Central Line
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VOICEOVER:

Welcome to ASA's Central Line, the official podcast of the American Society of Anesthesiologists, edited by Dr. Adam Striker.

DR. ADAM STRIKER (HOST):

Welcome to Central Line. I'm Dr. Adam Striker, your host and editor, and I'm here today with Dr. Christopher Steel, In-Patient Chief Medical Officer at White River Health System and Chair of ASA's PSH Implementation Guide Workgroup, as well as Dr. Jeff Angel, orthopedic surgeon at White River Medical Center and AAOS representative to ASA's PSH Steering Committee. AAOS is the American Academy of Orthopedic Surgeons. Not only have the two of them work together as surgeon and anesthesiologist, but they've collaborated from their respective perches at ASA and AAOS, and their successful collaboration has revolved, to some degree, around the perioperative surgical home, the subject of today's episode. I'm looking forward to hearing about their experiences.

Drs. Steel and Angel, welcome to the show.

DR. CHRISTOPHER STEEL:

Thanks. We're excited to be here.

DR. JEFFREY ANGEL:

Yes, thank you.

DR. STRIKER:

Well, let's start with the basics. Dr. Steel, if you don't mind starting us off, what is the perioperative surgical home and why should our listeners care about it?
DR. STEEL:

Yeah. Thanks so much, Adam. The perioperative surgical home is a seamless system of care that's patient centered, physician led and is a coordinated model of care designed to achieve the quadruple aim, which is improving health outcomes, improving patient satisfaction, reducing the cost of care, and providing satisfied medical providers.

As far as why listeners should care? It really helps hospitals move toward value-based payments, and it really helps engage specialists. Unfortunately, specialists have been left out in the standard ACO model, and the perioperative surgical home gives a way for surgeons, anesthesiologists, and other specialists a way to really get involved in this shift from fee for service to value-based payment.

DR. STRIKER:

Well, Dr. Angel, how does the PSH, perioperative surgical home, impact patient safety? What are the benefits to patients when it comes to social influencers of health and the like?

DR. ANGEL:

That's a great question. The PSH really helps in the area of patient safety. You know, before as a surgeon, we were getting patients clearances, and the clearance basically would, most of the time, would ensure that the patient would make it through the operation and be able to go back home and do okay.

But now we take it another step with the perioperative surgical home. We look at patients and we optimize them and try to decrease not only the things right around the surgical episode, but also own out from that. We try to get their lives better and try to optimize them where they don't have readmission rates, ongoing mortality rates that even occur farther out from the surgery. And by, by screening protocols that finds out areas of, of health that maybe they haven't paid attention to, like sleep apnea, things like that. So, these patients' safety really is enhanced by discovering things that might be under the surface before they come to surgery.

Another area is personalized pain control. We really are able to screen the patients, figure out what kind of exposure to opioids, if they're naive opioid patient, and then get them on a personalized pain protocol that really enhances the safety and not do, just do a one pain regimen for all like we did in the past.

And then finally, you know, there's a pathway through the PSH that's allowed us to address some of the large leading causes of death and disease burden in the US.

By doing the screening through the PSH protocol, we found that we are finding problems with patients' BMI, and with the smoking, and we're able to use the surgical perioperative period to convince the patient to change their behaviors and change their social influencers to where they can decrease their risk of having these bad outcomes from these things that we know are killers in the long run. So, we really have enjoyed not only the perioperative period, but helping the patient in their overall health as a result of doing the, the PSH principles.

DR. STRIKER:

Well, many of our listeners have heard the term perioperative surgical home. They may not understand all the details, but it may appear to them more in the abstract. But maybe if you could share a specific PSH success story which might help draw a picture for the listeners. How does this actually play out for individuals and the families, for instance, Dr. Angel?

DR. ANGEL:

You bet, would be great to do that. Take, for example, had a patient who came in and had a severe knee osteoarthritis, met the indications for a, a total knee replacement, and through our process, we discovered that they smoke. And so we had them going to smoking cessation program and delayed the surgery until they were optimized and, and, and not smoking, had their good nutrition was going preoperative exercises. And then when they came through the surgery, they did find afterwards, they came back for the post-op visit, and about three or four months afterwards, they came to my office and, and the patient said, "you know, Dr. Angel, don't get me wrong, my knee feels great and I'm so proud that I had this surgery done. But you changed my life when you had me quit smoking." So, very powerful motivator for a physician and a surgeon to hear that even outside their realm of a surgery, that they they're influencing patients' lives.

Another example would be a lady my partner had that had a high BMI, and she was through the process, she was encouraged and went into a weight loss program, and it took her a year, but she lost 100 hundred pounds. She still needed the knee replacement and had it done, and afterwards she had no complications and she came back to my partner and again said the same thing. She said, "man, my knee feels so much better and I can exercise and it really helps. But you know, you really changed my life by having me lose all that weight." So, from a patient/surgeon standpoint, what a great wow point in our careers and the patients' lives to have something so meaningful happen through the perioperative surgical home process.

DR. STRIKER:

Well, those are some great stories. It is, it's always so nice to make that kind of a difference in patients' lives. Just to try to color it a little more for some of our listeners who are probably wondering, you know, I do that anyway. I talk to them about their overall medical condition, and I can help them alter their lifestyle to help make them more optimal for surgical conditions. Just elaborate a little bit for our listeners, how does this differ in that regard from what they're doing now?

DR. ANGEL:

Yeah I would, I would say that the perioperative surgical home project actually helps me be more the details of all of the screening because we know there's several, several things, not just the main things we usually think of--cardiac and rena--but through the perioperative surgical home, we've got process places where we have team members of all kinds that are exposed to the patient beforehand and after the surgery that have point of contact to the patients that help them not only discover things that may be a safety issues or maybe a health issue the patient, but also help them remind them and educate them. You know, some of us respond more to certain kinds of people more than others. So having multiple points of contact in the perioperative surgical home process and, and it being a team approach rather than the just an individual physician before surgery and then after surgery. I think that is really kind of the essence of the PSH, of getting the patient inundated with decision points and with knowledge and education that they can make their life better and make it as safe as possible in the perioperative period.

DR. STRIKER:

Well, Dr. Steel, let's elaborate on that team approach. Can you explain to our listeners how this whole concept helps everybody perform effectively and more efficiently as a team, even beyond physicians such as nurses, administrators, IT managers, et cetera?
DR. STEEL:

Yeah, I'd love to. I think collaboration is one of the keys to the perioperative surgical home, it's right at the center of it. And so, you mentioned physicians, but you also mentioned a lot of other stakeholders. And when you try to set up a perioperative surgical home at your institution, one of the first things you need to do is identify who the stakeholders are in this process. And so, you mentioned many of them, the C-suite with, with all the administrators, IT, nursing, pharmacy, physicians, be it

surgeons, anesthesiologists, hospitalists, all of them have a large role in the perioperative surgical home and right in the center of all those is the patient.

And so, when you start a PSH, you identify them and set up regular meetings where you can all come together and the, probably the most important part of making this work and making it salient to each of these stakeholders is actually asking them, bringing them together and saying, in this patient care pathway, how is this a home run to you? And most of the time, most care providers haven't been asked that in their hospital system. And so, asking them what matters to them is really important. I can tell you as an anesthesiologist, efficiency, optimization, standardization is really important to me providing care. When we ask those questions to nursing, they want to hear about consistency, standardization, care, high degrees of care for their patients. The administrators want to see the efficiency or cost savings, reduced length of stay. Those are all things that most of them do, but I think it's critical to bring them together and ask those specific questions. In, in Arkansas, you can probably tell from my accent, we tend to call that singing from the same hymnal, and I think it's important that we all do that. You, you can't forget the patients in this whole model, specifically. Patients come at the middle, right in the middle of this, and we need to make patient centered decisions.

So, with that, we actually brought them in and the implementation guide process we had the, the National Health Council brought in, which are, which are patient advocates to help tell us what is important to patients. Payers are really big. We've brought payers into our collaboratives to tell us what matters to payers. They aren't all about the money. They want to see high quality. They want to see increased outcomes, patient reported outcomes for their patients. And if we can lower the total cost of care, which we can through most service lines in the PSH, that's a benefit to not only the payers, but most stakeholders there. So, I think those are the ways we typically involve not just physicians, but all the stakeholders in a PSH.

DR. STRIKER:

Well, I'm glad you brought it up about the payers. Often something that we often forget when we're obviously concentrating on patient care itself, but it's something we want to help impact, though, because this does impact everyone's life. And recently, Medicare fined a huge portion of hospitals for high readmissions. Obviously, these penalties are significant, and that can significantly impact the pay of physicians and other health care providers. Say your system reduced readmissions using PCH. Did that decrease disappear? What were the penalties? How exactly did that impact financially?

DR. ANGEL:

So in 2015, our health system, White River Health System, got a 2.53% penalty from CMS, which as, as you know, would be hundreds of thousands of dollars in penalties. Total joint program was a large part of that, so Dr. Steel still came to me had this idea about the perioperative surgical home and that he wanted to get involved with. And I had some, you know, questions, trepidations about it. But after we got over those, we started doing that.

In 2016, we maxed out our penalty. But since then, we have not had penalty. And this year we're one of the 18% of the hospitals that did not receive a penalty from, in the country from CMS. So, the PSH was a large part of that of, of orthopedics getting on a standardized protocol, and decreasing readmissions and improving patient safety and outcomes. Protocols were a big part of that, paying attention to post-operative visits, how many touches we saw the patient afterwards. Lots of things that the PSH helped us on that and optimization of patient beforehand was a large part of that as well.

So with this, we also were in the BPCI Program CMS and our hospital gain shared, some of the orthopedic surgeons gained shared during this time and that, and those and that was during the PSH implementation and helped us be successful in BPCI. So, it's been a financial boom to gain share and also to avoid penalties by CMS. And it kind of goes to the transparency because we all know that transparency is a, is a big thing in medicine now. And transparency is, is increasing both on quality and on pricing cost. And so the PSH, it allows us to be ready for the transparent era that's upon, upon us, that we can provide the safe, effective care and, and do it with good stewardship of, of finances.

DR. STRIKER:

Well, I know that there are probably misconceptions out there about perioperative surgical home, do you mind telling us a little bit about what you've heard and also perhaps why they're wrong?

DR. ANGEL:

Yeah. A perioperative surgical home, just like feelings I had when Dr. Steel came to me and talked to me about it is, there's a misconception by surgeons a lot of times that they're going to lose autonomy. And, you know, we're taught that we're the captain of the ship, captain the room. It's, it's our liability, it's our responsibility. We feel responsible. We're the ones seeing the patient the most before and after the

surgery, et cetera, et cetera. So, a surgeon can become pretty defensive about being the captain of the ship and making all the decisions and, and being involved in that.

But I quickly learned that the PSH you don't lose autonomy. Actually, you gain efficiency and maintain your autonomy because you're still in control of the protocols, you're still in to control the evidence-based medicine, things that we discover through time and, and continue to iterate the protocols in the treatments.

So, by doing that, we're not having to keep all of those in our mind and go through all those algorithms in our head on each patient. We're allowed to put that into the PSH process, and each member of the team is able to carry out those protocols. And we feel very comfortable and safe that things don't drop through the safety net. So we've seen that the surgeons really love that model when they see it, and when it comes to fruition so it's, it's really a good thing and it's easy to sell once you show them what happens in the PSH model.

DR. STRIKER:

Well, this is, this is a misconception I've heard before, whether it's perioperative surgical home or just protocols in general, protocolization of medicine, and that I've had colleagues in the past perhaps push back on the idea that I don't want to have any kind of recipe handed to me. I trained to be a physician. I treat each, each patient individually, individualize their plan, and protocols prohibit me from seeing that to fruition, and it, it devalues me as a physician. And I ,I guess both of you, I'm, I'm interested to hear what your responses are to that. Just the thought process in general of protocolization. I think the scientists in us, you know, the rational side of our thinking always is, yeah, we come up with protocols we can certainly evaluate and, outcomes on a larger scale and, and do what's best for a global population, if you will, or a larger population. But individually it does, it does stunt what, what I'm able to do. I just I'm interested to hear what both your thoughts are on just that, that thought process in general out of physicians.

DR. ANGEL:

Oh yeah, we go through this in our quality department and and throughout the hospital when we're talking to physicians, hospitalists on, on all kinds of programs. And number one is that I look at as that you still need the physician's brain on the protocol. A, a protocol used without the physician's brain is worse than the physician's brain without a protocol. So, when you use the protocol, it's like a pilot and a checklist. There are some esoteric things like you might forget pre-op to check

on a patient's kind of huge neck and that they have sleep apnea, things like that. You might not discover that they're smoking because maybe the patient's embarrassed and, and you and, and two or three other people have asked about it. We finally discover that they smoke. So, it's about discovering information and discovering information on the patient to make it as safe and effective care as we can. We have to have an extensive list and it has to be done every time.

So number one is, things don't drop through because the physician has such a complex thing thinking about surgery, and it's a difficult case and they're going to have to do, you know, certain things to make this case happen in, interop and their mind goes to the intraoperative thing that they're trying to do and especially implants and things like that and maybe they feel good about something in in the perioperative period. So number one, is it's just like a pilot always uses a checklist. It lets us be completely thorough.

Number two is when you look at protocol medicine and we talk about this in sepsis all the time in our hospital, when you look at when we use the order sets, there is no doubt when we instituted that our institution, that sepsis mortality went down as a whole. Each physician thought they, and would say, I was doing everything right and doing it by myself. But we know over and over when physicians use protocols that the whole safety and efficacy goes up when treating a patient's condition like sepsis or mortality or things like that. So number one is getting surgeons and, and providers, anesthesiologists to, to understand that it makes you thorough and you don't forget little details that are important.

Number two is that when you use protocols, the overall health of the patient population is improved. And so that's the big emphasis I have. Dr. Steel?

DR. STEEL:

Yeah, one thing I want to mention that I think a lot of people forget is that just because you order something doesn't mean it actually happens in real life. And a lot of times as physicians, we forget that. We think because we put an order in, it happens 100% percent of the time. But the more variation that we have and the more for a service line, it causes more challenges for nurses and other caretakers to actually deliver the care that you ordered. And sometimes there could be up to a hundred different decisions or touchpoints from one order set for total joints or something like that. And so, adherence to your orders, as if that, I tell surgeons, is very challenging, and that's the, one of the major benefits of the perioperative surgical home is by getting stakeholders like those nurses, like the pharmacies all at the table, we can work on very complex matters like adherence.

And so, my argument to protocols is that if we can make things reproducible, we can actually increase adherence rates. There's been wonderful studies done in perioperative medicine throughout the US, and Europe is very good on it that have shown that when we just tell people to do protocols, we have a very poor adherence rate. But through education, we can actually get that to 80-90% of the time. And so getting proper adherence is just critical in a very, very important part of the perioperative surgical home and with protocols in general, sometimes it's not about the actual order that you're trying to do. Sometimes it's related to the timeliness of the order. One, one example we just talked about in our medical staff meeting that Dr. Angle and I just had was on sepsis. If you use a sepsis protocol, we have built in the amount of time it takes the lab to do a lactic acid and fluid boluses. You can try and remember it all on your own, and you might even get all of it. But unfortunately, you're not going to put a specific note into the lab to tell them to prioritize that lactic acid level, to get it done in an hour, to adhere to these stringent protocols. So, I think it's really critical to know, that to properly perform system based practice means we've got to adhere to protocols.

DR. STRIKER:

Well, speaking of protocols, what is the difference between ERAS protocol and perioperative surgical home? Is one a subset of the other? Are they related somehow? If you could speak to the difference between those two for our listeners?

DR. STEEL:

Yeah, we believe that they're remarkably complementary. Enhanced recovery after surgery by many is thought of as multiple different specific order sets that can be adhered to. And if you adhere to them at a high, to a high degree, you can significantly improve the outcomes of your patients.

The perioperative surgical home is a complete system of care from the decision to actually have a procedure to recovery from that procedure, and it's the system that is created by that. And what that allows, is for us to take enhanced recovery protocols and simply put, those protocols inside of a PSH. And if you choose to use other protocols outside of enhanced recovery that are specific to your organization, a perioperative surgical home is perfect to do that as well. So the PSH focuses on reproducibly providing a high level of care from the decision to have surgery to after, whereas we believe that enhanced recovery after surgery protocols are the protocols that may be inside of your PSH, so we see them as remarkably complementary.

DR. ANGEL:

Yeah, I would just add that the protocols in ERAS can be inside of a system that looks at adherence, looks at accountability of who's doing it and getting them done right, and looks at metrics of how did we do in that. That's what the perioperative surgical home does. It sets up that system that not only has protocols in ERAS, but it also sets up the system of who does what when, and we look back at our adherence rate, our performance rate and see if processes are done all the time. What's the percentage they're done? And then we look at percentages of if we get the expected outcomes, did we get the expected patient safety?

So it's a whole culture of not just the protocols, but how are we completing those, making sure they get completed and then also measuring it and going back and improving so that system and, and, like in our place, we even get our orthopedic surgeons, we meet monthly now and go over these things. And before the PSH, we never did that. And so, we just did it informally in the hallway. Hey, you think we ought to start doing this? I read an article about it. But now we have, you know, real formal rules and time set up where we can set these up, be consistent and establish these protocols, but also measure, make sure they're being done.

DR. STRIKER:

Ok, so if I'm, say I'm an anesthesiologist, you know, small group somewhere, I'm listening to this or I've read about perioperative surgical home and/or enhanced recovery protocols and like, you know, I wanted to bring that to my system to bring that to my patients. I have no idea where to start, but I'd like to do it. Is this something that I should start small at and grow? Or is there a protocol, a system to follow, like right off the bat, involving multiple stakeholders?

DR. STEEL:

Yeah, I would say I'm really happy to answer that question because I've gotten that question many times over the last several years, and unfortunately, we haven't had as many resources to point them toward as we do right now. And as we, we mentioned earlier, the ASA has introduced the Perioperative Surgical Home Implementation Guide, which is actually available now. And what that allows us to do is take six years of knowledge about how the PSH works from three different collaboratives. We've had hospitals from all, not only all across the country but internationally that have used the perioperative surgical home in their health system and scaled it to multiple different service lines many times. So we've taken all those principles, we've taken the components that they use to do it, the examples and all

the tools that they use to succeed in their institution and put it all into one interactive PDF that's got what you need to get started.

It also has an introductory course that's paired to it that you can actually get CME credit for going through, that's going to tell you what you're actually going to get out of this guide and also how you're going to use this guide, specifically how an anesthesiologist, how a different stakeholder in this may want to use this guide. And what if you're just starting a PSH? Or what if you're wanting to scale it up? So all those are there.

If you're not interested in the guide, or you're wanting to wait, the ASA on their website has a lot of case studies, cases from a PSH where they've got webinars to talk about what people have done, examples there. We've got podcast, peer reviewed literature, the anesthesia Monitor articles as well as resources from the collaborative itself. A paper was written with all the different things that have been mentioned in literature regarding the perioperative surgical home, so all that is on the ASA's website as well.

And I'll tell you, just as a personal note, my, my answer is get going. A lot of people didn't have all these resources to get going. And so my answer is if you want to make a difference, start small. Find someone enthusiastic if you're an anesthesiologist, you need to find an enthusiastic surgeon. We recruit for personality, not for talent. So, we want somebody that's passionate and, and go work with them and don't ask how you're going to get paid for this or what's going to happen, but start getting people together by putting patients in the middle, figuring out who the stakeholders are and start having those meetings. And I, I firmly believe it's a great investment to get this PSH Implementation Guide because that's going to give you a blueprint to getting this done at your own institution.

DR. STRIKER:

Well, thanks, Dr. Steel. Is there a specific address on the ASA website that anyone can find the, the implementation guide?

DR. STEEL:

Yeah. If you go to www.asahq.org/pshguide (g-u-i-d-e), that's going to get you specifically to the guide. And if you go to the ASA's website forward slash psh, so that's going to get you to a lot of the PSH specific information that you need.

DR. STRIKER:

Fantastic. Well, you know, before we wrap this up, it, you know, it's unusual, representative of wo different specialties here with us and you two work together, came together, to implement the perioperative surgical home at your hospital. And so I'd be remiss not to ask your thoughts on how this all came together, looking back on everything and how it all played out and how it's going currently? Dr. Steel, let's start with you and then and then move on to Dr. Angel.

DR. STEEL:

Yeah, I'll tell you, back in 2010, 2011, our burning platform was the fact that for total joing replacement in the lower extremity, our readmission rate was more than 10%. And that caused, as Dr. Angel mentioned, that value-based purchasing and the hospital readmission reduction penalty over time, we, we ended up getting issued those and total joint replacement readmission is a big factor in those. And so over time, Dr. Angel and myself, we join PSH 1.0 Collaborative, the first collaborative, and focused just on those, and we were able to make a big difference. We, we quickly, in the first couple of years got our readmission rate down to 6%.

In PSH 2.0, the second iteration of the collaborative, we, we benefited from getting benchmarks and found that after we retired from patting ourselves on the back, getting to 6%, we found we should have probably been at 4% and we redoubled our efforts to get our readmission rate down lower. We also scaled that into other service lines outside of just total joint replacement in the lower extremity. As we scaled those up, we were able to start the regular meetings, engage the stakeholders. As Dr. Angel mentioned, we entered the Bundled Payment for Care Improvement Plan through CMS and, and did really well for our organization. Our quality did really well. And the, the momentum has continued with our regular orthopedic meetings. Like Dr. Angel mentioned, we've been able to drive quality. We've started using the Mako robot, which was hard to implement if you think it, you're adding CT scans and other processes, but with our PSH framework, it made it a lot easier. We were able to track a lot of extra data and eventually get to where we were able to send, in this pandemic, where we were unable to keep people in the hospital for multiple nights. We were able to send a lot of our patients home, this directly from PACU, after a total joint replacement, which we hadn't done in our organization before, and there were a lot of on the fly changes that needed to be done.

Dr. Angel mentioned getting the right people at that ortho improvement meeting. I'll tell you, we need physical therapy, obviously, to rehab with them, post-op day zero and our adherence rate to that was not very good when we started, and it required administration being at the table to commit the resources of having a physical

therapist there. And now it's something we track every month. Not only did they get therapy post-op day zero, but how many steps did they take during that therapy? So, we're able to consistently make our care better.

And even more recently, we started taking our patients and, and doing a cryoablation of some of the nerves of the, of the, of the knee prior to multiple weeks prior to surgery, so that we can reduce their pain weeks before surgery and improve their ambulation and reduce their opioids weeks before surgery so that we can, actually, that leads to reduced opioids, intra-hospital stay and even post discharge. And so, we're able to continue moving forward and improving the care for our patients. And it's, frankly, in my opinion, been a pleasure to be a part of. What are your thoughts, Dr. Angel?

DR. ANGEL:

Well, it's just, it just makes me happy to think about participating in, in the PSH and how far we've come.

I can tell you as a service line leader here at our hospital and, and also how the PSH principles and that we spread it to other service lines that it really makes me happy to know that when we have a problem that comes up from an individual physician or when we have a data point that is bad on some report or we're just wanting to keep up with best practices, I now know that there's a system in place that's automatically easy to insert those things in and to get performance.

So, keeping up with best practices, decreasing unwarranted variation and to quickly have team members respond, just like he mentioned physical therapy, we were having problems with patients the first day, first day after surgery of getting up after physical therapy. In our meeting, our team members of the PSH, all the stakeholders were there. We had nursing, we had physical therapy, we had PACU nurses, we had the surgery team, we had the, the orthopedic surgeons there. We were quickly able to come up, well, nausea might be a problem in some of these patients or they're, you know, getting done late in the day. How do we do that? And so we, as, as, as the PSH process and the team that were meeting, quickly responded with a plan of how to get the patient up and walk them 100 feet the day of surgery.

So, it, it's just, it's just real satisfying to know that we don't have to reinvent the wheel every time we have an aberrant data point that we need to work on, or that we have a bad process or outcome, or we have a patient safety thing, or that we can go to the meeting, have a system in place, have the stakeholders there. They're organized, they know that we're going to be measuring it, there's accountability and

it's just, it just makes you as a provider very, well, confident that there's a system in place to help you take care of patients.

DR. STEEL:

And Adam, I just want to mention from what Dr. Angel just said. He said the words happy a couple of times and satisfying, and kind of tying that back to what we said at the very beginning of what the PSH is, a patient centered, physician led coordinated model of care designed to achieve that quadruple aim. There's a lot of different ways to achieve good outcomes and to improve patient satisfaction and lower the cost of care. I'll tell you that one of the hardest things is going from the triple aim, which what we just described to this quadruple aim of satisfying your providers. And what Dr. Angel just described makes me smile because he's happy and he's satisfied. And I know that's a stereotype that everybody thinks surgeons are always happy and satisfied all the time. But, but I'll, I'll tell you, that's, that's been our experience, and it's really happy to share that with you.

DR. STIKER:

I'm glad you emphasized that at the end, that's probably a point we didn't we, yeah, we mentioned earlier, but didn't cover enough, because that is such a hot topic right now is physician satisfaction, burnout of clinicians. And, and to hear the story of the collaboration with you guys and, and how everybody came together is, it's really uplifting. And the people that really benefit are the patients. But to know that it's satisfying, I hope that encourages a lot of our clinicians and health care providers to, to pursue this as a mechanism to help create more satisfaction in their, in their jobs as well.

I want to thank you both for a really informative conversation. It's been a pleasure to talk to you and thanks for sharing your expertise and, and your opinions.

DR. STEEL:

Thank you so much for your time.

DR. ANGEL:

Thank you for allowing us to have a little piece of time of discussing these critical issues for our patients and also for providers and as surgeons, we really want what's best, and I think if we can overcome a few barriers it'll really be a great thing

because the PSH really has transformed our institution and, and I really appreciate all you guys and, and thanks a lot.

DR. STRIKER:

Thank you guys for your time. Thanks for all your hard work and thanks to everybody for joining us for this episode of Central Line. Please don't forget to visit asahq.org/pshguide to download the new implementation guide and also to learn more about perioperative surgical home. And please don't forget to subscribe to this podcast wherever you get your podcasts.

Please join us again next time, also. Thanks a lot. Take care.

(SOUNDBITE OF MUSIC)

VOICEOVER: