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OR Manager®

Education and information for OR decision makers

IN THIS ISSUE

IMPORTANT DATES

Join us February 10-12 at the Saddlebrook Resort in Tampa, FL, for the **OR Business Management Conference**, where perioperative business leaders will gather to discuss financial strategies and tools to boost surgical suite profitability.

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TECHNOLOGY

BY MATT DANFORD

Smart knee's advance heralds future of proactive postop care

Hip, shoulder, elbow, ankle—whatever the source of a patient's discomfort, orthopedic surgeon John Dundon, MD, maintains the same high standards of care. However, a recent interview with OR Manager revealed key differences in how he and his team treat a certain subset of total knee arthroplasty (TKA) patients: Those who opt for a "smart" implant.

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John Dundon, MD

For Dr Dundon's patients, this more

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LEADERSHIP

BY CYNTHIA SAVER

Collaborative leaders share strategies for gaining influence, building relationships

An organization is sometimes described as an organism that must adapt to changes in the environment to survive and thrive. In healthcare, successful collaboration between perioperative leaders and their peers in finance, human resources, and other areas is the oxygen fueling that process. In addition to being essential for patient safety, operational efficiency, and capability to adapt to change—all of which impact the bottom line—collaboration at the upper levels of an organization also promotes collaboration at other levels, as leaders serve as role models for staff.

But collaboration is not easy when perspectives, goals, and feelings are at odds. For example, decisions may be more about climbing the career ladder than choosing the best option. "Competing doesn't build strong relationships," says Michele Brunges, MSN, RN, CNOR, CHSE, director of perioperative services at UF Health Shands Children's Hospital in Gainesville, Florida. What does build strong relationships is trust.

Michele Brunges, MSN, RN, CNOR, CHSE

Continued on page 17

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EDITORIAL

Surgical ethics: Does money speak louder?

Although I am not a healthcare professional, working for OR Manager offers a peek behind the curtain. What I have learned so far has left me feeling a bit conflicted.

When I took this job back in December, I assumed the hospital ecosystem was driven entirely by the Hippocratic Oath. In my idyllic view, this was a place of healing, where saving lives is all that matters.

I was not totally naïve—there are enough news stories about greed and corruption in healthcare to scare anyone. However, I have since learned that there are many other important considerations in the minds of every healthcare provider, perioperative staff included. Chief among these is the drive for profit.

Balancing profit, patient care

According to the American College of Surgeons (ACS), corporatization in healthcare—defined in part as "the consolidation of healthcare entities into ownership by a central corporate force that guides or supersedes local autonomy"—has been rampant. Last year, "65 hospitals or health systems announced transactions regarding mergers or acquisitions, and the transacted revenue totaled more than $38 billion" amidst "nearly $5 trillion in [total] health expenditures in the US."

My general view on this has not changed: Healthcare should be about patients and their well-being, and never solely about dollar signs. However, it did not take long to develop a greater appreciation for the reality that the hospital, and the OR by extension, is deeply intertwined with the principles of profit and margins. As ACS put it, "the business of medicine is a significant economic force."

Still, the duality between patient welfare and financial imperatives left me with a mixture of concern and curiosity. Should I reconsider the deep trust I have traditionally placed in healthcare providers?

Profit and patient care. Money and safety. Are these mutually exclusive, or can they coexist? Or better yet, *should* they coexist? Why is profit even a concern? Why is healthcare viewed by some as a way to get rich?

Consider a recent article in Forbes titled "Combating the growing rate of unnecessary surgeries." The opening sentence is scary to read: "US hospitals and healthcare systems are being accused of supporting high rates of unnecessary elective surgeries, putting profits before patients, and not providing patient-centered, evidence-based care." The article also reveals that the pandemic-related pause in elective procedures significantly reduced health system revenue. Typically, "US hospitals struggle to earn an acceptable margin by caring for patients who clearly require inpatient medical care…and instead must rely on facility fees from non-emergency (elective) procedures." As such, "more and more health systems are getting called out on putting dollars ahead of patients."

This is a sobering perspective on the potential consequences of profit-driven healthcare—and exactly my fear. Analyses such as this raise legitimate concerns about how monetary motivations can sometimes lead to decisions that are not in the best interest of patients. What does this say about the state of healthcare in our country?

Without money, there is no care

After a few more months of considering such questions—months of research and countless conversations with perioperative nurses, including those on staff at OR Manager, our subscribers, and our conference attendees—I found my views evolving further.

Every single perioperative leader I have talked to and worked with since I started this managing editor role has shown a strong commitment to patient care. Yes, financial considerations and efficiency strategies are top of mind for most healthcare professionals. How-

ever, the overarching goal of providing efficient (and cost-efficient) care is improving the patient experience, not profiting at its expense.

ACS said it best in this March 2024 article, "Surgeons are prioritizing patients amid the corporatization of healthcare." It reads, "The flow of money into and out of a hospital or health system, whether it is considered corporatized or not, is something that also must be a priority as it supports patient care. […] If the corporatization of healthcare is a current reality, then it is important to look to areas where it can be used advantageously such as a larger health system…addressing financial shortfalls in small institutions, building infrastructure, and so on."

Statements like this reassure me that financial considerations, significant may they be, do not necessarily eclipse the commitment to patient care and safety. Profit and patient care are not mutually exclusive. They can coexist, and in fact, they do coexist, successfully, every day in a mutually beneficial give and take.

The intersection of healthcare and profit is not inherently negative. Financial health is crucial for any organization to sustain its operations, invest in new technologies, and attract skilled professionals. It is when profit becomes the primary driver that the risk of compromising patient care increases.

Putting the concept on the page

My work also helps me appreciate the benefits of the corporatization of healthcare. Increased funding can lead to better facilities, advanced medical equipment, and more comprehensive training for medical staff. These improvements ultimately result in higher quality care. The challenge lies in finding a balance where financial viability supports, rather than undermines, this primary goal.

The ongoing dialogue about the balance between profit and patient care is crucial. It encourages transparency, accountability, and continuous improvement within the healthcare system. As a writer and editor, I see my role as facilitating this conversation.

One example is the August issue cover story, "Smart knee's advance heralds future of proactive postop care," which outlines what early results from Zimmer Biomet's Persona IQ knee implant reveal about perioperative workflow implications of sensors that transmit information from inside patients' bodies. In this case, patients and caretakers use an app called mymobility that was developed in partnership with none other than Apple. Surgeon testimony also focuses heavily on the intersection of financial considerations with patient care.

The intertwining of profit and patient care in surgery is a complex and sometimes contentious issue, but not one without hope. Healthcare professionals remain dedicated to their patients, even amid financial pressures. As evidenced by the ACS article, associations, organizations, and providers align with the "desire to keep the practice of surgery centered on physicians and the patients they care for—and not allowing the corporatization of healthcare to interfere in that most defining dyad." **ORM**

—Matt Danford is managing editor of OR Manager.

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Lessons, best practices, success stories from perioperative and industry experts

BY ROSEMARY BABEAUX

Unpacking the impact of private investment on innovation, ASCs

One privilege of living at this time in history is the availability of choice, especially for health and surgical needs. Those who make healthcare their business understand this as well. According to Tanna et al, ambulatory surgery centers (ASCs) are spreading to rural areas, hospitals are creating hybrid outpatient surgery centers, and surgeons are becoming multifacility business owners. As documented by Rotenstein et al, many physicians and nurses are returning to school for business degrees as they seek to become entrepreneurs as well as providers.

However, physicians and nurses are not the only ones investing time and money into this market. Private investors and technology firms continue to seize on new business opportunities in this sector, simultaneously driving the healthcare innovation engine in ways that significantly impact the continuing evolution of outpatient care.

Ripe for investment

Accounting for more than 60% of all outpatient procedural care, ASCs are overwhelmingly privately held, small, for-profit enterprises, according to Lin et al. Some are owned entirely by physicians, hospitals, or corporate entities, while others are owned by some combination of the three (ie, physician-hospital, physician-hospital-corporation).

Compared to traditional hospitals, ASCs are generally more efficient due to their smaller sizes and focus on given specialties, among other factors, according to Friedlander et al. This efficiency can be attributed in part to the relative ease with which staff can become familiar with processes and technology, resulting in better use of time and less material waste. The authors also note that directing appropriate surgical candidates to ASCs rather than higher-cost inpatient settings could contribute to lower overall US healthcare spending.

Efficiency and other advantages of ASCs have proven attractive to investors. Although a recent Pitchbook analysis focused on greater caution among healthcare-focused private equity managers this year, the data therein revealed a total value of $120 billion for 972 investment deals in 2023 alone.

The life cycle of private equity healthcare deals spans 6 to 12 years, which is consistent with other industries, according to Lin et al. The authors also note that intangible assets, such as physician reputation and existing referral networks, can be more valuable to prospective buyers than an ASC's physical location and equipment. Additionally, case volume and throughput generally remain at the same levels as before the new ownership stake, although higher-volume baselines appear to be more attractive to investors.

Now, 5 and a half decades after the emergence of the first free-standing surgical suites, new partnerships are evolving. In addition to continued interest from private equity managers, healthcare is attracting investment from information technology (IT) companies that bring fresh perspective and much needed cash.

Innovation infusion

For IT companies, healthcare presents various opportunities to help improve service quality, reduce cost, and increase patient satisfaction. Recent examples of these investments include rideshare companies offering transportation appointments (with the possibility for insurance reimbursement), LG designing TVs for patient-care team interaction, and Best Buy's investments in remote patient monitoring, telehealth, and patient engagement with the acquisition of Current Health in 2018.

The most prominent examples are the massive platform technology developers: Google, Apple, Facebook, Amazon, and Microsoft. These companies create health value as they collect parameters throughout consumers lives, subsequently forecasting changes and trends. As documented by Gleiss et al, applications include using artificial intelligence (AI) to enhance imaging, record-keeping, and the use of smartwatches to detect atrial fibrillation, asthma, and other health conditions. Basu et al cite US Food & Drug Administration (FDA) approval of smartwatches with such capability as a first step toward empowering people to collect personal data and ensure rapid support from caretakers.

Meanwhile, Apple touts capability to assist with administering medication and accessing patient safety information. Microsoft Cloud for Healthcare is designed to support end-to-end security and interoperability of health data to improve care coordination and efficiency. Amazon Web Services and One Medical (a primary care company Amazon acquired last year) are designed to ease interaction with patients through medical imaging, electronic health record housing, and clinical research support.

In short, these juggernauts' pursuit of profit is contributing to more efficient, personalized healthcare—the kind of care already associated with privately owned, outpatient providers.

The ASC advantage

ASCs already thrive on being smaller and more nimble than traditional care providers. Studies in the Journal of the American Academy of Orthopaedic Surgeons provide evidence of that, attributing shifts from hospital-based outpatient departments to improved outcomes, safety, and profitability.

Changes wrought by the big tech firms can potentially help ASCs build on these advantages. A smaller company may not have an immediate use for costly, enterprise-level AI. However, informatics generated through newer technological enhancements can provide opportunities to increase customer value, personalize services, and adapt to patients' needs. Consider patients

who self-monitor their health status using smartphones and an ever- increasing array of applications and accessory devices. Such technology allows point-of-care and digital interaction to occur wherever and whenever the patient determines. Although useful in traditional settings, this capability is a natural fit for those with the means and inclination to choose their own private care providers, often for elective procedures.

Making the future bright

Private equity investment in healthcare is also associated with risk, such as prioritizing short-term profits over care. Meanwhile, privacy and AI oversight concerns abound with monster tech firms capturing health information.

For ASCs, large, nontraditional healthcare investments are not always beneficial. For example, Walmart tried to capture medical revenue with Walmart Health. If the company had been able to capture more patients, it might have gone after ASC procedural business such as pain management. However, Walmart Health exited the market in June, citing the expense of healthcare.

Nonetheless, progress so far indicates technology companies are unlikely to change course. The shift to outpatient services also seems unlikely to abate. The Centers for Medicare and Medicaid Services approved 37 procedural codes in 2024 to the ASCs covered procedure list, allowing procedures such as total shoulder arthroplasty to move to outpatient settings. Established healthcare stakeholders are also driving growth, as evidenced by companies like Stryker increasingly focused on ASCs specifically.

Additional regulation and governance will be required, and individual providers must educate themselves. As has been the case in other industries, growing pains are both inevitable and justifiable for positive change. **ORM**

—Dr Rosemary Babeaux, DNP, RN, NE-BC, EBP (CH), is global medical science lead for Cardinal Health.

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BY ANDREW DOLD

The toll of excess inventory and the role of ecommerce

I still recall being handed roughly 10 boxes of suture anchors to practice with years ago at New York University (NYU) medical school. "Aren't these needed here?" I asked incredulously. "Not at all," came the answer, despite a hefty price tag of $1,000 per box. In fact, getting the suture anchors off the shelves was seen as a welcome opportunity to shrink the mountain of overstock clogging up cupboard space. I did not realize it then, but the business I would later help to found—essentially a niche eBay for buying and selling medical inventory—had just taken root.

Excess inventory is a huge problem for care providers. Bought in bulk and shunted to the back of hospital storerooms, reams of medical stock items often expire without ever being used. Ecommerce presents a means of not only offloading items that might otherwise go to waste, but also buying necessary inventory at lower quantities and more affordable rates.

However, providers should think carefully about how to make the most of ecommerce platforms before committing to this approach. Technological solutions aside, efforts to solve overstock problems also are more likely to succeed with a better understanding of what drives supply costs and why supplies sit unused on OR shelves in the first place.

Costs mount

Recent industry financial analyses paint a mixed picture of post-pandemic recovery, in which inventory costs continue to plague many hospitals and health systems.

For example, Kaufman Hall's Hospital Flash Report data show progress for some larger providers. However, others report tight or negative margins amid the strain of decreased revenue and mounting costs. According to a 2022 analysis by the same company, those costs include a significant increase in nonlabor expenses, amounting to nearly $50 billion that year and increasing 16.6% on a per-patient basis since 2016. This expense includes supply costs, which analysis from Definitive Healthcare shows are second only to wages in terms of hospitals' overall cost.

Medical/surgical supplies constitute 15% or more of hospitals' total expenses on average.

The following insights provide further context on the situation:

- Even without the contribution of supply-related labor expense, medical/surgical supplies constitute 15% or more of hospitals' total expenses on average, Abdulshalam and Schneller show. In surgery-intensive hospitals, this figure can range as high as 30% to 40%.
- Per-patient hospital supply expenses increased 18.5% between 2019 and 2022, outpacing increases in inflation by nearly 30%, according to the American Hospital Association (AHA).
- Since 2017, surgical supply costs have risen by an average of about 6.5% each year, according to Definitive Healthcare.
- Hospital expenses for emergency services supplies experienced a nearly 33% increase between 2019 and 2022. These include equipment such as ventilators, respirators, and other sophisticated equipment that are critical to keeping patients alive in the emergency department.

Drivers of these rising expenses include inflation and supply chain disruptions. According to a report by McKinsey, "the acceleration in nonlabor costs, including supplies, hit the healthcare system hard in the early stages of the COVID-19 pandemic, especially in personal protective equipment. Global bottlenecks have also created supply chain difficulties and increased costs across the economy."

Rising patient acuity is another culprit. The AHA reports significant increases in the average length of stay for hospitalized patients during the pandemic compared to pre-pandemic levels, contributing to rising patient care costs across the board. The longer patients stay in the hospital, the greater the number and variety of supplies required to care for them. Meanwhile, ORs are accommodating more surgeries overall, including more minimally invasive procedures requiring more advanced equipment.

The net effect of these shifts is a continuous rise in demand for such equipment as suction machines, sterilizer machines, oxygen concentrators, anesthesia machines, operation tables, and more. Combined with economy-wide inflation and reimbursement shortfalls, these mounting costs threaten the financial stability of hospitals nationwide.

Waste persists

Rising costs aside, medical device and supply waste remains a difficult-to-address problem and financial strain for hospitals and surgery centers. According to a 2019 study in the Journal of the American Medical Association, annual costs have ranged from $760 billion to $935 billion in recent years, amounting to nearly one-quarter of total healthcare spending. Reasons for the waste include:

- ***Inadequate inventory management tools.*** An accurate record of items and supplies is essential to protect ORs from both material and financial losses. However, manually tracking and documenting products is a significant time and resource burden

on clinical staff. Manual processes limit the ability of inventory managers to access comprehensive and accurate data in real-time, leading to poor quality control and a lack of forecasting accuracy.

- ***Over-ordering.*** Vendor contracts often incentivize or require facilities to purchase certain supplies in bulk. The problem compounds if product lines are discontinued or converted, or if a health network renegotiates a vendor contract.
- ***Inconsistent surgery scheduling.*** Without a foundation for accurate purchase forecasting, facilities often over-order supplies rather than risk not having the required materials for an operation.
- ***Physician departures and preference changes.*** Different surgeons have different equipment and material preferences. When a physician departs, supplies purchased based on their preference cards may go unused and expire.

Even if low- or slow-moving inventory can be identified, a hospital may have few good options for dealing with it. Internal transfer within the facility or network might require a largely manual, time-consuming process. Selling to a wholesaler or liquidator offloads the inventory, but likely only for pennies on the dollar. Donating to charity is an option for offloading the material, but not for reducing costs. The case is the same for dumping the inventory, which also negatively affects the environment.

Why not solve all these problems by selling directly to other care providers online? Many hospitals are doing just that—and learning a few lessons in the process.

Solutions evolve

Online marketplaces dedicated specifically to healthcare offer advantages beyond avoiding liquidators and other more costly, time-consuming options for offloading excess inventory. They also offer an easy way to search for equipment and supplies at a fair market price. This capability is particularly beneficial for providers with lower budgets and fewer resources.

Per-patient hospital supply expenses increased 18.5% between 2019 and 2022.

However, the choice of platform matters. For example, some platforms have a middleman who takes ownership of inventory. Whatever the structure of the organization, verify that it can offer sufficient savings. Pennies on the dollar for unused equipment might not justify the time and expense of completing transactions.

With peer-to-peer marketplaces, transparent fees, prices and product details can help buyers make informed decisions. These marketplaces also should be secure, with a means of verifying all participants to confirm sales occur only among peers and involve only quality supplies and equipment.

Although different hospital ORs and ambulatory surgery centers have different needs, someone must take responsibility for managing transactions on the platform. Typically, this is a supply chain manager or inventory manager. Regardless, OR staff are often spread thin. Researching user-friendly marketplaces with support teams can help streamline the process of offloading excess inventory and procuring critical needed items.

Overall, peer-to-peer ecommerce platforms can provide a means of matching medical outfits with peers willing and able to purchase their excess supplies—and to do so without contributing to the mass overbuying that creates needless stock in the first place. What's more, the value-add of this approach extends beyond enabling individual providers to recoup sunk costs. In my own business, I am continually motivated by the desire to boost sustainability in healthcare, prevent waste, and reduce costs—not just for providers, but ultimately for patients as well. **ORM**

—Andrew Dold, MD, is co-founder of RevMed, a peer-to-peer, online marketplace for hospitals and ambulatory surgery centers to securely buy and sell medical devices, instruments, and equipment.

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READER'S CHOICE: OR AM TOP READ STORIES

Study: Standard preoperative fasting guidelines safe for GLP-1 patients

Preoperative use of GLP-1 receptor agonist (RA) medications such as Ozempic and Wegovy is safe, according to a study published in the June issue of the American Journal of Gastroenterology.

Controversy has swirled around these drugs due to the risk of slowed stomach emptying increasing a patient's odds of choking, according to a June 6 report in the Northeast Mississippi Daily Journal that provides context on the study. However, data from the 15 randomized studies included in the review showed only a minimal impact on gastric emptying among GLP-1 users, suggesting continued safety before surgery with minor precautions, like abstaining from solid food for a day.

Guidelines on GLP-1 use prior to surgery vary, the outlet reports. Until further data is available, the review recommends updating guidelines to advise GLP-1 users to continue therapy, follow the conservative approach of a liquid-only diet the day before surgery, and adhere to standard pre-anesthesia fasting recommendations.

—www.djournal.com/lifestyle/health/its-safe-to-take-glp-1-weight-loss-meds-before-surgery-study/article_563336d3-3751-598c-ba90-66d133ae9f19.html

Study: Surgeons cited for unprofessional behavior more frequently than other specialties

Surgeons are more likely to be reported for unprofessional behavior than any other category of physician, and pediatric specialists are least likely, according to a study published June 6 in JAMA Network Open.

Based on data from the Center for Patient and Professional Advocacy's Coworker Observation Reporting System (CORS), the findings cover more than 35,000 physicians across 193 hospitals and practice sites from 2018 to 2022. Overall, less than 10% of physicians were reported by coworkers for unprofessional behavior, and only 1% showed a pattern. Higher frequency of unprofessional behavior for surgeons was attributed to working in a stressful, high-stakes environment. Examples range from name-calling or other verbal disrespect to less common lapses in protocol and procedure.

Study authors emphasized the need for systemic changes to reduce stress and burnout. Limitations of the study include potential underreporting due to fear of retaliation and the lack of gender data, although previous data indicate women are less likely to be reported.

—www.jamanetwork.com/journals/jamanetworkopen/fullarticle/2819632

Florida allows C-sections outside hospitals amid controversy over safety, cost

Florida became the first US state to permit doctors to perform cesarean sections (C-sections) outside hospitals, siding with a private equity-owned physicians group advocating for cost reduction and a homier birthing environment, KFF Health News and HealthLeaders reported on May 28. However, the hospital industry and the American College of Obstetricians and Gynecologists warn that this could increase risks for women and babies.

The new state law is giving way to the creation of "advanced birth centers," where women presenting low-risk pregnancies can deliver babies vaginally or by C-section and stay overnight. Critics argue these clinics cannot match the safety of hospitals, citing potential staff shortages, inadequate training, and curtailed access to immediate life-saving care because of lack of emergency walk-ins acceptance. Despite this, Florida's legislation was influenced by Women's Care Enterprises, a private equity-owned group that lobbied for the change. The group argues many patients prefer not to deliver in hospitals.

Supporters, including Florida state Senator Gayle Harrell, believe these centers will address maternity care shortages, especially in areas where hospitals have closed maternity wards due to financial constraints. Senator Harrell compared this move to the opening of outpatient surgery centers, saying "birth centers will have to meet the same high standards for staffing, infection control, and other aspects as those at outpatient surgery centers."

Despite its opposition to the new birth centers, the Florida Hospital Association did not fight passage of the overall bill because it also included a major increase in the amount Medicaid pays hospitals for maternity care. Still, concerns remain about whether these centers will adequately improve maternal and infant health outcomes, particularly in underserved rural areas. The advanced birth centers must have hospital transfer agreements but their proximity to hospitals is not regulated, raising further safety concerns.

—www.healthleadersmedia.com/cmo/florida-allows-doctors-perform-c-sections-outside-hospitals

Patient files stolen in Ascension cyberattack

Personal patient data could have been compromised in the May 8 cyberattack on Ascension, the St. Louis-based healthcare system announced June 12.

Attackers accessed files from seven out of 25,000 file servers used for routine tasks, potentially containing Protected Health Information (PHI) and Personally Identifiable Information (PII). The breach occurred when an employee mistakenly downloaded a malicious file, characterized as an "honest mistake."

—https://about.ascension.org/en/cybersecurity-event

FEATURE STORIES

In-depth commentary and analysis of top-of-mind topics for perioperative leaders

Takeaways

- Transmitting health metrics directly from a surgical implant reduces the need for in-person followup and offers more objective data on recovery than patient-reported measures.
- This technology's potential extends beyond knees. Whatever the nature of the treatment, postop monitoring is critical.
- Patient education is essential for setting up the data feed, as well as addressing privacy questions and other concerns.

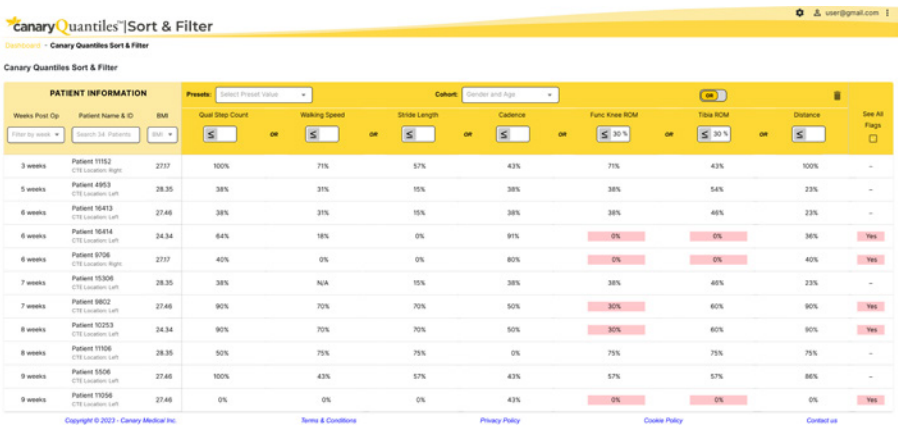
Smart implants, *Danford*

Continued from page 1

efficient, personalized form of remote care can extend quality-of-life improvements beyond the direct benefits of a reconstructed joint. There are no wearables or self-reporting requirements to manage; rehabilitation is tailored to individual needs; and visibility into the data can motivate more active involvement in patients' own care. And as long as recovery progresses normally, in-person appointments become less necessary. In addition to tracking how well a patient is recovering, the data can potentially alert surgeons to loosening or other problems with the implant itself.

Therein lies the financial viability of a nascent technology that remains costly for providers, says Dr Dundon, who performs surgical procedures at his own private practice and at the Tri-County Orthopedics group in addition to serving as chief of arthroplasty at Morristown Medical Center in New Jersey. Since his first experience with the technology—Zimmer Biomet's Persona IQ—in May 2023, he says postoperative visits among smart knee patients have been "cut in half." Fewer postop appointments translate to more slots for new patients who stand to benefit from the new technology. The net effect is a win-win. "Some of my patients live more than an hour away," he explains. "They've got a 2-hour round trip and 40 minutes in the office, all for me to walk in and say, 'thumbs up, looks good.' That's wasting everyone's time."

Persona IQ is touted as the first "smart" knee, but it is not the first or only example of technology that transmits data from inside a patient's body. In fact, Zimmer Biomet partner Canary



Canary's cloud-based interface enables sorting and filtering data to focus care resources on patients who need help most. Used with permission.

Medical, which developed the sensor and data platform, released similar technology for spinal and cardiovascular implants earlier this year (sidebar, *Beyond the smart knee*). In addition to remote patient monitoring of the sort practiced by Dr Dundon, this technology offers the promise of process-improving intraoperative feedback as well as monitoring of the health of the implant itself.

William Hunter, MD

Bill Hunter, MD, president and CEO of Canary, co-founded the company in 2012 based on the idea that implants could serve up data just like the latest smartphones. He envisions the path ahead proceeding similarly to diabetes treatment, which has evolved from finger-prick glucose monitoring to the more personalized (and more effective) approach of continuous monitoring. The hope is to leverage aggregate data to discover trends and anomalies across populations.

"No one wants to wait 6 weeks for an appointment—they want their answers right away—but on the other hand, we don't have nearly enough doctors and nurses," Dr Hunter says. "Those are two lines that are going in opposite directions. Digital technology has to bridge that gap, and it will. Medicine is going to be no different than everything else going on in the past 25 years."

Charles DeCook, MD

Charles DeCook, MD, an orthopedic surgeon at Total Joint Specialists near Atlanta, has a similar outlook. "Once something becomes smart, it never becomes dumb again," he says.

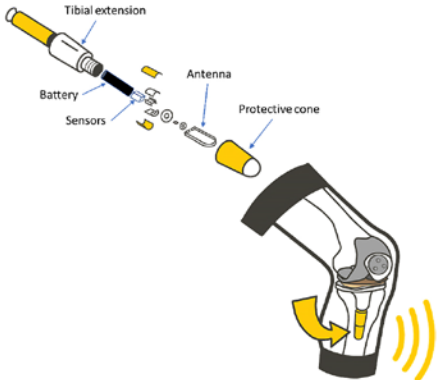
Whatever the merits of these predictions, perioperative leaders should know what to expect as smart implants expand. Ultimately, they will shoulder much of the responsibility for negotiating adoption, managing workflow changes, and educating patients and fellow staff. On a more basic level, these devices need champions—people willing to take responsibility for monitoring the data and engaging with patients to ensure the benefits of this emerging technology do not go to waste.

Understanding the technology

The source of the automatically collected gait metrics—the "IQ" portion of Persona IQ (an extension of Zimmer Biomet's line of "personalized" knees)—is essentially an implant within an implant: Canary Medical's aptly named Canturio te tibial extension (CTE). "Canturio" is Latin for "Chirp," which is also the acronym for the Canary Health Implanted Reporting Processor unit containing the 3D accelerometers and gyroscopes that measure the patient's gait and activity level. Every day, the implant transmits data collected via an internal radio and antenna to an internet connected base station in the patient's home. From there, data move securely to the cloud. Once-daily transmission and collecting data from 7 am to 10 pm, when patients are most active, ensures the implant battery last as long as 20 years, Dr Hunter says.

Care teams and patients view the data on the web or mobile devices via Zimmer Biomet's mymobility app, developed with Apple with the aim of using iPhone and Apple watch to facilitate engagement between patients and physicians. Dashboards break data down into displays of individual metrics—steps, speed, stride length, distance, and range of motion—as well as recovery curves: overlays of trends for various percentiles (5th, 10th, 25th, etc) among cohorts of patients grouped by age and gender. Persona IQ and mymobility are included in the postoperative (and, in the case of the latter, preoperative) portion of the orthopedic data feedback loop Zimmer Biomet aims to create with ZBEdge Dynamic Intelligence, a suite of integrated technologies that also includes the ROSA knee robot (a source of intraoperative data).

For Persona IQ, earning approval from the US Food and Drug Administration (FDA) in 2021 depended largely on ensuring the addition of electronics did not compromise the tibial extension's traditional function of stabilizing the knee prosthesis—a consideration likely to apply to any "smart" implant, Dr Hunter says. The anticipated 2025 availability of a shorter, 30-mm extension is likely to expand the pool of surgeons interested in using the system beyond those interested in the current 58-mm stems, says Jim Lancaster, president of Zimmer Biomet's global reconstruction business.



With integrated electronics, Persona IQ costs more to manufacture than an implant with a stem made solely from titanium alloy.

Jim Lancaster

The company declined to reveal the extent of the technology's adoption. However, Lancaster characterizes the customer profile so far as "diverse." Improved engagement with patients motivates many adopters, while others are focused on the technology's potential for efficiency gains, he says. Although most users so far are in the outpatient setting, he notes "this is more likely related to the shift in TKA from inpatient. We have users in [ambulatory surgery centers], rural, urban, as well as academic hospitals."

Climbing the adoption curve

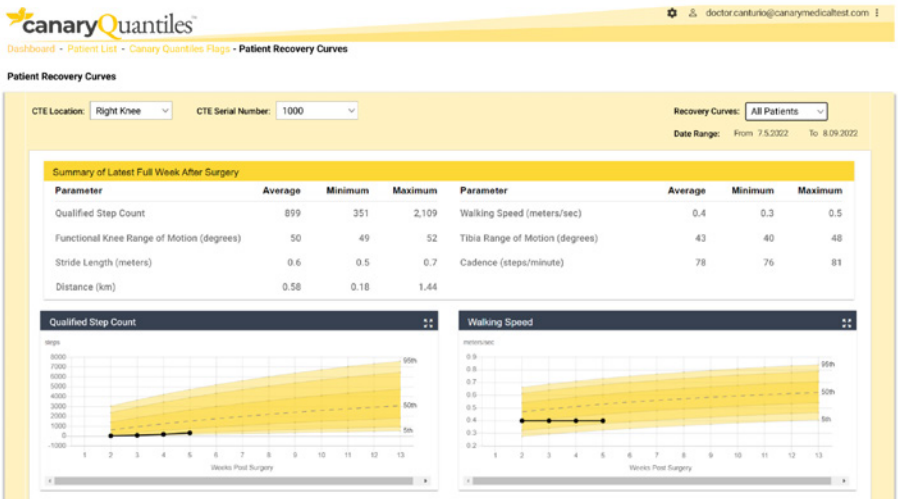
For Charles K Hanby, MD, an orthopedic surgeon in Fayetteville, Arkansas, the care setting matters when considering whether a smart knee is worth adopting. Based on a desire to "do what's right," he says the roughly 20% cost difference between Persona IQ and a traditional implant is always in the back of his mind when working at Washington Regional Medical Center, a nonprofit hospital where he is director of the Total Joint Center and chairman of the department of surgery. "Unfortunately, the hospital does not get any financial benefit, and it costs more," he says, specifying that Persona IQ costs almost 20% more than a traditional implant. "Every time I do one of these knees, the hospital loses a bit of margin. I am mindful of the increased price of the implant."

Charles K Hanby, MD

Cost is not the only reason why Dr Hanby is selective about who he recommends for a smart knee. Whether treated at the hospital or in private practice at Ozark Orthopedics, elderly patients and/or those with significant mobility issues benefit little from remote monitoring, he says. In many cases, the primary goal is not mobility, but reducing pain and improving comfort in patients with multiple health conditions for whom "500 steps may be normal," he says. Recovery curve data is not necessary to identify these patients as outliers who need further follow-up. He describes the "ideal" smart knee patient as "young, healthy, with a pretty good technology IQ—and it's even better if they live an hour or two away."

For now, Dr Hanby says between 15% and 20% of his patients are smart knee candidates. However, that number could easily climb to 50% "and maybe at some point even 100%" as the technology improves and costs decrease, he says.

Other surgeons are all-in. For example, Dr DeCook decided to recommend Persona IQ for all TKA patients after finding that suggesting smart knees



Examples of patient recovery curves. Used with permission.

for some and traditional TKA for others "created conflict." Additionally, he seems confident the growing body of data on these surgical procedures will soon eliminate the need for official disclaimers about how the kinematic data "have not been shown to provide any clinical benefit" and are intended only as a supplement to other physiological measurement tools. One recent example is a study he co-authored finding the implant data is "better and more indicative of patient satisfaction than PROMs."

Automatic data collection is important because it ensures "100% compliance" from patients, he says. In contrast, PROMs present drawbacks such as survey fatigue and lack of compliance with wearable instructions. In addition to reduced postop visits, he says remote monitoring detects problems and potential problems before patients are aware anything is amiss (sidebar, *Intervention gets smart: A case study*). "Another common scenario is when a patient is concerned that they have a problem, and we're able to say, 'Don't worry, you're actually in the top 5% compared to everyone else,'" he adds, noting that ruling out knee problems can also accelerate the path to a different diagnosis. Compounding the benefits, virtual patient visits are sufficient to adjust therapy routines for minor issues.

Managing workflows

A smart implant is pointless without someone—often someone who is not the surgeon—to "pick up the phone, contact the patient, and change their trajectory and treatment" based on insights from the data, Dr Hunter says. Otherwise, "this is just a really expensive way to accomplish nothing."

Dr Dundon says this process is simple for his team. The physician's assistant (PA) and nurses set aside time every day to examine spreadsheets of numbers and dive deeper into specific patients' data-curves for when they find red flags. Dr DeCook describes a similar scenario, characterizing the process of identifying outliers as a "quick review" that takes nurses and physical therapists "less than 60 seconds." Meanwhile, "We no longer see any [smart knee] patients in 2 weeks; the first visits are now 6 weeks after surgery," he says. "Before, we were unaware of patients struggling to ambulate or get knee motion back. Now, we are often aware before the patient is that they are not keeping up with the Joneses."

For those in the early phases of adoption, implant data can supplement in-person visits. For example, 2-week follow-ups are still the norm Hanby, who performed his first smart knee implant procedure less than a year ago. However, recovery curve analysis is part of the workflow for initial postop visits, conducted by his PA, as well as 6-week follow-ups, when he can correlate metrics with X-rays as part of deeper face-to-face discussions. "They find it motivating," he says about the data.

Dr Hanby's long-term plan is to incorporate automatic reminders and email templates to notify all patients with normal recovery curves that all is well at 50- to 54-weeks postop. "We just don't have that many patients who are a year out yet," he says.

All three surgeons say the impact to intraoperative workflows is minimal at most, amounting to no more than a few extra minutes of OR time. This is by design, developers say. "The intraoperative portion follows the same workflow as the standard Persona Knee workflow when a stem is used," Lancaster says. "The only difference is the Zimmer Biomet support team will make sure the implant is functioning properly just prior to implantation."

The surgeons also spoke to the need for additional focus on preparing patients. Instructions indicate setting up the base station is a relatively simple matter, but it is essential for surgery to proceed (likewise for facilitating timely delivery of the equipment). "You'd be surprised," Dr Hanby says, recalling patients arriving for surgery only to find that, contrary to previous testimony, they actually did not have wi-fi or a home computer. Less tech savvy patients also might struggle with registering in the mymobility platform, ensuring the data is uploading, and other aspects of working with mobile and web-based applications.

In short, patients should be aware "they have a little bit of responsibility to make sure that communication is

happening," Dr Hanby says. After all, they own the data. Technically, they are the final arbiters of whatever Zimmer Biomet, Canary, or care providers can do with it. This is where questions about putting sensors into people become complicated.

Addressing privacy concerns

Some patients' concerns are really no concern at all—there is no location-tracking GPS sensor in the implants, for instance. The three surgeons interviewed for this article also agree that if microchipping or mind control enter the conversation, then perhaps the patient should reconsider getting a smart knee.

However, patients need not be susceptible to wild conspiracy theories to have concerns about sharing personal medical information. A particularly wary implant recipient might be reassured by the knowledge that they own the data. As Dr Dundon puts it, care providers, Canary, and Zimmer Biomet have access only "as long as they give us access." Even after signing consent forms, patients can simply unplug the base station whenever they want. Additionally, Lancaster points out that data used for research and development by all of those parties is also aggregated and deidentified in accordance with HIPAA.

All parties interviewed for this article maintain they do not sell or share data with outside commercial interests. However, Dr Hunter answered affirmatively when asked if an individual care provider's privacy policy could potentially supersede Canary Medical's. Asked about the threat of insurance companies using smart implant data to deny care or otherwise acting contrary to the patients' interests, as has been documented with sleep apnea treatments (References, NPR), he points out this is "one of the most controversial topics in healthcare"—a concern with deeper roots and broader implications than surgical implants. "What if genetic testing shows you're going to develop early Alzheimers, or you're at very high risk of heart disease? Does your insurance carrier stop covering you? This [is a discussion that goes] all the way to Congress," he explains.

Put simply, a patient with a smartwatch probably has more to worry about than one with a knee implant—at least for now. "We're quite a bit away from insurance companies being able to interpret [implant data] and have some sort of 'ah-hah' moment," Dr Hanby says. As for technology developers, Dr Hunter and Lancaster both emphasize that surgical implant data is classified as personal health information (PHI) subject to much stricter regulation than metrics gathered from, say, a wearable. Dr Hunter says business associate's agreements (contracts designed to protect PHI) with care providers can be as long as 60 pages.

Similarly, Dr Dundon counters questions about potential hacking with questions about the value of the data for a hacker. "I'm just not sure anyone is going to find that very interesting," he says. Regardless, the data is well-protected, Lancaster says, citing measures ranging from encryption to anti-malware tools to efforts focused on physical datacenters and personnel.

Looking ahead

Thorny questions about smart implants extend beyond the insurance company scenario. Could implant data be used to rank surgeons and/or care providers—and is that a bad thing? Could a provider be held liable for neglect if a patient experiences problems despite a remote feed of real-time data? How will caretakers be compensated for reviewing and analyzing gait metrics? Whatever the answers, there is no question that smart implant technology is expanding, with Kelmers, et al referencing "the rapid growth in number of smart implant technology related patents."

As for Persona IQ specifically, early adopters and technology developers say early results are not the only encouraging indicator of a bright future for the technology. In less than 2 years, capability has advanced from "a bunch of numbers on a page—we had no clue what any of it meant" to "recovery curve analysis—we can make predictive algorithms and predictive patterns," Dr Dundon says. Now armed with a volume of Persona IQ data that exceeds the total data volume of the Swedish Knee Arthroplasty Register (the oldest national registry dedicated to joint ar-

Beyond the smart knee

Applications for Canary Medical's Canturio sensor systems extend well beyond knees. This year alone, the company received FDA approval one new devices and completed human trials on another.

One is the Canturio Lumbar Cartridge (canturio lc), which was recently granted FDA Breakthrough Designation and provides data to assist postoperative treatment of degenerative disc disease. Specifically, the device tracks the progression of fusion and early detection of clinically significant instability, partial fusion, and nonfusion.

The second example is a cardiac auscultation sensor device that recently underwent its first human trials and marks the company's first step outside orthopedics. This system uses sound to detect and monitor symptoms of congestive heart failure externally, without requiring placement of sensors within the blood vessels.

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Canary Medical completes cardiac sensor device trial. Medical Device Network. February 13, 2024.

Intervention gets smart: A case study

A recent article co-authored by Dr Dundon and published in the Journal of Orthopaedic Experience & Innovation demonstrates Persona IQs potential for prompting more timely intervention in patients' care.

The study presents the case of a 47-year-old female with severe degenerative arthritis whose experience was uneventful for the first two weeks postop. However, by 4.5 weeks post-surgery, she reported increased pain, and data revealed declines in walking speed, stride length, and tibial ROM compared to her TKA peers. These deviations were detected through the continuous data feed from the smart implant, prompting an early evaluation 3.5 weeks prior to her scheduled routine 8-week follow-up visit. Further discussion with the patient led to early manipulation under anesthesia (MUA) that normalized knee ROM. After 6 weeks of physical therapy, she demonstrated full extension and 125 degrees of flexion (up from 70), swelling had improved, and she could walk without a limp.

"This previously unavailable objective data provides an opportunity to understand real-world activities of daily living more comprehensively and detect concerns between routine follow-up visits," the authors write, thus addressing limitations of traditional in-office performance evaluations. Meanwhile, the utility of patient-focused PROM – which are becoming common amid the proliferation of value-based care—"depends largely on what information is captured, how complete the information is, how inclusive they are, and how representative they are of the patient population at large. However, their usefulness may be limited by their subjectivity and reliance on pain rather than movement as a metric of success."

Overall, the case highlights how "remote monitoring with the smart implant has the potential to improve patient compliance, increase physician and patient engagement, and provide data critical for an early intervention that impacts recovery."

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throplasty), researchers' natural next step is "using that data to predict functional outcomes" for different groups of patients, he continues—essentially, using gait metrics to predict and address complications like infections and blood clots before they escalate.

Dr DeCook says he also anticipates implant data collected post-surgery to inform approaches to future procedures. For example, the latest robotics enable alternatives to traditional "mechanical" alignment, which can result in pain or instability for some patients, he explains. Kinematic data from a smart implant opens the door to a complementary capability: determining the best position based on what data patterns reveal about the differences between, say, a taller patient with obesity and a shorter one without the same condition.

As for questions about long-term reimbursement for monitoring knee implant data, Dr Hunter points out that remote care enabled by smart implants synergizes well with the tenants of value-based care. "It's three times more expensive to look after the patient who has the knee than it is to put in the knee." Ideally, reductions in imaging, hospital readmissions, repeat surgeries and other cost contributors will be reflected in caretakers' compensation. "It's really common in our industry that reimbursement lags behind technology," he says.

Advocates like Dr DeCook aren't worried about reimbursement. He summed up his feelings in a recent LinkedIn post: "Before the smart knee, the only metric I cared about was how my X-ray looked and what the patient told me at their follow up. Sure, we collect PROMs, but I have never really used it to become better," he wrote. "This has all changed… Now, I know that some of our patients are worried, and they shouldn't be… [S]ome of our patients are telling us they are doing well, when in reality they are not… [W]e tell our patients to expect to hit a wall at [7] days because we know more than we ever have about our patients. Now, we know how to be better." **ORM**

—Matt Danford is managing editor of OR Manager.

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Takeaways

- Successful collaboration requires prioritizing teamwork and aligning new projects and ideas with the overarching goals of the organization.
- Strategies for making the case for a new project or initiative include establishing subject matter expertise, tailoring the message, and having a win-win mindset.
- The most influential leaders understand others' perspectives and communication styles and are willing to flex their own.

Collaboration, *Saver*

Continued from page 1

Coming to agreement is easier if others "know you are coming from a good place and are looking out for them," she says.

Brian Dawson, MSN, RN-BC, CNOR, CSSM

Building influence also means showing respect, says Brian Dawson, MSN, RN-BC, CNOR, CSSM. Upon becoming system vice president for perioperative services at CommonSpirit Health in Chicago, he made it a priority to schedule in-person meetings with the president, chief nurse executive, and chief operating officer of each hospital in his system. "Physically getting on a plane and sitting down with them showed deference and respect," he says.

Betty Jo Rocchio, DNP, CRNA, CENP

With an established foundation of trust and respect, perioperative leaders can improve collaboration by tailoring their messaging, adapting to different communication styles, leveraging influence-building strategies and tools, and advocating for organization-level support. Whatever the nature of the collaboration, the primary focus should always be on teamwork, says Betty Jo Rocchio, DNP, CRNA, CENP, senior vice president and chief nurse executive for Mercy, a Chesterfield, Missouri-based system with more than 50 hospitals in four states. "Preserving the team and the way we interact is more important than any one decision we're going to make," she says. That's the power of teamwork."

Tailoring the message

Rose Sherman, EdD, RN, NEA-BC, FAAN

Focusing on shared values, such as optimal patient care, is a natural approach to forging collaborative partnerships with fellow leaders. However, Rose Sherman, EdD, RN, NEA-BC, FAAN, professor emeritus at Florida Atlantic University of Boca Raton, cautions leaders not to assume everyone who works in the same organization has the same mental model about the work that is done. "Our mental models are formed from our professional education, our values, and our goals," says Sherman, who is the author of *The Nuts and Bolts of Nursing Leadership: Your Toolkit for Success* as well as *The Nurse Leader Coach: Become the Boss that No One Wants to Leave*.

As an example, she cites a discussion about improving perioperative throughput. The chief surgeon is thinking about how many cases can be booked into the OR and how productive surgeons can be. The CEO is thinking about how to maximize ROI from rooms and equipment. The perioperative nurse director is wondering how turnover time can be increased without compromising safety or burning out staff. Successful collaboration addresses the problem from every stakeholder's perspective.

This outcome is more likely if messages are tailored for those who need to hear them. "You have to be able to speak about things that are important to them," Dawson says. "I think of the information you need the other person to understand as the chorus to a song. It has to be repeated over and over again."

As an example, Dawson cites a recent change to OR productivity measurement that required working with the executive vice president (VP) of finance. In this case, the "chorus" boiled down to the idea that providing the right level of staffing to deliver quality care allows the organization to generate more revenue at a lower cost. "Procedural care (like the OR) are key places in healthcare where contribution margins can be positive," he explains. "In every other aspect of healthcare, you're trying to save dollars, not generate them."

In the end, the finance VP signed off on a plan to change the productivity measures, which are now more accurate. "The change is 100% the result of my working with a leader from another department to demonstrate that I understand healthcare business and how it relates to the OR," Dawson says.

Another factor in Dawson's success was approaching the discussion with the mindset that everyone could come out with a "win," he says—avoiding unnecessary expenditures (a win for the finance VP) and ensuring sufficient staffing (a win for Dawson).

Building an influential case

Successful collaborations like Dawson's recent efforts with measuring productivity require demonstrating that "you know what you're talking about," he says. To establish himself as a subject matter expert, Dawson did his homework on productivity and communicated that he knew how it impacted the financial health of the organization.

As a means of forming partnerships and gaining valuable information, Daw-

SCARF model

Based on neuroscience research, David Rock's SCARF model outlines five domains that influence someone's behavior in social situations. The definitions below are from Rock. The questions, composed by Sherman, reflect what the leader may be thinking.

- **Status:** our relative importance to others. Are you respecting my status in this organization?
- **Certainty:** our concerns about being able to predict the future. Am I sure of how this might impact my future practice?
- **Autonomy:** our sense of control of events. How much control do I have in this situation, and am I being given choices?
- **Relatedness:** our sense of safety with others. Do I feel safe in this situation, and will my voice be heard?
- **Fairness:** our perception of fair exchanges between people. Is this a fair decision, and am I being treated fairly?

Each area can activate a reward or threat response, so reducing threats and increasing rewards can promote collaboration. For example, the threat of uncertainty can be reduced with details about planned strategies, and the reward of certainty can be increased with clear objectives and timelines.

son encourages perioperative leaders to actively build a network with their peers, such as by connecting with others on LinkedIn. However, leaders may fail to take this step because they feel that others will think they do not know what they are doing if they seek advice or help. "That's a big mistake," Dawson says. "It's important for us as leaders to have a network of individuals who can support us—who understand the situations we're in and can help us with shared learning to tackle the challenges we face every day."

Having an internal network can help with laying the groundwork for discussion of proposed projects or other agenda items. "If there is something on the agenda (for the leaders' meeting) that I know is going to be sticky, I'll talk to people ahead of time about the

nursing perspective to shore up my position," Rocchio says. "You need to understand where intersections might occur and make sure you have what you need, whether it's data or being able to have the right conversation ahead of time."

Perioperative leaders also must take care to align a new project or idea with the organization's initiatives when they prepare to make their case, Rocchio says. As an example, she cites her experience presenting a plan to meet nurses' demand for greater flexibility in the wake of the COVID-19 pandemic. A flexible workforce model that included a gig option aligned with one of Mercy's key focus areas, workforce strategy.

However, persuading others that the $2 million investment would attract staff, reduce turnover, and save money in the long run required more than just alignment. To build her case, Rocchio turned to data, working with nursing leaders and workforce team to conduct a literature search and publish an article about changing the workforce model, including the demand for flexibility. Rocchio then created an analytics package to assess potential savings, based on reduction and rates of agency staff. A key component of the presentation was how the organization could develop a dashboard for the CFO and other stakeholders to easily view results and track progress toward goals. "If you're going to ask somebody to take a risk on what you're bringing forward, you have to be able to measure it to know its success, or they'll never take another risk with you," she says.

Monthly reviews of this dashboard confirm the project to be among the most successful workforce initiatives, Rocchio says. In fact, the CFO helped develop the dashboard. "Having a partner helps you make a stronger case," she says.

Communicating effectively

Understanding others' communication styles—and being willing to flex one's own—is essential to building solid partnerships. "Many nurse executives have a relational style of communication, while their CFOs or CEOs may have more of a directive or analytical approach that's focused on data and brief communication," Sherman says. A nurse leader who fails to make points quickly and succinctly will lose their audience—and the ability to influence. "Emotional intelligence is key; you need to get good at studying a room and pivoting when your presentation strategy isn't working," Sherman says.

We think people will make the right decision once we communicate the facts, but that is not true. Instead, people tend to take the path of least resistance.

Brunges points out that courses on emotional intelligence, as well as assessment tools such as the Meyers-Briggs Type Indicator, can help nurse leaders recognize and learn about how others communicate. "We need to embrace differences rather than pushing back against them," she says.

Effective communication also depends on understanding others' likely responses to our messages. Zoe Chance, a senior lecturer at Yale School of Management and author of *Influence Is Your Superpower*, writes that we think people will make the right decision once we communicate the facts, but that is not true. Instead, people tend to take the path of least resistance, even though they want to act on their values. For this reason, "Being a logic bully won't necessarily influence decision making," Sherman says. Instead, consider using tools such as the SCARF model to gain influence by communicating more effectively (sidebar, *SCARF model*).

Upon encountering resistance to a new idea, it is important to listen and keep an open mind. "You want to know what's going to work best, and every situation is different," Rocchio says, adding that conflict can be constructive. "You don't want everybody to just agree without carefully thinking about it. I don't think you get the best results that way."

Offering a pilot can make a project more palatable, Brunges says. She might say something like, "Let's just try it for 2 weeks. We'll circle back and if it's not working, we don't have to do it."

Those encountering resistance also may want to consider advice from organizational psychologist Adam Grant. In his book, *Think Again*, Grant writes that he likes to argue like he's right, but

Deep listening

Zoe Chance, author of *Influence Is Your Superpower*, recommends the tactic of "deep listening," which helps the listener "hear" more than the words the other person is saying.

- Listen for what they are thinking. This is the most basic goal; the next steps go beyond this.
- Listen for what they are feeling. Label their emotions to help your understanding.
- Listen for the thoughts that are being left unsaid. However, know that your interpretation could be wrong.
- Listen for the other person's values. Why do they care about the things they are saying?

After listening, reflect back what they said and add your own interpretation to be sure you are correct in your understanding. Deep listening can help build relationships and work through conflicts.

Collaboration challenges

In any organization, there will be those a leader connects with easily and those who pose greater challenge because of personality differences. Yet, collaboration is still necessary. "You don't have to be friends, but you do have to work together," Sherman says. "Even people we don't like have some good qualities." She suggests focusing on what the person can bring to the table that can contribute to better decision making and looking for reasons behind the behavior, which can help the leader to feel empathy.

In cases where the leaders you have to collaborate with use tactics you disagree with, Dawson suggests having a learning mindset. "Think about what you can learn from that person, even if it's learning how not to behave," he says.

In difficult situations, Sherman recommends asking: What would the best outcome be in this situation? "Research shows that if you start with a goal, your actions and behaviors will be directed toward that outcome," she says. Anticipating arguments and conducting a cognitive rehearsal with a colleague can help reduce stress. If there is an impasse or the leader feels very angry, it is best to agree to disagree and reschedule to allow time for emotions to cool and consider what has occurred.

Rocchio goes back to the "why" she is having the conversation. She also strategically picks her difficult conversations. "Everything isn't worth risking the personal relationship," she says, adding that it is important to take the personal aspect out of the discussion. "That can be hard, especially for young leaders."

Books such as *Crucial Conversations: Tools for Talking When Stakes Are High* can help leaders develops scripts for responding to these situations.

listen like he's wrong (sidebar, *Deep listening*). He encourages people to rethink assumptions and be willing to change their minds.

Grant also recommends asking questions about a person's concerns and what might help change their minds. However, it is also important to know when to stop. "Too often we push and push our viewpoints, causing the other person to become more entrenched," Sherman says. "You have to recognize that diversity of opinion is part of what you work with in leadership and see conflict as being healthy." In some cases, the timing is not right, so the project needs to be revisited at a future date.

Providing organizational support

At the organizational level, formally scheduling standing meetings and other forums for connection can help encourage interdisciplinary collaboration. At Children's, Brunges meets regularly with directors of the two other towers that do inpatient surgery to discuss issues. The three also keep in touch by text and email.

One example of a successful collaboration between the three leaders was having kidney transplant personnel travel to the north tower, where Brunges works and where the bulk of other pediatric cases are performed, to conduct that surgery. "In looking at the number of cases and having conversations, we concluded that was the best thing for patients," she says.

At Mercy, Rocchio is part of a 12-member senior leadership team that meets every Monday for 2 hours to set strategy and track progress toward goals. "We have a standing agenda, share what's happening in our areas, and touch base about what might occur that week," she says.

A "playbook" developed for each fiscal year reflects agreement about where to spend money based on organizational strategy and goals. For example, calls to reduce nursing turnover in this year's playbook supported the decision to increase nurses' pay. "I always make sure that what I'm bringing forward is supported by the playbook," Rocchio says.

Hosting one of the leadership team's quarterly meetings with the board off-site leaves time for fun, which helps foster relationship building, Rocchio adds. Sherman also endorses this strategy, noting that off-site events help build a sense of community and trust among leaders. "In general, we are much more civil and show more grace to people we know personally," she says.

Leaders also can get to know one another by attending education programs that build skills such as conflict resolution. More informal "lunch and learn" programs can serve as forums for leaders of different areas, such as supply chain or risk management, to discuss issues and challenges, which helps the others understand their perspectives.

Organizations can also craft job descriptions to set expectations for collaboration early. Sherman suggests considering a candidate's ability to collaborate when conducting an interview and including teamwork as part of evaluations. "What gets measured gets improved," she says. **ORM**

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

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Further reporting on pre- and postoperative operations, outpatient facilities, specialized departments, and service lines

BY TARSILLA MOURA

ASC management is a skill: A day in the administrator role

The administrator of an ambulatory surgery center (ASC) wears many hats, doing every odd job in the book to keep their free-standing center safe, compliant, and operational. But what does "wearing many hats" mean exactly?

OR Manager spoke with Nyleen Flores, CPMSM, CPCS, CPCO, CASC, chief administrative officer at Lake Oconee Orthopedics, LLC in Greensboro, Georgia, to get to the bottom of the complex role of an ASC administrator.

Nyleen Flores, CPMSM, CPCS, CPCO, CASC

"Putting it simply, I would break the ASC administrator role into four categories: event planning, event coordination, compliance assurance, and problem solving," Flores says. On a typical day, she explains, the admin will cycle through different tasks that fall under those categories. It might go something like this:

- ***Event planning***—conducting a thorough business review is critical for strategy and planning, Flores says. "Are we meeting our numbers? Do we have our quota for the day? Were there any cancellations, or any issues with reps? How many implants are we using daily?"
- ***Event coordination***—the ASC administrator has to make sure all the events that were supposed to happen that day actually happen. "An event could be a departmental meeting, an HR situation, a regulatory mandated check, or even a surgical procedure," Flores says. "Whatever is on the docket that was meant to occur has to occur."
- ***Compliance assurance***—rounding with the team is "extremely important," she says. "A round means checking in with your scheduler, the front desk, your clinical director, and taking a pulse on the day." The goal, she adds, is to get ahead of any issues that may arise and ensure the team is equipped to address them. That type of preparation, however, is only successful when all team members are feeling secure with their training, up-to-date with their certifications, and in tune with each other.
- ***Problem solving***—the ASC administrator needs to be comfortable with interruptions, Flores stresses. "Something always comes up. Physicians will need something done, bills will need to be paid, a staff conflict will need to be reconciled, and it goes on," she says, adding that the key is making sure everyone is on target and they are doing what they are supposed to be doing.

The attitude the administrator brings to the ASC will be the attitude reflected throughout it.

Documentation is also critical. The administrator's role involves a lot of oversight, she says, and for that, the paper trail needs to be solid. "As the administrator, we may not be the one actually running the drill, but we're the one making sure the drill is being done in a timely manner and it's reported appropriately by whoever we have assigned to that task."

Sound familiar? It should be. What Flores is describing is the makeup of a traditional C-suite team in the hospital setting. "That doesn't exist in an ASC. The administrator is the CEO, CFO, and COO of their center," she says.

Changing profiles

Non-nursing roles have begun rising through the ranks in greater numbers. Some have joined the ranks of the top decision-making voices inside an ASC alongside veteran nurse leaders—who traditionally held the ASC administrator position until COVID-19 fundamentally changed healthcare operations. "An ASC administrator doesn't have to be a nurse. That job—my job—is not clinical," Flores says. "An ASC administrator is not there to be in the OR."

Flores herself is not a nurse. She makes the case that just like nurse leadership can learn the business side of running an ASC and become an effective administrator, a business manager can come to understand the clinical demands and become an effective advocate for the clinical staff. "I spent 12 years running an office after I helped a nephrologist open his practice, then I got into medical staff services management and learned how an entire hospital runs," she says, crediting that administrative experience for her success today.

Her experience spans various aspects of healthcare management, which equipped her with a comprehensive understanding of both the clinical and business sides of healthcare. "Learning the hospital makeup and governing rules made all the difference because it helped me understand what they [clinical staff] do."

And knowing what every role in the ASC does is important, she stresses. As both planner and coordinator, the ASC administrator must know enough to determine what kind of people to surround themselves with to successfully run the center. "We're in charge of development, of leadership, and of defining roles. The growth of your center depends on you, and you depend on your people," she says.

Combating stigma

Was running an ASC without nursing credentials challenging? Flores answers yes, but not for the reasons she expected. It wasn't the lack of clinical experience that made things difficult for

her in the beginning. "Historically, it's been nurses running ASCs," she says. "When I took over the center, I had half the nursing staff quit because they refused to work for a non-nurse. They didn't give me the opportunity to show them what I could do. I faced a lot of stigma."

Flores stresses that she does not believe a non-nurse is always the best choice for an administrator's job, just like she does not believe a nurse is always the best choice for the job. "My point is everyone should be respected for the knowledge they have and the job they can do," she says. "Again, the administrator is not there to be in the OR. It's a really complex role, and the clinical side is only a piece of it."

It took her some 6 months to overcome the bias she encountered. The turning point? When she stood up to fight for the nursing staff and what they care about. "The biggest complaint from nurses is their voices aren't heard," Flores says. "They want to speak up for themselves and their patients, but they're often dismissed. The day I stood up for a nurse against a surgeon, and I didn't demean her, they realized I understood them. The minute they felt I respected their role was the minute they started respecting me for my role. It was a great feeling."

Flores clarifies that ASCs led by non-nurses still have nurse leadership present. "In the hospital setting, there's the chief nursing officer. The equivalent of that role in the ASC is the director of nursing," she says, adding that the director of nursing is there to direct the clinical aspect of what is happening behind the administrative scenes. "That person should never be the same as the administrator, it's too much for one person. But a few centers still combine the roles. It depends on the size."

The average ASC—some 90% of them, Flores adds—has between two and six ORs, and they are usually financially constrained. Some states even have Certificate of Need laws, which restrict the establishment of new ASCs to single specialty-facilities. In smaller centers, the director of nursing might double as the infection prevention lead or the risk manager. The "hospital size surgery center" is an outlier, and according to her, ASCs that large may have department leads reporting to that director. "Not the executive though. The ASC only has the one administrator to manage everything," she says.

Currently, Flores is busy with consultancy projects before she sets off to establish a brand new center. One such project is transitioning an ASC from paper-based processes to an electronic health record system. As expected, it involves streamlining operations and ensuring compliance, which has been a significant undertaking requiring the expertise of an administrator.

"It starts at the top," she concludes. "Whatever attitude the administrator brings to the ASC will be the attitude reflected throughout the ASC. If you're an administrator who wants something done, know you have the ability to do it, so go make it happen." **ORM**

—Tarsilla Moura is senior editor of OR Manager.

The ASC admin's five 'major hats'

The "multifaceted world of ASC administrators" was the topic of a recent video published by the Health Industry Distributors Association and Emily Spooner, president of ambulatory surgery center (ASC) consultancy Marisa Consulting, LLC; director of surgical operations at Procision Software, an ASC platform, in Florida.

Spooner, who is also former CEO of South Florida Same Day Surgery Center, focused specifically on five main leadership areas where ASC administrators can make the most impact. They are:

- **Clinical operations**—making sure the patients are safe and they leave the ASC just as healthy as when they walked in, if not healthier. This includes managing patient flow, safety, and risk. In the video, Spooner called it a "small part of what [they] do every day, and yet it is the most important part."
- **Physical plant**—Spooner said "there are so many things that can go wrong in the physical plant and so many things that have to go right." She cited the example of a generator going out, which is near catastrophic and caused surgeries to completely stop for that period. This also includes humidity and temperature control.
- **Business office**—includes scheduling, registration, billing, and other duties related to revenue. "As soon as that patient is scheduled for surgery, that's when that revenue cycle starts," she said. Areas of inefficiency with this "hat" include checking insurances and getting all pre-authorization forms done.
- **Materials management**—has many different components, with Spooner saying the most important one is "being able to estimate what your cost is going to be versus your reimbursement." She added, "Every time a new surgeon or a new specialty comes to one of my centers, we go through their list of most cases and price those out."
- **Overall administration**—an "admin really is in charge of human resources, hiring, firing, all of the staff and anesthesia scheduling, and all the credentialing," she said. Administration of personnel is important, and developing relationships with nurse management is crucial.

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BY TARSILLA MOURA

The US News journey to introduce a new 'best' ASCs ranking

Some 800,000 knee replacements and 550,000 hip replacements are performed in the US each year. Factoring in the ever-expanding aging population, projections show the figure for knee replacements alone will explode to 3.5 million procedures being done annually by 2030—and that is just one type of procedure within a single specialty. Is it any wonder the number of surgery-focused facilities is rising rapidly to meet the needs of this upcoming patient population?

Ensuring the right resources are in place to guarantee patient safety is challenging for providers. For patients trying to find the right medical care, keeping up with the latest advances in technology and treatment is exponentially more daunting. Patients seeking healthcare services have several choices, each promising the best care possible. How accurate are these promises? Determining which healthcare facility excels in specific areas of medical specialty requires robust, reliable data.

Ben Harder

For 34 years, US News & World Report has been a resource for patients facing this complex decision-making process with its annual Best Hospitals rankings, which are based on analysis of millions of visits and admissions across the US. However, the increasing availability of outpatient surgery centers—one of the most impactful trends in response to America's aging population—has contributed to a growing gap: The rankings include clinics offering services under a hospital's purview, but not free-standing ambulatory surgery centers (ASCs). "We've been integrating data from hospital outpatient departments [HOPDs] into our hospital ratings, but given the shift in case volumes to ASCs, it was imperative for us to expand," explains Ben Harder, managing editor and chief of health analysis at US News.

Enter the Best Ambulatory Surgery Centers rankings.

Nationwide benchmarking

Published May 14, the new rankings focus exclusively on the increasingly popular outpatient facilities some patients have been favoring: facilities that do not bill Medicare for surgery as sites that are part of a hospital, a category that excludes HOPDs. The rankings cover four key specialties: colonoscopy and endoscopy (gastroenterology), orthopedics and spine, ophthalmology, and urology. Evaluation criteria include emergency visits, unplanned hospital admissions, and complication rates, adjusted for risk based on patient demographics and prior health conditions. This level of data analysis was meant to ensure the rankings accurately reflect the quality of care provided by ASCs, recognizing those that achieve or exceed national performance benchmarks without unfairly penalizing lower-performing ASCs at first glance.

Volume was one factor for which US News accounted. "We identified 18 benchmark procedures that we're interested in across these four specialties. We picked the most common procedures in each of these specialties that are performed in ASCs," Harder explains.

Not all ASCs offer the same services, however, and a specialty like orthopedics offers a lot of variability. "There are some 99 procedures possible in orthopedics and spine, including spinal fusion, knee and hip replacements, rotator cuff repairs, and so on. But one ASC may only do spine surgery and not hips and knees," Harder says. "We made sure to compare that ASC to other ASCs that offer not only the same specialty, but the same spectrum of

Other best ASC rankings

Although evaluating free-standing ambulatory surgery centers (ASCs) is new for US News & World Report, two other prominent outlets have been doing their own rankings for some time.

One is the Leapfrog Group. On its website, it states: "The highest-performing surgery centers on the Leapfrog ASC Survey are recognized annually with the prestigious Leapfrog Top ASC award. The award is based on excellence in upholding quality standards across several areas of patient care. This includes staffing, hand hygiene, infection rates, practices for safer surgery and error prevention." In 2023, 27 ASCs earned Leapfrog's Top ASC Award. Nine specialties were represented: gastroenterology, general surgery, ophthalmology, otolaryngology, orthopedic surgery, urology, neurological surgery, obstetrics and gynecology, and plastic and reconstructive surgery.

The other is Newsweek, which has been ranking ASCs for 4 years. Newsweek's ranking includes an actual score based on a national online survey and quality metrics data that is listed next to the ASC facility's name. "This year, we've expanded our list to 550 facilities, evaluating and recognizing centers in the 25 states with the most facilities based on Centers for Medicare & Medicaid Services data," global editor in chief Nancy Cooper wrote. "For the remaining states, we have grouped facilities into four regions: Northeast, Midwest, West, and South. We base our rankings on recommendations from medical professionals and a thorough analysis of the facilities' performance data."

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care. They are being measured in their performance in their patient population against other ASCs that treated a similar patient population."

The rating system was the same even for ASCs offering different specialty services. "A multispecialty practice that offers both endoscopy and ophthalmology care will get two different ratings," Harder explains. And speaking of endoscopy, Harder assures expected hospital visits following a procedure done in an ASC were not counted against that ASC—something to consider for interventional endoscopic services, for instance. "The main outcomes in our methodology are emergency department visits and unplanned hospital admissions. Unplanned is key here."

Cost was another consideration in determining a bad outcome. "The amount that Medicare pays for different services is very standardized," Harder says. "So we also looked at the cost of complications, as in, what was the intensity of the care required to assist the patient through the complications they encountered?" A mild infection that required an emergency department visit and antibiotics but did not interfere with same-day discharge will generate a relatively small cost, he explains. "That's very different from someone who developed sepsis and gets admitted because they had a deep surgical site infection. That's a much more severe complication that will manifest itself in higher reimbursement from Medicare."

Improving the ASC 'Rosetta Stone'

Using primarily Medicare claims data enabled assessing performance without placing a reporting burden on the ASCs. "This approach allows us to track a patient's journey through the healthcare system after they leave an ASC, which is critical for assessing the quality of care and outcomes," Harder notes.

The new US News ASC rankings are also designed to help patients make informed choices by comparing facilities on a national rather than regional standard. "Our goal is to identify high-performing ASCs and provide a benchmark that reflects quality care across the country," Harder says.

> **"We want providers to benchmark themselves...and we want patients to have access to all options available to them, so they can choose."**
>
> *— Ben Harder, US News*

However, some organizations have raised concerns about relying on Medicare data to rank ASCs. For example, quality measures for ASCs offering ophthalmology services included outcomes such as emergency department visit rates, mortality rates, and total allowed payment due to complications within 30 days post-procedure. However, The Academy of Ophthalmology called the means of attributing complications to ophthalmic surgery "unclear," arguing that these outcomes did not "capture the quality of ophthalmic surgeons or patients' visual and quality-of-life outcomes." The Academy feared the public might misinterpret these ratings as reflecting the quality of ophthalmic surgery rather than the ASC facility and its associated staff.

Ambulatory Surgery Center Association (ASCA) CEO Bill Prentice discussed similar concerns in a recent ASCA Audio Update. Relying solely on Medicare quality reporting data could exclude high-performing centers that do not serve many Medicare patients, he said. He also noted that some inaccuracies in the data have been reported, and he advocated for better efforts to warn faciliites of data review opporutnities far enough in advance to make the rankings as accurate as possible. Prentice, however, affirmed that US News has been open to feedback in ongoing discussions about issues raised by ASCA members.

US News also has its own ideas. Although this year's ranking is limited to free-standing ASCs, the organization sees potential for an ASC-HOPD comparison in the future. "I won't say that it will always be divided," Harder says. "I think that, if a patient is deciding between the ASC and the hospital's outpatient department, we want them to be able to make an established comparison between those. Our goal is to create a Rosetta Stone for public access across the different settings."

Another future opportunity is expanding the specialties being analyzed for this ranking beyond the aforementioned four. But even then, Harder assures, the comparison will stay fair. "We won't pit one specialty against another," he says. "An endoscopy center, for example, is going to be measured on its outcomes in endoscopy patients. That center will get one rating in colonoscopy and endoscopy services, while an eye center will get one rating in ophthalmology, and so on."

Understanding the inaugural results

Of the nearly 5,000 ASCs US News evaluated using 3 years of Medicare data, fewer than 15% (717) earned a 'High Performing' rating, according to the May 14 press release announcing this year's results (more than 6,000 Medicare-licensed ASCs are in operation nationwide). This was the breakdown for each specialty:

- Colonoscopy & endoscopy (2,029 ASCs evaluated, with over 3 million patients and two procedure types): 249 high-performing centers
- Orthopedics & spine (2,326 ASCs

evaluated, with 490,000 patients and nine procedure types): 219 high-performing centers
- Ophthalmology (1,979 ASCs evaluated, with over 2.7 million patients and four procedure types): 196 high-performing centers
- Urology (694 ASCs evaluated, with over 300,000 patients and two procedure types): 53 high-performing centers.

For each specialty, the following states have the greatest number of "best" ASCs:
- Colonoscopy & endoscopy: California, Florida, and Pennsylvania
- Orthopedics & spine: California, Florida, and Georgia
- Ophthalmology: California, Florida, and Texas
- Urology: California, Georgia, Maryland, and New Jersey.

"There are three main outcomes being looked at," Harder says. "One is unplanned admissions closely following a procedure done in an ASC. The other is the level of intervention received as a result of a complication, and the third is the cost associated with said intervention."

Returning to the interventional endoscopic procedure example, Harder explains: "If someone has a colonoscopy in an ASC, then days later they are being admitted in the hospital for a bowel perforation that requires surgical intervention, that's a serious complication. But, if they have a colonoscopy and two weeks later get admitted to the hospital for cancer resection, that's because they were diagnosed with cancer during said colonoscopy. That's not an unplanned admission, but rather, a desirable outcome of an unfortunate screening result. We treat those two types of events differently."

While the distinction is clear, it brings up another consideration: risk adjustment. "We accounted for the eventuality that an ASC may be disproportionately treating a higher risk population," Harder adds. "Pre-existing conditions and social determinants of health were also analyzed to make sure we weren't being one-dimensional when looking at not so positive outcomes."

In this conversation, Harder emphasizes how critical it is to have robust, reliable data in healthcare. "The power of data is immense," he says. "It's so important to have all this information about a patient's journey. We need to be able to understand not just the initial encounter, but everything that happened to that patient before and after, to get the full picture." Healthcare is only becoming more complex. Having visibility on key pieces of data will not only help healthcare professionals provide better care, but also empower patients to better advocate for themselves.

"That's really what this and our other rankings are for," Harder concludes. "We want providers to benchmark themselves against the best of the best and try to meet that standard. And we want patients to have access to all options available to them, so they can choose the healthcare facility and team that work best for them." **ORM**

—Tarsilla Moura is senior editor of OR Manager.

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