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SYMPOSIUM: ABJS CARL T. BRIGHTON WORKSHOP ON HEALTH POLICY ISSUES IN ORTHOPAEDIC SURGERY

Executive Summary

Aligning Stakeholder Incentives in Orthopaedics

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Introduction

Productive discussion and analysis of how to align stakeholder incentives in orthopaedics requires identifying the key stakeholders, understanding their perspectives, delineating the issues necessitating alignment, and being willing to delve into contentious areas. The participants of the 2008 ABJS Carl T. Brighton Workshop in Tampa, Florida did just this and pushed themselves to never lose sight of Dr. Carl T. Brighton's questions: "Where are we now?"; "Where do we need to go?"; and "How do we get there?" We summarize the discussion, thoughts, and work presented by the workshop participants surrounding the very important topic of aligning stakeholder incentives in orthopaedics and key areas in need of focus. These key areas include insurance reform, specialty hospitals, physician-hospital alignment, physician-industry relationships, regulatory changes, movement beyond physician-centric issues, and the overall need to create value for the healthcare system. We have addressed the pertinent questions surrounding stakeholder alignment in orthopaedics and laid out the groundwork needed to answer Dr. Brighton's last question, "How do we get there?" Concluding remarks address the necessity of leadership by orthopaedic surgeons to drive change in these key areas.

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Background

Key stakeholders in orthopaedics include physicians, hospitals, suppliers, payors, patients, and policymakers. Although these groups have different perspectives and interests, their ultimate goal is the same: to improve the quality of care for patients with musculoskeletal disease. The genesis of many of their differences can be traced back to educational training with further development in the environment in which these stakeholders function professionally, and by virtue of the different inherent goals of their respective professions [2, 8]. In general, physicians want good patient outcomes, autonomy, efficiency, and fair compensation for their work. Hospitals want to provide high quality, cost-effective care to their patient population, and to decrease their risk. Suppliers want to foster loyalty and sales of their products. Payors want to add value, cover lives, and in the case of commercial payors, generate profits. Patients want good outcomes, transparency, and trust. Policymakers want to maximize health benefits with a fixed amount of healthcare resources. The critical question is how to align these different perspectives and interests.

There are multiple areas which could benefit from alignment of incentives among orthopaedic stakeholders. There is the need for effective dialogue between clinicians, hospital administrators, payors, suppliers, patients, and policymakers in order to improve quality and efficiency and to reduce administrative costs and waste in the system. Moving forward with these goals will require credible data, an improved evidence base, transparency, particularly involving cost and quality, and the need to address over- and under-utilization of services. There is the need to address conflicts of interest, to work on new payment models, and to move away from "zero-sum competition". Overall, there is great need to create value for the healthcare system and to assure accountability.

What Are Some Contentious Areas?

Insurance Reform

Efficiency, transparency, and creation of value for the healthcare system are key issues related to alignment in this area. In order to address these issues, collaboration between providers and payors is needed. Yet, how does one start this collaboration?

Data sharing with physicians, beyond practice profiling, is critical for improved quality and practice efficiency. Yet, establishing a dialogue and mutual sense of trust and respect between physicians and insurance companies is difficult. There is great need for improvement of the healthcare infrastructure to lead to better efficiency, decreased overhead, reduced frustration, improved transparency, and improved physician-payor relationships. How is this movement started? How does one help create a more efficient system and decrease insurance premiums?

The value that insurers provide in healthcare needs to be evaluated and understood. The medical profession itself needs to take ownership and start to be providers of this value. As a means to this goal, the medical profession needs to become more proactive in ongoing attempts to determine the best models to improve the quality and efficiency of patient care. Lastly, insurers could provide great value by funding continuing medical education, research, and addressing the problem of the uninsured.

Specialty Hospitals

Surgical specialty hospitals offer clinicians the opportunity to provide focused, efficient care delivery to a specific group of patients. However, concerns about physician ownership, self-referral, and patient selection bias have led some policymakers to raise concerns about the impact of surgical specialty hospitals on the viability of general hospitals [4, 6]. Efficiency, creation of value, conflicts of interest, issues of overutilization, and new payment models are key issues related to alignment in this area. In order to address these issues, collaboration is needed between physicians and hospitals.

The need for equitable solutions for the general community hospital versus the specialty hospital has emerged as an important area for consideration and discussion. Conflict exists between the need for coverage of services at general hospitals versus the opportunity for orthopaedic surgeons to provide focused, high quality, efficient care for their patients in specialty hospitals. Conflict exists due to the perception of "cherry picking" by specialty hospitals, leaving the more complex and poorer reimbursed patients at community hospitals. Use of community hospitals in emergency situations for specialty hospital patients has emerged as a contentious issue without current resolution. How specialty hospitals and general community hospitals can learn from one another and collaborate to assure improved outcomes must be further clarified.

Issues of patient protection have also arisen with the emergence of specialty hospitals. How does one evaluate the potential conflict of interest and overutilization when a surgeon recommends surgery at a specialty hospital where he/she has ownership? What is the best solution for the patient when complications arise at the specialty hospital?

A new type of payment reform called episode of care or bundled payments has added to the debate regarding hospital-physician alignment. Bundled payments involve a single payment from an insurer to a physician-hospital organization which incorporates both professional fees and hospital/technical fees for a given episode of care. Although several demonstration projects employing bundled payments for hip and knee replacement are ongoing, issues related to defining the episode of care, how the payments are divided among the stakeholders, and the impact on quality and efficiency have yet to be resolved [1].

Lastly, an area in need of thorough evaluation is the relationship of physician-owned hospitals to outcomes, surgeon efficiencies, patient satisfaction, industry influence, and patient demands for certain therapies.

Physician-Hospital Alignment

Improved physician-hospital alignment requires leadership on both sides, incremental building of relationships, development of trust, good communication, fairness, co-management, and a vision to look beyond self-interests to collaborative approaches for improving quality and efficiency of care. Physician-hospital collaboration is particularly needed surrounding long-term solutions to cost

containment, quality, prevention of complications, and new reimbursement models involving bundled payments.

Although gainsharing arrangements, in which physicians receive a share of hospital savings attributable to their efforts, are a potential short-term cost-containment solution, the sustainability of savings for the long run is questioned. In addition, legal considerations including Stark and kickbacks complicate this method of alignment [3, 5, 7]. Smaller community hospitals may be at a disadvantage for supporting change for physician-hospital alignment due to lack of volume or efficiencies. How can this be addressed?

Physician-Industry Relationships

Cost efficiencies, evidence-based information, and creation of value are key issues related to alignment of physician-industry relationships. In addition, there is a great need to move away from "zero-sum competition" in the physician-industry-hospital triangle.

Concepts for alignment of physician-industry-hospital and movement beyond "zero-sum competition" include focus on the influence of supplier representatives, development of specific guidelines relating to physician-industry relationships, involvement of suppliers in cost-efficiencies, physician input on hospital and payor value analysis teams, attention to the relationship between surgeon preference and leverage used by industry with hospitals for implant pricing, consideration of unbundling of the implants from the representative, and use of evidence-based information as a basis of alignment. The question is, how to initiate these concepts? How would a center for comparative effectiveness help in this arena? Lastly, what is the value proposition for the use of "older" implants versus the newest and more expensive implants in terms of patient outcomes?

Other Physician Focus

The need to move away from "zero-sum competition" and the need to create value for the healthcare system are key factors for physician focus for alignment of stakeholder incentives. Older regulations and laws that limit the current system are in need of attention and reform. Going forward, physician input will be critical in the areas of health information technology, integrated care delivery models, and prioritization of scarce healthcare resources.

An ability to move beyond traditional physician-centric issues will be essential as health care reform initiatives begin to take shape. Physicians need to focus on global issues that cross specialty lines, quality of patient care, the reasons they initially entered medicine as a profession, and they need to organize with collaborative groups surrounding common issues. And, most importantly, physicians need to speak up for their patients.

Conclusions

Alignment of stakeholder incentives in orthopaedics is a difficult area due to the different incentives and interests of the stakeholders. Areas in need of attention include insurance reform, orthopaedic specialty hospitals, physician-hospital relationships, physician-industry relationships, regulatory changes, and the focus on physician-centric issues. Despite these challenges, there are multiple issues necessitating alignment.

The participants of the 2008 ABJS Carl T. Brighton Workshop listened to the perspectives of different stakeholders in the context of workshop presentations and came together to address Dr. Brighton's questions "Where are we now?" and "Where do we need to go?", as detailed above. Yet, the question "How do we get there?" remains.

Physician leadership is critical as a driver of change for: (1) aligning goals of efficiency between insurers and providers; (2) addressing tensions surrounding orthopaedic specialty hospitals; (3) building primary leadership and trust between hospitals and physicians; (4) addressing issues surrounding industry relationships; (5) organizing within the profession to focus on common issues and move beyond physician-centric issues; and (6) focusing on creating value for the healthcare system. It is the hope of the workshop leaders and participants that physicians consider the sentiment and recommendations from these proceedings as a starting point to become the drivers of change to achieve alignment of stakeholder incentives in orthopaedics.

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