McGuireWoods

Episode 104: Orthopedic Expansion Through Hub-and-Spoke, With Chris Day

Episode Summary

In this episode of The Corner Series, Geoff Cockrell, McGuireWoods partner and host, is joined by Chris Day, CFO of Growth Orthopedics. Chris shares how Growth Orthopedics' platform is expanding into underserved markets through a hub-and-spoke model, extending clinics up to two hours from surgical centers to increase access to care.

Tune in for his insights about how private equity investment improves healthcare access and why the wave of retiring baby boomer physicians will fuel continued consolidation.

Transcript

Voice over (00:00):

This is The Corner Series, a McGuireWoods series exploring business and legal issues prevalent in today's private equity industry. Tune in with McGuireWoods Partner Geoff Cockrell as he and specialists share real world insight to help enhance your knowledge.

Geoff Cockrell (00:18):

Thank you for joining another episode of The Corner Series. I'm your host, Geoff Cockrell, a partner at McGuireWoods. Here at The Corner Series we try to bring together deal makers and thought leaders at the intersection of healthcare and private equity investing.

(00:32):

Today I'm joined by Chris Day. Chris is the CFO at Growth Orthopedics, a large private equity-back orthopedic platform. Chris, if you could introduce yourself and Growth Orthopedics, and then we'll jump into some questions.

Chris Day (00:45):

Sure thing. It's great to be here, Geoff. My name is Chris Day. I'm the CFO at Growth Orthopedics. We are backed by Trivest based out of Miami. Locations in Kentucky, in Texas, and in Maine, both practice groups and surgical centers. Prior to joining Growth Orthopedics back in January, I was at a longterm care provider group called Eventus WholeHealth based out of Charlotte, North Carolina, which is where I live. Just worked my way up through leading finance functions to get to this point. Really excited to be here.

Geoff Cockrell (01:18):

Thanks, Chris. At Growth Orthopedic, you mentioned a number of states that you're in, very diverse states. I think you said Kentucky, Massachusetts, Maine. How do you guys think about where to expand when you're looking at different locations? What are some of the drivers of that choice?

Chris Day (01:32):

Sure. I think that there's a few factors. One is regulatory. Any time you're expanding a medical practice of any type, you have to be careful about the environment for both practices, and just labor law and things like that where you're going into. You want to try to stay out of areas where it's an extra burden on having APPs do work. You need them to be able to do their jobs with less supervision if possible by the physicians because they have their own job to do. You also want to make sure you got a favorable outlook towards employers.

(02:04):

But when it comes to orthopedics, a big factor is just concentration and the combination of a practice that is prepared to sell along with that surgical center, which is really the place to make the rest of the month there. And having a population center you can expand from. When you're expanding, a lot of times what you're doing is almost a hub-and-spoke model. You plant your flag in a metro and then you want to grow out in concentric circles from there. What's your future stage look like to grow this practice is a big factor there as well.

Geoff Cockrell (02:32):

When you're looking at that hub-and-spoke model, how far into less dense areas do you think about that? Because on of the big drivers as healthcare is evolving is trying to figure out models that'll work in less dense areas. How do you guys think about that?

Chris Day (02:48):

Sure. It's really very geographically different. For example in Kentucky, there's a lot of areas pretty quickly when you get out of Lexington, which is where we're based, that folks, they don't have that huge amount of options where they would have another surgical center to go to, for example. Planting a clinic as far as two hours away from our surgical center can still feed patients to it. We see them in the clinic two hours away and they have to go to the surgical center in Lexington for the procedure because there's just nothing nearby. You transfer to a different area and it might be as close as 30 minutes.

(03:20):

The key thing is market intel. Understanding commuting patterns, and traffic, and the density of care in an area. The closer together it is, the less geographic spread. The further apart, the less dense the population, the more you can spread out geographically. You're going to end up with more pressure though in a situation where you can't have doctors go to multiple locations. If you have a very less dense territory, doctors may not be able to travel far enough where you would otherwise get people. You might have to hire another set of docs who can support the clinic that's that far away.

(03:50):

But you really need a very detailed analysis of how far people travel for work as a primary thing, and how close together the medical resources they have. There's off-the-shelf ways to do that, and there's also ways to do that using census data and internal analysis. You have to combine all those and come up with a thesis surrounding it.

Geoff Cockrell (04:07):

Adding that all up, it sounds like you see some of those factors line up that you see moving into more rural areas as a real growth opportunity. Is that a fair way to think about it?

Chris Day (04:17):

It can be. The main thing is does the cost structure work, and will you be bringing in business that you couldn't otherwise get. The biggest risk that happens a lot of times, and we're running into it and other places run into it, is cannibalizing resources. If you open a new clinic up and it's so close that you're just taking patients who were going to your other clinic and sending them to the next one, you're not growing the business. The biggest risk isn't so much going too far afield, it's going too tight and paying additional rent for people you'd be seeing anyway at your normal location.

(04:44):

I think that's the instinct unfortunately, especially because doctors, they always have to be in-person and they're always traveling and seeing patients, is to stay a little tighter in. You really have to look outward if you want to grow the business and not just make it more convenient for customers and more convenient for your doctors.

Geoff Cockrell (05:00):

It's an interesting line if inquiry to me because one of the pressure points in private equity investing in healthcare is there can be critiques that private equity attention can detract from the core aims of healthcare policy of improving outcomes, improving access, and improving the overall cost trajectory. I'm interested to hear, you guys are finding strategies to expand into areas that might have less service otherwise. How big of an impact do you think private equity's role in that, in bringing capital to some of those ideas are to opening access in some of those communities?

Chris Day (05:38):

Yeah. I think that's a lot of the misconception surrounding investment in healthcare. There's an assumption that there's some way to make money by just stripping out things and doing a bad job. That's just not how it works. Payers will cut you off if you don't provide good results when it comes to private pay. The government will audit you. If you're looking to drive margin in a thing where your reimbursements are fixed by plus or minus a Medicare rate, you need to find new ways to do it that deliver better results to the patients.

(06:09):

There is no way really, other than stripping the assets and selling it and selling it for parts, which is not going to make you a lot of money in the long run anyway for you to make money in investing in healthcare and in provider-based healthcare without providing quality results. Because if you don't, it's going to fall apart anyway. Someone needs to buy your company. Someone needs to be there and saying, "This is a good asset we want to continue." You can't just get rid of it to no one in particular.

(06:35):

I think that's just a misconception. It's understandable because there's a lack of trust. It's people who don't have medical degrees helping out people who do. But there's also, when you don't have professionalized back office, you don't have professionalized investment support that comes with that sort of investment. You have people who are very, very smart, very, very qualified, but they're very, very smart and qualified primarily in treating people and not in making the business better for those people. And not making the customer service better, and not making the locations better. That's all more of the MBA than the MD.

(07:07):

Really, the key is the partnership. I think where private equity does do it wrong is when they get into the clinical side. Where the clinicians do it wrong is when they push on the business side. If we can develop a good partnership where your MBA class, your private equity or your support folks are really helping grow the business, and maintain its margins, and make sure that it's strong and helping out the patients, and then the clinicians are doing their jobs to treat the patients, you get the best outcome for everyone.

Geoff Cockrell (07:33):

As you're looking to grow, where do you see green space? Is it new markets? Is it employing the strategy of branching further into less dense areas, some combination of those? Where's the green space?

Chris Day (07:47):

There's a few different places. First, obviously it's optimizing the use of a space. What's transparent to a patient is how you are getting a surgical room ready, what equipment is being used, how on top of things technologically. Are you investing in the newest asset that will allows us to do more surgeries? All of a sudden, a procedure that took three hours and made the surgeon's hands real tired takes half

that time and doesn't, and it's the better outcome for the patient. Those technologies exist, you need capital to invest in them. Those investment in new technologies and in better operational effects helps everyone.

(08:21):

Then you have other things like we're in a very evolving world, especially in orthopedics. Because the thing with orthopedics you could always just not get that surgery. You're not going to die usually from not getting your knee fixed or getting your hand fixed. It's a quality of life issue. You need to basically find people and payers that are willing to make that connection and provide good coverage, and make them want to use their surgical center and use your practice. It's about going straight to these unions, and going straight to these larger factories and saying, "Hey, we can provide the service to your employees who are currently insured and they'll have better outcomes. They'll be feeling better and they'll be better employees." Then it'll be a virtuous cycle instead of a negative cycle. You have to be on top of the new payer models and things like that. You can't just sit there and plan a shop, and hope people show up.

(09:07):

You've got the green field when it comes to expansion of technology, increase optimization of usage. You've got the payer mix and making sure that you're finding new patients. I know as a CFO, we have our own health plan that we're trying to find ways to save money on our end. You always have to be working with the large employers nearby. Then finally, it's bringing services that otherwise were not present at a better price point than nearby. If you get a surgery at a surgical center, your insurance plan and you personally will save money over a hospital almost nine times out of 10. How are we going to make sure that we can provide that service in a way that is not over-built, but also enabling that pulling from the high cost center to a lower cost center?

Geoff Cockrell (09:46):

You're building relationships with large employees in particular, one of your key drivers of, for lack of a better word, advertising?

Chris Day (09:53):

Yeah, absolutely. When you're looking at where you're going to go and who you're going to talk to, every time an employer hits a certain size, they basically become self-insured. They're financing their own insurance. Even if they use the network of Blue Cross Blue Shield, or Optum, or whatever the big one is. They might use their network, but they're taking on that risk which means they suddenly care about the costs. If you can get to a point where you're able to market directly to them, you're really helping out a lot of things and you're helping out those employees then get better benefits probably, because whatever percent that company saves, some of it's going to get passed on in savings to the employee and some of it's getting passed on in better coverage to the employee. It's a win-win for everyone there.

Geoff Cockrell (10:31):

Going back to your green space analysis, is an assessment of the presence of large employers in a community and what they're doing part of your analysis of what might be a good market to go into?

Chris Day (10:45):

Sure. Again, with orthopedics, it doesn't hurt to be near places that are big employers, employers with the type of jobs where people get achy. If you're working in a steel mill or you're digging a mine, you're more likely to need an orthopedist than if you're sitting at a desk. But even then, you might need carpal tunnel syndrome sort of thing. Analyzing the size and scale of employer groups and what they do for a living is very important.

(11:07):

Conversely, you don't want to be in a spot where it's mostly retirees who are going to be on Medicare and the Medicare reimbursement rate is lower on a per procedure basis. They're also more likely to have more stop gap surgeries. But if you're in a different business in healthcare, that might be where exactly you want to go. I came from longterm care. If you wanted to be making your most money, it's not about private payer, it's not about the big employers. It's about what's the demographics of the area? Is it a place that's primarily retirees? That's the place you want to go to, instead of a place that's highly 30-year-olds who are working in the steel mill sort of thing.

Geoff Cockrell (11:40):

Let's talk about the payer mix a little bit more. Orthopedics obviously have a mixture of government reimbursement, sometimes older people. But also, younger people. When you think of the optimal mix, how are you able to impact that? Is that a function of front end decisions about what kind of geographies and the demographics you're going to go into? Or do you have some ability to impact that regardless?

Chris Day (12:05):

Yeah. Listen, the main thing is that you want to make sure that you're providing the same clinical outcomes and the same clinical care to everyone, regardless of what their payer is. That's rule number one. That's when I talk about private equity doing things right and wrong. Let the doctors treat the patients the way they're supposed to be treated no matter what card they bring into the office.

(12:22):

That said, where are you going to place the office? Are you going to place it in the spot that's going to be more likely to attract it? How are you going to market? Are you going to go on the internet, marketing to people who have a certain things in their Facebook profile versus other ones, or doing newspaper advertisement? There is ways you want to target the right customer and you want to target the right geography associated with that. But once they walk into your office, you have to treat them the same way. That's the line you got to draw there. Leverage your money towards growing the business that you want and serve all the ones that show up to your door, essentially.

Geoff Cockrell (12:55):

As you're moving into new markets or expanding in existing markets, what's your mix of de novo expansion versus acquisitions?

Chris Day (13:03):

I think that what you look at is the different types of acquisitions. You've got your big we're going to buy a larger practice that has a surgical center. Maybe it's four, eight rooms, something like that, surgical center. It's got seven to 15 doctors. That's a decent size acquisition in the orthopedic space. But there's also many smaller ones that one would almost call organic growth. We call them an acqui-hire. That's a thing that applies throughout the medical filed. You've got these one or two doctor practices whose maybe got two to four APPs. Their nurse practitioners or your PAs doing their own thing, getting towards retirement, and they're looking to find a way to monetize what they built. They're nearby to something else you own already.

(13:43):

You've got your big flag planters and then you've got your expansion opportunities. The expansion opportunities are both obviously marketing and growing organically, and spending in sales, and things like that. But then, there's these acqui-hires where you talk about getting these very, very small practices, tacking them on, giving them a good plan that they can get a part to, some sort of earn out. You can really grow your practice that way in a lot of ways very well. The key is overlapping things. Certain things you always need to have in-person when it comes to support, when it comes to front office, things like that. It's all about radiuses, whether it's with customers or employees, or things like that. If you understand what your radius is on a front office employee and you find a guy who's got a small office outpost in the suburbs, and you know you can have people staff both offices together, then all of a sudden you can acquire that for a small amount of money and expand that way.

(14:30):

There's many ways to do it. I think that what happens is a lot of times in healthcare is that CFOs and M&A teams, they get hung up on these larger deals and those are great and important. But there's so many smaller deals that, if you have a good system and a good technique to doing it, you can really keep rolling up these one and two doctor practices and really expand that way in an extremely friendly economic way.

Geoff Cockrell (14:55):

How do you think of the relationship with health systems in the markets that you're serving? Are they partners, are they antagonists? Maybe frienemies, somewhere in between? How do you think of those relationships?

Chris Day (15:07):

I think it's a little bit of that last one. The way that the health systems work is they try to get a little bit into everything. Parts of them really care about saving money and they don't care who the patient goes to if they're getting good quality care and saving money. Parts of them are trying to be the ones that are making the money and picking up the same pieces that are being sent out. Sometimes you

end up with conflicts within a health system where one group doesn't care where it goes and the other group extremely cares where it goes. The first group cares about cost, the other one is trying to make the money.

(15:35):

What you've got to do is try to be very aware of those groups. I know in the Charlotte area you've got Novant, you've got Atrium. In the Lexington area, you've got University of Kentucky. Raleigh, North Carolina has got UNC, these larger health groups. The biggest thing is that there are certain things that they always will try to save money on. Surgeries are one of them. If you can have a good surgical option and they don't have it, where it's not in their hospital and it's something they could send offsite to, then you can even pull doctors from them to do surgeries at your surgical center for example, even if they're not part of your practice because that's the way it's legally structured. It's a place to do surgeries. But then they're going to look at getting into that space. It's always a give and take. Frienemies is a great definition of what you're doing there, in terms of balancing working together and also recognizing that these guys have a lot of weight behind them. They're trying to make as much money as possible while they're serving the patients.

Geoff Cockrell (16:29):

Same question with national ASE chains. They can be partners, they can be antagonists. How do you think about a relationship with them?

Chris Day (16:37):

Yeah, I think it's both. Again, we're a partner with one of those on one of our surgical centers, and the other two we run independently. They can be great, especially as you're starting out in this field. When you make your first acquisition of a practice group and maybe it didn't have a surgical center, or maybe it has one and you don't have that internal expertise yet at the MSO level. That could be really helpful. But you've got to be careful what you're getting into with them, one, because they have their own angle towards returns and they have their own structure. You could own 100% of it and they could still run the whole business. Then you might find yourself disagreeing with something and there's not much you can do. Conversely, they may decide they want to build one right near yours and you all of a sudden have a rival that you have to deal with.

(17:15):

I think it's one of those things where it's always better if you can to build the internal expertise to do that, and then own this geography you're in and make it so that no one views an opening. Everyone who comes to your territory says, "Hey, that's the surgical center. The best we can be is the second-best one. We're not going to invest in that area. Let them run their own thing." Then you're getting all the margin, you're not paying anyone else to run it, and you're not worried about anyone incurring on your territory.

Geoff Cockrell (17:41):

How do you navigate relationships with providers, especially in orthopedic? Which the stereotype is always it was all the jocks who went to med school, so big personalities. What are some of the levers that you can pull that will preserve and build those relationships?

Chris Day (17:57):

It's interesting, because the thing with ortho surgeons, I've worked with other general practitioners, and psychiatrists, and things like that. I think the term jocks of healthcare is it's a misnomer in a sense that that implies a lack of intelligence. They're extremely smart folks. They are so smart. What it is is they have this culture where if you talk to them about orthopedic surgery, it's the same way as if you talk to a Giants fan about the Giants, or a Yankees fan about the 1996 Yankees. They're enmeshed in it. It's what they socialize about, it's what they talk about. They're always researching new techniques. They're always bragging about how awesome they're doing at a specific thing because they're doing awesome at it, and they're proud of it, and because they really spent a lot of time working at it.

(18:40):

These people live to get better at their techniques and what they're doing. They look at every single surgery as a challenge to them. What you have to do is harness that raw brain power and competitive streak, that's where it's like a jock, in the sense where you're the quarterback. I played football in high school. You're out there, you're going to try to win every game. They're out there to win every surgery. If you can talk on that level and say, "How are we going to make this be a win for you as a surgeon who's trying to do the best result for their patient?" They're just, "Hey, I'm going to work eight hours today, I'm going to get it done." They'll work 24 hours a day if it takes it to make it work.

(19:14):

You've got to direct them and speak that language of executing to the highest level. They're always working a lot of hours, so they have to feel that they're getting value for it. If you're coming in as an MSO, especially a private equity-backed one, you've got to tell them the story, "We know you're going to work 14-hour days because that's what you are, you're a hard worker. Let's make those 14-hour days worth two-times what they were before because we can work together. As opposed to just feeling like you're always trying to catch up financially with the work you're putting in, because you're never going to slow down." It's a great culture. It's a great group of folks who just always prioritize the best outcomes for the patients, I've found. They're excited about it. There is that locker room feel of just cheering each other on and competitiveness that's really, really fun to be around.

Geoff Cockrell (19:57):

What's your optimism for the next, let's call it two years of consolidation in the orthopedic space? For a long time, we've had lots of conversations on the podcast about longtime provider consolidation had only tailwinds. Those are more mixed now, whether it's labor pressures, cost of capital, regulatory pressures. From where you sit, what is the prognosis for consolidation in orthopedic over the next, let's call it two years?

Chris Day (20:26):

I think that you're still going to see a lot of consolidation. I think that there's a group of folks, a large batch, the Boomer generation of surgeons who are getting towards retirement or have passed retirement and are still working. They're going to want to get out of it. There's not many people up there that they could bring up and say, "I'm going to hand my practice over to this one doc." You go down to the Millennial, or even at this point the Gen Z level of docs that are coming in, and they don't have necessarily the financials right now just based on macro factors to buy a practice whole cloth from someone. I think that pressure of retiring docs seeking to monetize and get somewhere where they know their patients will be taken care of and they know there's going to be a way to steward it will enable continued consolidation.

(21:08):

I think what you do have though is the risk of these macro factors. Like I said, I don't think it's ... Generally speaking, healthcare is a pretty recession-proof business. People need to see doctors. Whether they're without a job or not, whether the tariffs or not, or anything like that, they need to see a doctor. Orthopedics, if you're in that bad a shape financially, you can limp if you need to. You don't get that thing fixed. If your hand hurts, you put a brace on it. I've dealt it myself. I was a paratrooper, I've dealt with limping for a while. There is that risk on the macro effect of how good is the economy. But I think longterm, I think consolidation, it's the only pathway forward for a lot of the way the structure of the healthcare industry is. The hope is that the groups who are doing it the right way where they care about improving the business and let the docs run the clinics are the ones that won out in that race.

Geoff Cockrell (21:51):

Chis, this has been a super interesting conversation, but I think we'll end it there. Really appreciate you joining the podcast. Great conversation. Thanks again.

Chris Day (22:00):

Great. Thanks, Geoff. It was great being here.

Voice over (22:06):

Thank you for joining us on this installment of The Corner Series. To learn more about today's discussion, please email host Geoff Cockrell at gcockrell@mcguirewoods.com. We look forward to hearing from you.

(22:19):