

Perioperative Surgical Home Collaborative Update

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The Perioperative Surgical Home (PSH) Learning Collaborative 2.0, which functions to rapidly accelerate the spread of leading practices, ends March 31, 2018.

As a reminder, the PSH model is a patient-centric, physician-led, team-based system of coordinated care that guides patients through the entire surgical experience, from the decision to undergo surgery to 30 days post-discharge and beyond. The goals are to provide cost-effective, high-quality perioperative care and exceptional patient experiences. This is achieved through care re-engineering, shared decision-making and seamless continuity of care for perioperative patients. The American Academy of Orthopaedic Surgeons, American Urological Association and the American Academy of Physical Medicine and Rehabilitation have all endorsed the PSH model and have representatives on the PSH Learning Collaborative Steering Committee. Dr. Pease (community hospital), Dr. Stier (academic medical center) and Dr. Ferrari (pediatric hospital) provide a few insights for each unique setting.

Learning Collaborative members have submitted more than 28,700 unique patient records with more than six months still remaining. The members have demonstrated significant outcomes in quality, patient experience and total cost of care reduction. While the focus was initially on establishing the PSH team and re-engineering the processes of care across the entire acute care episode, now members have implemented payment models to support this work. Members have outlined savings of \$1,000, \$2,000, \$4,000 and even up to \$10,000 per patient. A Learning Collaborative survey in August 2017 demonstrated that 55 percent of



respondents had implemented at least one payment model, and an additional 16 percent were in the process of developing their payment model. The most common payment models were:

- Comprehensive Care for Joint Replacement (CJR) – 10 members
- Bundled Payment Care Improvement (BPCI) – nine members
- Medicare Accountable Care Organization (ACO) – nine members; and
- Medical Directorship – eight members.

Other reported payment models included commercial shared savings, clinically integrated networks (CIN), Medicaid bundles, co-management or hospital quality efficiency programs (HQEPs).

The Learning Collaborative hosts a biannual meeting where members network, accelerate learning and attend sessions relevant to the work they are doing in their pilots.



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During the fall 2017 national meeting of the PSH Learning Collaborative, these were the most popular sessions:

- *Experiences with Quality Payment Program (QPP) Panel:* Gary Loyd, M.D., Henry Ford; Sonya Pease, M.D., M.B.A., TeamHealth; Chris Steel, M.D., White River Medical Center; and Scott Sumner, M.B.A., University of Florida College of Medicine.
- *Health Policy and PSH Payment Update:* Joe Damore, FACHE, Population Health Vice President at Premier.
- *Coaching: How to Be an Effective Champion for Your PSH:* Dawn Cambron, BSIE, MSM, Premier.

During the meeting, several institutions provided updates regarding their experiences with implementing PSH pilots. The academic medical center environment presented an excellent opportunity to pilot a comprehensive PSH care model. The anesthesiology department and the department of urology, in partnership, developed a PSH program focusing initial efforts on the preoperative and postoperative phases of surgical care for patients undergoing major urologic surgery. By redesigning their preoperative evaluation process into a more comprehensive approach, they were better able to identify and optimize issues that adversely impact outcome. Postoperatively, the PSH team co-managed and coordinated all aspects of care, with particular emphasis directed at acute pain, chronic disease management and transitional care. The incorporation of procedure-specific, evidence-based clinical pathways reduced clinical variability and facilitated the implementation of PSH initiatives. Although data analytics remained the greatest challenge confronting the program, over the 13-month data collection period, they demonstrated statistically significant reductions in both postoperative complications and average length of stay. During the three years of their PSH pilot, they learned that patience is necessary in building a credible program; nevertheless, within an academic medical center context, a comprehensive team-

based PSH care model can clearly improve outcomes, reduce hospital cost per discharge, and create opportunity in which to drive additional surgical volume. Based on the PSH urology experience, the program is expanding to the adult neurosurgery service line, with additional plans to pilot a surgical oncology ERAS program. Importantly, the PSH care model can be readily adapted to a variety of surgical service lines, providing the framework necessary for the transition to value-based care models.

Participating in the PSH 1.0 Learning Collaborative was very timely for TeamHealth. They took the lessons learned and the traction gained on many of the clinical pathway redesign elements in standing up the PSH model to over 30 partner hospitals who were mandated to participate in the CJR bundled payment program. Simultaneously, TeamHealth Hospital Medicine division began participating voluntarily in the BPCI. All of a sudden, all the work they were doing to better optimize patients prior to surgery to drive down complications and skilled nursing home utilization became the markers of success for these episode-based care payment models. What they have learned over the past four years in both PSH Learning Collaboratives is that not only can they improve patient outcomes they can also impact the financial performance of these bundled episodes. In the CJR locations where they have successfully implemented PSH initiatives, there was a significant reduction in the overall episode costs. At the BPCI locations, the PSH team learned to better navigate the various episodes of care to better synch with the clinical initiatives and resources available at each location. Transitioning to value-based care and alternative payment models requires not just the re-engineering of how to deliver care clinically, but more importantly it requires learning new skills around managing the risks associated with these episodes of care. The learning curve has been steep and

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fraught with many lessons learned, but the PSH model better prepares community hospitals for further ventures in advanced BPCI and other proposed new models.

The greatest value for the PSH processes in the pediatric surgical population is in shortening the inpatient length of stay and decreasing the use of high-cost hospital resources. The largest allocation of health care spending in this population is the coordination and integration of care for children with chronic complex diseases. An important component of cost-saving strategy is to identify comorbidities and optimize patients' health in advance of surgery and general anesthesia. In children with neuromuscular scoliosis, as the number of chronic conditions increased from 1-3 to ≥ 10 , the median LOS increased 60 percent, median hospital cost increased 53 percent and readmission rates increased significantly. Many pediatric centers have demonstrated both a decrease in inpatient length of stay and reduction in ICU admissions for surgical correction in patients with idiopathic and neuromuscular scoliosis by implementing PSH concepts. Similar savings can be realized for other pediatric surgical populations, including those undergoing both open and endoscopic craniosynostosis repair, approach and long gap esophageal atresia repair and children undergoing laryngeal cleft repair. A program to triage laryngeal cleft repair patients away from postoperative admission to the intensive

care unit has resulted in a 23 percent decrease in the individual cost of the perioperative episode of care for each patient and a savings of 70 ICU bedded days over a period of 18 months.

Because of the success of the current collaborative, ASA, in partnership with Premier, will be convening the next iteration of the collaborative, the PSH Learning Collaborative 2020. This new collaborative will feature two cohorts. The Core Cohort is for organizations who need more support and guidance to plan and implement their first PSH pilot. The Advanced Cohort is for organizations with at least one PSH Pilot or like pilot in place that would benefit from further optimization and system-wide conversion to multiple service lines. The Advanced Cohort members who are considering joining a voluntary bundle like BPCI advanced in 2018 will have access to Premier's opportunity analysis tool, which provides critical guidance about how individual organizations will perform in various bundles programs to make a more informed choice about whether to participate and which bundle program to join. The goals of the PSH Learning Collaboratives remain constant: to re-engineer care delivery, develop and share leading practices for rapid implementation, and create payment models to sustain the outcomes that have been successful in many different health care settings.



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