Considerations for an Outpatient Total Joint Arthroplasty Program
Presenters

Frank Gilbert
Executive Director

Rustin Becker
President & COO

Jen Edmonds
Research Analyst
Proliance Orthopaedics and Sports Medicine
A Service of Proliance Surgeons, Inc.

Proliance Surgeons
- 35 locations in and around Seattle, Washington
- Surgical Specialist Group with services in Orthopedics, General Surgery, ENT, Ophthalmology, and OB/GYN
- 250+ Board Certified Surgeons
- Over 650,000 patient visits and 85,000 surgeries, majority in our own ASC

Proliance Orthopaedics & Sports Medicine
- 3 sites – Bellevue, Redmond and Issaquah
- Owned 4 room ASC, MRI, and 2 PT practice sites
- 2 JV ASCs, one with each competing health system in our area.
- 18 surgeons – full spectrum of ortho services
- Over $22M in practice net collections, 61,000 patient visits and 10,000 surgeries (more than half done in our ASC)
Today’s Learning Objectives

• Clarity around definition of outpatient Total Joint Arthroplasty Program
• Identify the drivers of an outpatient Total Joint Arthroplasty Program
• Recognize the operational considerations and potential challenges of an outpatient Total Joint Arthroplasty Program (TJA)
• Analyze the components of a high-performing outpatient Total Joint Arthroplasty Program
• Evaluate their practice’s capability for implementing an outpatient Total Joint Arthroplasty Program
• Assess whether to add outpatient Total Joint Arthroplasty Program to an existing facility or build a new surgery facility
• Conclusions
Drivers of an Outpatient TJA Program
Patient Demand

- Patients are taking on greater responsibility for their cost of care, making an outpatient procedure more attractive
- Home recovery and a lessened risk of HAI are additional draws for outpatient TJA
  - Home support (ADL) companies are becoming more prevalent and able to assist those with fewer available support resources
- In 2016, estimated about 40 ASCs nationwide were performing same day TJA procedures
- Outpatient TJAs are expected to increase 77% (over next 10 yrs)
- Inpatient volume is expected to increase 3% (over next 10 yrs)
Payer Demand/Bundled Payments

• Medicare has launched a mandatory comprehensive joint replacement bundled care program, pushing providers to lower cost per episode of care

• CMS proposed changes to the inpatient-only list in the 2018 OPPS proposed rule, including the removal of total knee replacement procedures from the list

• Private insurers are beginning to actively support the migration of these procedures to the ASC
Bundled Payments

• Larger, self-insuring companies with physically demanding work processes are driving many orthopedic surgical procedures to the ASC (including joints) through:
  – The creation of narrow networks with providers agreeing to price concessions and quality/outcomes monitoring
  – Bundled pricing that encourage providers in the market to collaborate on service provision under the “fixed” price
Outpatient TJA as Value-Based Care

TKA Cost Breakdown Between Same-Day Discharge and Inpatient Groups
Operational Considerations for Entry
Market Demographics

In the US, roughly 95% of inpatient total lower extremity total joint replacements are without major complication or co-morbidity as a secondary diagnosis.
Market Demographics
By 2027, patients in the 65+ age cohort will account for 70% of all lower extremity total joint replacements (w/o MCC) in the U.S. This is up from 64% in 2017.
Market Demographics

Estimated 30% of total hip and knee replacements could move to an ambulatory setting over the next 10 years. Some believe this number could be much higher. The below scenarios showcase the conservative and more aggressive forecasts for these services.

US Total Joint Replacement of Lower Extremity Cases w/o MCC
Ambulatory Case Projections

- **15%/30% Scenario**
- **30%/45% Scenario**
Operational Considerations

<table>
<thead>
<tr>
<th></th>
<th>Traditional Orthopedic ASC Case</th>
<th>Ambulatory Total Joints (Hips and Knees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avg Mins in Pre-Op</td>
<td>60</td>
<td>90</td>
</tr>
<tr>
<td>Avg Mins in OR</td>
<td>70</td>
<td>90</td>
</tr>
<tr>
<td>Avg Mins in PACU1</td>
<td>45</td>
<td>70</td>
</tr>
<tr>
<td>Avg Mins in PACU2</td>
<td>70</td>
<td>500</td>
</tr>
</tbody>
</table>

• ASC’s planning to offer total joint replacements will likely need to offer extended hours to account for the extended recovery time of these patients
  – Total Joint cases should be completed around noon for centers wanting to close by 8pm
  – Cross-trained, flex positions could be considered to ensure proper staffing of recovering total joint patients
  – Early morning hours will also be necessary to account for extended pre-op time

• To maximize utilization and profitability, consider backfilling OR time with quick cases requiring minimal recovery (ie Ophthalmology, Pain, etc). Must have support space to accommodate volume
Competitive Landscape

• Potential competitor reactions to the launch of an outpatient program should be considered on a market-specific basis

• Will the program be a differentiator?

• Regulatory concerns – Would CON be an issue?

• Partnerships/Joint venture with physicians can mitigate competitive risk
  – Partnerships between physicians and health systems can mitigate competitive risk
Securing Physician Buy-In

- Physicians will need to contribute time that could be spent in other areas of the practice in order to develop the program.
- Their buy-in is crucial, so organizations that pursue this should provide evidence of patient outcomes, operational planning, and facilitating them in agreeable scheduling.
- Costs of cases not taken must be worth sacrificing.
- Agreement on who is providing what services and resources is critical.
Complexities in Cost Reduction

• Short/outpatient stays for total joint arthroplasty are associated with lower costs; there are a few caveats:
  – Programs must be established with critical pathways
  – Patient screening and pain management practices are imperative to lowering costs
    – Implants costs must be managed
  – Care management is crucial. Must reduce need for hospital admit post-discharge and reduce the risk of needing revisions in a few years

• Patient costs must also be well understood:
  – Copays for all necessary visits and care can lower the cost savings
  – Patient costs associated with recovery may also be higher than anticipated
  – Free standing ASC are more sensitive to cash flows so deposits and payment plans are more critical

• Waste in areas like instrument processing, equipment and training can quickly add up to impact cost savings on both sides
Overnight Stays

• Overnight stays can quickly make outpatient TJA complex from both cost and operational standpoints

• This needs to be considered whether the facility can and will allow for them or not

• A good hospital partner is needed to accommodate transfers if the ASC won’t allow overnights
  – Use transfers VERY judiciously!

• There are additional (often high) costs such as additional, more expensive space, dietary, security, and staffing in accommodating overnight stays
  – Challenging to find staffing, especially nursing, willing to work nights in an ASC
  – Physician responsibility needs to be established for covering overnight needs (e.g. is the surgeon to be called for problems or the anesthesiologist?)
The High-Performing TJA program
Patient Screening

- Patient selection is the most important factor in performing a successful ASC TJA, BUT...
  - Patient expectation is the most important predictor of final discharge disposition.
- Patient anxiety and capacity for supported home recovery must be considered, unlike in inpatient procedures.
- Dieticians, PCPs, psychologists, and cardiologists are additional providers that should be consulted in risk assessments.
- Data collection and assessment should be utilized to continually improve the program and outcomes.

Patient selection, patient selection, patient selection!!
Anesthesia and Pain Management Strategy

• Biggest factors driving inpatient stays for joints are:
  – Comorbidities
  – Pain control regimen that can’t (easily) be self-administered at home
  – Uncontrolled nausea

• Careful patient selection will address the comorbidity issue

• Anesthesiologists skilled in outpatient anesthesia and the latest pain management techniques can take care of the rest.
  – Multimodal pain management incorporating the use of nerve blocks

• Management of patient expectations through pre-operative education is also critical.
Patient Education

• Clinical navigators should work to educate patients via multiple communication channels.
  – Physician owned ASCs typically don’t employ these resources
  – Mostly handled through MA or surgery scheduling staff
  – For a robust ASC TJA program, a coordinator position is worth considering

• Patients must be aware of the at home care needs they will have, including any options for use of mobile technology

• Caretakers will need to be included. They are vital to successful outpatient care and need to be engaged
Staffing and Scheduling

• Proper staffing types and levels to ensure fast turnovers of operating rooms is imperative to achieve a high utilization rate
  – Adjacencies/connectivity between pre- and post-op spaces can allow for flex staffing to insure ratios are met efficiently as volumes between departments ebb and flow

• Timing and ordering for different types of cases is important
  – Mornings will be the typical times for TJA procedures to allow for increased recovery time
  – Complementary procedures will need to be scheduled so as not to compete for resources needed to TJA (operating and recovery space, equipment, supplies, sterile processing capacity, etc.)
  – Be careful to avoid backups in recovery spaces!
Staffing and Scheduling... continued

• Fridays are typically not used for scheduling, because next day follow up is typically needed.

• There will be more complex training needs with an outpatient TJA program.
  – TJA procedures are longer and more complex.
  – OR charge nurses and surgical assist staffing will need additional training.
Clinical Partnerships

• Services not currently existing within a practice or ASC must be managed through strong partnerships:
  – Physician-managed anesthesiology
  – Care management
  – Skilled-Nursing Facilities (bundle payment busters!)
  – Home health

• Technology platforms should be evaluated to facilitate training and operational management.
Care Management Options

• Rigorous medical screening and optimization, along with multi-specialty care programs to control pain, limit blood loss, minimize adverse reactions to anesthesia, and mobilize more quickly, help patients recover from surgery more quickly and avoid unnecessary medical interventions.

• Choosing the wrong patient can result in a “bundle buster.”

• Again, patient selection is the key to success.
  – Choosing the wrong patient can have significant negative repercussions.....
    – Bundle busters
    – Transfer issues
    – Licensure impacts
Partnerships
Partnerships
Joint Ventures, anyone?

• Partnerships between physicians and hospitals can help create a successful free standing ASC-based TJA program.... but, they must be done correctly!

• Communication is key.
Get it in writing.... Contracts and agreements are essential and must address:
– Program management
– Governance
– Ownership percentages
– Revenue and cost sharing
– Voting rights

• Health systems used to only be capital infusers, now they can be fully participating, revenue generating partners through:
– Ownership of primary care practices and influence over referrals
– Employed surgeons operating in the ASC
Existing Facility or New Build Options
Considerations for New Facilities

• Location, cost, timing, etc. must be considered.
• Operating Rooms need to be closer to hospital size for extra equipment.
• Increased space and equipment for sterile processing and clean supply storage
  – TJA requires more supplies and instrumentation that must be processed quickly to ensure quick room turnovers.
• More (and larger) private recovery spaces than a typical current ASC, especially for overnight stays.
  – Some type of entertainment is helpful.
  – More comfortable recovery bedding should be provided.
  – Need capability for patients to shower.
• Supporting waiting family/caregivers with a family hub or retail or café partnership.
Considerations for New Facilities... continued

• Easy transport of the patient in and out of the facility and covered pickup
  – Critical for ortho procedures, in general

• The aesthetic may want to be more of a boutique feel.

• Proximity to a hospital campus.
  – Easier for physicians to take cases later in the day at the hospital.
  – Patient and surgeons more comfortable doing more complicated cases with a
    hospital is nearby.

• Proximity to lodging for family/caregivers for overnight stays
  – Allows “marketing” services to patients out of the area.
Determinants for Existing Facility Modification

• Existing facilities can be challenging in terms of appropriate space/size of operating rooms, supporting care, and patient care.
• Existing ORs may be too small and not “expandable”
  – An additional room might be needed to do TJA.
• The ORs also need Nitrogen lines run into them.
• May need to create new or modified admit and recovery spaces
  – Turnover and recovery times are longer for prepping for the next case, can back up admit rooms and recovery.
Conclusions
Takeaways for TJA Program Success

• First decide whether it makes sense. Things to consider include.....
  – Reimbursements are greater, but so are case costs.
    – Lower cost, lower reimbursing procedures could be displaced.
    – In aggregate, they might be equal or better profitability?
  – Facility renovation or new construction costs might be prohibitive.
  – Location might be a challenge.
• Connect with providers experienced in outpatient TJA to glean lessons learned
• Identify a champion who can gather support
• Pace growth to ensure expertise
• In spite of and because of complexities, outpatient TJA is something that ASCs and health systems must consider and cannot be adopted rapidly.
Presenters

Frank Gilbert
Executive Director

Rustin Becker
President & COO

Jen Edmonds
Research Analyst

For more information or questions please email: info@erdman.com