

# ORTHOPEDICS AND SPINE

Strategies for Superior Service Line Performance



MARSHALL K. STEELE, MD

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MARSHALL K. STEELE, MD

**+HealthLeaders**<sup>Media</sup>  
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# About the Author

## Marshall K. Steele, MD

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Marshall K. Steele, MD, has been involved in healthcare for more than 40 years in a variety of roles. He is a board-certified orthopedic surgeon and a member of the American Academy of Orthopedic Surgeons and the American Association of Hip and Knee Surgeons.

After finishing his orthopedic residency and serving in the Navy, he joined his father in orthopedic practice in Annapolis, MD, in 1977. By the time he retired from surgery in 2006, Steele had grown the practice into a 17-physician subspecialty orthopedic group that included programs in joints, spine, physiatry, sports medicine, foot/ankle, and hand.

Between 1996 and 2005, Dr. Steele also served in administrative roles at Anne Arundel Health Systems. As medical director of the operating room and surgical business development, he defined the core elements of excellence and created the model for patient-centric care, which he used to assist in the development of the organization's service lines—known as destination centers of superior performance—in joint, spine, and vascular surgery. These centers have proved to provide



a superior patient and family experience, greater surgeon efficiency, higher market share, enhanced profitability, and national recognition.

In 2005, Dr. Steele founded Marshall Steele & Associates ([www.marshallsteele.com](http://www.marshallsteele.com)), which provides assessments, planning, implementation, and management of destination centers. The firm facilitates hospitals' long-term success by employing systems for electronic collection of patient-reported outcomes as well as benchmarking and trending of clinical, operational, financial, patient experience, and functional data.

Dr. Steele has written many articles on leadership and service-line development as well as one other book, *Sideline Help: A Guide for Immediate Evaluation and Care of Sports Injuries*, published by Human Kinetics in 1996. He can be reached at [marshallsteele@marshallsteele.com](mailto:marshallsteele@marshallsteele.com).

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- Judy Jones, MS—vendor relationships, excellence
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# Prologue

Since I finished medical school in 1971, much has changed and much has stayed the same. The technology has quickly outpaced my initial education, but even after nearly four decades, our culture of independence and reliance on individual performance persists. This has served us well in the past. However, the future will require a culture not of independence, but interdependence; not of individual performance, but of systems performance.

When I began orthopedic practice in Annapolis, MD, in 1977, most orthopedic surgeons were generalists. Half my practice came from the emergency room. The term “sports medicine” was just being introduced. Most of us thought of it as marketing and not substance. My father, Marshall Steele Jr., an orthopedic surgeon at the Naval Academy, spent most of his time caring for sports injuries. There were few civilian programs or centers in the country that could provide rapid access, accelerated rehabilitation, community education, and service for either young or old athletes.

In 1979, after a spending a few days in New York City with Dr. James Nicholas, one of the first sports doctors in the country, I returned anxious to create a sports medicine center in Annapolis. This resulted in the hiring of a fellowship-trained

sports medicine orthopedist, sports-oriented physical therapists, and athletic trainers and physicians to provide education and support for our community athletic programs. Our success was enhanced by engaging many nonorthopedic physicians in both the care of athletes and coverage for local sports events.

Having the right people was vital, but creating systems (structure and processes) was equally essential. This included the development of a leadership team, a sports hotline number, a walk-in clinic, disease-specific educational tools, weekly articles for our local sports pages, and a guide for coaches in caring for injuries (*Sideline Help*). The incredible success of this center spawned my interest in service lines. Using this as a model, we developed additional programs for our practice in arthritis, spine, foot and ankle, and hand.

Despite the success of these programs, much was missing. We did not have coordinated care throughout the entire continuum, patient-reported outcomes were not being measured, operating room (OR) efficiency was lacking, and there was no organized system of care for joint and spine patients who were hospitalized after surgery. The end result was a mediocre hospital patient experience, fragmented care, more time in the lounge than the OR for surgeons, little hospital profitability, and outmigration of patients. A change was needed.

In the mid-1990s, I assumed several official administrative roles at Anne Arundel Medical Center in Annapolis. This included medical director of the OR and director of the surgical initiative (business development). As I contemplated what to do, two individuals were influential in my thinking: Dr. John Barrett, an orthopedic surgeon in Florida, and Regina Herzlinger, PhD, a Harvard professor and

author of the landmark book *Market-Driven Health Care*. Their thoughts, combined with the support of hospital administrators Bill Bradel, Chip Doordan, and Sue Patton; Dr. Stephen Faust, an orthopedic colleague; and Dr. John Martin, a vascular surgeon, enabled us to transform the care we provided in joints, spine, and vascular surgery.

Specialized units, effective leadership structures, accountability, and creative delivery systems were created within the hospital. Our results were extraordinary: We improved the patient experience, family participation, quality of care, and profitability. The outmigration of the past became immigration as we doubled market share and increased volumes up to sevenfold. Perhaps more importantly, these programs led to much better physician-physician and physician-hospital collaboration.

These successes were noted both domestically and internationally. Hundreds of hospitals visited us. However, post-visit surveys revealed that very few hospitals were able to implement this model themselves. A combination of being too busy, having little expertise in project management, no physician champion, and trying to improve incrementally seemed common roadblocks. These hospitals failed to realize that we were advocating transformation, not reformation of their old systems. Many of you reading this book run the risk of making the same mistake. When building a destination center, principles and people must be synchronized with structure and processes to achieve optimal results. I believe that this is how we can transform care.

I am so passionate about this that in 2005, I retired from surgery after 31 years and launched Marshall Steele & Associates as an implementation company to help hospitals and physicians make this transformation. Traveling the country has only strengthened my respect for and belief in the absolute desire of physicians, nurses, allied health professionals, and administrators to do the right thing. However, in assessing hospitals, I have learned that most still have the very traditional care and leadership model that was present in the 1970s when I started practice. Care is not patient- and family-centric by our new definition. The knowledge that patients and families possess to improve systems is not being used to make changes. It is rare that one person has or is responsible to manage all the metrics and care. Rather, management and care is done in silos by various departments and individuals. Even today, less than 5% of hospitals and physicians collect and aggregate information on whether their interventions actually helped their patients.

In an environment in which quality must be demonstrated and cost must be wrung out simultaneously, this will need to change. We have made a small dent. By spring 2009, our company had successfully implemented a program or two in more than 65 hospitals from coast to coast. These hospitals, ranging in size from 25 to 800 beds, are seeing the same great results that we experienced in Annapolis. However, there are 6,000 hospitals that need up to 20 or more programs apiece. It's a big task.

Healthcare is complicated, maybe the most complicated of any industry. There are many challenges in trying to transform care. Skeptics are everywhere, given the history of failed initiatives and broken promises. Changing the culture and the thinking of the individuals involved is just as vital for success as changing the care model.

Many well-intentioned individuals believe that physicians won't change. I disagree. However, you must create with them a compelling vision that they believe in and provide the data to support it.

This book does not contain all the answers. Rather, it is a combination of principles and experience of both the dedicated professionals in our company who are responsible for implementation of these programs as well as other colleagues with particular expertise in this area. These individuals are all acknowledged on p. ix.

One thing I have found is that there is a community of likeminded folks who are determined to make healthcare better. They are not waiting for the government to accomplish this. They understand that it can only be done by those of us on the front line. I welcome you to this community and to this journey. In the 1960s, my great-uncle Frank Laubach wrote a book, *Each One Teach One*. Using its principles, he taught much of the African continent how to read. He understood that nobody is smarter than everybody. As you read these pages, I hope they will spark new ideas. Please e-mail them to me at [marshallsteele@marshallsteele.com](mailto:marshallsteele@marshallsteele.com). In so doing, you will become part of our community. I will share your ideas with others as I'll share theirs with you. I look forward to hearing from you.

Sincerely,

Marshall K. Steele III, MD





# Overview of Orthopedics Today

Playwright George Bernard Shaw said, “The reasonable man adapts himself to the world. The unreasonable man tries to adapt the world. All progress is made by unreasonable men.” I am hoping that those of you reading this book have some unreasonableness within you. This book is not about maintaining the status quo in medicine but changing it so that progress can be achieved.

Healthcare prices continue to rise and quality remains inconsistent. Nonetheless, we spend significantly more on healthcare than any other nation, and the U.S. healthcare system continues to receive poor grades on outcomes, quality of care, and efficiency.<sup>1</sup> Say what you might about how the grading is done, the trends are troubling. As Harvard economist Regina Herzlinger, PhD, pointed out in her 1997 book *Market-Driven Health Care: Who Wins, Who Loses in the Transformation of America’s Largest Service Industry*, patients can find out more about the car they are going to buy than the results of the surgeon who has recommended surgery. Similar concerns were echoed by former speaker Newt Gingrich in his 2006 book *The Art of Transformation*: “Anything that is not personalized and

responsive to changes in the individual, and which does not provide the customer with information about cost and quality, will rapidly find itself replaced by something that meets that standard of expectation.”

Few organizations are able to meet this standard today. Tomorrow’s patient will have even higher expectations of care and service. The public, the government, and the employers who pay for health insurance are getting restless. Transparency in cost and quality is emerging. Almost everyone agrees that healthcare and insurance are too expensive and that the system is fragmented and difficult to navigate. It is clear that the patient experience needs to be improved, quality needs to be more consistent, and errors must be reduced.

I like Yogi Berra’s philosophy: “It’s tough to make predictions, especially about the future.” These days, we hear a lot of predictions, particularly when it comes to healthcare reform. President Obama has called the transformation of healthcare a moral and fiscal imperative. The hallmarks of his healthcare reform will be increased coverage and better services. He has stated that he wants to see payments for results, not just procedures; adoption of electronic medical records; and reduced reliance on expensive emergency department (ED) care. He wants healthcare to be more affordable by providing a public option for health insurance. This could signal the beginning of the end of employer-paid health insurance, which has already begun a steady decline. He expects to pay for all of this with increased efficiencies. Whether these changes become reality remains to be seen.

## Is Healthcare a Commodity?

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As a result of medical information being available to the public, some say medical care is becoming a commodity. The traditional doctor-patient relationship is all but extinct. Drugstores and other industries are providing medical care while you shop. Healthcare is no longer local. With the prevalence of information, the ease of travel, and hospitals wanting to care for patients coming from long distances, medical tourism has emerged. Medical tourism is not restricted to patients who travel from one country to another to receive medical care. More frequently, it is when patients travel from one county or one state to another. This has changed the hospital-community relationship. Community hospitals must step up or lose their elective base.

The number of patients needing healthcare, especially orthopedic services, is growing quickly; however, the number of orthopedic surgeons to care for them is not keeping pace. Orthopedic coverage in EDs is at risk in many hospitals. Each day, more and more hospitals are paying doctors to be on call. With margins below the 2.5% level for many hospitals, this becomes an additional burden.

Despite a wealth of uncertainty, several things are for sure. Hospitals and surgeons will be asked to do more with less. Costs must be reduced while quality improves. Transparency will become mandatory. There will be winners and losers. Those who accept the status quo and cling to the broken system of the past will not be the winners. The community hospital and its physicians must create a product and brand equal to or better than that of its larger competitors. It won't

be enough for them just to think or say they are excellent; they will be asked to demonstrate their results. All the government can do is provide us with the right incentives. It cannot transform healthcare. That can be done only by those of us in the trenches.

### **Outlook for Surgeons**

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Surgeons will at least be able to count on having plenty of patients. For joint surgeons, the loss of reimbursement has been significant. In 1978, a total joint replacement reimbursement was \$5,000. In 1994, it was reduced to \$2,100, and by 2007 to \$1,280. Whether surgeons will be fairly compensated and can increase their efficiency to handle more patients is unclear.

Given the economic pressures the country is facing, surgeon reimbursement is likely to decrease in real dollars rather than rise. Affected by this decline in reimbursement, surgeons will continue to find other avenues of income, such as surgical hospitals, ambulatory surgery centers, MRI, physical therapy, orthotics, and prosthetics. Providing these profitable services once provided by the hospital has created more stress on the hospital margins. Hospitals have asked the government to curb this activity. Just when we need closer physician-hospital relations to solve our issues, we have increased tension. Politicians have been debating the relative merits and pitfalls of having surgeons involved in this sector of healthcare. In this current environment, expect that debate to intensify. It is likely that more restrictions will be forthcoming.

Patients will continue to expect perfection from surgery. They feel that if we could put a man on the moon, we should certainly be able to provide nearly perfect healthcare. Physicians are held to a very high standard to do just that, and if they do not, they often find themselves in court. It is also unlikely that Congress will enact any significant tort reform, meaning that very costly defensive medicine and high malpractice premiums will continue.

With all this turmoil, many excellent orthopedic surgeons and large groups are now opting to become employed by hospitals. Compensation is usually based on relative value units worked. Employed surgeons still have significant governance in day-to-day practice decisions. I have observed this working quite well in many places. Goals can be more easily aligned. The orthopedic practice that I founded in 1977 has chosen this route. With the expected shortage of surgeons and national policy changes, this may be the best option for both parties. Whether employment becomes a success story for all involved will not be known for several years.

## **The Traditional Model**

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One of the major flaws with traditional medicine is that we don't have a comprehensive system of coordinated patient-centric care. We have an "it depends" medicine. With specialization (a good thing) has come fragmentation. Everyone operates within silos. Primary care doctors have their systems and set of beliefs, as do surgeons, anesthesiologists, professional staff members, and so on. From their viewpoint, the care they are giving is excellent. However, this individualism, which to date is sacrosanct in healthcare, leads to multiple plans of care for the same condition.

Consider that for a procedure as straightforward as a total joint replacement, there could be as many as 10 care plans for a patient in the same hospital, depending on which professionals are involved. Having that many choices is not a good idea, even if they are evidence based. Operating within these silos can be costly and potentially harmful to the patient. It reduces efficiency for the staff while increasing the risk of error.

Henry Ford did not reduce the costs and improve the quality of his cars by improving individual performance. He did it by developing a system that was focused and repeatable. This did not result in incremental improvement but a transformation. Changing the fragmented, individualized practice we have used in this country for the past 100 years will not be easy. Our profession is dominated by professionals who often resist any thought of standardization as an encroachment on their independence. But incremental improvements won't get us to where we need to be. We need a transformation.

Tomorrow, with transparency and access to knowledge, patients, employers, payers, and physicians will be able to find out who has succeeded in making this transformation. They will seek out those institutions and physicians that can demonstrate superior performance. Patients will drive past one hospital after another to seek care at these institutions. Physicians and nurses will seek them out as the best places to work. They will become branded as destination centers. It can be done. It is being done. You can do it.

## Destination Centers of Superior Performance

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Surgeons are beginning to realize that their reputations are tied to the hospital-patient/family experience. Therefore, it is vital that they improve the care and experience of patients. Hospitals and surgeons must create a common vision for great patient care. One solution that has proven itself very effective is to create sophisticated service lines, which we like to call destination centers of superior performance. We take the best of traditional care and management—highly trained and qualified people—combine it with the needs of our patients—great experience and outcomes—and build it into a system of care. This is done by having the physicians and hospitals come together to create systems that are patient-centric and cost-effective.

The service line approach to orthopedic care represents a huge opportunity to resolve these challenges and more. “Service line” is a term borrowed from manufacturing industries that promote product lines. Similarly, hospital service lines seek to organize care delivery by disease processes, assemble dedicated clinicians and staff members to handle the entire care process, and coordinate with overlapping service lines.

I recently had the opportunity to explain this business approach to a teacher friend of mine: One service line, such as oncology, equates to language arts; another service line, such as cardiovascular, equates to mathematics; women’s services equates to biology; and so on. Without service lines, one teacher would need to teach every subject. Can it be done? Sure. But would a great English teacher be as good at teaching science as a great science teacher? Maybe not.



This concept in healthcare was brought to my attention in the 1990s through the work of Regina Herzlinger, mentioned previously, who studied healthcare and determined that hospitals and patients would be much better off if hospitals and doctors developed efficient niche service lines, which she called “focused factories.” Although the term “factory” offended many healthcare workers, who conjured up images of patients traveling down an assembly line, Herzlinger brought to light the notion that patients are better served in a specialty environment.

Many clinicians find that they are more effective in a service-line environment. For example, nurses working in the traditional model of care may find it difficult to provide patients the personal attention they need, as they are saddled with complexity, inconsistencies, inefficiencies, and paperwork. Some have told me they feel as though they are professionals on a team, not part of a professional team. A professional, specialized team, in contrast, is able to deliver care that is more efficient for physicians and clinical staff members and more personalized for patients.

Herzlinger’s book and other articles at that time spurred interest in developing service lines across the country. Unfortunately, most hospitals focused on advertising service lines, not creating patient-centric care or implementing the core elements of excellence that we advocate in this book. They failed to create the structure and processes that would create a unique experience for patients, an effective work environment for physicians and staff members, as well as a system to manage for ongoing improvement. Without a great product, the dollars spent on advertising were wasted. Some even thought the service-line approach didn’t work. Approaching the service line purely from the advertising side does not work. You need to create a unique product and measure your results. Then you can tell the public

what differentiates you and why patients should seek care from your physicians and institution.

### ***Opportunities abound***

Because of the many systems and specialties linked to orthopedics, there are several potential types of orthopedic service lines in the inpatient and outpatient arenas. Depending on your organization's areas of expertise, you could offer one, two, or a full array of orthopedic service lines. As my principle expertise is in the creation of total joint replacement and spine centers, I will use this model as a frequent point of reference throughout the book. Although the concepts I provide generally apply to all orthopedic subspecialties, we will discuss the nuances of components including joint surgery, spine surgery, fracture care, arthritis care, sports medicine, and more in Chapter 10.

Service line development in musculoskeletal care is the perfect place to start. Primary hip replacements are expected to increase in demand by 174% by 2030, and primary knee replacements by 673%. Hip revisions are expected to increase by 137%, and knee revisions by 600%. Nationally, back and neck pain represent the second most frequent reason patients see a doctor (the first is the common cold). More than 13 million people annually visit physician offices for back pain. Chronic back pain accounts for 15% of all sick leaves and is the leading cause of adult disability.

New surgical technologies for the spine have enabled this market to experience over 10% growth per year during the past decade. Geriatric fractures are on the rise, and many can be prevented. Sports medicine, a term used only as a marketing

tool when I started practice, is now the preferred path for young orthopedists and patients to provide and receive care. Foot/ankle and hand centers are being created as well to provide patients with more comprehensive care.

As you read the following chapters, you will benefit from the cumulative experience of our team and other colleagues who have been involved in the development and management of orthopedic and spine destination centers. Even in today's fast-changing, increasingly technological world, the principles of leadership, excellence, management, patient-centric care, measuring results, and process improvement discussed in the pages that follow will endure.

### Endnotes

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1. Catherine Arnst, "U.S. Health-Care System Gets a 'D'," *Business Week*, [www.businessweek.com/technology/content/sep2006/tc20060921\\_053503.htm](http://www.businessweek.com/technology/content/sep2006/tc20060921_053503.htm) (accessed June 18, 2009).

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