OrthoServiceLine

"Developing an Outpatient Joint Replacement Program"

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- Aligns patient and provider expectations
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- Increases patient satisfaction

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DEVELOPING AN OUTPATIENT JOINT REPLACEMENT PROGRAM

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BOSS
Boston Out-Patient Surgical Suites

WHAT IS YOUR VALUE PROPOSITION?

- Patient benefits
  - Experience
  - Quality
  - Recovery
  - Cost
- Surgeon benefits
- ASC benefits
- Insurer benefits

WHERE TO BEGIN?

- Surgeon interest
- Surgeon experience
- Facility feasibility
- Are you an ortho center?
- Patient interest/demographics
- Resources (anesthesia, PT, recovery)

FACILITY ASSESSMENT

- State regulations
  - Notification for new services?
  - 23 hour permissible?
  - Physician/CRNA required entire length of stay?
- Facility layout
  - Spatial considerations
    - OR size
    - PACU size

FACILITY ASSESSMENT

- Facility layout
  - Bathroom location/layout
  - Patient privacy vs. private room
  - Space for family
  - Patient comfort
- Staffing considerations
  - Experience - all areas
  - Extended hours
  - Staffing structure

FACILITY ASSESSMENT

- Physician consideration
  - MD/CRNA on site?
  - Follow-up protocols
- PT consideration
  - On-site vs. contract
  - Nursing performs assessment
- VNA/Home health care
  - Relationship
  - Contracted services?
  - Direction/protocols

FACILITY ASSESSMENT

- Misc.
  - Dietary - progress to a light meal?
  - DME
  - Supplies & equipment
  - DVT prevention
  - Discharge methodology
  - Transfer agreement
  - Ambulance agreement
  - Provisions for staff education

DEVELOP A CLINICAL PATHWAY

- Elements:
  - Preop
  - Patient selection
  - OR/interoperative
  - Anesthesia
  - PACU
  - Orders
  - Extended care

CLINICAL PATHWAY: PRE-OP EDUCATION

- Education
  - Individual tour
  - Group class
  - DVD
  - Education guide (KEY)
  - Schedule of events

CLINICAL PATHWAY: PRE-OP EDUCATION

- Essential elements
  - Tour of facility/comfort
  - Introduction to staff/patient navigator
  - Meet with anesthesia
    - Level of communication
  - Meet with PT
  - Consistent message (KEY)
  - Education guide

CLINICAL PATHWAY: PATIENT NAVIGATOR

- Patient navigator
  - Nurse/clinical
  - Consistency
  - Contact info given
- Apps
  - Financially +/-
  - Prevents cancellations
  - Patient comfort/stress level

PATIENT SELECTION

- Must be "standard" - coordinated with surgeons and anesthesia
- Are you utilizing a computerized risk assessment?
- Surgeon should lead the charge in office
- ASC confirms elements initially when patient is booked for surgery

PATIENT SELECTION

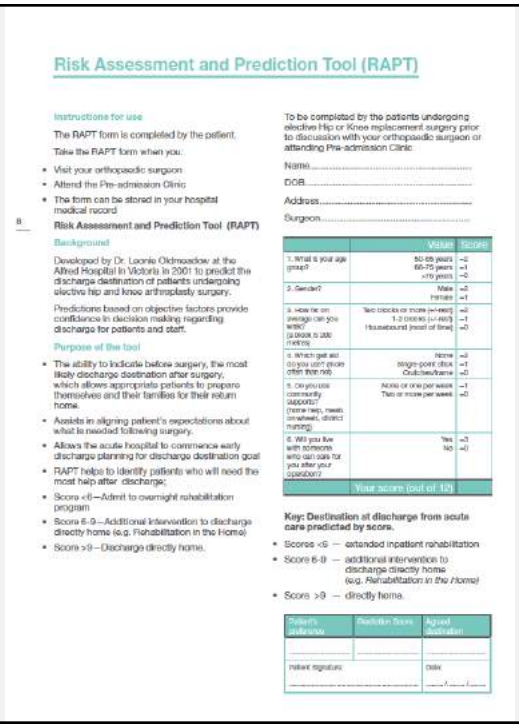
- Key elements:
  - Age <70 yo (exceptions)
  - ASA 1 or 2
    - Minimal comorbidities
    - HbA1C <7.5%
  - BMI < 35
  - Absence of clotting disorder (INR)/anemia (H & H)
  - Absence of sleep apnea (STOPBANG questionnaire) vs. controlled
  - Patient's physical fitness level
    - Routine exercise; ability to run; upper arm strength assessment

PATIENT SELECTION

- Key elements:
  - Patient motivation (KEY)
  - Absence of a history of:
    - substance abuse
    - pain-management issues
    - smoking
  - Strong network of caregivers (family)
  - Acceptable home environment (physically and emotionally)
  - Straightforward surgery (non-revision, deformity, etc.)

PATIENT SELECTION

- RAPT scoring tool:
  - https://www.ahsa.com.au/web/patient_info/rapt_form/download
  - Must have a score of 9 or greater



Risk Assessment and Prediction Tool (RAPT)

Instructions for use

The RAPT form is completed by the patient.

Take the RAPT form when you:

- Visit your orthopaedic surgeon
- Attend the Pre-admission Clinic
- The form can be stored in your hospital medical record

Risk Assessment and Prediction Tool (RAPT)

Background

Developed by Dr. Leonie Oldmeadow at the Alfred Hospital in Victoria in 2001 to predict the discharge destination of patients undergoing elective hip and knee arthroplasty surgery.

Predictions based on objective factors provide confidence in decision making regarding discharge for patients and staff.

Purpose of the tool

- The ability to indicate before surgery, the most likely discharge destination after surgery, which allows appropriate patients to prepare themselves and their families for their return home.
- Assists in aligning patient's expectations about what is needed following surgery.
- Allows the acute hospital to commence early discharge planning for discharge destination goal
- RAPT helps to identify patients who will need the most help after discharge;
- Score <6—Admit to overnight rehabilitation program
- Score 6-9—Additional intervention to discharge directly home (e.g. Rehabilitation in the Home)
- Score >9—Discharge directly home.

To be completed by the patients undergoing elective Hip or Knee replacement surgery prior to discussion with your orthopaedic surgeon or attending Pre-admission Clinic

Name.....

DOB.....

Address.....

Surgeon.....

	Value	Score
1. What is your age group?	50-65 years 66-75 years >76 years	=0 =1 =2
2. Gender?	Male Female	=2 =1
3. How far on average can you walk? (a block is 200 metres)	Two blocks or more (>400m) 1-2 blocks (<400m) Housebound (most of time)	=2 =1 =0
4. Which gait aid do you use more often than not)	None Single-point stick Crutches/frame	=2 =1 =0
5. Do you use community supports? (home help, meals on wheels, district nursing)	Alone or one per week Two or more per week	=1 =0
6. Will you live with someone who can care for you after your operation?	Yes No	=3 =0
	Your score (out of 12)	

Key: Destination at discharge from acute care predicted by score.

- Scores <6 — extended inpatient rehabilitation
- Score 6-9 — additional intervention to discharge directly home (e.g. *Rehabilitation in the Home*)
- Score >9 — directly home.

Patient's preference	Prediction Score	Agreed destination

Patient signature: Date:

	Value	Score
1. What is your age group?	50-65 years 66-75 years >75 years	–2 –1 –0
2. Gender?	Male Female	–2 –1
3. How far on average can you walk? (a block is 200 metres)	Two blocks or more (+/-rest) 1-2 blocks (+/-rest) Housebound (most of time)	–2 –1 –0
4. Which gait aid do you use? (more often than not)	None Single-point stick Crutches/frame	–2 –1 –0
5. Do you use community supports? (home help, meals on wheels, district nursing)	None or one per week Two or more per week	–1 –0
6. Will you live with someone who can care for you after your operation?	Yes No	–3 –0
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Key: Destination at discharge from acute care predicted by score.

Scores <6 — extended inpatient rehabilitation

Score 6-9 — additional intervention to discharge directly home (e.g. *Rehabilitation in the Home*)

Score >9 — directly home.

Patient's preference	Prediction Score	Agreed destination
.....	.....	.....
Patient Signature:		Date: ...../...../.....

CLINICAL PATHWAY: HOME ASSESSMENT

- VNA vs. home-care
- PT assessment
  - VNA vs. outpatient PT program
- Home assessment form
- Straight to outpatient?
- Give "helpful hints" in patient education guide
  - E.g. food preparation, eliminating potential obstacles, etc.

CLINICAL PATHWAY: PRE-OP

- Admit patient in standard fashion
- Arrival time? 1.5-2 hrs., dependent on antibiotics, anesthesia (block/fluids)
- IV antibiotic regimen
  - Standard ancef vs. combo vs. Vanco
- Pre-op "cocktail"
  - Celebrex, Tylenol, Gabapentin, Lyrica
  - Scopolamine patch?

CLINICAL PATHWAY: PRE-OP

- Nerve block
  - TKA - Adductor canal; selective tibial nerve block
  - THA - none vs. adductor canal
  - TSA - interscalene nerve block
- Spinal vs. GA
  - Short-acting (KEY)
- Indwelling catheters +/-

CLINICAL PATHWAY: PRE-OP

- Other considerations:
  - "Standard" instructions: e.g. no nail polish, loose fitting clothing, shoes, etc.
  - Hibiclens distributed in office for pre-surgery antiseptic
  - Crutch/walker-training at pre-op visit or at least in pre-op prior
  - DVT Prevention:
    - Pneumatic compression boots
    - TEDS
    - Surgeon post-op prophylaxis
  - MRSA screen (KEY) - who coordinates/timing

CLINICAL PATHWAY: INTER-OPERATIVE

- Instrumentation
  - Standardize as much as possible
    - Drapes/supplies and instrumentation
  - "Specials" for each surgeon
  - One tray-custom kits (pre-op templating)
  - Power!
  - Vendor rep relationships - rep should take charge
  - Ensure instrumentation/implants with extras present at least day before

CLINICAL PATHWAY: INTER-OPERATIVE

- Staff in earlier to open case; extra staff
- Experience important - lean on rep for guidance
- Table set-up
- To OR in standard fashion
- Tourniquet - +/- (new technology)
- Anesthesia in right away
- TXA +/-: administration prior to incision

CLINICAL PATHWAY: INTER-OPERATIVE

- Images/templating
- Surgeon/assistant in room right away
- Prep more complicated
- Minimally invasive/hemostasis
- Step-wise decrease in tourniquet pressure
- Procedures quicker than you think
- Sterile dressing/DME

CLINICAL PATHWAY: INTER-OPERATIVE

- Other considerations:
  - Infection control
    - Limit traffic (KEY)
    - Laminar flow
    - Hoods
  - Inter-op "cocktail" (KEY)
    - Exparel
    - Surgeon preference
    - Technique important
  - Multiple cases (instrumentation, etc.)

CLINICAL PATHWAY: PACU

- Standard Phase I pathway
  - ICE! (cryo-cuffs?)
  - Oxygen
  - More antibiotics (surgeon preference)
  - Nausea prophylaxis
- Analgesics
  - Physician dependent
  - Limit if possible

CLINICAL PATHWAY: PACU

- Recovery should be "standard" because of nerve blocks/cocktails
  - Hips may progress slower
- Communicate with PT (if available)
- Ambulate when patient fully awake
  - Start slow
  - Proceed to "laps"
  - Stairs +/-

CLINICAL PATHWAY: PACU

- Discharge criteria
  - Stable vitals
  - Diet resumed (consider more robust food for these patients)
  - Little to no nausea
  - Pain under control on oral meds
  - PT clearance
    - Pivot to wheelchair
    - Stairs?
    - Walker vs. crutches

CLINICAL PATHWAY: PACU

- Other considerations:
  - Strong discharge instructions
  - Ensure they have facility and surgeon contact info
  - Ensure they understand what to look for
  - DVT prevention
  - VNA info/contacted with update
  - PT plans
  - Navigator
  - Education guide

CLINICAL PATHWAY: EXTENDED CARE

- VNA follow-up
  - Same day if early discharge
  - Next day if not
- Phone calls
  - Night of/next a.m./1-2 weeks out
- PT
  - Same vs. next day
  - Move towards outpatient only

CLINICAL PATHWAY: COMPLICATIONS

- Transfer agreement
  - Surgeons should have privileges at the hospital
- Transfer protocol
- Communication
- Follow-up

ELEMENTS OF EFFICIENCY

- Pre-op education crucial
- Consistent flow
- Consider consistent "joint team" to start
- Ensure patient arrives with enough time
- Rep to ensure all instruments/supplies/preferences in facility prior
- Rep to help with set-up initially and coaching tech throughout case
- Crosstrain staff as soon as possible

ELEMENTS OF EFFICIENCY

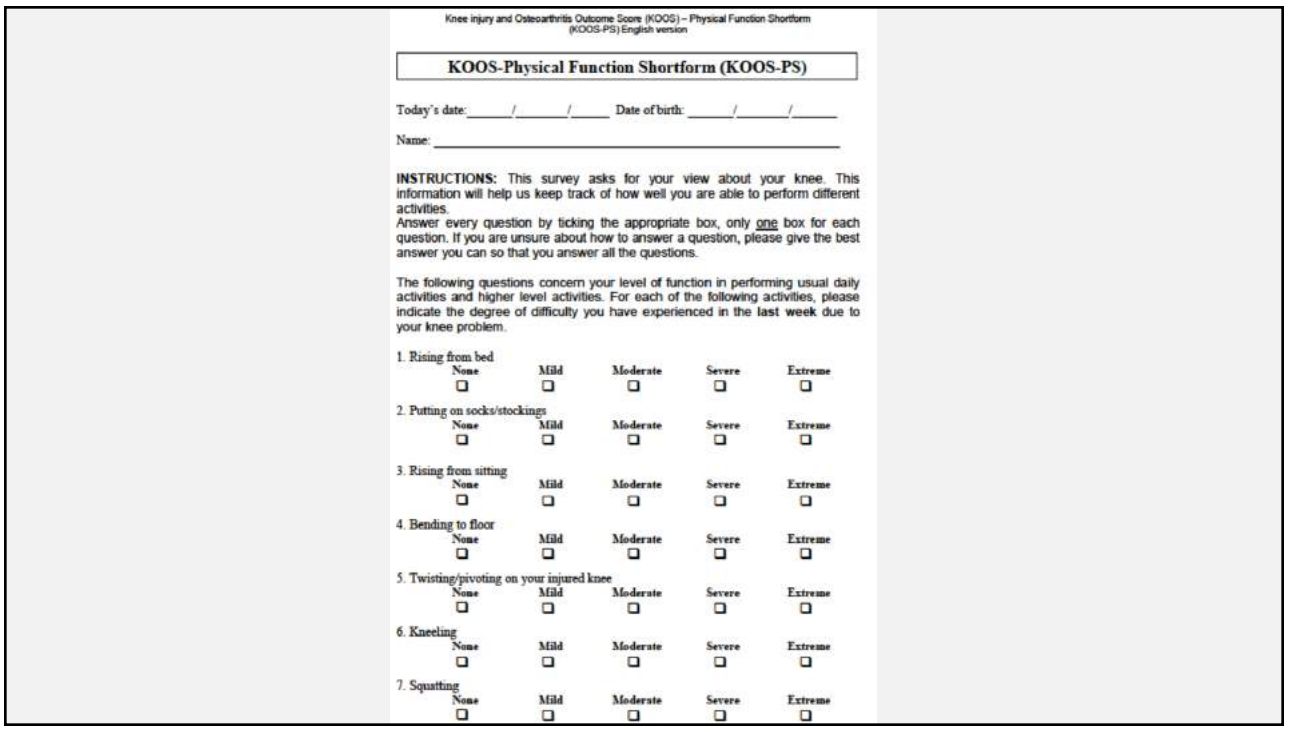
- If multiple cases, consider swing room (team to set-up/prep/close)
- Instrument room efficiency
- PACU to communicate well with PT
- PACU staff should read patient and don't be afraid to progress if symptom-free
- Bring family members in ASAP

SCHEDULING CONSIDERATIONS

- To start, do these cases first thing in a.m.
  - 6:30
  - Have surgeon bump back a bit
- OR incision time quicker than you think
  - Leave time for set-up/closing
- Consider PACU "back-up"
- If multiple cases, consider swing room
- Communicate with all parties (pre-op, PT, etc.)

FOLLOW-UP

- Patient navigator app
- Hip Disability Outcome Score (HOOS)
- Knee Disability Outcome Score (KOOS)
- Record patient satisfaction
- Suggest performing 10 and reviewing whole process for improvement
- Consent from patients for follow-up/marketing
- Report for insurers



Knee injury and Osteoarthritis Outcome Score (KOOS) – Physical Function Shortform (KOOS-PS) English version

KOOS-Physical Function Shortform (KOOS-PS)

Today's date: _____/_____/_____ Date of birth: _____/_____/_____

Name: _____

INSTRUCTIONS: This survey asks for your view about your knee. This information will help us keep track of how well you are able to perform different activities.
Answer every question by ticking the appropriate box, only one box for each question. If you are unsure about how to answer a question, please give the best answer you can so that you answer all the questions.

The following questions concern your level of function in performing usual daily activities and higher level activities. For each of the following activities, please indicate the degree of difficulty you have experienced in the **last week** due to your knee problem.

	None	Mild	Moderate	Severe	Extreme
1. Rising from bed	☐	☐	☐	☐	☐
2. Putting on socks/stockings	☐	☐	☐	☐	☐
3. Rising from sitting	☐	☐	☐	☐	☐
4. Bending to floor	☐	☐	☐	☐	☐
5. Twisting/pivoting on your injured knee	☐	☐	☐	☐	☐
6. Kneeling	☐	☐	☐	☐	☐
7. Squatting	☐	☐	☐	☐	☐

MARKETING

- Patient consent/waiver
- Shoot pictures/video
- Press release
- Communicate with media outlets
- Consider marketing group
- Word-of-mouth
- Radio spots vs. TV
- Patient give-aways

INSURANCE NEGOTIATIONS

- Ensure you are talking to the right people
- MD to MD initially
- Meet at facility - all parties involved (surgeon, anesthesia, manager, nursing)
- Have some data for them
  - Studies
  - MD data
- Share your clinical pathway prior
- Emphasize your patient selection & planning for complications

INSURANCE NEGOTIATIONS

- Know your costs:
  - Implants ("average" knee implant: $4,320 – Range: $2,100-$6,600)
  - Disposables (cement, mixing bowl, saw blades, fixation pins, sutures, prep, antibiotics/meds (exparel), pulse lavage, sterile tourniquet?)
  - DME
  - Staffing commitment
  - Intangibles: app, increased OR usage/commitment, marketing

INSURANCE NEGOTIATIONS

- Know your cost/minute of OR time
- Know what your absolute lowest reimbursement can be
- Know what the hospitals get:
  - TKA: Avg. $31,124 ($11,317 - $69,654)
  - THA: Avg. $30,124 ($11,327 - $73,987)
    - A study of Cost Variations for Knee & Hip Replacement Surgeries in the U.S., BCBS & Health of America Report, January 21, 2015
- Do you have to pay for PT/VNA/ancillaries?
- Negotiate for winning on both sides - (volume shift x lower cost for insurer)

INSURANCE NEGOTIATIONS

- Case costing TKA:
  - Cost/minute: $10-$15/minute - total OR time = 120 minutes = $1,800 in overhead
  - Implant - $ 4,320
  - Cement/mixing bowl/blades/pulse lavage (inclusive): $350
  - Misc. supplies (pack, drapes, sutures, meds): $300-650 (exparel)
  - Hood: $30/hood x 3?
  - DME: ???
  - "Extra" staffing - $100-200
  - Total cost: $7,410

BUNDLED PAYMENTS

- Insurers want this down the road
  - Shared risk
- Should consider starting with just addition to fee schedule until you scale
- Can work on bundle over time
- Questions:
  - Who will administer it?
  - Who/what is included?
  - What time frame is included?

BUNDLED PAYMENTS

- 90 day bundle very difficult
  - Re-admittance/complications are the issue
- Same-day bundle possible?
  - What's the value proposition?
  - Are your surgeons willing to bundle post-op visits?
  - Are your PT's willing to bundle visits?
- Is pre-op/labs included?

BUNDLED PAYMENTS

- "Typical" bundle to include:
  - Facility
  - Physicians' services
  - Home health services - PT and/or skilled nursing
  - Outpatient PT
  - Radiology
  - Laboratory services
  - Overnight stay or rehab stay if needed
  - Complications - ED service and/or hospital admission

BUNDLED PAYMENTS

- Potential exclusions:
  - DME
  - Pharmacy
  - Transportation
  - Any clinically unrelated service

BUNDLED PAYMENTS

- Often a performance or quality component
- Choose a number of outcome measures including patient experience, e.g.
  - Infection rate
  - Functionality status
  - Pain level
  - Patient experience
- Booked withhold and this payment component paid on outcomes

VENDOR NEGOTIATIONS

- Attempt to standardize (no more than 2)
  - More difficult than sports/trauma
- Educate them on reimbursement/implant reimbursement, etc.
- Attempt to "partner"/marketshare for volume
- Explain ramp-up phase and commitment over time
- Find out what else they offer
  - Discounts if purchase power/tourniquets/instruments

VENDOR NEGOTIATIONS

- Attempt for "all-in" price
  - Including disposables (cement, mixing bowl, blades, pulse lavage, fixation pins)
- Start with pricing and revisit over time
- Ensure you factor in reps. service history/reputation
- Rebate program?
- How will they handle instrumentation, etc.
- Consulting program/site visits

CONSULTING COMPONENTS

- Can consult/advise on all aspects including:
  - Payer contracting strategy
  - Developing infrastructure/clinical pathway
  - Patient selection criteria and patient education
  - Order sets and care plans
  - Implementation and efficiencies
  - Materials management - trays, sterilization and flow, storage

CONSULTING COMPONENTS

- Can consult/advise on all aspects including:
  - Staff education and competencies
  - Discharge process and post discharge care
  - Marketing aspects
  - Building volume and scaling

STAFF EDUCATION

- Key component
  - Surgeon techniques
  - PACU what to expect
  - Anesthesia - technique and blocks
  - PT
  - Vendor-led
  - Consider educational opportunities
  - Consider establishing "joint team" to lead the charge

WHAT NOW?

- Can surgeons begin to do an "outpatient joint" at hospital and then transition to ASC?
  - Will hospital allow this?
- Develop clinical pathway on paper
  - Be sure to utilize "joint team" of lead surgeon, lead anesthesia, nursing, techs, admin
- Consider a consultant
- Reach out to insurers

WHAT NOW?

- Consultant
  - Vendors have educational opportunities
  - Vendors have consulting relationships
  - They can "do it all"
  - Still need to do A LOT of legwork yourself
  - It is do-able, GET STARTED!
- Be a leader!!!

GOOD LUCK!!!!

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- Bundled Payments: Keys to Success in Orthopedics and Beyond
- Starting an Outpatient Joints Program
- Establishing Orthopedic Centers of Excellence
- Hospital-Physician Alignment
- Ortho Service Line Strategies

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