STRATEGIES FOR SURGICAL DEPARTMENT AND OPERATING ROOM SUCCESS IN THE VALUE-BASED PAYMENT ERA

By: Julian D. ("Bo") Bobbitt, Jr., J.D.*

There are still some parts of the country where a typical conversation about value-based payment ("VBP") models, such as accountable care organizations ("ACOs"), might find them described as a flawed government theory, as part of "Obama Care," the "next big thing" to save health care like gatekeepers and capitation supposedly were, another wedge between me and my patient, and so on. In other parts of the country, there are stirrings of interest in VBP. Still rare is the acknowledgment that VBP and ACOs are inevitable and that they might present strategic opportunities for proactive leaders.

I. WHY IS CHANGE INEVITABLE?

Health spending is unsustainable, even before coverage expansion of the 2010 federal health reforms. With 19% of Gross Domestic Product ("GDP") being the rough estimate of the amount the United States can collect in taxes and other revenues, by 2035, Medicare and Medicaid are predicted to consume 13% of GDP and health care costs will consume 31% of GDP. In other words, health care alone will cost well over all we collect. By 2080, absent drastic change, Medicare and Medicaid will consume all of our tax and other revenues, and total health spending will claim 46% of GDP. The rest—defense, education, roads, etc.—we can only pay for by borrowing. President Obama was the first President facing bankruptcy of the Medicare System during a term in office.

There is consensus that much of this is avoidable. The now-famous *New Yorker* article by Dr. Atul Gawande showing Medicare spending to be twice as high in McAllen, Texas as in El Paso, became required reading in the White House. Dr. Gawande wrote: "The real puzzle of American Healthcare…is not why McAllen is different from El Paso. It's why El Paso isn't like McAllen. Every incentive in the system is an invitation to go the way McAllen has gone."[1]

The Congressional Budget Office Report on the ACO's predecessor, the Bonus-Eligible Organization, includes this rationale: "[P]roviders have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists." These dysfunctions in our current system, for which the ACO is seen as a partial remedy, have been given much of the blame for our country's health care system

[1] Gawande, M.D., Atul, *The Cost Conundrum*, The New Yorker (June 1, 2009).

costing 50% more as a percentage of GDP than any other in the world, but ranking only 37th in overall health and 50th in life expectancy.[2]

Because of the crisis, drastic efforts at health care cost reform are inevitable. President Obama stated it bluntly: "So let me be clear: If we do not control these costs, we will not be able to control the deficit."[3] Private insurers see it, too. The President of Blue Cross and Blue Shield of North Carolina stated: "[T]he market must continue to change. The system that brought us to this place is unsustainable. Employers who foot the bill for workers' health coverage are demanding that BlueCross identify the providers with the highest quality outcomes and lowest costs."[4]

Flattening the cost curve is possible through VBP's marketplace incentives without rationing care, imposing new taxes, or drastically cutting provider reimbursement. Doing nothing is not an option, and all the alternatives are unacceptable to academic medical centers. In short, there is no "Plan B." Even without federal health reform, the sheer unsustainability and flaws of our current system are driving the movement to payment for value, not volume. Recent data showing the abatement of Medicare cost increases suggests that VBP is working and will give added momentum to the shift.

The payment for health care is moving inexorably and with growing swiftness away from fee-for-service's "pay-for-volume" to VBP. These changes are coming simultaneously from different directions such as Medicare's Value-Based Purchasing, ACOs, bundled payment initiatives, and aggressive steerage by private payors to narrow networks, limited to just a few high-value health systems and networks. For academic medical centers in general, and surgical departments in particular, the question is not "whether" to prepare for value-based care, but "how?" There are core capabilities essential to academic medical success.

Academic Medicine Has Particular Issues – Academic medical centers ("AMCs") train doctors, discover new treatments, and care for the most challenging patients. AMCs provide more than 40% of charity care, and account for 20% of all hospital admissions, surgical operations, and outpatient visits,[5] yet, they face multiple systemic challenges. Funding sources are changing, research costs continue to rise faster than sources of funding, and AMCs are perceived to be "high-cost" providers in an accountable care environment focused on lowering costs.

[2] World Health Organization, *World Health Statistics*, 2009.
[3] President Barack Obama, interview excerpt, July 23, 2009.
[4] Brad Wilson, President of BlueCross BlueShield of North Carolina, *The News & Observer* (January 29, 2011).
[5] 2011 AAMC Databook: *How Do Teaching Hospitals Serve America's Communities?*, AAMC.

II. CHANGE IS COMING; IT WILL BE BIG—WHAT SHOULD HOSPITAL SURGICAL DEPARTMENTS DO ABOUT IT?

A. **Strategies Applicable Generally** – First, all health care organizations today should assess what its future state value-based care model needs to look like. They should understand the core capabilities needed for success, assess existing competencies, and develop a plan for "closing the gap" to obtain the remaining needed capabilities.

According to Deloitte LLP, a viable health system value-based care model must contain the following six core capabilities:

1. Leadership and Governance – This includes governance system of accountability, physician leadership decision-making rights and responsibilities, performance measures to inform clinical and business decisions, and communication and change management approach.

2. Clinical Integration – This includes care coordination and transition processes; **c**linical protocols and guidelines; tools/processes to support integration and care coordination; quality, safety, and outcomes; population health management/care management/disease management (vs. case management); and patient engagement/satisfaction.

3. Business Operations – This includes process standardization, **s**ervice operations, customer relationships, **r**ating and underwriting, performance improvement, **r**esource management, cost management, marketing and sales, legal and compliance, and revenue cycle.

4. Information and Integration Services – This includes clinical information systems, data warehouses, analytics and business intelligence, interoperability and data sharing, population health reporting, and secured health information.

5. Network and Physician Alignment – This includes high-value network composition, physician alignment, community/public health programs and services engagement, **p**rovider evaluation and performance metrics, and quality and performance reporting.

6. Incentive Alignment – This includes economic model, value-based risk arrangements, distribution model, compensation and incentives, and third party agreements.

B. **Strategies for Surgical Departments** – The above strategies apply to all stakeholders. They are designed to maximize value, the highest quality at the lowest cost for a patient population. But what specifically should you do?

1. Strategies for ORs and Surgical and Anesthesiology Departments – The compass bearing for all activity is simple: Value – the highest quality at the lowest cost. Article length limitations prohibit detailed treatment of the highest impact value-add strategies, but here are a number to consider:

a. Coordinated Perioperative Process Management (the "Surgical Home") – There are a number of evidence-based best practice protocols to improve the quality and "wheels-in-wheels-out" efficiency of care for patients receiving surgery from pre-op to discharge. This collaboration involves not only surgeons but anesthesiologists, hospitalists, and case managers. Focus on reducing avoidable case time segments and turnover bottlenecks.

b. Effective Block Scheduling – Departments work with surgeons to develop block schedule protocols such as longer block lengths, utilization thresholds, and a percentage of open rooms for emergencies.

c. Complex Patient Management – Certain patients, such as the morbidly obese patient with multiple co-morbidities, will be both frequent and complex surgical patients. From pre-operative workup, anticipation of issues, and need for multidisciplinary impact through pathways to discharge transition to the patient's medical home, significant value-add opportunities arise.[6]

d. Pre-Op Opportunities – Scheduling and screening protocols avoid cancellations, anticipate patient needs, and improve scheduling timing accuracy. Perrin W. Jones, M.D. is utilizing a pre-anesthesia testing tool to guide perioperative testing for patients at Vidant Medical Center in Greenville, North Carolina. It contains specific questions and decision trees so as to be implemented by a nurse under physician supervision. This has reduced day-of-surgery cancellations by 70%, the number of tests by about 35%, and testing associated costs by about 60%. According to Dr. Jones, "This is an opportunity to coordinate care across a difficult transition point involving primary care physicians, anesthesiologists, and surgeons."

2. How About Academic Surgical Departments? – Here are five strategies recommended by PricewaterhouseCoopers:

a. Build the brand by holding faculty accountable for cost and quality.
b. Become part of a larger community network.
c. Push the envelope on new kinds of extenders to increase effectiveness.

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[6] Bobbitt, J., *et al., The Anesthesiologist's ACO Toolkit*, (March 31, 2011); http://www.tac-consortium.org/resources/Anesthesiologist_ACO_Toolkit.pdf.

d. Become an information hub to realize a return on HIT investment.

e. Align the research pipeline with clinical and business strategies.[7]

IV. CONCLUSION

By working together, anesthesiologists, surgeons, and hospital OR managers can realize significant value improvement that will be rewarded under value-based medicine. Though faced with additional challenges, there are specific strategies academic surgical departments can employ to optimize themselves for the new era of medicine.

**** Mr. Bobbitt is a senior partner and head of the Health Law Group at the Smith Anderson law firm in Raleigh, North Carolina. He has many years' experience assisting physicians form integrated delivery systems. He has spoken and written nationally to primary care physicians on the strategies and practicalities of forming or joining ACOs. This article is meant to be educational and does not constitute legal advice. For additional information, readers may contact the author (bbobbitt@smithlaw.com or 919-821-6612).***

[7] PwC Health Research Institute, *The Future of the Academic Medical Center*, http://www.pwc.com/us/en/health-industries/publicatins/the-future-of-academic-medical-centers.jhtml. PwC commissioned an online survey of 100 AMC leaders; however, not all survey questions received responses from the entire group of participants. References to data from the PwC Health Research Institute AMC Leader Survey are based on responses received.