The American perspective: The perioperative surgical home

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DISCLOSURE
I have no financial relationships with commercial support to disclose.
Introducing Perioperative Surgical Home

Vision

This new patient-centered model is designed to achieve the triple aim of improving health, improving the delivery of healthcare, and reducing the cost of care. These goals will be met through shared decision-making and seamless continuity of care for the surgical patient, from the decision for surgery through recovery, discharge, and beyond. Each patient will receive the right care, at the right place, and the right time.
The Perioperative Surgical Home (PSH)

• The PSH is a patient-centered, physician-led, interdisciplinary, and team-based system of coordinated care.

• It spans the entire surgical episode from the decision of the need for an invasive procedure – surgical, diagnostic, or therapeutic – to discharge and beyond.
A Coordinated System of Perioperative Care

Preoperative
- Patient engagement
- Assessment & triage
- Optimization
- Evidence based protocols
- Education
- Transitional care plan

Intraoperative
- Right personnel for patient acuity and surgery
- Supply chain
- Operational efficiencies
- Reduced variation

Postoperative
- Right level of care
- Integrated pain management
- Prevention of complications

Long Term Recovery
- Coordination of discharge plans
- Education of patients and caregivers
- Transition to appropriate level of care
- Rehabilitation and return to function
- Reduced variation

Quality Improvement ↔ Database

Supporting Microsystems
- Nursing
- Pharmacy
- Human Resources
- Laboratory
- Central Supply
- Social Services
- Radiology
- Info Technology
Creating a Seamless System of Team-Based Care

Patient Centered Medical Home

Perioperative Surgical Home
Aligned with the Ongoing Shift from Volume to Value

The PSH is a care delivery model with outcomes that are aligned with the goals of a variety of value-based payment models, including:

- CMS’ Bundled Payment for Care Improvement (BPCI) Program
- CMS’ Comprehensive Care for Joint Replacement (CJR) Program
- CMS’ Medicare Shared Savings Program (MSSP)
- CMS’ proposed Episode Payment Model (EPM) program
- Medicaid Bundled Payment Programs
- Commercial Accountable Care Organizations (ACOs)
- Commercial Bundled Payment Programs
Payment reform

- Traditional fee-for-service
- Reduced reimbursement
- Bundled payments
- Accountable Care Organizations
Disrupt relationships
we have made in patient safety. Surgeons are typically not interested in the medical management of their patients and are currently not involved in their preoperative optimization. It is our opinion that while hospitalists are interested in getting involved in the management of the PSH, they lack the fundamental understanding of perioperative physiology that results from the surgical experience and thus are not ideally positioned to deliver optimal postoperative care.
The American College of Surgeons (ACS) has a long-standing expectation that its members will safeguard their patients’ care throughout the course of surgical treatment. The ACS Statements on Principles state, “The surgeon is responsible for the patient’s safety throughout the preoperative, operative, and postoperative period, including the responsibility for eliminating wrong-site, wrong-procedure, and wrong-patient surgery.”

The College and other stakeholders are now developing recommendations on how best to ensure that patients receive safe, high-quality surgical care. Some of you may be familiar with the perioperative surgical home (PSH), which the American Society of Anesthesiologists (ASA) has proposed. The ASA has brought forth the PSH as a model of delivering health care throughout the patient’s entire surgical care experience—from decision making through recovery.

Under the PSH paradigm, the patient’s care would be coordinated by a director of perioperative services. The ASA suggests that a physician is best suited to this role. Application of this concept must be compatible with the surgeon’s sense of responsibility for overseeing all aspects of surgical patient care, although surgeons welcome collaborative efforts to ready patients for an operation with the anesthesiologist acting as partner. The leaders of the ACS and the ASA have been discussing perioperative care, and the ACS will continue to work with the ASA to ensure that all of the surgical patient’s needs are properly met.
What’s in a name?

A rose by any other name

would smell as sweet
“That’s Where the Money is...”

— Willie Sutton
tainable once patient volume increases substantially. We are now moving to a model in which a designated anesthesiologist will supervise designated nurse practitioners who will manage the coordination of care and adherence to protocols of these patients.
An Analysis of Methodologies That Can Be Used to Validate if a Perioperative Surgical Home Improves the Patient-centeredness, Evidence-based Practice, Quality, Safety, and Value of Patient Care


Improved Transitions and Coordination of Care

Reduction in Avoidable Rehospitalizations

PERIOPERATIVE TRANSITIONS COACH
assures timely, appropriate, and coordinated transition from home to inpatient stay and then to post-discharge setting, using standardized yet patient-friendly and materials and clinician-focused formats.

Three Key Design Elements

- Patient and Family Engagement and Shared Decision-Making
- Cross-Continuum Team Collaboration and Integration
- Health Information Exchange and Shared Care Plans

Preoperative assessment of need, eligibility, availability, and initial planning for transition from hospital to home or a step-down rehabilitation, with financial counseling.

Postoperative integrated inpatient care activated, from the post-anesthesia care unit to intensive care unit and/or regular inpatient unit.

PERIOPERATIVIST and other care team members project and communicate the patient’s post-discharge plans, to home or a step-down rehabilitation setting, to the patient, family caregivers, and the patient’s primary care physician (“Medical Home”).
# PSH Primary Metrics

**PSH Primary Metrics:**
- 13 metrics – 11 clinical; 2 survey
- 24 sub-metrics – 16 clinical; 8 survey

<table>
<thead>
<tr>
<th>ID</th>
<th>Name</th>
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<tbody>
<tr>
<td>PSH-IE1</td>
<td>PSH First Case Delayed on Day of Surgery (IP and OP)</td>
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<tr>
<td>PSH-IE2</td>
<td>PSH Day of Surgery Case Cancellations (IP and OP)</td>
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<tr>
<td>PSH-IE3</td>
<td>Timeliness of Outpatient PSH Surgical Case Discharge</td>
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<tr>
<td>PSH-IE4</td>
<td>Average Length of Stay for Inpatient PSH Surgical Cases</td>
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<tr>
<td>PSH-CS1</td>
<td>Outpatient PSH Surgical Case Mortality</td>
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<tr>
<td>PSH-CS2</td>
<td>Discharge Disposition of Inpatient PSH Surgical Cases</td>
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<td>PSH-CS3</td>
<td>Unplanned Upgrade of Care for Inpatient PSH Surgical Cases</td>
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<tr>
<td>PSH-CS4</td>
<td>Unplanned Upgrade of Care for Outpatient PSH Surgical Cases</td>
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<td>PSH-CS5</td>
<td>Non-mortality Complications for Adult Inpatient PSH Surgical Cases</td>
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<td>Non-mortality Complications for Pediatric Inpatient PSH Surgical Cases</td>
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<td>Inpatient PSH Surgical Case Mortality</td>
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<tr>
<td>PSH-PC1</td>
<td>PSH Patient Experience at Discharge</td>
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<tr>
<td>PSH-PC2</td>
<td>PSH Patient Experience 30 Days Post-discharge</td>
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Practice and Outcomes of the Perioperative Surgical Home in a California Integrated Delivery System

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BACKGROUND: In this article, we report on the implementation and impact of a Perioperative Surgical Home (PSH) model for the total knee arthroplasty at an integrated delivery system (Kaiser Permanente).
Reduced Length of Hospitalization in Primary Total Knee Arthroplasty Patients Using an Updated Enhanced Recovery After Orthopedic Surgery (ERAS) Pathway

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Why does it need a PSH?

For a surgical home to provide an improved patient experience, coordination between anesthesiologists and other providers, such as hospitalists, is not only possible but necessary (Adesanya & Joshi, 2007; Merli, 2005).
Surgical comanagement by Hospitalists

Geriatric comanagement reduces perioperative complications and shortens duration of hospital stay after lumbar spine surgery: a prospective single-institution experience

As some surgeons or medical subspecialists may have less time to dedicate to the minute-to-minute inpatient care, while spending daytime hours in the operating room (OR) or outpatient clinic, hospitalists may have more time to dedicate to hospital processes, helping generate standardized management streams that could improve patient satisfaction, hospital care transitions and overall hospital flow.
PERIOPERATIVE CARE BOOT CAMP

Perioperative Surgical Home | Enhanced Recovery After Surgery

Houston, TX, June 9-11, 2017

Sold Out!

“Grasp the actual nuts and bolts needed to implement the PSH and ERAS models at your hospital”

Zeev Kain, MD, MBA
Founder: Perioperative Surgical Home Summit
Perioperative Brain Health Initiative: Anesthesiologist leadership in improving population health

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Our Mission

To arm physician anesthesiologists and other clinicians, hospitals, patients and their families caring for older surgical patients with the tools and resources necessary to optimize the cognitive recovery and perioperative experience for adults 65 and older undergoing surgery.

Postoperative delirium is the most common surgical complication for older adults.

And it is preventable in up to 40% of all patients.
Tools & Resources to Improve Brain Health Management

A collection of resources is available to help you undertake change to improve brain health management for older patients around the time of surgery including useful links and tips from anesthesiologists experienced in improvement.
Key Questions to Ask Your Patients

Below is a series of questions that providers need to ask their patients prior to surgery. M.E.D.I.A. refers to Memory, Episode, Drugs, Items and Aides.

A positive response to items 1-3 (M.E.D.) indicate risk for adverse cognitive outcomes and should trigger a preoperative cognitive evaluation, while items 4 and 5 are designed to reduce delirium.

1. Memory
   Have you ever had a problem with your Memory or thinking ability after hospitalization or surgery before?

2. Episode
   Have you ever had an Episode of confusion, or imagining things that were not real?

3. Drugs
   Are you taking Drugs to help your thinking or memory such as Namenda (memantine) or Aricept (donepezil)?

4. Items
   Are there personal Items, such as photos or a favorite music CD, that you can bring to remind you of home and family?

5. Aides
   Do you have Aides, such as eyeglasses, hearing aides or dentures that you can bring to help you reorient after surgery?
Patient Stories and Improvement Stories

The following real cases are typical cognitive outcomes for some of our older patients following anesthesia and surgery.

Case #1, 67-year-old woman:
**RACI CHART**

**Responsible**
- The person who actually carries out the process or task assignment
- Responsible to get the job done

**Accountable**
- The person who is ultimately accountable for process or task being completed appropriately
- Responsible person(s) are accountable to this person

**Consulted**
- People who are not directly involved with carrying out the task, but who are consulted
- May be stakeholder or subject matter expert

**Informed**
- Those who receive output from the process or task, or who have a need to stay informed
My vision

• When we transition from volume to value, we will need to be more engaged in patient care
• Perioperative Care - SURGEON IS ACCOUNTABLE BUT MAY DELEGATE
  • eg. Urology, Ortho at UCI, Kaiser
• Decision making with regard to surgery - ANESTHESIOLOGIST AS CONSULTANT
• Intraoperative ERAS - ANESTHESIOLOGIST RESPONSIBLE
• Postoperative Care - ICU - ANESTHESIOLOGIST RESPONSIBLE
  • Ward - NURSES RESPONSIBLE, ANESTHESIOLOGIST OR SURGEON OR INTERNIST/HOSPITALIST INFORMED
  • WHO IS ACCOUNTABLE - EG. CARDIAC SURGEONS DELEGATE TO ANESTHESIOLOGIST AT PENN
• Post-discharge - SURGEON ACCOUNTABLE BUT MAY DELEGATE TO INTERNIST