



June 22, 2015

The Honorable Orrin G. Hatch  
Chairman  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Johnny Isakson  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

The Honorable Mark R. Warner  
Committee on Finance  
United States Senate  
219 Dirksen Senate Office Building  
Washington, DC 20510

Dear Chairman Hatch, Senator Wyden, Senator Isakson, and Senator Warner:

The American Society of Anesthesiologists (ASA), on behalf of more than 52,000 members, is writing in response to your May 22, 2015 letter to stakeholders requesting recommendations to improve care for Medicare patients with chronic conditions. We applaud the Committee for seeking alternative payment strategies that will increase care coordination, facilitate the delivery of high quality care, and reduce the growth in Medicare spending. In developing legislative solutions, the Committee should include chronic pain, which has a tremendous impact on patients' health and on Medicare spending, in discussions on how to improve care for patients with chronic conditions. In addition, ASA has developed and is working with provider organizations to implement a new model of coordinated care – the Perioperative Surgical Home (PSH) – which is designed for all patients undergoing surgery and invasive procedures with the goal of improving health, improving the delivery of healthcare, and reducing the cost of care.

Chronic pain has a tremendous impact on the Medicare program, both in terms of the number of patients who suffer from chronic pain and in its cost to the system. As noted in the 2011 Institute of Medicine (IOM) Report, *Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research*, and in ASA's Committee on Pain Medicine statement, "Chronic Pain Can be a Multisystem Disease," when pain becomes chronic it is no longer merely a symptom, but a disease in itself that fundamentally alters the entire nervous system with significant psychological and cognitive changes. According to the IOM report, approximately 100 million U.S. adults suffer from chronic pain conditions, more than the

number affected by heart disease, diabetes, and cancer combined. These painful conditions cost \$560-635 billion annually in direct medical treatment costs and lost productivity, and in 2008 Medicare spent at least \$65.3 billion, or 14 percent of all Medicare costs, on pain care. Given the tremendous impact of chronic pain on the Medicare program, the Committee should include chronic pain in discussions on how to better coordinate care for chronic conditions.

In addition, ASA has developed and is collaborating with provider organizations to advance the PSH, a patient centered, innovative model of delivering health care during the entire patient surgical/procedural experience; from the time of the decision for surgery until the patient has recovered and returned to the care of his or her Patient Centered Medical Home or primary care provider. The goal is for each perioperative patient to receive the right care at the right place and at the right time, with better patient satisfaction, fewer complications, and decreased costs. More information on the PSH is available at: <https://www.asahq.org/psh>.

Too often, perioperative care plans are variable and fragmented.<sup>1</sup> There is variation in preoperative testing protocols, unnecessary testing, and inconsistent or deficient preoperative assessment and patient preparation for surgery (e.g., education, nutrition, prehabilitation). There also can be inefficient intraoperative care, including cancellations and delays in procedures, highly variable and unpredictable surgical times, use of excessively costly medical supplies and implants, and suboptimal blood management. As it is currently structured, postoperative pain care can be lacking or inappropriate, and once a patient is discharged there are poor care transitions and patient follow-up, which can lead to potentially avoidable readmissions.

The PSH directly addresses these weaknesses in perioperative care. Examples of key elements of the PSH may include:<sup>2</sup>

- Early preadmission assessments and admission through a centralized preoperative area/clinic;
- Preoperative innovations such as “prehabilitation” programs for targeted patients, and a triage system to identify which patients need to attend a preadmission clinic or program;
- Operating room (OR) delay reduction techniques, increased OR efficiency through improved OR flow, and scheduling incentives to reduce cancellations and increase efficiency;
- Integrated pain management and early postoperative mobilization by physical therapy and integrated acute-care and rehabilitative care; and

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<sup>1</sup> American Society of Anesthesiologists. (2015). The Need For The Perioperative Surgical Home. Available at: <https://www.asahq.org/~link.aspx? id=F4B6FE52C7824248BF88E22020EB9C15& z=z>

<sup>2</sup> Kash BA, Zhang Y, Cline KM, Menser T, Miller TR: The Perioperative Surgical Home (PSH): A comprehensive review of US and non-US studies shows predominantly positive quality and cost outcomes. *Milbank Quarterly* 2014; 92(4):796-821. Available at: <https://www.asahq.org/~link.aspx? id=F4B6FE52C7824248BF88E22020EB9C15& z=z>

- Improved coordination of care from postoperative to discharge home, and identification of patients who need home care services to avoid discharge to a skilled nursing facility.

The PSH incorporates all clinicians who understand the surgical implications of medical disease and treatment across the continuum of surgical care. It reduces costs by implementing evidence-informed approaches and reducing duplication of services. The PSH also provides a common point of contact for patients and families, and empowers them to participate in their own care and recovery.

At present, the ASA is sponsoring a PSH Learning Collaborative that has engaged 44 hospitals and health systems nationwide to come together to learn from one another and to enable the rapid development of the PSH. With pilot projects ranging from total joint arthroplasty to radical cystectomies, these organizations are making significant progress in improving patient care and reducing health care costs. Early results indicate significant decreases in lengths of stay, reduction of patient pain scores, and reduction in the rate of blood transfusions among other promising results. We are looking forward to further data collection from the participating facilities, as well as enrolling a new cohort of facilities in a learning collaborative in 2016.

On June 27-28, ASA will host its second annual Perioperative Surgical Home Summit. With more than 425 registered participants, the Summit offers a more in-depth look at the PSH model and includes lectures from experts in leading institutions that are currently piloting and developing perioperative surgical homes. Participants will also engage in roundtable and panel discussions to encourage collaboration on implementing the PSH in their own institutions.

We hope that ASA can be a resource to the Committee as it moves forward with its chronic care reform efforts. Please do not hesitate to contact Manuel Bonilla ([m.bonilla@asahq.org](mailto:m.bonilla@asahq.org)), Chief Advocacy Officer, or Nora Matus ([n.matus@asahq.org](mailto:n.matus@asahq.org)), Director of Congressional and Political Affairs, via email or by telephone at (202) 289-2222 if we can be of further assistance. Thank you for your leadership in improving care for Medicare patients with chronic conditions.

Sincerely,



J.P. Abenstein, M.S.E.E., M.D.  
President  
American Society of Anesthesiologists