OR economics

Shared savings change dynamics between a hospital and surgeons

An agreement with orthopedic and spine surgeons to share savings has enabled a large medical center to make major strides on its implant costs. It’s also provided eye-opening opportunities to improve patient care.

Under the agreement, termed gainsharing, a hospital and physicians enter into a formal contract to share savings through a mutual effort to reduce costs for certain services without jeopardizing quality.

The project, now in its third year at St Luke’s Regional Medical Center in Boise, Idaho, has contributed to savings averaging more than 50% for premium total joint implants.

St Luke’s now pays an average of about $4,800 for a total joint prosthesis, down from about $10,000 when the project began, notes Angela Christensen, MBA, BSN, RN, administrator of surgical services.

Sharing savings
The biggest savings were in Year 2, totaling $6.5 million out of $30 million to $35 million spent for joint and spinal implants. Christensen acknowledges St Luke’s probably was paying more for implants than others and thus had a bigger opportunity for savings.

About half of the surgery at St Luke’s is spinal and joint procedures. St Luke’s and its sister Meridian Medical Center have an annual volume of about 900 total joints and 500 spinal procedures.

The gainsharing arrangement is administered by Goodroe Healthcare Solutions, a unit of VHA Inc, which negotiated the legal agreement with the surgeons, maintains the database for patients treated under the agreement, and provides data analysis.

Savings from the project are shared 45% by the hospital and 45% by the physicians, with 10% set aside in an educational fund for the staff.

A new day for implants
Gainsharing has changed the dynamics with surgeons. At the beginning, Christensen says, vendors would often bring in an implant a surgeon had requested, and the hospital didn’t know about it until it received the invoice.

As in most hospitals, the orthopedic surgeons and neurosurgeons have close relationships with vendors. Surgeons often have worked with the same brand of implants since residency and rely on the service vendor reps provide.

Rather than limiting surgeons’ choice, St Luke’s savings have come through a capitated approach to implant pricing and engaging the surgeons to work with the hospital.

“We wanted to make sure the clinical end user had the decision of which vendor to use,” she says.

To help change the dynamics, Christensen formed a 3-person team, consisting of herself, because she has a relationship with the surgeons; the contracting director of
supply chain; and the OR business manager.

The capitated pricing approach pays vendors a specified amount for each implant construct, regardless of vendor, an approach many organizations have adopted. The hospital has 6 total hip constructs and 6 or 7 for total knees.

“It took a lot of trust,” Christensen says. “You have to be hand in hand with the surgeons. Communication is number one.”

The team asked for the surgeons’ support. For example, if a vendor took issue with the construct pricing, they asked if the surgeons would be willing to wait 30 days to use that vendor while the hospital negotiated.

She’s seen a closer relationship develop with the surgeons.

“They’re now comfortable calling me or the business manager and saying, ‘The vendor is telling us this new thing is coming out. Can you find out how much it will cost? I told them I couldn’t use it without the permission of the hospital.’ That has never happened before.”

Transparency builds trust

Transparency with the surgeons is essential to develop trust, she adds.

“We let them know all the vendors we have contracted with and what we are paying for each construct.” Surgeons signed a confidentiality agreement pledging not to give the pricing information to vendors.

The hospital also shares the surgeons’ data with them in regular reports. Trust has reached the point where the surgeons’ average cost per case is reported by name.

“We have had open, candid discussions,” says Christensen.

One surgeon, for example, always used 2 packages of antibiotic-impregnated cement for a primary total hip. His colleagues questioned that, saying the literature didn’t show the antibiotic cement makes a difference in infection rates. The surgeon decided he wouldn’t change his practice, but at least the conversation occurred.

Data highlights outcomes

Tracking quality data is a key to help ensure patient care doesn’t suffer from cost reduction efforts. The Goodroe database provides detailed information on patients’ demographics, comorbidities, and outcomes.

St Luke’s was pleased to learn, for example, that 80% to 90% of its total joint patients are discharged to home rather than a rehab facility, which exceeded the Goodroe benchmarks.

It also found opportunities to improve. The data showed that elderly hip fracture patients with comorbidities had a higher length of stay, at 9.5 days, and a higher mortality rate than the benchmarks. They also had more complications like pneumonia and deep vein thrombosis.

That prompted a review by the clinical staff and surgeons to see what they could do differently.

“It was good to have the surgeons around the table talking about what each felt was important for these patients,” Christensen says.

“We were actually able to map the critical pathway with an entire order set. Before, each surgeon did his own thing.”

Among the issues: Should patients be rushed to surgery so they could get out of bed sooner to prevent pneumonia? What about patients who are on Coumadin or have comorbidities like poorly controlled diabetes or malnutrition?

Anesthesia providers got involved to discuss what type of anesthesia was best. Elderly patients who have general anesthesia can have problems with confusion. Regional anesthesia has advantages for pain control without motor loss, less use of
opioids for postop pain, and physical therapy.

**Collecting the data**
Though the project entails a lot of data collection, Christensen says it’s manageable.

Most data fields are similar to those documented by nurses in the OR information system. These were mapped to the Goodroe database. For the 10 to 15 fields that could not be mapped, a clerical person enters the data.

The OR business manager administers the project, ensuring data integrity and preparing quarterly presentations for the surgeons.

**Gainsharing lessons**
Christensen offers these lessons from the project:

- Do your homework up front to develop constructs with clear definitions. Link the vendors’ brands names to the appropriate constructs so there is no confusion.
- Make sure definitions are all inclusive to cover, for example, cutting blocks, screws, and pins.

The need for inclusive definitions became clear when one vendor introduced a new total-knee technology that allowed a custom cutting block for each patient. That meant the patient needed a CT scan (an additional patient charge), plus the cost of the cutting block, which could only be used for that brand of implant.

Gainsharing started the hospital on the path toward greater collaboration, enabling breakthroughs not only on costs but also for safer, more coordinated care. ❖

—— Pat Patterson

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Have a question on the OR revenue cycle?

Keith Siddel will respond to questions in the column. Send your questions to editor@ormanager.com

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