Total joints present increasingly attractive option for ASCs

The migration of total joint replacements for knees and hips from inpatient hospital ORs to hospital outpatient departments and ambulatory surgery centers (ASCs) is spreading.

On November 1, 2017, the Centers for Medicare & Medicaid Services (CMS) bolstered the trend when it approved the removal of total knee arthroplasty (TKA) from the inpatient-only list for 2018. Total hip arthroplasty (THA) and partial hip arthroplasty are still on the inpatient-only list, but outpatient surgery advocates are pushing for CMS approval of these procedures as outpatient.

The Ambulatory Surgery Center Association (ASCA) reported an eightfold increase in the number of US ASCs performing outpatient joint replacements in the past 3 years, from approximately 25 to 200. “As more physicians and ASC teams get the training and experience they need to safely and comfortably move these procedures into the outpatient setting, we can expect the volume performed in hospital outpatient departments and ASCs to increase,” says Steven Miller, ASCA chief operating officer.

“Total joints in the ASC is the hottest topic in orthopedics right now,” says Michael Kimball, an orthopedic surgeon who performs both THA and TKA at the Outpatient Surgery Center of La Jolla in La Jolla, California. “There were a large number of sessions about outpatient total joint at the American Academy of Orthopaedic Surgeons’ annual meeting, and a growing number at every meeting we attend.”

Dr Kimball began doing total joint replacements at the Outpatient Surgery Center of La Jolla 7 years ago. He says he prefers the ASC setting because of greater efficiencies, higher patient satisfaction, and lower infection rates. “I couldn’t get enough OR time at the hospital to do my cases,” he notes.

**Look for low risk, high volume**

Research has shown that low-risk patients are successful candidates for outpatient hip and knee replacement. They can leave the ASC within 24 hours with low risk of complication, infection, or readmission to the hospital within 5 days of the procedure, and patient satisfaction rates are high.

“ASCs operate in a way to get the patient in and out with a more pleasant experience. A 7 am case starts at 7 am, and I can be in my office seeing patients by 8:30,” Dr Kimball says. “If I do the surgery at the hospital, I will not get to my office until 9:30.”

“Patients with commercial insurance who choose to have surgery at a surgery center pay approximately 30% to 50% less than a patient having the same procedure in a hospital,” he adds. “These are some of the highest-paying cases that we do.”

Sg2, a healthcare analytics and consulting company, projects that 52% of all primary knee replacements caused by osteoarthritis will be performed in an outpatient setting by 2026.

“Unless hospitals come up with effective strategies to retain these volumes, factors such as independent surgeon ownership of ASCs, rising consumer demand for affordable pricing, and pending site-neutral legislation will lead to much of these volumes moving to ASCs,” Kristi Crowe, Sg2 vice president, comments in a blog.

In order to be successful, ASCs must have physician champions who are comfortable doing total joints in the outpatient setting and can teach and collaborate with the ASC staff to fold these procedures into the ASC, according to Troy Sparks, BSN, RN, CNOR, regional vice president and total joint program coordinator for AMSURG, which partners with 263 ASCs.

“Not every surgeon is interested in or comfortable taking care of patients outside the hospital,” Sparks says.

At the Surgery Center of Long Beach (California), an AMSURG partner, a committee consisting of everyone who interacts with the total joint patient developed its program around the surgeons’ preferences, says LaVerne Haller, RN, the center’s administrator. “We copied the surgeons’ preference cards from the hospital OR and met with them weekly to learn their preop and postop preferences until we developed a program they would like to have implemented here,” Haller explains.

The Surgery Center of Long Beach has been doing both total knee and total hip replacements for 4 years. In December 2017, the center received the first-ever Center of Excellence Award in Orthopaedic Certification by the Accreditation Association for Ambulatory Health Care (AAAHC) (sidebar, p 26).

**Assess volume and value**

To determine if a total joint program is financially feasible, ASC leaders must project volume and payer reimbursement. “Do you have just one surgeon who might bring one or two cases every 6 months, or several surgeons bringing multiple cases each month?” Sparks asks. “I would say centers should do at least a couple of cases per month at a minimum so that staff stay competent with the routine and the preferences of the surgeon.”

This is especially important when starting out because of the initial
costs to modify a surgery center for total joints. “For some centers, these may be minor because they are already doing uni-compartmental knees or other large orthopedic cases, and they already have things like power equipment, instruments, positioning devices, and other equipment necessary for these procedures,” Sparks says.

Other centers may be starting from scratch and will need adequate power equipment, augmented sterile processing, a specific OR table, and modification of a private room or an area in recovery designated for 23-hour stays, according to Scott Leggett, co-managing director of Convergent Same Day Orthopedic Strategies, a consulting firm. Leggett developed the consulting company with his business partner Tom Wilson to advise other ASCs on building total joint programs based on the lessons they learned at the ASCs they manage in San Diego and Monterey, California. Dr Kimball sits on the advisory board of Convergent, whose mission is to get surgery centers “joint ready,” according to Leggett.

“There are so many aspects of total joints that need to be addressed,” says Leggett, who with Wilson also co-owns Global One, a third-party administrator for bundled payments in the ASC. “We found that when we met with ASCs about negotiating bundled payments, very few had intentionally thought through all the pieces, including negotiating reimbursement.”

Return on investment is a factor of facility need, size, number of total joint surgeons, and capital investment, Leggett says. Data collected at the facilities Leggett and Wilson operate indicate that with appropriate payer contracting to ensure appropriate payment and implant pricing, an ASC can annually add as much as six figures to its bottom line with as few as three to five total joint arthroplasties per month.

While awaiting future Medicare rulings on coverage, surgery centers and device manufacturers will continue to negotiate reimbursement with commercial payers. However, the cost savings at surgery centers works both ways: Although costs can be lower, so can reimbursement, especially if commercial payers reimburse at Medicare rates that may not include carve-outs for medical devices.

“Data collection will be extremely important as we negotiate with payers,” Leggett says.

The American Joint Replacement Registry, the official registry of the American Association of Hip and Knee Surgeons, requests that ASCs performing total joints submit their data to its national registry at ajrr.net.

Establish protocols and procedures
“The most successful ASCs doing total joints are the ones that have evidence-based programs and protocols in place that everybody follows,” Leggett says. “Unlike a hospital, at an ASC there’s no discharge planner or a department that coordinates everything around the surgery. You have to build your own program using the staff you have, from preoperative evaluation to managing postoperative home health. These are the issues that somebody else takes care of for surgeons at the hospital. But at an ASC, you either need to come up with the protocols on your own or hire a consultant to do it for you.”

At AMSURG, Sparks—along with the company’s physician advisory board and selected physician champions—developed a total joint implementation guide that follows evidence-based best practices and industry standards established by AAAHC.

The Joint Commission has an orthopedic certification as well.

“One of our first hurdles was developing protocols to care for patients staying overnight at our center,” Haller says. “That’s new for most ASCs.”

AAAHC creates new orthopedic certification for ASCs
The Accreditation Association for Ambulatory Health Care (AAAHC) is rolling out a new orthopedic certification program for ASCs seeking to demonstrate high quality of care and compliance with rigorous industry requirements.

After an ASC has achieved overall accreditation, it can acquire the certification to demonstrate excellence in orthopedics by meeting specific industry standards. The requirements touch on several aspects of the ASC orthopedic specialty, including credentialing and privileging of providers, rigorous prescreening criteria to ensure optimal patient outcomes, and clinical care based on current evidence-based guidelines.

“AAAHC-accredited ASCs requested an orthopedic certification to create an organized structure that ensures high-quality delivery of care and strong patient outcomes in orthopedic procedures,” says Tess Poland, MSN, BSN, RN, senior vice president of accreditation services for AAAHC.

The orthopedic certification program standards and the 2018 Accreditation Handbook for Ambulatory Health Care, which includes updated standards for 2018 and the Centers for Medicare & Medicaid Services’ emergency preparedness requirements, are available at aaahc.org/publications. More information is at aaahc.org/en/Certification/Program-Levels.

Establish patient selection criteria
“You need to develop your patient selection criteria and stick to it,” Sparks says. Standards for total joint patient selection are more narrow than for other surgeries performed in an ASC because of the size, complexity, and recovery time required for these cases.
For example, an ASC may have a body mass index threshold of 45 for patients undergoing general surgery, but that may be 35 to 40 for total joint procedures. There are other factors to consider as well, such as diabetic status and cardiac history, Sparks says.

The Surgery Center of Long Beach worked with Convergent to develop its patient selection criteria. Convergent has studied patient selection criteria extensively and created a preoperative assessment tool the company says accurately predicts patient success for outpatient THA or TKA.

Convergent physician advisors presented the tool methodology at the 2017 annual meeting of the American Academy of Orthopaedic Surgeons. It is available online by contacting info@convergent.com.

“You’re picking winners,” says Dr Kimball. “Patients are in better shape, have lower ASA [American Society of Anesthesiologists] scores, are motivated to recover quickly, and have support at home to help them.”

The screening data also are important when educating regulators and insurance companies about the safety and quality of outpatient total joints, Dr Kimball says.

“Patients still need to be qualified outpatient candidates. We’re not doing anything different in pre-screening than we would do for an ACL [anterior cruciate ligament] or hernia repair. And if someone wakes up with chest pain after a total joint procedure, it’s the same protocol that it would be for a bunionectomy. Everybody is screened, and everybody has preoperative clearance for outpatient surgery,” he explains.

**Deliver preoperative education**

Managing expectations through preoperative patient education is imperative, Sparks says. The Surgery Center of Long Beach gives a VIP tour of the facility prior to surgery.

“It helps ease some of the anxiety because patients have already been here and seen some of the faces of the people who will be caring for them,” Haller says.

AMSURG is testing a virtual patient education pathway that rolls out patient education materials online in digestible chunks, “rather than sitting through an extensive class where patients and their home caregiver may not retain all of the information,” Sparks says.

The online tool educates patients about the procedure as well as pre- and postoperative care, and it also provides automated phone calls, text messages, emails, and phone app notifications throughout the perioperative process. After surgery, an online tool collects patient satisfaction data. Convergent has developed its own educational series as well.

“What we found when we started to take a deep dive is that the easiest part of doing total joints in the ASC is the surgery itself,” Sparks says. “The surgeons and staff are skilled, and the joint looks the same to them wherever they do the surgery. The puzzle that we had to solve is getting the right patients to the surgery center and giving them the proper education beforehand and the proper follow-up afterward.”

There has been a dramatic shift from overnight stays to patients going home within 4 to 6 hours postoperatively. With appropriate selection, education, planning, and postoperative support, this model is attractive to patients, payers, and providers, says Dr Kimball, who still prefers that his patients stay overnight.

“For your peace of mind and for patients’ peace of mind, keep them there 23 hours if you have that capability,” he advises. “Until an ASC has all of its protocols in place and the postoperative home care—especially pain management—is running smoothly, centers will have a better understanding of and more control over how patients are feeling if they stay the first 23 hours.”

Although some ASCs have dedicated private overnight rooms for 23-hour stays, others devote a section of the postanesthesia care unit to recovery. At the Surgery Center of Long Beach, total joint patients recover in a corner bay with a privacy curtain. The center added a TV, dimmable lights, and comfortable chairs for visitors.

**Post-discharge care**

After patients leave the ASC, some centers have physical therapists waiting to meet them at home; others begin physical therapy after the first postoperative appointment with the surgeon.

“The key is continuity and consistency in postoperative home care,” Dr Kimball says. “This is critical to making outpatient total joints work, particularly if you are sending people home the same day. You must have a standardized perioperative plan, with physical therapy and home health caregivers in place who are following the protocols you’ve established for pain management, anticoagulants, and physical therapy.”

Leggett says it can be challenging to find home care companies that work with PPO (preferred provider organization) patients and not just Medicare.

Dr Kimball also notes that newer telemedicine apps can monitor patients’ wound temperatures and mobility, and report the data back to the surgery center.

When there is inadequate support at home, Dr Kimball’s surgery center works with a nearby skilled nursing facility. For continuity of care, he hires the
same hospitalists who round on his orthopedic patients at the hospital to round at the skilled nursing facility.

Future outlook

The cohort of appropriate patients for outpatient total joint replacement will increase, with volume expected to reach 3.5 million procedures by 2030, according to Leggett.

“Total joints are the next ACLs,” he says. “Just a little over 10 years ago, ACLs were done primarily in hospitals, and now almost 100% are done in surgery centers.” He urges ASCs to consider adding total joints, especially if they already do orthopedics: “If you’re a joint-ready surgery center and prepared to take on these volumes, it’s going to mean a lot of business for your surgery center. The volume potential is tremendous.”

Leslie Flowers is president of Flowers Communications in Indianapolis, Indiana.

References


removal contracts to management of capital purchases, under the new management she had to attend multiple meetings and contend with the typical hospital’s bureaucracy.

“After the first year, my job got boring; it wasn’t challenging enough,” she says. Three years after the sale, Hoefl-Hoffman left the organization. The experience of being acquired made her take a closer look at her career, which was beneficial, she says, because she loves her current job.

Joint ventures

Like hospitals, some ASCs may need to seek support from a larger entity to help them survive in the competitive, demanding world of healthcare. In the case of physician-owned ASCs, Hoefl-Hoffman recommends pursuing a joint venture. “That way, the larger facility has a percentage of the business, but doesn’t get involved in the day-to-day operations,” she says.

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.

References
