are non acgme fellowships
Combination of 1,2, and 3
We have one non ACGME billing fellow supported by the dept
We have a split: some pay for themselves and some are paid by the hospital
4 are hospital funded, 1 Dept funded (not in an ACGME approved program)

2014 AOC Annual Benchmark Survey

Specific to Physician Assistants, please select the sentence below that best describes how the bulk of your PAs are funded.

Answer Choices	Responses	
The faculty member who "owns" them is responsible for funding them, the PA generates receipts which defrays from costs to faculty member.	**22.58%**	**7**
The PAs work for the Department and are funded via the Department, and the PA generates receipts which defray from costs.	**51.61%**	**16**
We do not employ PAs	**3.23%**	**1**
Other	**22.58%**	**7**
Total		**31**

Other (please specify)
PAs are funded via their receipts but any shortfall is covered by a support agreement with our Hospital.
We have one PA who is supported by funds from the hospital
We used to receive the reve and costs for PA's in the dept; with the new Funds Flow Model we are currently under, the PA's are now paid by the Med Ctr
However, the faculty member who "owns" them is also responsible if Hospital Support (50%) and PA generated receits are not sufficient to cover the PA costs.
we are moving towards having a PA/APN department service op
Combination of 1 and 2
Our comp plan allows for the department to pay for 0.5 FTE mid-level. anything above that, the provider is responsible for.
The health system pays for the majority of the costs, but some are offset by a faculty member or their own receipts.
Some generate revenue but not all. Underwritten in funds flow.
In our comp model, the individual and group benefit from PA revenue, so the cost is allocated 50% to the supervising MD and 50% to group shared overhead.

2014 AOC Annual Benchmark Survey

Some Departments are on a funds flow model with their health systems or hospitals where there is support tied to $/WRVU that flow to the Department. If you are on such an arrangement, please select from below to describe your situation.

Answer Choices	Responses	
We receive a budgeted amount of money based on projected $/WRVU and the total amount we receive per WRVU is FIXED based on that.	**22.58%**	**5**
We receive a budgeted amount of money based on $/WRVU and the total amount is later adjusted based on what happens with our actual collections (if collections are strong, the $/WRVU could be increased as result).	**51.61%**	**3**
Total		**8**

Other (please specify)
hospital profit ish shared with departments based on wrvu, can fluctuate up or down based on hospital results and department productivity
None
Funds flow model is currently in a committee phase, but being looked into
We receive funding based on Medical Center Investments which is not tied to our production
No dcirect correlation between $/WRVU and budget allocation which remains primarily based on P&L subsidization
$/WRVU models are in the near future, but currently in place. VERY INTERESTED IN MORE INFORMATION FROM AOC ON THIS SUBJECT
we are in the process of negotiating a model like this.
we are in the process of negotiating a model like this.
Budget based on revenue targets; bonuses paid to MD's if exceed budget targets.
Support payments from the COM are fixed. The hospital does not tie production to financial support due to increased scrutiny in Florida re: self referral and anti-kickback enforcement

2014 AOC Annual Benchmark Survey

Some Departments are on a funds flow model with their health systems or hospitals where there is support tied to $/WRVU that flow to the Department. If you are on such an arrangement, please select from below to describe your situation.

(CONTINUED)

Other (please specify)
Funds flow is based on medical directorships, fililng negative margin in capacity based services, paying for a % of centralized supports (HR, Marketing, IT, etc) and paying for hospital based APPs who the department employs.
We receive funds flow from our healthcare system, but it is not based on wRVU at all.
We received a fixed annual amount that is re-based every 3 years.
We do not receive any budgetary dollars
Funds flow is not tied to WRVU
NA, at leat as I understand the question - no specific institutional $ that flow to the Dept based on faculty clinical productivity
N/A

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APPENDIX: The Data that follows reflects historicals from prior year report.

Full Time Ortho Surgeon Specific Data Points

Surgical Faculty Specifics					
	FY 09 Average	FY 11 Average	FY 12 Average	FY 13 Average	Trend
Average Collections per surgeon	$754,770	$806,972	$796,470	$848,272	↑
Average WRVUs (modifier adjusted) per surgeon	8,741	9,209	9,317	9,302	
Collections/WRVU	$86	$88	$86	$91	
Average TOTAL Compensation of surgeons including ALL SOURCES OF INCOME including bonus. Please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$428,356	$461,599	$466,393	$517,072	↑
Compensation as % of Receipts	57%	57%	59%	63%	↑
Comp/WRVU	$49	$50	$52	$56	↑
Average starting BASE salary for new hires coming out of fellowship for their first year on your staff (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only)	$268,341	$282,667	$288,732	$302,069	↑
Typical Bonus for a 1st year faculty member who is arriving out of fellowship.	N/A	N/A	$24,638	$22,845	
How many years do you guarantee a salary in your offer letter to the new hires?	N/A	N/A	2	2	
How many total surgeons (including 1st years and Chairman) in your program? (Head count)	16	19	23	23	

31 Programs provided the data tied to above. The rise in "average collections per surgeon" and "average total compensation" are driven by some year over year programmatic increases but also by the inclusion of a number of several new participants with very high productivity departments who also exhibit higher dollar for dollar reimbursements (given their geographic locations). However, what is interesting is the increasing compensation as % of receipts as well as increasing comp/WRVU. This is being triggered largely by increasing funds flow to Departments via collaborations with their hospitals, health systems, and SOMs in co-management agreements and other transfers.

APPENDIX

Full Time Ortho Surgeon Specific Data Points: *Median, Average, Ranges*

Surgical Faculty Specifics			
	FY 13 Median	FY 13 Average	FY 13 Range
Average Collections per surgeon	$836,637	$848,272	$520,781 - $1,421,344
Average WRVUs (modifier adjusted) per surgeon	9,219	9,302	5,805 - 14,189
Collections/WRVU	$91	$91	$64 - $125
Average TOTAL Compensation of surgeons including ALL SOURCES OF INCOME including bonus. Please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary)	$505,478	$517,072	$303,873 - $816,730
Compensation as % of Receipts	61%	63%	*41% - 116%
Comp/WRVU	$55	$56	*$39 - $69
Average starting BASE salary for new hires coming out of fellowship for their first year on your staff (please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only)	$300,000	$302,069	$200,000 - $400,000
Typical Bonus for a 1st year faculty member who is arriving out of fellowship.	$25,000	$22,845	$0 - $100,000
How many years do you guarantee a salary in your offer letter to the new hires?	2	2	1 - 3
Salary Range in your program including bonuses (full time surgeons). Please do not include any employer contributions to retirement or fringe benefits. This datapoint is to be compensation only and should not include the Chairman's salary.			"Lowest reported = $180,000 Highest reported = $1,593,000"
How many total surgeons (including 1st years and Chairman) in your program? (Head count)	22	23	8 - 38

*Keep in mind that the ratio in isolation does not provide context around what enables the department to exist in this way. Specifically, a program that pays out 116% of its receipts or $69/WRVU can not afford to do this unless it has access to other revenues coming in (reserves, $ from hospital, SOM, Health system, co-management agreement, VA, state, etc.)

APPENDIX

Endowments & GME

MIscellaneous			
	FY 13 Median	FY 13 Average	FY 13 Range
Please list the total principal amounts of all ENDOWMENTS in your Department. Please note than an endowment principal is a large chunk of money that you cannot access except for the interest income it generates each year. Examples are endowed professorships. The principal is the amount that generates the interest and what you enter here should NOT include available balances in your endowments.	$4,112,500	$6,346,500	$0 - $24,500,000
How many residents and fellows in total are there in your program?	32	31	8 - 53
How many FTE of residency coordinators (these FTE are not to be confused with your Program Director who is an MD) do you employ to manage above?	1.0	1.4	0.6 - 4.0
Specific to your Program Director, what % of his/her time is protected for serving as GME Program director?	20%	25%	7% - 50%

APPENDIX

External Funds Flows Coming to Departments: *Trends*

External Funds Flow Coming into Your Department					
	FY 09 Average	FY 11 Average	FY 12 Average	FY 13 Average	Trend
Do you receive any revenue from ancillaries? If so, how much per year and for what specific ancillaries?	29% YES	34% YES	41% YES	50% YES	↑
Do you receive any revenue as part of shared profitability with your hospital, health system, or SOM? (i.e. ASC)?	31% YES	38% YES	41% YES	37% YES	
Payment for call coverage? If so, how much?	57% YES	38% YES	56% YES	67% YES	
Does your Chairman receive any kind of support tied to his/her role as Chairman? If yes, please specifiy amount and source.	N/A	66% YES	70% YES	93% YES	↑
Please provide a listing of any medical director type revenue/stipends received in your Department (that are not reported in your entries above).	86% YES	88% YES	85% YES	90% YES	↔
Do you receive any Residency Program Director or Coordinator funding, if so please specify.	N/A	59% YES	81% YES	80% YES	
Do you receive funding for any of your subspecialties beyond what is written above (i.e. Pediatrics, Oncology, Trauma).	N/A	59% YES	59% YES	53% YES	
Do you receive any start up funding for new clinical or research hires?	N/A	78% YES	81% YES	77% YES	↔

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