TODAY'S AGENDA

Outpatient Joint Replacement (OJR)

• Historical Progression of TJA Procedures
• Industry Demand for Change
• Marshall Steele Approach
• Results

OUTPATIENT JOINT REPLACEMENT: 5 FACTS!

1. The percentage of the M|S joint database that represents outpatient joint replacements has doubled each year over the last 3 years (still less than 2 percent).

2. Outpatient joint replacement requires everything be “perfectly executed”.

3. Controlling overall cost of the continuum of care for a specific disease state is important when looking at reimbursement and payment reform changes.

4. Direct Costs for an outpatient versus inpatient joint replacement in a hospital can be 25% less.

5. Patient requirements of an improved experience, lower cost, reduced risk of infection, and efficient throughput may translate into the ultimate demand for an outpatient joint program.
SAFETY - PATIENT SELECTION

- Patient less than 65 y/o unless a uni-knee candidate (Medicare) with definitive diagnosis and who has been pre-assessed by medical consultant
- Fully informed/educated patient/family regards surgical care process and discharge expectations
- No co-morbid medical conditions that might lead to hospitalization
- Motivated patient willing to aggressively pursue rehabilitation on an outpatient level
- Family support system for maintenance of home care
- Suitable for straightforward primary joint replacement

SAFETY – FACILITY REQUIREMENTS

- Staff adequately trained in the surgical care of a joint replacement patient
- Orthopedic implants and equipment suitable for joint replacement with backup
- Anesthesia protocols allowing same day or 23 hour discharge
- Pain management protocols
- Blood management protocols (pre, peri-op, and post-op)
- Transfer agreements with local hospital (ASC)
- 23 hour permit for patient care with staff/facility to manage patient/family (ASC)
- Follow-up appointments confirmed prior to discharge

TJR TIMELINE FROM A SURGEON PERSPECTIVE

- 1983: Mayo Clinic Fellowship: THA/TKA 5-7 days
- 1984: Return home: Total Hip Patients in bed 10 days in slings
- 1991: TVC program initiated: TKA stay reduced from 5 to 3 days
- 2002: Out-patient (23 hour stay) Uni-Knees performed in ASC
- 2011: In-patient stay for THA/TKA average 2-4 days
WHY MOVE TJR TO OUTPATIENT SETTING?

• Improve Quality/Patient Safety
• Greater Surgeon Control
• Cost Savings
• Increased Revenue
• Outpace the Competition
• Patients are Asking – New Option for Joint Replacement
• Anticipating the Future Direction of Healthcare (i.e. bundled payments)
• Other

WHAT IS NEEDED TO ACHIEVE SUCCESS?

• Superior Clinical Outcomes
• Cost Savings For Insurance Companies and Patients
• Profitability For Surgeons/ASCs
• Extraordinary Patient Experience
• Positive Word of Mouth Marketing
• As Good or Better than Inpatient TJR
• Will Out-patient Joint Replacement in ASC Become Standard?...

ENGAGING SURGEONS – WIIFM?

• Patient Satisfaction
• Staff Satisfaction
• Reduced Complication Risk By Having Patients Return Home ASAP
• In ASC, Surgeon Control of Entire Care Process Including Time Management
• In ASC, Potential Financial Benefit Depending on ASC Ownership Structure and Payor Regulations
Do You Believe Outpatient Joint Replacement is Here to Stay?

- Yes
- No
- Not Sure

Are You Currently Performing Outpatient Joint Replacement?

- Yes
- No
- Would Like To

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WHAT SURGEONS PERFORMING OJR ARE SAYING...

Q: To successfully bring total joints to an outpatient setting, what procedures and protocols must be in place? Chad Burgoyne, MD, The Spine & Orthopedic Surgery Center (Santa Barbara, CA):

- The most important factors in performing a joint replacement as an outpatient procedure are the coordination and protocols that allow the surgical team to provide streamlined service.
- The surgical team needs to be consistent and well trained in joint replacements; the shorter the surgical time, the less pain and subsequent anesthesia is required, and the more the patient is able to participate immediately in therapy comfortably. Second is the anesthesia team. With a combination of spinal, regional and local anesthesia, we are now able to have postoperative patients that need little to no pain medication in the first days after surgery.
- The nursing staff must also shift their focus to enable the efficient discharge of patients. Their role is as much coach as caregiver. They must care for, educate, facilitate and encourage all in one breath. All the resources and steps must be in place so they can focus on the task at hand. Finally, there is the therapy team. The therapists must organize their days around the operating room schedule to minimize down time. A patient cannot be allowed to sit in bed and simply "recover." The therapists must be available to start ambulation within the first hour after surgery is complete.


SURGEONS DOING OJR...

Q: Are total joints trending outpatient or inpatient, and why?

- Dr. Burgoyne: Joint replacements are most definitely trending towards an outpatient model. At the most basic level, long inpatient stays are simply not necessary. Often my patients are bored, requesting discharge by the second day after surgery. The reality is that there is not much we do for patients during their two- to three-day hospital stay. If their pain is well controlled with the regional anesthesia, they are usually sitting around waiting for the one to two hours of therapy they receive. Why not sit at home and come in for outpatient therapy daily instead?
- Dr. Riordan: Clearly outpatient joint replacements are trending upward. Our experience, as well as that of other facilities in our region, is that an exciting increase in patient and surgeon demand for this service is occurring. ASCs are ideally positioned to lead this movement that lowers costs, controls complication rates, improves satisfaction and is preferred by patients.

Q: Are insurance companies coming onboard with outpatient joint replacements?

- Dr. Scioli: The insurance companies will be more inclined to endorse these procedures being performed as an outpatient once adequate data exists to support the practice as being safe and effective. Medicare and Medicaid should allow for certain criteria to exist such that special cases could be done as an outpatient. In time, outpatient joint replacement will gain the traction it needs to become routine.
- Dr. Riordan: Insurers were initially cautiously supportive or sitting on the sidelines as interested observers. Lately, insurers have contacted us regarding our outpatient joint program, requesting data, asking to gain an understanding and even promoting our model in their other markets.
- Dr. Burgoyne: Medicare has acknowledged this trend and is revisiting their policies in regards to payment for outpatient joint replacements. Once they allow for outpatient arthroplasties, it is likely other insurance companies will follow suit. With rising costs and the large volume of procedures to be performed in the coming years, I think this shift to outpatient care is crucial to maintaining access to these vital procedures.

There are some roadblocks to outpatient arthroplasty, as described by Dr. Lombardi:

- Patient Fear/Anxiety
  - Patients are afraid of the unknown, not knowing what is going to happen
  - Patients are afraid of the pain associated with the procedure
- Risk Factors
  - Patient co-morbidities
  - Medical complications as a result of the treatment
- Side Effects of the Treatment
  - Narcotica/anesthesia
  - Blood loss
  - Surgical trauma

HOW DO WE SUCCESSFULLY TRANSITION?
SERVICE LINE APPROACH – THE PATIENT EXPERIENCE

People
  - Alignment/Structure
  - Management from Metrics

System of Care
  - Patient Focused

Enabling Systems
  - Tools and Materials

Culture
### OUTPATIENT JOINT REPLACEMENT

#### Program Components

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<th>Infrastructure</th>
<th>Clinical Program</th>
<th>Management</th>
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<td>Service Line Leaders</td>
<td>Outpatient Clinical Pathway</td>
<td>Outcomes</td>
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<td>Physician Participation</td>
<td>Standardized Plan of Care</td>
<td>Marketing</td>
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<td>Patient Selection</td>
<td>Patient Education</td>
<td>Program Sustainability</td>
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<tr>
<td>Facilities &amp; Equipment</td>
<td>Service Providers/Partners</td>
<td></td>
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<tr>
<td>Surgery Scheduling</td>
<td>Staff Training: OR</td>
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<td></td>
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<td>Post-op</td>
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<td></td>
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<td>Emergency Protocols</td>
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- Home Health/SNF
- Procedure Training/Competency
- Room and Procedure follow-up

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### OUTPATIENT JOINT REPLACEMENT

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### STANDARDIZED PROTOCOLS

<table>
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<tr>
<th>Protocol Name</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mobility Checklist</td>
<td></td>
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• ASC Reported Outcomes
• Patient Reported Outcomes
The Program improves the Metrics the Metrics improve the Program

ASC – JOINT PROGRAM METRICS

CLINICAL
Complications
Cardiac
Pulmonary
Renal
Hematology
Wound
Neurosurgery
Other

OPERATIONAL
Case Volume
Length of Stay
Hospital Admissions
Discharge Disposition
Emergent Transfer
Readmission
Cancellations

FINANCIAL
Direct Costs
Indirect Costs
Reimbursement
Reimbursement Type
Contribution Margin

OPERATING ROOM
Surgery Time
Prep Time
Exit Time
Duration Accuracy

FUNCTIONAL
SF-WOMAC
Knee Society
Harris Hip

SATISFACTION
Overall Satisfaction
Likelihood to Recommend

MONTHLY PERFORMANCE IMPROVEMENT MEETINGS
• Analyze Results by Procedure, Surgeon, Anesthesiologist
• Identify Trends/Comparisons
• Tease Out Strengths and Opportunities
• Develop Action Plans
• Manage Outliers
PATIENT REPORTED OUTCOMES

- Did the Intervention Succeed?
- Are the Patients Satisfied?

Surgery Post-op Survey

Aggregate Reports

Real-time 6-12 Months Annually

Patient Results Quarterly

PATIENT REPORTED OUTCOMES

• Simple Data Collection, Analysis, Benchmarking Tool
• Survey at Pre-op and Post-op Intervals
• High Patient Compliance Rate
• Portable
• Secure
• Efficient: 15 To 25 Questions (< 6 Minutes)
• Customizable

PATIENT REPORTED OUTCOMES

iPad: Easy to Use for Patients and Staff

PERFORMANCE IMPROVEMENT TEAM

• Dashboard Report
  - Evaluate Progress
  - Set Goals
  - Benchmark: MS 1 day LOS: Your Own Performance
  - Share Results with Key Stakeholders
• Program Sustainability
  - Using Data to Help and Physician Leadership to Effectively Manage the Service Line with Comprehensive, Actionable and Relevant Outcomes Data
MULTIFACETED MARKETING PROGRAM
Program Display Board, Brochures, Patient Guidebook and Recovery Tracker, Website, Radio and TV

OUTCOMES MARKETING
Share with Key Stakeholders – PCP – Surgeon – Payers - Community
- Patient Recovery
- Improved Quality of Life
- Low Complication Rate
- Discharge Disposition/Plan of Care
- Excellent Patient Experience

SUMMARY: OUTPATIENT SURGERY CENTER, ANYWHERE USA
LAUNCH APRIL 17, 2014

<table>
<thead>
<tr>
<th>Metric</th>
<th>Results: Q2 – Feb 2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeons</td>
<td>4 participating surgeons</td>
</tr>
<tr>
<td>Volume</td>
<td>TKR: 13; THR: 18 Total case count YTD: 31</td>
</tr>
<tr>
<td>Discharge</td>
<td>Home Health: 0; Outpatient PT: All</td>
</tr>
<tr>
<td>Average LOS/Hours</td>
<td>9.1 hours; NO OVERNIGHT STAYS</td>
</tr>
<tr>
<td>Complications</td>
<td>None</td>
</tr>
<tr>
<td>Readmissions</td>
<td>None</td>
</tr>
<tr>
<td>Unplanned ED</td>
<td>None</td>
</tr>
<tr>
<td>Physician Visits</td>
<td>None</td>
</tr>
<tr>
<td>Avg. Insurance Contract Price</td>
<td>Around $25,000 – $27,000</td>
</tr>
<tr>
<td>Average Contribution Margin</td>
<td>~ $11,000 – $16,000 depending on payer</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>“I had surgery in the morning, went home on crutches four hours after the surgery and returned to work part time a week later. (Nick R.)”</td>
</tr>
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Summary: Outpatient Surgery Center, Anywhere USA
Launch October 17, 2014

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<thead>
<tr>
<th>Metric</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgeons</td>
<td>15</td>
</tr>
</tbody>
</table>
| Volume                  | Complete: 20
               Scheduled: 7      |
| TKR                     | 15      |
| THR                     | 12      |
| Uni TSR                 | 3       |
| TSR                     | 3       |
| Discharge Home Health   | 45      |
| Outpatient              | 1       |
| Average LOS / Hours     | 31:15   |
| >8 hrs.                 | 15      |
| Complications           | None    |
| Readmissions            | None    |
| Unplanned ED / Physician Visits | None |
| Avg. Insurance Contract Prices | Pending |
| Avg. Contribution Margin| Pending |
| Surgeon Satisfaction   | "It couldn't have gone any smoother – I want to bring all my patients here." |

Lessons Learned

- Physician Leadership/Staff Teamwork/Administrative Support
  - Necessary for Effective Change and Sustainability
  - A Program vs. Providing the Service
- Care by Experts with Standardization and Best Practices
  - Better, Faster, Less Expensive, More Compassionate
  - Predictable Outcomes, Reduced Complications
  - Develop one day discharge standard in-patient before out-patient
  - Consider initiating program with Uni-Knee patients
- Reduced Variability Care Systems
  - Shortens the Time
  - Efficiency, Surgeon skills in operating room (less than 2 hour cut to close time)
  - Safety
  - Cost Effective
- Transparency with Data
  - Leads to Continuous Improvements
  - Creates Trust Between Surgeons, Staff and Administration
  - Create the "WOW" Factor
- Word of Mouth

Thank You!

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