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Quality improvement

Orthopedic PSH a prime model for value-based care—Part 2

Organizations that have adopted the perioperative surgical home (PSH) model of patient care have reaped the benefits of improved outcomes and a healthier bottom line. In particular, the PSH has a proven track record for colorectal surgery and orthopedic surgery.

In part 1 of this two-part series (OR Manager, August 2017, pp 16-19), we reviewed the value of the orthopedic PSH and initial steps for establishing the model. Here we discuss how to promote success.

Look for early successes

Thomas Vetter, MD, MPH

Building a PSH can seem overwhelming given the scope of the project. "This is an undertaking of at least 3 to 5 years," says Thomas Vetter, MD, MPH, department of surgery and perioperative care at Dell Medical School, University of Texas at Austin.

Dr Vetter previously co-led the PSH at the University of Alabama at Birmingham (UAB). "It would be unrealistic to think you can accomplish this in a couple of months."

The recommendation from Jimmy Chung, MD, FACS, CHCQM, senior director for perioperative services at Providence St Joseph in Renton, Washington, is to "start small and go slow." He advises choosing one thing to improve upon that has the potential for success.

"Start where there are willing volunteers and where you see the most opportunity," says Peggy Naas, MD, MBA, who, along with Jeffery Angel, MD, represents the American Academy of Orthopaedic Surgeons (AAOS) on the American Society of Anesthesiologists (ASA) PSH Collaborative Steering Committee. "Create a burning platform by focusing on an area where there is already an identified issue like where you're losing reimbursement."

Leaders then help others move forward. "Don't get bogged down in perfection," she adds.

The bottom line is to build a success story. "Once people see improvement, they are going to be excited about doing something else," Dr Chung says.

Jimmy Chung, MD, FACS, CHCQM

Dr Vetter recommends choosing a single key performance indicator or something that affects a key indicator. "Tackling an operational element doesn't mean you've created a perioperative surgical home, but it's certainly a step in the right direction," he says. "Starting with low-hanging fruit and getting an early win or two really boosts everyone's confidence, and good news travels quickly."

That low-hanging fruit can be as simple as standardizing preoperative laboratory testing.

One area commonly targeted early in the process is patient preoperative optimization. "Not all hospitals have a prehabilitation service that coordinates optimization," says Colleen Walsh, DNP, RN, ONC, ONP-C, CNS, ACNP-BC, immediate past president of the National Association of Orthopaedic Nurses and an advisory board member for the American College of Perioperative Medicine. "Instead, patients get shuffled from one place to the next."

That can be bad for patients. "Data show that when a patient has been optimized, surgical site infections, mortality, and costs go down," Dr Chung says.

Devanand Mangar, MD

At Tampa General Hospital in Florida, a physician assistant sees patients in the preoperative optimization clinic, which is overseen by an anesthesiologist, according to Devanand Mangar, MD, chief of anesthesia at Tampa General and regional medical director for TEAMHealth Anesthesia. Other hospitals have a nurse practitioner who sees patients.

Part of optimization is communicating with patients and families. "We discuss the entire process of surgery, including the recovery and rehabilitation process," says Asokumar Buvanendran, MD, director of orthopedic anesthesiology and vice chairman of the department of anesthesiology at Rush University Medical Center in Chicago.

Dr Buvanendran, a strong proponent of PSH and president of the American Society of Regional Anesthesia and Pain Medicine, adds that patients go to physical therapy before surgery for assessment and preparation as needed.

Early ambulation

Colleen Walsh, DNP, RN, ONC, ONP-C, CNS, ACNP-BC

Early ambulation needs to take into account that many total joint patients are obese. "Hospitals that want to successfully launch a PSH need to invest in safe patient handling equipment," Walsh says. That might include beds that can be converted into a chair position.

Walsh recommends having physical therapists to help ambulate patients in the postanesthesia care unit (PACU) or educate the PACU nurses. "PACU nurses do not routinely ambulate patients, and total hip replacement patients require special precautions when getting out of bed," she says. "Physical therapists are best suited to ambulate these patients safely."

Nurses who will be helping patients walk need to understand how to correctly assess patients before getting them out of bed.

Multimodal pain management

Peggy Naas, MD, MBA

Multimodal pain management is essential to facilitate early ambulation. "We know the responses that will happen after surgery, so we can preplan the appropriate medications to administer preoperatively and during surgery that can combat inflammation, which can cause pain," says Dr Buvanendran.

He was the lead author of a 2016 study of multimodal pain management and enhanced recovery in total knee arthroplasty (TKA) patients. Those who underwent minimally invasive TKA had an average length of stay of 15 hours, with an average of 12 hours for when discharge criteria were met. Nearly a third (30%) reported no pain during the hospital stay.

Asokumar Buvanendran, MD

Dr Buvanendran notes that administering a nonsteroidal anti-inflammatory drug before the surgical incision is made has reduced the amount of opioid medication needed after surgery.

Walsh says many hospitals now have multimodal pain protocols, but those protocols need to differentiate between opioid naïve vs opioid tolerant patients.

Another issue is who writes pain medication orders. "It's not unusual for patients to be followed by several different services, especially if they weren't optimized before surgery," Walsh says. "Only one service should be writing pain medication orders."

When he was at UAB, Dr Vetter says, an anesthesia-intensivist team managed patients during their hospital stay after surgery, including those in the ICU. "As patients made their way from one unit to another, there was continuity of care, which contributed to the reduction in length of stay and costs," he explains.

Discharge

Discharge is a time when communication breakdowns can easily occur. "Patients may come to a big city to have surgery done, but they want to rehab in their own setting," Walsh says. A nurse navigator can help manage this type of transition of care challenge.

Be a coach

The coaching required for a PSH team is partly based on its maturity level. "At first, you give mostly positive feedback and act as a cheerleader," says Christopher Steel, MD, director of anesthesia services, codirector (with Dr Angel) of the PSH, and chief medical quality officer at White River Health System (WRHS) in Batesville, Arkansas. "Later on, people will seek out more constructive criticism."

During the first several meetings, he says, the team discussed only "wins," but after about a year, the group began focusing only on what needed improvement and how to accomplish that.

Part of being a coach is sharing knowledge. "Many physicians don't understand how hospitals are paid and how hospitals and physicians will be paid in the future," Dr Naas says. "They need to understand what's driving healthcare and why changes need to happen."

She adds, "OR leaders need to enable their staff and get them the resources they need."

Initially, Dr Steel says, it's important to work on baseline quality measures and how to improve them.

"After that, you start looking at different financial and efficiency measures; that's important for any capitated model," he says.

Track metrics

Christopher Steel, MD

Dr Steel says the three most important metrics to track for total joints are length of stay, readmission rate, and discharge deposition. "Those are the ones that matter for bundled payment." For outpatient surgery, hospitals should track hours stayed postoperatively or percentage of overnight stays.

"The readmission rate for those patients is usually pretty low, so we don't track that," he says. He also suggests adding patient satisfaction and, until an effective multimodal pain management program is in place, pain scores.

Leaders of PSH teams emphasize the importance of data. "Data are how you persuade the skeptics. Collect data before, during, and after implementing changes," Dr Vetter says.

Walsh adds that the electronic health record should have a section where clinicians can explain any necessary deviation from a protocol.

Sustain the gain

The PSH will be sustained partly because of changes in healthcare. "Surgeons can see that change is coming," Dr Mangar says. "They are pushing to do bundling." He adds that focusing the patient also helps. "We sell it as a concept that it's all about the patient," he says, adding that he uses trust, transparency, and truthfulness to achieve buy-in and sustained interest.

It also helps to avoid complacency. "We've been doing this for 3 years, and there is still room for improvement," Dr Steel says. "Compare yourself to national benchmarks, not just to yourself." ✣

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