Outpatient Total Joint Arthroplasty

Roadblocks and Pitfalls

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The knees are the

first thing to go

Disclaimer / Conflict of Interest

None

Credits

The Far Side – Larson

Calvin and Hobbes – Watterson

SNL

Bizarro – Piraro

Bloom County - Breathed

The New Yorker

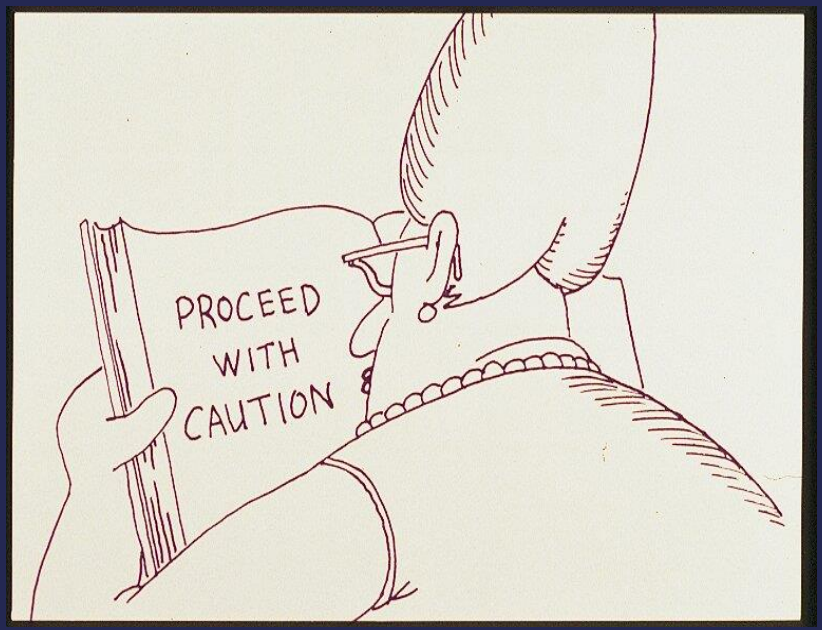
Becker – Misc. sources

Better to be aware (of potential problems)
in advance
than surprised later

It IS the right thing to do
if done properly

- Cost effective – overall and for patients
- High Quality - Outcomes as good OR BETTER than hospital based
- More convenient
- High patient satisfaction
- Even CMS likes the idea

- YOU can (should) make money
- BUT >>>>>>>>>>>>>>>>>>



Why add Total Joints?

Everyone else is doing it in NOT the answer

Big Picture Questions - Honest Answers

- How does it fit your vision – *if at all*
- Do you REALLY have a market for ASC OP TJA
- Do you have buy in and support from key players

- It is OK to say *NO*

Error #1

How do you (and physicians) see OP TJA in your case mix

Is everyone on the same page?

- Occasional
  - A few on occasion – RED FLAG
  - A few to get comfortable and grow with experience
- Significant Volume
- Primary Volume – a center for OP arthroplasty

- Which Total Joints – *may not be what you expect*

Error #1

How do you see them in your case mix LONG TERM?

- It is not the same as adding a new arthroscopy or ENT case (low risk / consistent patient volume)

- Defines return on investment (time and $)
- Determines efficiencies
- Dictates comfort levels
- Impacts case costing
- Is essential in reimbursement negotiations

Error #2

Have you done your homework

- Provider Profile - Quality AND Efficiency
  - Readmission rate
  - Complication rate
  - Number of OP joints (at hospital)
  - Potential Volume (patient clinical profiles)
  - Not everyone who wants to do OP TJA should
- Payer profile
  - Do they understand
  - Are they interested
  - How will this impact current contracts
  - Potential volume (patient insurance profiles)

Courting Payers and Patients

"All things being equal"

They are NOT

Be prepared to make your case

Buy In

YOU must approach THEM

Insurance

Employers

Patients

Commercial Payer Buy In

- You MUST Know your costs
  - Don’t waste your time or theirs if you do not know your bottom line
  - “Tell us what you will accept” is not negotiating
  - Be prepared to fight for carve outs
  - Be prepared to walk away
  - Be willing to come back to discussions

Commercial Payer Buy In

- You MUST be able to provide quality metrics
  - Facility
  - Surgeon
  - Patient satisfaction
  - Have a plan in place for long term monitoring AND be able to present

Commercial Payer Buy In

- You MUST market vs. your competitors
  - ASCs cost less
  - ASCs are more adaptable to patient needs – explain how this is even more applicable to TJA
  - Be prepared to break a few eggs – this is “just business”

Error #3

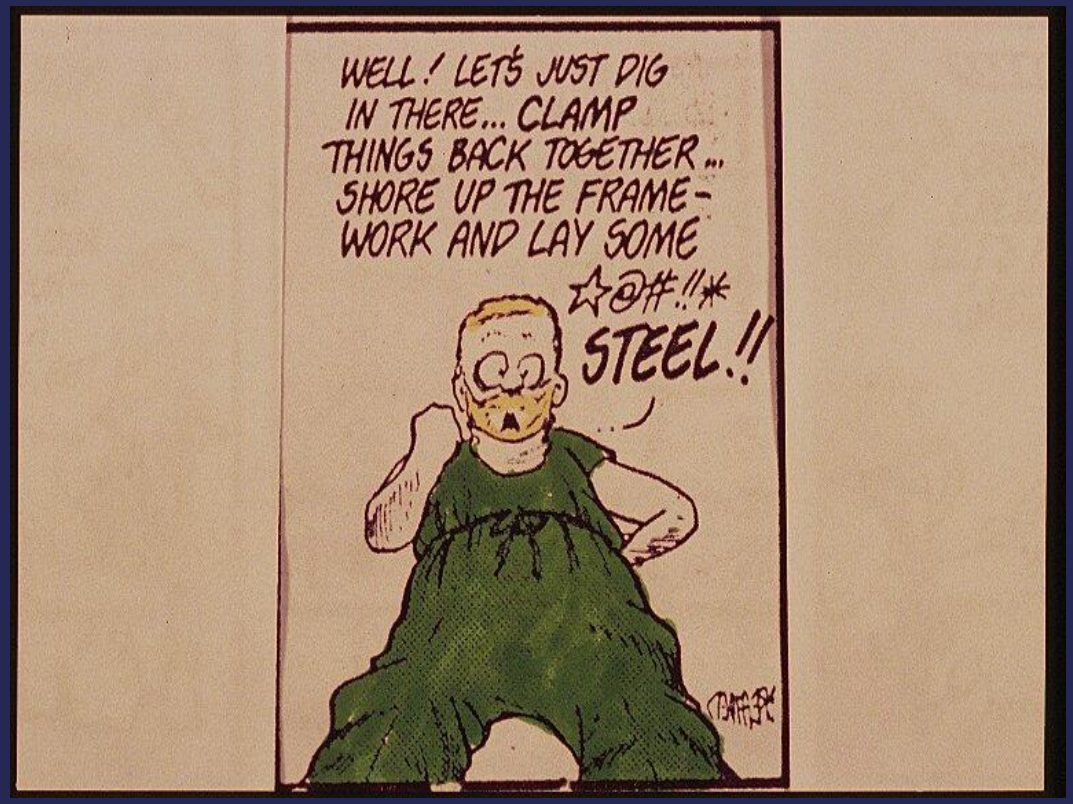
Hospital based mentality vs OP efficiency

- Planning is everything – scheduling, education, pre op and post op management - dictate success
  - "Touches" – shifts from facility to provider
  - Ownership – define and accept (new) role(s)
  - Less room for "error"
- Execution – what happens in the OR should be the simple part
- Safety net – "Just keep them overnight" – ***NOT an option***

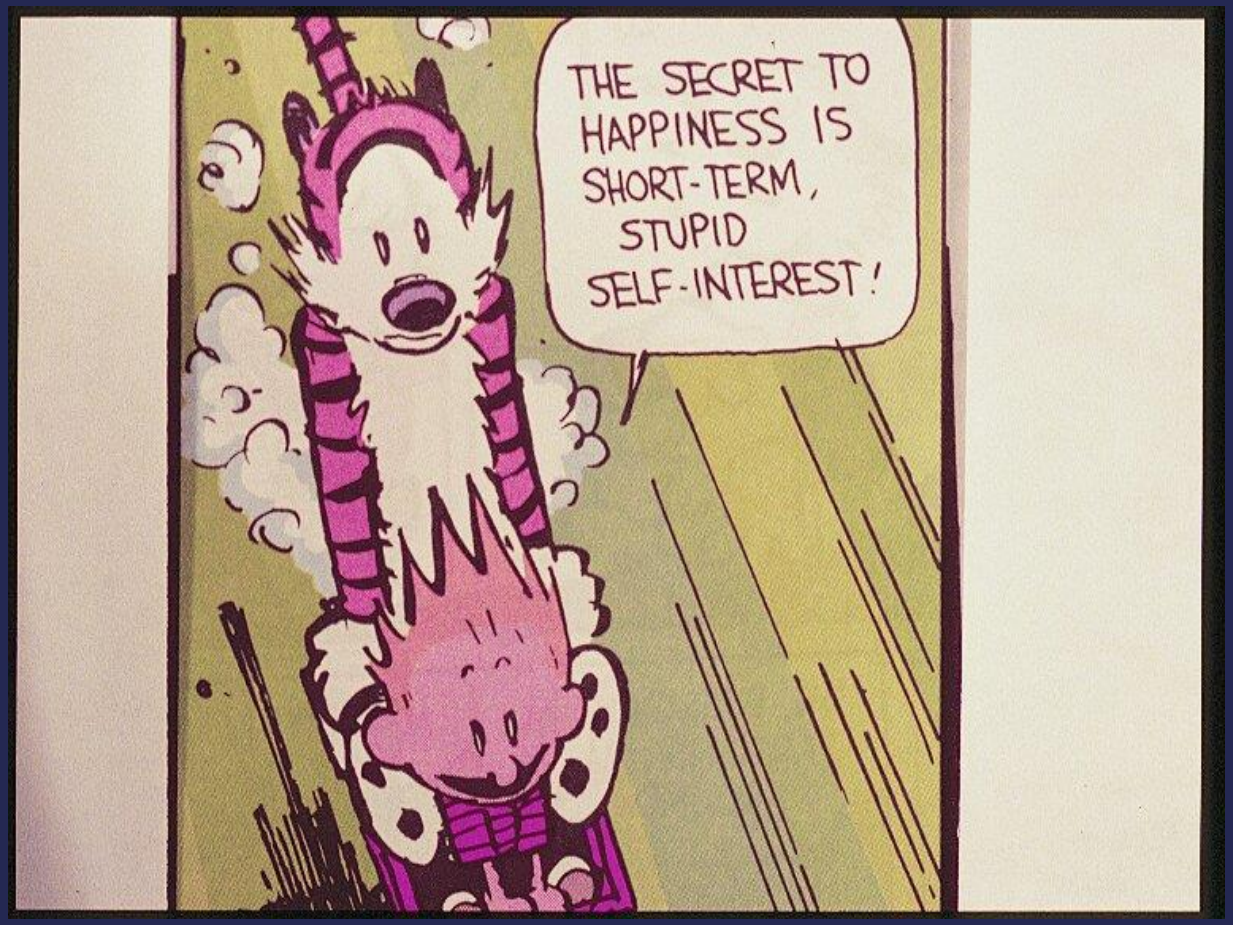
Take the best of hospital practices and add OP efficiency

Error #4
Lack of Vision / “Champions”
it MUST be a team effort

- Physician user(s)
- Staff
- Anesthesia
- Fiscal
- Administration
- Education
- Scheduling



it is LOT of work
and
it is easier to say ***NO***



Where things go off track

- Facility
- Fiscal
- Provider
- Patient Selection
- Non facility factors
- Implementation and Practice

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Facility

Physical Plant – will it support or inhibit an Arthroplasty program?

- OR size
- Central Sterile
- Storage
- Pre /post op

OR size

we can make it work vs it will work vs ideal

- Min sq. feet
  - 400 - 500 sq. ft. (non arthroplasty)
  - 600 – 700 sq. ft. (arthroplasty / multilevel spine)

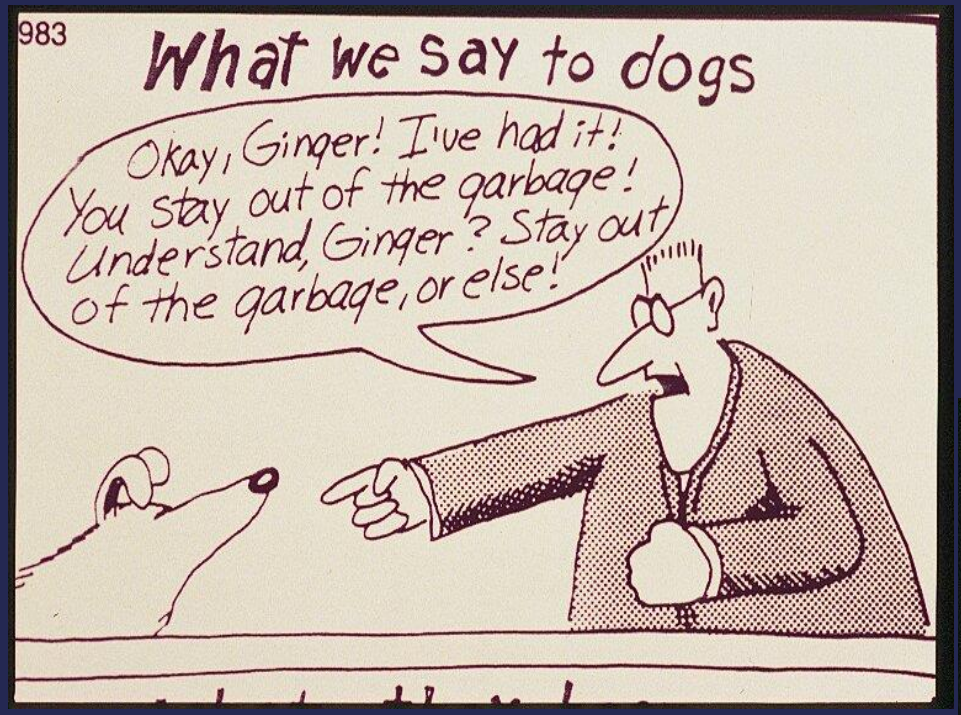
- OR Table (Hanna, specialized shoulder)
- Back table(s)
- Pans / trays / equipment

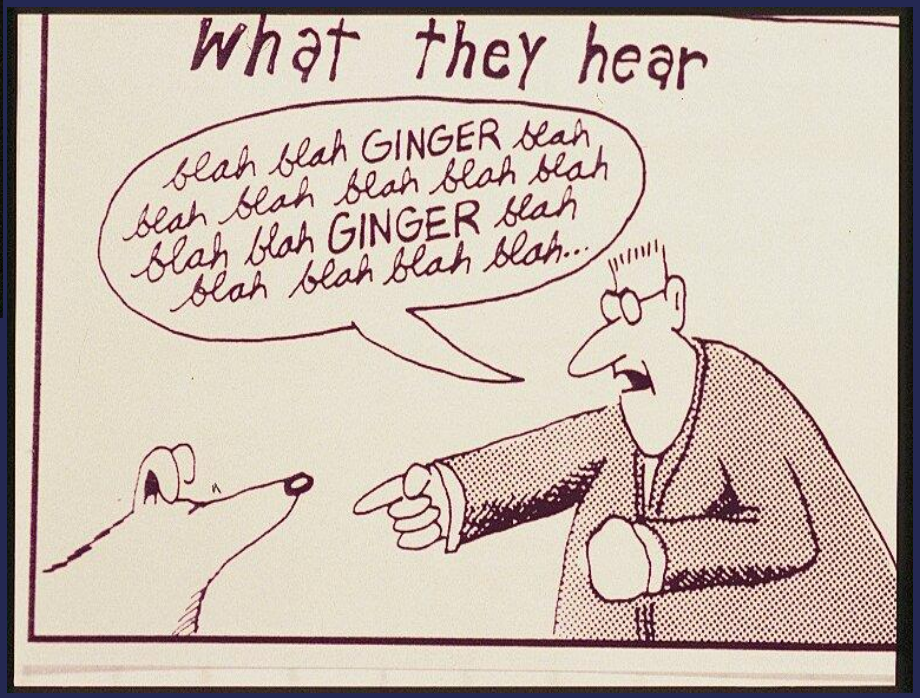
- This is NOT arthroscopy
- What can be pared down?

  Case profiling may dictate

- We like our toys and we want ALL of them BUT some can do more with less

Surgeons and their Toys
consensus among users





Central Sterile

- Can the current space - decontam and autoclave unit - handle the instrument volumes and pans (size)
- Can it accommodate ALL of the pans (number) in one run
- Can your STAFF handle the added volume and complexity

- Will a new (bigger) autoclave/CS be required?
- Will it fit?

- Remodel??? (=$$$$$$)

Storage

NO facility ever has excess storage space

- Were will you put all the equipment (tables, space suits, additional instruments – saws/drills)

- What about implants
  - On Demand / pre op planning vs “every size possible”
  - They take up (more) space!
  - Multiple systems vs one vendor

Patient flow - Post Op

- Can you accommodate the extended recovery time?
  - 2 hr. max vs 4+ hr. (case type will dictate)
  - Beds
  - Staff
  - Space for family
  - Extended recovery needs (Ginger Ale and crackers aren't enough)
  - Respect for other patients

Patient flow - Post Op

- Can you do initial ambulation?
  - Who
  - Where
  - When
  - How many times

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Fiscal

- Do you have scheduling space for the cases
- Impact on current cases / current fiscal profile
- Case costing
- Realistic volumes vs volumes for financial success

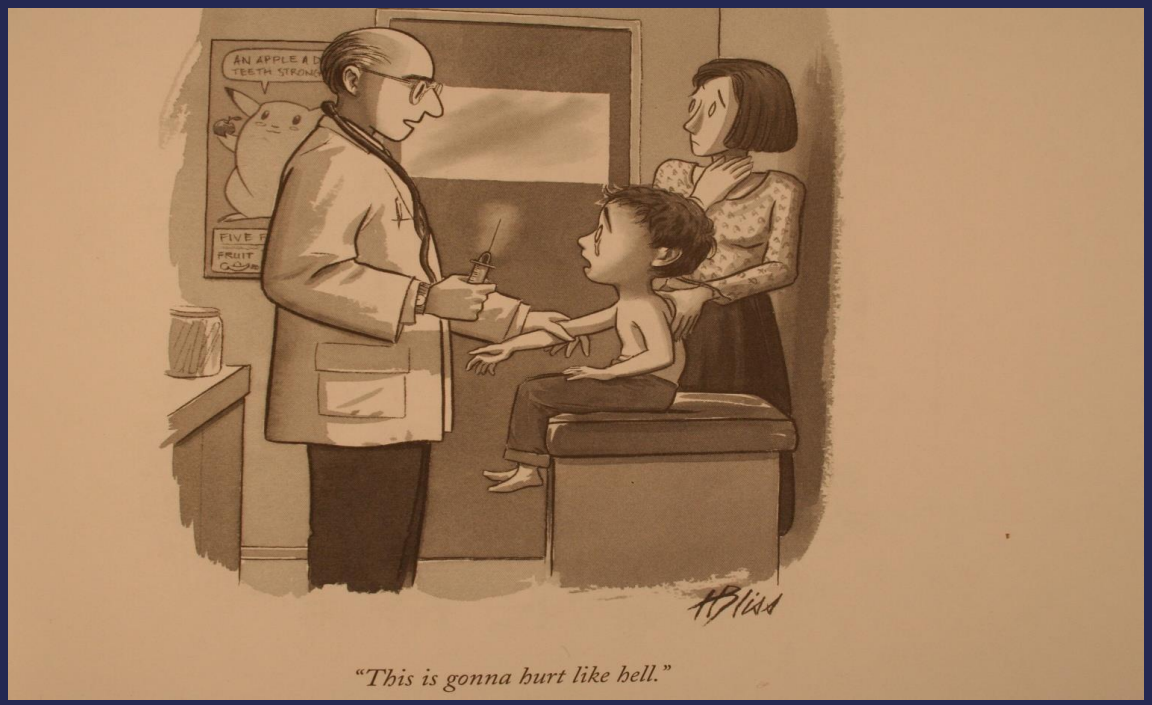
Impact on current cases

- Will it add providers/cases
- Will it negatively impact current users
- How / where does it fit the schedule
- AM only vs multiple arthroplasty cases
- Dedicated Total Joint room / day

- Will it be a net $+ or a “shift”

Case Costing

- Hard goods and equipment
- TJ specific trays
- Implants
- TJA “add ons”
- Staff



“This is gonna hurt like hell”

Case Costing
hard goods and equipment

- This stuff is expensive
  - Standard Ortho table $70-80K vs Hanna table $180-200K
  - Space suit / PPE Exhaust suit x # staff and surgeons
  - “Heavy duty tools”

- Amortization of the upfront developmental cost should be included in case costing

- Where does the money come from?
  - Debt service
  - New investor
  - Sale of additional shares
  - Financial support from equipment suppliers

Implants
volume = savings

- Do you try to please everyone – *NO*
  - Single vendor
  - Single implant system
  - There MUST be consensus
- Purchase vs Consignment
  - How do you get best cost
    - Implant
    - PMMA
    - Dressings
    - “Add ons”

Add Ons

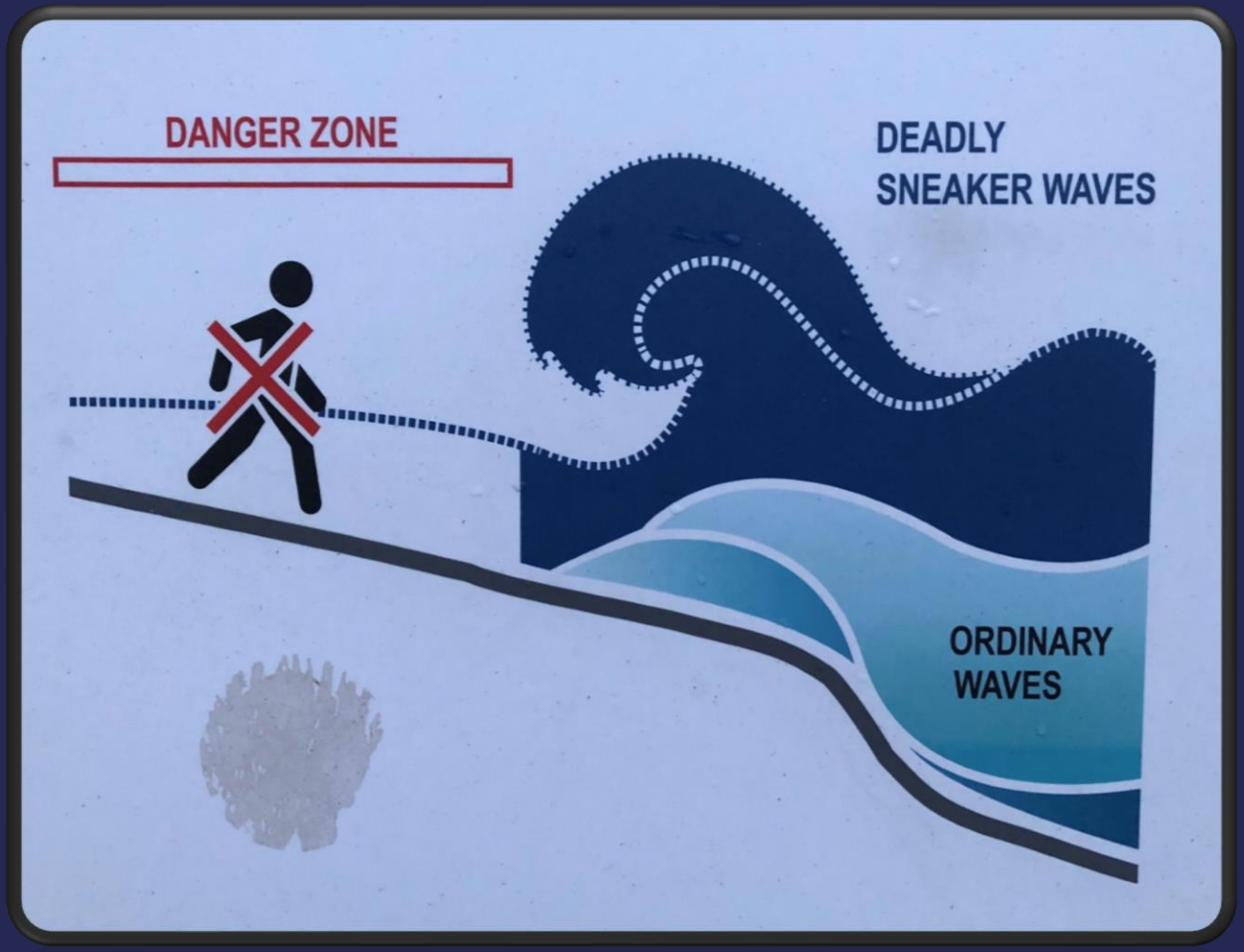
this (again) is not arthroscopy

- There are costs unique to arthroplasty

- There are add ons essential for OP success

Don’t turn your back

unexpected costs



Arthroplasty "Centric" Costs

Medications and supplies "unique" to TJA

- TXA - 2.5 gm max @ $131/gm
- Exparel - $170/ 10 ml, $310/20 ml
- IV tylenol - $35/vial
- Dermabond – $24/vial

- $500-$600/case

- Minimize "surprises"

Ancillary Needs - Durable goods
where supplied / how paid

- Assist ambulation devices
- ADL devices
- Sling
- Incentive Spirometry
- DVT program
  - Compression
  - Meds
  - Instruction

- “Day of” is not acceptable ($ or patient care)
- NOTHING is free
- Somebody gets a bill
- Make sure it is not you

Scheduling – Precertification - Coding

- Must be coordinated
- Must be PERFECT
- Live or die by correct AND CONSISTENT coding
  - Facility/surgeon/anesthesia – SAME CODES
  - Operative note(s) must support
    - Surgeon
    - Anesthesia

Templated Procedure Notes

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Provider

things you do not want to hear

- Surgeon

I want to do OP total joints at your facility, make it work for me

My office is too busy / I don't have the staff

It won't be a big deal to do a couple on occasion

- *Anesthesia*

I did not expect to have a total joint on the schedule today

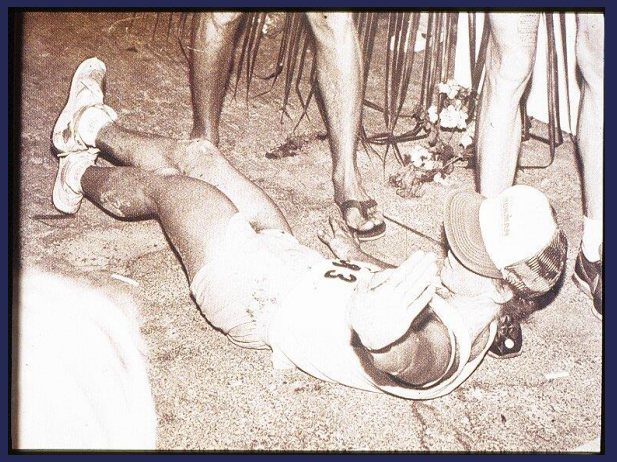
This is what I prefer

Is it really a good idea to be doing these here?

I don't like to do this regional block

Provider
"A" game mentality

- Skill set is assumed but must be verified
- "Slow is fast" vs *just slow*
- The "in OR" component should be the "given"
- Defined protocols - pre op and facility
  - Developed in agreement
  - Applied consistently
- Anesthesia
  - No pushback - buy in to the concept
  - Efficiency
  - OP mentality
  - Clinical skills



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Patient Selection

- Clear patient selection criteria
  - BMI
  - ASA 1, 2
  - NO chronic pain
  - Support services
  - D/C capability
    - Transport
    - Ambulatory ability
- Adhere to selection criteria (~~ASA creep~~)

ASA “creep”

- “expand patient parameters to operate on patients who may be
  - older
  - overweight
  - have serious health conditions”

- It should be a conscious decision
- Taking in to account health capabilities and support services
- ASA 3 “B”

Patient Selection

Yes, it IS “cherry picking”

Selection = Success

Pick the best patients for the environment

ASCs do more with less ($)

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Non Facility Factors

each (outside) step is more important – less “wiggle room”

- Patient (and support) education
  - Joint school
- Durable goods, assist devices
  - NOT the day of surgery
  - Instruction in use
- Scheduling
  - ASA/comorbidities, PST, Pre op clearance
  - Insurance pre cert
  - IT TAKES MORE WORK
  - MUST work as a team - surgeons office/ASC staff (admin and nursing)
- Prehab
  - Instructions, practice
  - Pt health optimization
- Rehab (post procedure, post facility)
  - Where/who/how

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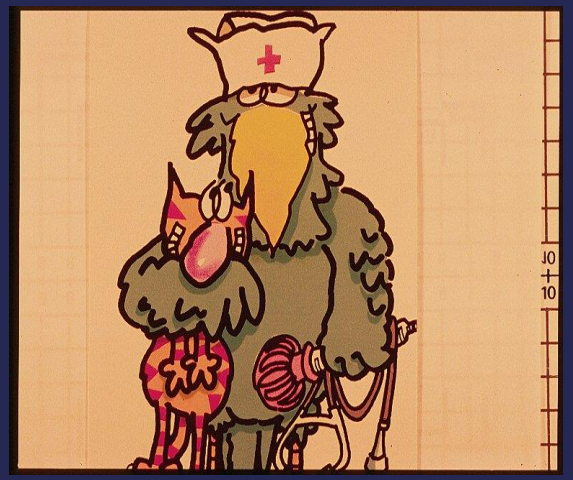
Implementation and practice

- Staff education - new is frightening
  - By the surgeons – what is expected, what staff can expect
  - By the facility – how will these cases fit, new work flows
  - Between provider officer and facility
- Defined protocols
  - Input from everyone
  - Worst case scenario
- Monitoring
  - Q/A for Pt care and contract development
- Follow up – Pt satisfaction
- Willingness to adapt
  - Use what you have learned
  - GROW the program



What may not be reasonable (at this time)

May be possible

with the right planning and approach

Thank You

someone has the answers to your quest

Questions?