Strategies for Achieving Orthopedic Service Line Success

By Stacey Lang

The orthopedic service line has long been relied upon to bring stability and positive margins to an otherwise volatile mix of services offered by most hospitals—community and tertiary organizations alike. Orthopedics has traditionally been a “low maintenance” service line—a consistent, uncomplicated performer with minimal need for administrative oversight, despite its high-cost technology and equipment and complex patient needs.

Over the past 20 years, however, the lifestyle expectations of aging baby boomers, demands of surgeons, and marked increases in innovation by orthopedic companies across the nation have dramatically altered this once placid landscape. This changing landscape brings with it opportunity for growth across the entire orthopedic continuum.

To ensure a financially viable orthopedic service line, hospital and health system leaders, including those in healthcare finance, should act definitively and quickly to control costs, improve efficiency, and perhaps most important, establish strong and trusting relationships with their orthopedic surgeons. Healthcare leaders should employ a number of strategies to support orthopedic success.

Develop Innovative Partnerships

The need for collaboration, trust, and partnership between hospitals and orthopedic surgeons as they work to provide high-quality, patient-focused care remains high. Yet managing the surgeon/vendor dynamic can be distinctly challenging, even for the most experienced administrator.

Relationships between case representatives and orthopedic surgeons in the operating room (OR) are forged during training, as is surgeons’ comfort level with a particular manufacturer of implants, and once a strong level of trust has been developed, these relationships are hard to let go. Vendor case representatives often participate in clinical discussions well before patients present to the OR. In many instances, the case representative will speak with the surgeon in advance of a scheduled case, reviewing films and assisting with implant selection and case planning. This individual often is present in the OR to ensure that each of the necessary components utilized during a surgery are in place, properly prepped, and organized in a way that is consistent with surgeon expectations. Case representatives also play an integral role intraoperatively by providing advice and technical assistance during difficult cases. A skilled case rep can become, at some organizations, the surgeon’s “right-hand man” (or woman), filling a service gap that may exist due to a lack of consistency in surgical teams or a lack of experience among assigned OR staff.

The close working relationship between orthopedic surgeons and vendor representatives can lead to the introduction of new and often more expensive technologies and products in the hospital OR. Over time, influenced by this relationship, surgeons may lobby the hospital for the purchase of new—and often more expensive—products recommended by the vendor. When hospitals and orthopedic surgeons are not aligned in containing implant costs, the surgeon-hospital relationship can become contentious as surgeons come to view the hospital as the naysayer and the vendor as the provider of consistency and support.

Orthopedic service line leaders would be wise to develop and enforce expectations around contracting and vendor behavior. The OR should be declared a “sales free zone” to the greatest extent possible. Often, the area around the scrub sink can be fertile ground for the introduction of “must-have” products to surgeons. Such behavior should not be tolerated. Likewise, case reps should not be permitted to occupy the surgeon’s lounge; rather, they should be present only for the actual assigned case.

The opportunities to effect change via improved vendor contracts are well known. Whether via cap pricing, value analysis teams, or preferred vendor relationships, measures that control the introduction of new technology in the OR should be included in any agreement.

For such an effort to be successful, it is essential that the goals of all involved—surgeons, vendors, and the hospital—be aligned so that benefits can be realized by all parties. Service line administrators should be mindful of the friction that may result when hospital leaders attempt to alter or even disrupt these relationships to reduce implant costs.

Although unfettered access to surgeons by vendor case representatives on a daily basis does pose risks, there is no question that the presence of such representatives in the OR fills a very real need in many hospitals. Cost-containment efforts of the past decade have led to employment of lean OR staffs with multiple competing priorities. It is simply not possible for some hospitals to provide the same level of support to orthopedic surgeons as vendor case representatives provide without a significant investment in additional staff and associated training that they may not be able to afford.

Devise an Implant Selection Strategy

Orthopedic implant device costs for procedures such as total joint replacements constitute the majority of the total cost of care for these cases, and the demand for implants is growing at a rapid pace as the number of orthopedic surgeries increases. Hospitals pay different prices for the same implants according to their negotiated rate. To ensure better pricing, hospitals should devise a sound implant selection strategy that promotes surgeon input and collaboration, such as through the formation of an orthopedic implant selection committee that includes representation from key orthopedic surgeons.

Ultimately, recommendations from the implant selection committee could include eliminating a surgeon’s preferred vendor. To encourage a shift in loyalty, the benefits of such a change must be real and of mutual benefit to the hospital as well as to the surgeon(s). Any surgeon directly affected must be involved in the decision if he or she is to support such a process change.

Surgeons often will argue that removing a preferred vendor from the list of approved options will affect quality of care within the service line. This perception cannot be ignored; however, a surgeon who makes such a claim should be required to validate it through peer corroboration, independent documentation, or other means. If the argument cannot be justified, additional conversations should take place based upon factual, rather than anecdotal, information.
Physicians also should be given incentives to collaborate to promote the alignment of goals. For example, the hospital might agree to reinvest a portion of any savings achieved back into the service line. At one hospital, employing these strategies resulted in a reduction in vendors from thirteen to three over a six-month period.

Hospitals with multiple surgeons that lack established new product and technology management processes are especially challenged. It is not uncommon for a robust orthopedic service line to contract with 10 to 15 implant suppliers or more. Although the negative financial implications associated with this practice are commonly recognized, the very real operational risks are perhaps less readily apparent. Inventory control, storage space for necessary supplies, and the management of consigned products become exponentially more difficult when dealing with multiple vendors and implants that can exceed tens of thousands of dollars in cost. Implementing process change to gain some control over the costs associated with orthopedic implants is essential.

Meanwhile, the role of hospital CFOs and other senior healthcare finance leaders has been forced to evolve. Proactive involvement of the CFO or other finance leader during the vendor and implant selection process is now the norm. Indeed, a healthcare finance leader should participate on the implant selection committee, along with at least one orthopedic surgeon, the service line administrator, a contracting/vendor relations appointee, and other representatives as appropriate.

When devising an implant selection strategy, external expertise should be employed only after appropriate vetting. In the past, implant manufacturers were free to offer any number of “support programs” to physician groups and hospitals alike. Recent decisions by the U.S. Department of Justice, and increased awareness among hospital compliance officers, have largely restricted the scope of materials, education, and program management tools that can be provided by implant manufacturers. Several orthopedic implant manufacturers have changed their business practices in response to this shifting environment—for example, by forming (or even purchasing) separate companies functioning under the silent umbrella of the manufacturer to provide consultative services around orthopedic program efficiency, process improvement, and cost containment.

Because implant prices are among the main drivers of cost within the orthopedic service line and the main driver of revenue for the orthopedic vendor, the probability of success in cost reduction or control under the direction of the vendor is unlikely. For this reason, the use of consultants who are not constrained by vendor relationships, who possess clinical orthopedic experience, and who are skilled in facilitating physician collaboration and alignment is recommended. Involvement of a qualified expert third party can serve to diffuse any dissension during the difficult conversations between surgeons and hospital leaders that are apt to take place.

**Establish a Forum for Open Communication**

Too often, interactions between hospital administrators and orthopedic surgeons are sporadic and contentious, occurring largely in response to issues rather than proactively. Success depends on the creation of a forum for meaningful dialogue, in which the free exchange of ideas and concerns is strongly encouraged. This level of communication can be achieved through the formation of an orthopedic steering committee. The results of any recommended actions or process changes should be timely and measureable. The ability to demonstrate responsiveness to issues raised during such meetings will help to establish trust and build the bank of good will from which to draw when addressing difficult issues around vendor selection.

In short, today’s C-suite executives must not only “walk the walk,” but also “talk the talk.” Particularly in the absence of a clinical background, hospital administrators should educate themselves on the clinical components, trends, technology, and imaging advances related to orthopedics. It is imperative that those responsible for the management of this service line be conversant in and knowledgeable about all aspects of care for orthopedic patients. Taking the time to become educated will help immeasurably in discerning physician needs versus wants.

**Build a Bundled Payment Structure**

The orthopedic service line is one that is ripe for implementing a bundled payment strategy mostly due to its high-volume procedures, elective patient nature, and wide continuum-of-care services. Currently, an increasing number of hospitals are adopting some version of a bundled payment initiative. Bundled payments can help position hospitals for value-based business models and support enhanced care coordination, a more efficient and patient-centered focus, improved quality, enriched value, and reduced costs.

Hospitals should take the following steps in building bundled payments around the orthopedic service line.

**Determine which episodes of care should be the focus of bundled payment.** Hospitals should first decide which procedures to include (e.g., a single procedure only or the entire orthopedic service line offering). They then should determine whether the episode should include preoperative diagnostics through follow-up care or just the inpatient surgical procedure itself. For instance, hospitals can bundle payments from a particular payer for all inpatient major joint procedure cases performed (e.g., MS-DRGs 461, 462, 466-470, 483, 484, and 506-508). If a hospital contracts with CMS in its Bundled Payment for Care Improvement (BPCI) initiative, the hospital’s chosen convenor (a general contractor that plays the role of insurer and manager of the program) will dictate the episode of care setting.

**Build and maintain friendly working relationships with orthopedic physicians and all physicians involved in the episode of care.** Involving physicians in the planning process will ensure they are on board with the program and will encourage physician advocacy once the program is implemented. Physician education sessions also support transparency and build physician trust.

**Limit physician preference for expensive device implants.** Methods should be in place for enforcing agreed-upon guidelines, such as through the implant selection committee.

**Employ the use of sophisticated data systems.** Data is essential in preparing for and operationalizing bundled payment programs. Robust cost-accounting systems should not only be present, but also be capable of supporting detailed reporting and analysis.

**Perform a detailed analysis of cost savings opportunities.** The hospital should ascertain how much it must reduce costs to make up for the decreased negotiated lump sum payment. Areas to begin focus should include opportunities to reduce length of stay, streamline post-procedure recovery, address procedure start-time delays, and enhance staff recruitment and retention to minimize turnover costs.

**Prepare for payer negotiations.** It is imperative to understand—in great detail—key risk areas (e.g., postoperative complications) and to know which patients are most likely to have the best procedural outcomes. This information should be used for leverage in risk-adjusting payments. Lessons learned from previous demonstration projects and pilots can be used to assist in preparations.

**Determine the payment distribution process.** Readily available data detailing physician utilization and case involvement will become critical in outlining how to pay everyone involved in the care episode. Often, one check will be paid, usually to the hospital, who then must distribute payments accordingly. Thus, transparency throughout this
process will be critical. Agreements will need to be established with all expected providers of care.

**Plan to discuss the new process with patients.** A detailed communication plan will be required to educate physicians and staff on how to prepare patients for the new bundled payment program and explain to them how it will work. One huge bill can be daunting and is likely to alarm patients; therefore, it is important to explain that patients are paying the same amount under bundled payment and that the process simplifies things for them by eliminating the need to keep track of multiple bills.

**Differentiate from the Competition**

Care of orthopedic patients, when delivered properly, requires a unique combination of resources with respect to personnel, facility investments, patient amenities, and staff education. The need for an additional investment to differentiate an orthopedic surgery program is particularly challenging when measured against tightening criteria for payment and the move toward accountable care organizations (ACOs) and bundled payment arrangements.

In light of these financial challenges, many organizations mistakenly focus solely on cost control rather than also on providing the resources necessary to ensure an exceptional patient experience. Orthopedic care is predominantly elective, and a substantial percentage of patients self-refer. Furthermore, the care delivered essentially transforms a “well” person into a “sick” patient, at least for a short time. The treatment often results in increased pain, decreased mobility, and increased dependence during the immediate post-operative period. For these reasons, approaching consumers as customers as opposed to patients via an exceptional “concierge” care model can help to distinguish a program and provide a distinctive experience. Enacting a proactive versus reactive approach to patient concerns regarding facility considerations, patient amenities, education, and adaptive requirements is the best way to define and improve the patient experience.

Adoption of this proven care model not only differentiates an organization among competitors, but also elevates the program’s clinical reputation. Positive recognition by the public within a defined market can be a powerful driver of volume. Resulting increases in volume—often 10 percent or greater in the first year following adoption—will improve bottom line profitability in any organization willing to invest the necessary time and effort.

The purpose of discussions around the continuum of care or patient experience should not simply be to find ways to package existing care delivery models in a new way. With orthopedic care, the key to success is in first broadening the definition of the organization’s orthopedic care continuum from the traditional episode, consisting of only a surgical procedure, to the entire experience, from pre-op to any resulting follow-up care. The initial step is to recognize each opportunity to affect patient choice and potentially improve patient satisfaction along the entire care continuum, which requires the adoption of a “home-to-home” approach to patient care.

Understanding all of the access points for patients to enter an orthopedic care continuum is important. Commonly overlooked areas include places such as community outreach events. Sports screenings for the local high-school football team may not result in direct surgical revenue, but they can elevate a program’s visibility and provide exposure to available expertise and diagnostic or preventive services to mothers and fathers, who are the main decision makers for healthcare choices for any family. Injury prevention programs for local employers or for community pre-hospital providers likewise provide an excellent opportunity to showcase capabilities and to differentiate the way care is delivered.

Ultimately, it is crucial to truly understand all revenue streams associated with orthopedic patients and work to ensure they are retained in the system. Although the value of surgical cases and associated radiology revenue is recognized, all too often, other potential sources of revenue, such as pre- and postoperative therapies, pain medicine, home care, and durable medical equipment, are not at the forefront of retention strategies within hospitals and health systems. Similarly, the value of cross-referrals among related physician specialties, like podiatry and rheumatology, should be recognized, cultivated, and tracked to achieve maximum capture.

Engaging in “secret shopper” activities enables hospital leaders to experience first-hand the challenges that patients may have in entering the orthopedic care continuum and can provide an invaluable look into the orthopedic care continuum through the eyes of the potential patient. Difficulty scheduling for physician consultation or for diagnostic testing or rehab therapies, often the front door for an orthopedic patient, may mean lost opportunities to impress—and these missed opportunities are not often tracked in many organizations.

Hospitals also should consider the number of outpatient cases that are being performed in ambulatory surgery settings outside the organization. Freestanding surgery centers not affiliated with hospitals will remain strong competitors for outpatient orthopedic care because they will continue to capture growing market volume as patients’ preferences change.

**Sound Approaches for Orthopedic Service Line Health**

The potential for hospitals, orthopedic surgeons, and vendors to collaborate in improving value has never been greater. The complexities of healthcare reform provisions related to ACOs, quality performance measures, and bundled payment programs will add yet another dimension of complexity to the orthopedic service line. These key components of reform require a previously unrecognized level of physician and hospital collaboration to ensure mutual financial success. Carefully implementing these strategies will build a foundation for partnership, trust, and improved financial performance—and ultimately, a better patient experience.

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