Solid teamwork and a commitment to high-quality patient care are the hallmarks of a successful healthcare facility. But egos sometimes get in the way, and competition among surgeons in the orthopedic service line at St Louis-based SSM Health Care was impeding progress. The surgeons were affiliated with three independent groups, and just being together in the same room was uncomfortable for them.

“We had that surgeon mentality that if another surgeon is doing a knee replacement, he took it from me, and I should be doing it,” orthopedic surgeon William Schroer, MD, told OR Manager. “We spent too much time battling each other, and we weren’t really moving our service line forward at the hospital.”

Dr Schroer believed the orthopedic groups performed a high enough volume of total joints that they could create a new entity—a hospital within a hospital—so he invited the heads of the other two groups to meet him off campus for a drink to discuss the idea.

Six months later, the three surgeons—Dr Schroer, Fallon Maylack, MD, and Terry Weis, DO—had formed their own limited liability company (LLC). Six months after that, they contracted with SSM DePaul Health Center for medical management of the Joint Replacement Center, a 24-bed unit within the hospital. Through this hybrid medical directorship, the once-competing surgeons became collaborators.

‘Souped-up medical directorship’

As the SSM Health Care network’s service line executive for orthopedics in 2007, Lisle Wescott needed to find ways to grow market share in joint replacement services. At the time, the orthopedic surgeon groups were very competitive, she says. “If I put an article in the paper about one of the orthopedic surgeons, another one would bring it to me and ask why he wasn’t featured in it.”

Wescott says she applauds the three surgeons for what they have achieved. “It was a big deal having them come to the table and work jointly. All I had to do was provide the data and the information, and they did the rest. It was beautiful,” she says.

The first order of business was to craft a physician alignment model that would protect the interests of the three surgeons and the hospital—in addition to passing regulatory hurdles. They looked at traditional comanagement models and medical directorships, and ultimately came up with what Wescott calls “a souped-up medical directorship” in which the three surgeon partners formed an LLC that contracted with SSM to manage the Joint Replacement Center.

Wescott says she calls it a souped-up medical directorship because it is more than just physicians being paid to direct a program, go to meetings, and work on a few key objectives. “It is really about their being at the table and managing and leading and being held accountable to agreed-upon quality and satisfaction metrics.”

Their contract with the hospital included specific quality measures, so that a portion of compensation was tied to obtaining quality goals, such as patient satisfaction and compliance with Surgical Care Improvement Project (SCIP) measures.

“We wanted it tied to these goals rather than just being an extension of an hourly wage,” says Dr Schroer. “If we met the goals, we got the compensation. If we didn’t meet them, we weren’t compensated.”
The result has been 99.89% compliance with SCIP measures and patient satisfaction scores above the 90th percentile since the opening of the Joint Replacement Center at DePaul (sidebar, p 17).

Peer pressure to cut costs

Becoming medical directors of the Joint Replacement Center involved a significant amount of work and input, and still does 7 years later, says Dr Schroer.

The management agreement included a structure for improving and standardizing the three phases of a joint replacement patient’s care—preoperative, intraoperative, and postoperative. Each of the lead partners was assigned a particular phase as physician champion.

Though the agreement allowed the medical directors to implement a change if all three agreed on the basic principles, Dr Schroer says they did not want to “run roughshod” over their partners, so they always met with them and went through item by item the decisions they were making.

“Most differences stemmed from the way we were taught in our residencies,” Dr Schroer says. For example, one surgeon was using a $30 suture and everyone else was using a $5 suture. When asked why, he said that’s what he had been using ever since his residency.

“Suddenly he was at a table with 10 other surgeons asking him why he was using a $30 suture and they were all using a $5 one that worked just as well,” says Dr Schroer, “and he answered, ‘I can use that. Nobody ever asked me.’”

That and many other issues were resolved very quickly, simply by getting everyone together in a room and discussing them, he says.

In addition to meeting with their surgeon partners, the three directors met every Thursday morning, and they met monthly with a multidisciplinary team that was involved in each step of standardization across all three phases of care.
These meetings continue today. Team members include the OR director, OR orthopedic nurse manager, Joint Replacement Center director, physical therapist, social worker, and representatives from any service that the patients will use during their stay.

**Strict implant policy**
The three directors worked with the entire orthopedic department, including surgeons, nurse managers, supply chain personnel, and administrators, to consolidate implant purchases. By limiting implants to three vendors, the directors ultimately saved SSM more than $2 million.

The directors had to play “hardball” with the other surgeons and the vendors to limit implant choices and meet the price criteria, says Wescott.

Implant choices ultimately had more to do with the surgeon’s comfort level than the implant itself, she says. “It’s like driving your car. You are familiar with the controls, the radio stations, and the seatbelts. It’s really more about you than the car.”

In the meetings, one surgeon would say: “I prefer my vendor. I prefer my implant.” And one of the directors would answer: “You can use this implant. You just don’t want to.”

Having one surgeon challenge another in front of their peers is more powerful than anything any administrator can do, says Wescott.

From an administrative standpoint, however, the directors also had to “toe the line,” she says. “Once they decided that vendors would be limited to three, it had to stay three, even if one of their favorite vendors wasn’t one of those chosen. They had to be true to their word. And they were. And for the first time, that really changed the landscape in our market.”

**Standardized care**
As the surgeon champion for standardizing order sets, Dr Schroer first gathered all of the surgeons’ preoperative, postoperative, and inpatient orders and looked
for the commonalities and the variables. The details were hammered out in multidisciplinary meetings.

Standardization included working with the hospital to open a surgical evaluation center. Patients go there 10 to 14 days before surgery to be registered, and RNs do a preoperative assessment and enter the information into the electronic medical record.

Nasal swabs to screen for *Staphylococcus aureus* colonization, diabetic screening, and sleep apnea screening are standard for all patients.

If patients are positive for *S aureus*, they go through a decolonization program that consists of nasal mupirocin ointment and chlorhexidine gluconate showers before surgery, says Dr. Schroer.

All patients attend preoperative classes and discharge classes taught by the patient care liaison team leader, Mary Reedy, RN. Reedy and two other nurses hired by the surgeons see all of the patients when they are on the unit, and they do all of the patient education.

“We work very closely with the nurses and surgeons and coordinate the patient’s care from beginning to end,” says Reedy.

She was on the committee to streamline the patient care pathways, and she says the surgeons and nurses were basically all doing the same things but with different approaches. “They all came together and found a reasonable approach and made it standard for all patients,” she says.

The surgeons teamed with the anesthesiologists to standardize preoperative orders. “We got rid of a large number of unnecessary lab tests, and we no longer type and cross-match two units of blood or type and screen for primary joint patients,” says Dr. Schroer.

Postoperatively, all patients go to the 24-bed unit, which has a dedicated physical therapist and case manager. These two plus the charge nurses, surgeons, and nurse liaisons meet every Friday about the following week’s patients.

“We talk about anything special or different, such as a 6 ft 6 in patient who will need a longer bed or which patients are taking narcotics before surgery for pain because they are harder to deal with painwise after surgery,” he says.

The group also looks at which patients are coming back for a second total joint. Those patients are put in one of the eight rooms that are larger and more comfortable.

“Standardizing the order sets was a big accomplishment,” says Dr. Schroer. “Standard orders give the unit nurses a huge amount of confidence in how they are treating the patients.”

For example, he says, when pain management protocols are the same, the nurses don’t have to ask questions such as, “Is this patient Dr. Smith’s or Dr. Jones’s? Am I allowed to give this medication if they are throwing up, or do I have to give a different medication?”

It really improves the quality of care when nurses know the patients are going to be treated in a similar fashion, he says.

**Training for consistency**

Before the 24-bed unit was opened, a 7-day training session was held for everyone who would be encountering the patients, including housekeeping, food services, social services, RNs, and clinical aides.

“Mainly what we did,” says Dr. Schroer, “was sell them on the idea of standardization and our ‘golden rule’—treat the patients as you would like to be treated—and we reminded everyone why they got into healthcare in the first place.”

Expanding on the theme of Malcolm Gladwell’s book, The Tipping Point: How Little Things Can Make a Big Difference, Dr. Schroer says they told everyone, “If you do the little things well—if you smile when you talk to the patient, if you are pleasant, if you say thank you and you’re welcome—the patients will respond to it.”

In training for consistency, notes Wescott, the attendees also discussed how they would greet patients in their rooms:
• What is the housekeeper going to say?
• What is the nurse going to say?
• What is the therapist going to say?

“We wanted it to be consistent in terms of messaging so that the patient’s experience would be top notch,” she says.

The group also talked about customer service, says Wescott. “We asked: ‘How are you going to delight the patient?’”

Answers given included:
• For patients who were returning to have a second joint replaced, the nurses planned to make a sign saying “Welcome back, we are excited to see you again” with a balloon attached and put it in the patient’s room.
• The unit secretary said, “Before my shift starts, I am going into each patient room and introduce myself so when the patients turn on their call lights, they will hear my voice and know it is me.”

Each person came up with their own idea, says Wescott, but the overall goal was the same: “We are going to delight our patients.”

The anesthesiologists talked to the group about the types of blocks being given to the patients, so that everyone, even the housekeepers, would know how to respond if they saw a patient trying to stand who shouldn’t be.

The physical therapist took the entire group through training on how to transfer patients and how to safely move them from the bed to the chair. “Not everyone would be doing this, but we wanted them to know how to do it safely in the event they had to assist with those processes,” says Wescott.

The intent was to achieve consistency and standardization while still having flexibility to individualize care, she says, and the results have been very positive.

The patient response has been amazing, says Dr Schroer. “Patients tell me all the time: ‘I have never been on a hospital floor like this one.’”

Within the first 3 months after the unit was open, patient satisfaction scores went from middle of the road to the 99th percentile (sidebar, p 18).

Evolution to employment
For the past 3 years, the surgeons have been employees of the hospital.

“It was an evolution,” says Dr Schroer. “It made sense because we were all working together, and we had a common vision of where we thought medicine was going. An employment model, long term, made sense for us.”

When they went to the employment model, another group of orthopedic surgeons joined them, bringing the total number of surgeons to 16.

“We are very fortunate at the success of this program, and I give the surgeons a lot of the credit,” says Wescott, who is now president of SSM St Joseph Hospital West in Lake St Louis, Missouri.

“I am no longer working with the Joint Replacement Center on a day-to-day basis, but the surgeons and the staff remain committed and the work continues,” says Wescott. “That is the mark of a great program,” she says, “when the folks who worked to birth something move on to other things, and it keeps growing and remains successful.”

—Judith M. Mathias, MA, RN

Reference