American Society of Anesthesiologists®

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April 26, 2018

Via online submission:

The Honorable Peter Roskam, Chairman
The Honorable Sander Levin, Ranking Member
Subcommittee on Health
Committee on Ways and Means
Washington D.C. 20515

Re: April 26 Health Subcommittee Hearing - Identifying Innovative Practices and Technology in Health Care

Dear Chairman Roskam and Ranking Member Levin:

On behalf of the American Society of Anesthesiologists (ASA) and our 52,000 members, we are pleased to provide information to the Committee regarding the innovative practice model known as the **Perioperative Surgical Home (PSH), a coordinated model of care that has demonstrated practice improvements in a number of existing sites and offers great promise if further promulgated to additional surgical practice sites.**

History of the PSH

Having devised and championed the concept of the anesthesia care team in the early 1980s, anesthesiologists have been at the forefront of team-based, collaborative care for decades. As healthcare increasingly transitions from an emphasis on volume to one of value, the importance of teamwork becomes ever-more crucial.

The American Society of Anesthesiologists (ASA) formally introduced the perioperative surgical home (PSH) in 2012 as an innovative patient-centered model of care designed to achieve the quadruple aim of gratify providers, improve population health, reduce care costs and satisfy patients. The PSH model is a patient-centric, team-based system of coordinated care that guides patients through the entire surgical experience, from the decision to undergo surgery to discharge and beyond, with the goal of providing cost-effective, high quality perioperative care and exceptional patient experiences. This will be achieved through shared decision-making and seamless continuity of care for surgical patients.

Recognition of the PSH

Perhaps the strongest core feature of the PSH model is the team. Alongside the many thousands of individuals who have been involved in PSH programs throughout the country, the PSH model – and the ASA's first two PSH Learning Collaboratives – are being increasingly embraced by a variety of influential healthcare organizations.

In November 2017, as part of the Medicare Quality Payment Program Final Rule for 2018, Centers for Medicare and Medicaid Services (CMS) finalized the inclusion of a PSH Care Coordination Improvement Activity (IAs) and a PSH Population Management Improvement Activity under the 2018 Merit-based Incentive Payment System (MIPS). Further, the PSH Care Coordination Improvement Activity also received the rare distinction of being eligible for the Advancing Care Information (ACI) bonus under the 2018 MIPS. This is the first time that the PSH model was recognized by the CMS.

In March 2018, the American Board of Medical Specialties approved the ASA to be a Multi-Specialty Portfolio Sponsor. This designation means that physicians who are board certified by one of 21 ABMS Member Boards participating in the Portfolio Program can now earn Maintenance of Certification Improvement in Medical Practice (Part IV) credit for their involvement in the Perioperative Surgical Home (PSH) Learning Collaborative through their own individual boards.

Further, the ASA recognizes that for PSH implementation to be successful, providers must work together in a coordinated fashion. As such, it is essential that the ASA collaborate with team-based care member organizations to facilitate and support these teams through the implementation process. We have engaged multiple, medical societies, healthcare professional associations, national hospital/health system associations and patient advocacy groups about the PSH Initiative. Because of this engagement:

- the PSH has been endorsed by the American Academy of Orthopaedic Surgeons, the American Urological Association and the American Academy of Physical Medicine and Rehabilitation
- the American College of Surgeons (ACS) and the ASA have developed a joint statement, which was published in both the ASA and ACS communication outlets later this month, where both specialties acknowledge the importance of collaboration in the development of physician led-team based models,
- the American Hospital Association (AHA) has provided tremendous marketing/communication support of the PSH activities and has jointly provided webinars and podcasts with the ASA on the PSH model and
- the ASA is in the process of refining the PSH model to align to the National Health Council's Patient-Centered Value Model Rubric

PSH Practice Improvement Documented

The PSH has been established at a number of practice sites throughout the country and care improvements have followed at many of those sites. Practice improvement examples of PSH pilots include:

- One regional medical center saved $1.5 million in the first year.
- A Midwest Academic Center reduced LOS for total joints from 4.6 to 2.1 days.
- A pediatric institution reduced a 30-day readmission rate from 8.33 percent to 7.5 percent for laryngeal cleft patients while reducing average cost approximately 20 percent.
- An academic center saved $10,000 per cystectomy case compared to pre-PSH cases.
- A major health system improved room turnover by approximately eight minutes, reduced length of stay for hip/knee arthroplasty cases from an average of 110 hours to 51 hours and cut the readmission rate for hip/knee arthroplasty cases in half.

These outcomes demonstrate that the PSH is a viable and effective care model that can be incorporated into institutions of any size and for a wide variety of procedures and modalities. To review additional outcomes from PSH pilots across the country, please visit the PSH journal articles website:

https://www.asahq.org/psh/resources/journal%20articles

Development of the PSH – the PSH Learning Collaboratives

In 2014, ASA teamed with Premier, Inc., a leading healthcare improvement company, to establish the first PSH Learning Collaborative, which brought together subject matter experts and leading institutions from across the country to learn from each other.

The nearly 100 institutions and healthcare professionals who participated in the first two Learning Collaboratives reported positive outcomes that have benefited their organizations and their patients in sometimes surprisingly short periods of time. Attached is a member map of the organizations that have participated in the first two iterations of the PSH Learning Collaborative. Below are some of the outcomes of the PSH Learning Collaboratives 1.0 and 2.0.

PSH Learning Collaborative 1.0

The first PSH Learning Collaborative brought together 44 leading healthcare organizations from across the country to define the model, pilot the model, institute iterative improvement, collect data and assess whether the model proves superior to conventional perioperative care. Through active collaboration and shared learning, the founding members of the collaborative demonstrated that the PSH is an innovative model of care with the potential to drive meaningful and lasting change in perioperative costs, outcomes and experience for patients nationwide. The first learning collaborative completed its work in November 2015 and boasted some of the following outcomes for various PSH pilots initiated in the PSH Learning Collaborative:

- 64 pilots in various service lines including orthopaedics, colorectal, urology, general surgery, ENT, Spine, Neurosurgery, etc.
- 32% decrease in pharmacy costs in adenoidectomies
- 53% decrease in overall costs in adenoidectomies
- 28% reduction in average length of stay in joint replacements
- Decrease from 11.9% to 1.9% in readmission rates for total hip replacements
- Decrease from 6.3% to 3.7% in readmission rates for total knee replacements

PSH Learning Collaborative 2.0

Building off the success of this initial effort, the ASA and its partner Premier, launched the second PSH Learning Collaborative on April 1, 2016 which will conclude March 31, 2018. The second iteration of the PSH Learning Collaborative offered some exciting new features such as two participant options and provide more personalized and hands-on support. There are 57 organizations participating in the PSH Learning Collaborative 2.0. The following outcomes are some of the results from various PSH pilots in the PSH Learning Collaborative 2.0:

- 192 pilots planned or underway including orthopaedics, colorectal, pediatrics, general surgery, gyn/onc, urology, CABG, bariatrics, etc.
- 50% reduction in readmissions for orthopaedic patients
- 27% reduction in length of stay for colorectal surgery
- 54% reduction in length of stay for total joints

- 50% reduction in operational costs for laparoscopic nephrectomies and open nephrectomies cases
- $4000 average cost of case reduction per orthopaedic case

PSH Learning Collaborative 2020
Recruitment for the PSH Learning Collaborative 2020 is now complete. The collaborative will begin in May 2018 and run for two years. The press release announcing the PSH Learning Collaborative 2020 can be found at the following link:

https://www.asahq.org/about-asa/newsroom/news-releases/2018/02/asa-and-premier-launch-next-generation-of-pshlc

This iteration of the collaborative will assist facilities in PSH pilot implementation, optimization and expansion into new service lines or system-wide conversion.

It will also help facilities overcome the challenges they face with making the change to value-based payment. Organizations will be guided through participation in mandatory and elective bundles and understanding the impact that the Quality Payment Program (QPP) of the Medicare Access and CHIP Reauthorization Act of 2017 (MACRA), including the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs) will have on their organization. This effort is important because value-based payment is quickly being adopted by private as well as public payers.

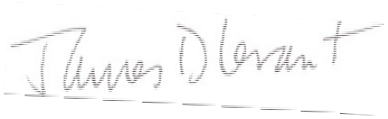
To meet the unique needs of organizations interested in healthcare redesign, institutions can choose from two participation options. The first, the Core Collaborative, is designed for organizations interested in learning more about the PSH model of care and those in the early stages of implementing a PSH pilot. The other, the Advanced Cohort, is designed for organizations looking to optimize or expand their PSH pilot. Advanced Cohort participants also can be part of the Bundles Payment Add-On option, which allows them to assess their facility's benefits and risks in participating in the various bundled payment programs. Regardless of which learning track an organization chooses, institutions will complete the program with the confidence, tools and resources to begin the next phase of PSH pilot implementation.

PSH's Role in Modernizing the Medicare Program
Given that the environment around APMs is constantly shifting, ASA has been hard at work not only analyzing this complex system but also thinking strategically about how the benefits of the PSH can fit into the current advanced APM landscape. The PSH, as an innovative, multidisciplinary care model, is well suited to have a varied and robust impact on health care delivery reform. Given this, we would recommend that the PSH model be integrated into existing surgical advanced alternative payment models. The PSH model would work with an existing advanced APMs to provide the necessary team-based care integration that is vital for these APMs to be successful. The advantage to this approach is that the existing work that has been done on these payment models can be leveraged to expand participation for specialists who have limited opportunities currently.

As the PSH model is aligned with the ongoing shift from volume to value, the ASA has recommended that CMS recognize the PSH model as an innovative delivery care model that could be employed to achieve the goals of any surgical based Advanced Alternative Payment Model.

Thank you for your leadership in identifying innovative practices and technology in health care. We appreciate the opportunity to provide our comments as the Committee on Ways & Means continues to work on this issue. Please do not hesitate to contact Manuel Bonilla, Chief of Advocacy and Practice via email at m.bonilla@asahq.org or by phone at 202-289-2222 or Economics and Practice Innovations Executive, Roseanne Fischoff, MPP via email at r.fischoff@asahq.org or by telephone at (847) 268-9169 if we can be of further assistance.

Sincerely,



James D. Grant, M.D., M.B.A., FASA
President
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