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Call for Proposals

2019 OR Manager Conference and PACU Manager Summit

Proposals are being considered for the 2019 OR Manager Conference and PACU Manager Summit.

Visit www.ORManagerConference.com/callforpresentations2019 to submit yours today! All submissions must be received by October 19, 2018.

Salary/Career Survey

OR leader job satisfaction high despite volatile industry

A steady stream of changes and upheaval, ranging from increased use of bundled payments for reimbursement to the pressure of filling open positions with qualified staff, are affecting OR managers' ability to be successful. Despite the challenges, more than two-thirds (67%) are satisfied with their jobs or positions, according to the 2018 annual OR Manager Salary/Career Survey. More than half of respondents (55%) don't plan to retire until 2027 or later, up from the 42% in 2017 who said they planned to retire in 2026 or later.

But the news from the survey isn't all positive. Significant areas of dissatisfaction remain; for example, fewer than half (46%) of respondents are satisfied with their total compensation. This is not surprising, given that salaries are flat compared to 2017. And although job satisfaction is high, it's less

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Disaster response

California fires threaten safety of OR staff

On Monday, July 23, a trailer blew a tire at the intersection of Highway 299 and Carr Powerhouse Road in the Whiskeytown district of Whiskeytown-Shasta-Trinity National Recreation Area in Northern California.

As the driver tried to stop, the wheel's rim scraped against the asphalt and threw some sparks into very dry grass along the side of the road, starting the Carr wildfire, the sixth most destructive fire in California's history.

On Thursday, July 26, the wildfire jumped the Sacramento River and was making its way into the city of Redding, causing the evacuation of 38,000 people.

Driven by drought, low humidity, and gusty winds, the fire spawned a fire whirl in Redding, generating wind speeds of up to 143 mph—the equivalent of an EF-3 tornado—and triggering a wave of destruction, including the collapse of power lines and trees being uprooted or having their bark blown from them.

Leave immediately

By Thursday afternoon, the fire was within three miles of Shasta Regional Medical Center, a member of Prime Healthcare. Recognizing the danger to the community and potentially to the

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Orthopedic bundled payment models on the fast track—Part 2

According to a 2016 McKesson report, payers expect value-based reimbursement, including bundled payments, to grow from a third of their business to a majority of it in 5 years. And as noted in Part 1 of this two-part series (OR Manager, September 2018, 1, 13-17), bundles are advancing on multiple fronts, including government, commercial payers, providers, hospitals, and ambulatory surgery centers (ASCs).

Lana Smith, MSN, RN

But what is the impact of bundled payments for orthopedic procedures (the most common type) on OR leadership? "OR directors are important stakeholders and need to be involved with bundles," says Lana Smith, MSN, RN, corporate director of service lines at Adventist Health in Roseville, California. "Many complications can potentially occur at the intraoperative phase, and OR directors also work hand in hand with surgeons, who are driving the program." Adventist has 20 hospitals in Hawaii, California, and Oregon.

When it comes to creating pathways for standardizing care, which helps optimize bundled payments, having OR directors at the table can make a difference, Smith says. For instance, the participation of OR directors from several hospitals led to an Adventist Health practice bundle that cut surgical site infections after total hip arthroplasty (THA) by half in just 1 year.

Steven Schutzer, MD, an orthopedic surgeon who is cofounder and medical director of the Connecticut Joint Replacement Institute at Saint Francis Hospital and Medical Center in Hartford, says it's no longer an option for OR directors to ignore the bundled payment train. "Either they step up and get involved, or they risk getting left at the station," he says.

The healthcare market is starting to shift to bundled payment models for orthopedics. "When market share starts to move, it's not going to be moving a few cases from one place to another. It will be moving hundreds or thousands of cases because patients now are often members of large health systems. If a big system signs a narrow network with a large employer and you're not in that network, you're out," Dr Schutzer says.

To ensure future prosperity, OR managers and other healthcare leaders need to determine how bundled payment models fit within their organization.

Conduct an assessment

Dave Terry

Dave Terry, CEO and founder of Archway Health in Watertown, Massachusetts, recommends that those considering getting involved in bundled payments conduct a readiness assessment (sidebar, p 16). "If you decide you are ready, choose to participate in at least a couple of bundles," says Terry, who helps physician practices manage bundles.

Terry recommends providers and organizations first consider Centers for Medicare & Medicaid Services (CMS) programs such as Bundled Payments for Care Improvement (BPCI) Advanced and Comprehensive Care for Joint Replacement (CJR). "They give you a tremendous amount of data, and the rules are well defined, although complicated," he says.

According to Terry, commercial payers are reluctant to share data to the extent that Medicare does, and—because every plan has a different contract system—it can take time to negotiate an agreement. "Medicare has invested tens of millions of dollars in time and effort to work with partners in these programs. They're not perfect, but they are well thought through," Terry says. Participants in Medicare programs have free access to data. "There is no more efficient way to get this data," he says. "And they give you the data every month."

Deirdre Baggot, PhD, MBA, RN, a national expert on bundled care, recommends organizations first look at their quality performance before considering bundled payments. If there are basic gaps, they should close them, and then they should consider volume. "Bundles don't work very well in small-volume organizations because you have to have enough volume to distribute the risk," she says.

Get the right people onboard

Cynthia Emory, MD, MBA

"Have the right stakeholders at the table from the start," says Cynthia Emory, MD, MBA, associate professor and vice chair, department of orthopedic surgery at Wake Forest School of Medicine in Winston Salem, North Carolina. "Some health systems might plan to incorporate surgeons and providers later in the planning, but it's important to have healthcare provider input early on to ensure everyone is looking at things in the same way." She adds that involving the right people, including a quality expert, also helps to avoid overlooking important factors that affect how the bundled payment is set up.

Some hospitals have turned to internal physicians on staff to help drive programs. At Adventist Health, for example, a physician employed by the health system works to engage physicians in a corporate project addressing redesigning care for THA and total knee arthroplasty (TKA) patients.

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Build physician partnerships

Jeffry Peters

At Adventist Health, Smith has seen firsthand the difference that surgeon involvement makes: "Out of the three hospitals that participate in CJR, the one that had the biggest improvement after starting the program had the most involved surgeons."

Jeffry Peters, CEO of Surgical Directions, a consulting company based in Chicago, notes that orthopedic surgeons participating in bundled payment models have good clinical outcomes and—thanks to greater efficiency—they can do more procedures within their block time.

To better partner with orthopedic surgeons, Peters suggests understanding their needs. "They don't want to have to manage the patient preoperatively," he says. Organizations can set up prehabilitation programs to optimize patients for surgery. "Start preparing patients the moment they are scheduled for surgery," Peters says. That includes identifying comorbidities and providing education. Prehabilitation will pay off down the road with better outcomes.

Smith recommends enforcing prehabilitation requirements. For example, patients may be told their case will be delayed and potentially canceled if they don't attend their preoperative education class.

Surgeons also want their patients' pain managed well because early ambulation in the postanesthesia care unit facilitates early discharge. "Most patients in this country are being discharged 1 day after total joint surgery because of the advances in anesthesia and pain control," Peters says, noting that clinical protocols can help organizations achieve that goal.

Hospitals and ASCs can meet surgeons' desire for efficiency by having specialized orthopedic teams who can anticipate their needs. "Surgeons want to put their hands out and have the ORT [operating room technologist] immediately know what instrument they need," Peters says. To gain precious minutes, OR leaders might want to consider flipping rooms for surgeons who perform eight or more total joint arthroplasties a day.

"Surgeons are looking for a total package that meets their patients' needs and their own need for efficiency," Peters says. Dr Schutzer adds: "The OR manager has to convince surgeons in private practice that this [bundled payment] is worth their time. It requires a distinctly different mindset than traditional fee for service, as well as a willingness to collaborate on a more standardized approach to healthcare delivery."

Raise cost awareness

Working directly with surgeons and being transparent about costs can also help increase cost awareness. "I see that my partners and other surgeons across the country [who participate in bundled payments] are much more aware of the costs of what they do, including the cost of implants, and are more aggressive in negotiating contracts with vendors," Dr Emory says. "We may have used four or five vendors before, and now we are using one or

Bundled payment readiness assessment

According to Dave Terry, chief executive officer and founder of Archway Health, organizations that are weighing whether to participate in or develop bundled payments to market to commercial payers should consider the following questions:

- Is the leadership of the organization engaged and committed? "Whether it's the C-suite of a hospital or key partners in a physician practice, they need to be committed to going down this road because it's hard," Terry says.
- Who on the team will be responsible for the day-to-day management, and is that person well positioned in the organization? "You want someone who is known to be successful in implementing new initiatives," Terry says.
- What does the data analysis show? Leaders need to consider factors such as volume, patient variability, and whether there is opportunity for improvement.
- Do we have any experience in value-based care contracting? Examples include Medicare Advantage, accountable care organizations, and any other contracts that are not based on fee for service. If experience is lacking, the organization may want to consider partnering with a bundled payment services firm with expertise in the area.
- Do we have a care management infrastructure? This refers to a team of nurses or other care coordinators who follow patients throughout an episode of care.

Deirdre Baggot, PhD, MBA, RN, a national bundled care expert, suggests these additional questions:

- Do we have an organization-wide electronic health record, or will we be implementing one soon?
- Do we have the technology to scale our efforts with employers and commercial payers?
- What percent of our reimbursement portfolio should be composed of new payment models?
- Are our patients engaged? Unengaged patients are more costly because they fail to make healthy choices.

"Once you know you have leadership commitment and the necessary organizational capacity, you can then start by focusing on improving the process and outcomes," Terry says.

two because we can negotiate a more favorable cost by limiting the number of vendors." After establishing vendors, Dr Emory recommends organizations next look at supplies and prehabilitation of patients.

Cindy Mahal van Brenk, MS, BSN, RN, CNOR

Even when surgeons drive the bundles, a positive partnership with the hospital is essential. At Advocate Lutheran General Hospital in Park Ridge, Illinois, Cindy Mahal van Brenk, MS, BSN, RN, CNOR, vice president for surgical services, collaborates with a large orthopedic surgeon group that has THA and TKA bundles with both CMS and commercial payers.

"We work with them on lowering cost per case, improving efficiency, and optimizing their patients before surgery," Mahal van Brenk says, noting that the hospital benefits from a reduction in length of stay even when it is not part of the bundled payment contract. "Physicians are engaged, and that's a perk," she says, adding, "I believe patients are getting a more customized treatment plan."

Analyze the data

Dr Schutzer recommends using time-driven activity-based costing, developed by Professor Robert Kaplan of the Harvard Business School, Boston, to determine the true costs of delivering healthcare (sidebar at right). "Unless you understand what your actual costs are, you won't know where you can cut costs and how to price your bundle," he says.

"We want to provide the best care for patients, but be aware of the overall cost of that episode of care, and be strategic about allocating resources," Dr Emory says.

Providers should consider what is truly needed for an optimal outcome. "Not every patient needs physical therapy [PT] after surgery," Dr Emory says, adding that many THA patients no longer receive PT because clinicians learned it wasn't necessary. Early data show that TKA patients who don't receive PT end up with the same degree of motion as those who do receive therapy—it just happens later in the recovery process.

The team developing bundle-related pathways and protocols has to consider every touch point in the episode of care. A simple example is after-hours contact numbers for patients to call. The analysis helps standardize and streamline service delivery to all patients, not just those in the bundle.

Establish pricing

Steven Schutzer, MD

"Don't just look at the mean fee-for-service reimbursement in your community and add a little to price the bundle; that is not value-based," Dr Schutzer says. "You need to base price on your actual cost of delivering the healthcare service plus a fair profit margin." The purchaser community will also be looking for a reasonable discount on the total cost of care, he adds. "Your goal is to then make it up on new volume." The organization should use the mean of the episode cost (not the highest cost) for the procedure. Market data can be purchased through companies such as Truven Health Analytics.

To discourage cost outliers, surgeons who use more expensive implants that do not demonstrate added value may have to pay the difference for this unproven technology from their share of the bundled payment, Dr Schutzer says.

Baggot recommends tracking whether the bundle is decreasing costs and increasing profits.

Pathways and protocols used with bundled payments provide an opportunity to find ways to improve outcomes and cut costs even after the initial bundle is implemented. For example, Smith says, dramatic reductions in readmissions at one of the CJR hospitals led the team to discover that the hospital had a prehabilitation program.

"We were able to look at complications and readmissions, and use the data to further improve care," she says. The pathway was revised to include prehabilitation.

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Time-driven activity-based costing

Time-driven activity-based costing (TDABC), pioneered by Harvard Business School professor Robert S. Kaplan and Steven R. Anderson, founder and chairman of Acorn Systems in Houston, Texas, requires estimates of only two items:

- the unit cost of supplying capacity
- the time required to perform an activity (such as a healthcare activity).

"It looks at the unit cost of delivering service and the time it takes to deliver that service," explains Steven Schutzer, MD, a surgeon who is cofounder and medical director of the Connecticut Joint Replacement Institute at Saint Francis Hospital and Medical Center in Hartford. "You should understand the true cost of care for each step of the care pathway, including the cost for the surgeon, anesthesiologist, hospital, and all providers involved in the bundle for the full episode of care," he says.

Completing the analysis, which should include the full 90-day episode of the bundle, helps identify areas where costs can be reduced. "Even if you choose never to negotiate a bundled payment contract, by simply understanding the actual cost of delivering a service, the spillover effects of undergoing a TDABC analysis will be substantial," Dr Schutzer says.

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Bundled Payments

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What does the future hold?

Deirdre Baggot, PhD, MBA, RN

"The real growth will be outpatient bundles for joints and spines, and expanding those bundles to other procedures," Peters says. Current requirements for performing certain orthopedic surgeries in the hospital will go away, and ASCs will be able to keep patients for up to 23 hours. "The ambulatory setting is half the cost of a hospital, which gives payers real cost savings," he notes. Peters sees ASCs as ideal conveners (the entity responsible for coordinating the bundle and contracting with partners) because most are joint ventures with surgeons.

"Everything is leading to bundles for elective procedures," Mahal van Brenk says. Standardization and protocols are essential for bundles, and these tools will also continue to spill over to non-elective procedures and acute episodes of chronic diseases.

Already many hospitals, including Advocate, have protocols for managing hip fractures. "We work to optimize these patients so they can get into the OR within 24 to 48 hours, which improves their outcome," Mahal van Brenk says.

But not everything on the horizon is rosy. Dr Emory raises the issue of long-term sustainability of a program defined by targets. "What happens when everyone meets the target?" she asks.

Smith agrees, noting that CJR hospitals in each specified metropolitan statistical area are compared against each other: "It gets harder each year as everyone keeps lowering their costs."

Terry says Medicare bases pricing on trend data. Improvements in THA and TKA have reduced costs by 7%, and Medicare has extended that trend into 2019. "We think that's too aggressive because it presumes that even more costs are going to come out," he says. Terry anticipates movement to a bundle type of DRG within the next 3 to 5 years.

Baggot says penetration of bundled payments and other alternative payment models into the healthcare market depends on three factors:

- **Number of resources.** "You need the private money of commercial payers and other players," she says. "The notion that CMS is going to scale this, and then commercial payers will follow, really is flawed; CMS moves much too slowly for that."
- **Political will.** "When the economy is doing well, you often see less political will to change," Baggot says. She adds that the average Medicaid director is only in the position an average of 18 months.
- **Technology.** "CMS is still pretty manual," Baggot says. Commercial payer involvement should accelerate the development of technologies for tracking and payment processing.

"Fee for service is going away, and we're looking at some kind of capitated payment," Smith says. "I'd rather be in the mix now to lower costs and improve quality, especially if I have the opportunity to get some money back, as opposed to waiting for CMS to say, 'this is what you will be paid,' and scrambling to lower costs while you're improving quality. It's better to be in the boat rowing toward the goal than wading behind it." ✣

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.

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