You Can Do This: Here's How

The Business Model for Perioperative Care

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January 24, 2014

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Topics to be Covered

- Introduction and Starting Perspectives
- Getting Prepared: What to Study & Know
- Getting Actively Involved & Getting Connected
- Collecting and Sharing Information
- Selecting a Strategic Approach
- Getting Started & Moving Forward

Introduction and Starting Perspectives

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Why? ➔ The Value Agenda

Harvard Business Review

PROVIDERS MUST LEAD THE WAY IN MAKING VALUE THE OVERARCHING GOAL

BY MICHAEL E. PORTER AND THOMAS H. LEE

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Why? ➔ Battling Public Perception

HEALTH

PAYING TILL IT HURTS The High Earners

The New York Times

Patients' Costs Skyrocket; Specialists' Incomes Soar

By ELISABETH ROSENTHAL JAN. 18, 2014

A number of high-income specialties — radiology, ophthalmology, **anesthesiology** and dermatology — are often called the **"lifestyle specialties,"** because training is more compatible with a home life than some other disciplines and there are fewer emergencies in these fields.

"... I am guessing they forgot about obstetric and trauma anesthesia care and late night emergency surgery on septic octogenarian patients with small bowel obstructions."

- Brilliant ASA member.

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Motivation and PCMH Implementation

Higher Implementation Scores	Lower Implementation Scores
• Took active role in learning	• Felt a need for external teaching
• Took the initiative to promote change	• Felt a need for external direction in promoting change
• All or most team members invested in change	• Placed responsibility on one person; had influential resistors

Source: Selected findings from Robert Wood Johnson Foundation. *Assessing and Increasing Readiness for Patient-Centered Medical Home Implementation*. Research Summary No. 9. March 2012. Page 5.

Capability and PCMH Implementation

Higher Implementation Scores	Lower Implementation Scores
Barriers = challenges to overcome:	**Barriers = imposed obstacles:**
• Time demands necessary to produce desired change	• Time demands are unfeasible and cut into patient volume
• Quickly implemented and benefited from HIT	• HIT too costly and time-consuming; lack of "champion"
• Expected hard work and long-term, accepted failures & successes	• Expected quick change; thought process was too much time and effort

Source: Selected findings from Robert Wood Johnson Foundation. *Assessing and Increasing Readiness for Patient-Centered Medical Home Implementation*. Research Summary No. 9. March 2012. Page 5.

Challenges to PCMH Adoption

- **Start-up and maintenance costs can be high.**
- **Payer incentives don't always align with necessary tasks.**
- **Physician adoption can be a major challenge.**
- **Robust health information technology is essential.**
- **The model doesn't fit well with all types of practices.**
- The supply of primary care physicians is inadequate.

Source: Deloitte Development LLC. Issue Brief: *Medical Home 2.0: The Present, The Future*. 2011.

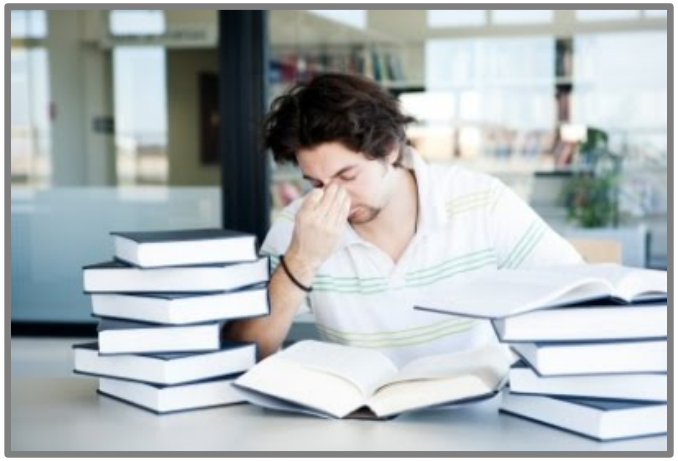
Is There a Compelling Reason?

- **It's the best delivery model for quality and cost-effective (i.e., high value) surgical patient care. It helps achieve "the Triple Aim."**
- **Anesthesiologists are in the best position to lead the PSH initiative; and it's the best way to demonstrate the value of the physician anesthesiologist.**
- **If we don't take the lead, someone else will (e.g., hospitalists, surgeons). In some circumstances, that might be "okay."**
- **The SGR proposals encourage alternate payment models (APMs); the PSH is a vehicle for APMs.**
- **The risks associated with "doing nothing" are too great.**

(Pre-)Starting “How”s

1. **Talk to your practice (yourself); conduct a preliminary informal assessment.**
   - Regarding interest level, willingness to work, and organizational capacity and capabilities.
2. **Review & internalize the “lessons learned” from the PCMH implementation journey .**
   - i.e., the importance of motivation and perspective on “barriers”
3. **Develop a shared vision of “why” and the PSH “elevator speech” for your HCO administration, patients, and practice partners (and yourself).**

Getting Prepared



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4. Recognize that "Masterful work requires preparation."

"
- **Identify the multiple—and possibly competing or conflicting—goals for your project, and to whom those goals matter.**
- **Figure out the best people to help with this project, and how to mobilize people around a shared goal.**
- **Get clear on the scope of the work and make sure the resources are in place.**
- **Build on learning from previous projects, and draw strength from experience and knowing your own strengths."**

Source: Batalden P. Making improvement interventions happen–the work before the work: four leaders speak. *BMJ Qual Saf* 2014;23:4-7.

5. Review PSH-Relevant Articles

The Perioperative Surgical Home (PSH)

A Comprehensive Literature Review for the American Society of Anesthesiologists

by

Bita Kash, PhD, MBA, FACHE
Kayla Cline, MS
Terri Menser, MBA
Yichen Zhang, MS, MA

Submitted to the American Society of Anesthesiologists (ASA)
August 30, 2013

ASA Contact:
Thomas R. Miller, PhD, MBA
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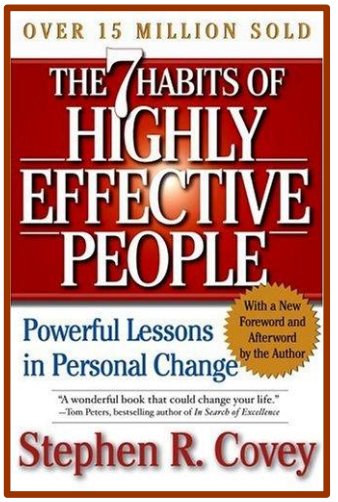
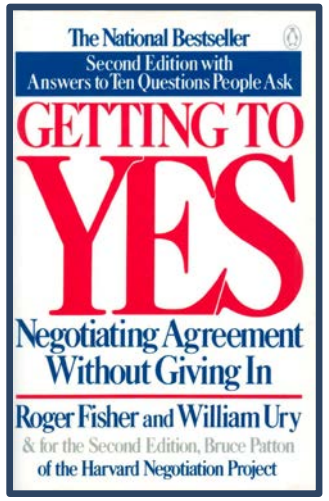
6. Review Relevant Non-PSH Material





- Donabedian A. The quality of care: how can it be assessed? *JAMA*. 1988;260;1743-48..
- Jensen NF, Tinker JH. Quality in anesthesia care: Lessons from industry and a proposal for valid measurement and improvement. *Clin Perform Qual Health Care*. 1993;1(3):138-51.

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7. Get to Know Change Management…

- = the process, tools and techniques to manage the people-side of change to achieve the required business outcome.

- Incorporates the organizational tools to help individuals make successful personal transitions resulting in the adoption and realization of change.

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…And Know the Challenges of Change

Leading Change: Why Transformation Efforts Fail
by John P. Kotter

Change Through Persuasion
by David A. Garvin and Michael A. Roberto

Leading Change When Business Is Good: An Interview with Samuel J. Palmisano
by Paul Hemp and Thomas A. Stewart (Editors)

Radical Change, the Quiet Way
by Debra E. Meyerson

Tipping Point Leadership
by W. Chan Kim and Renée Mauborgne

A Survival Guide for Leaders
by Ronald A. Heifetz and Marty Linsky

The Real Reason People Won't Change
by Robert Kegan and Lisa Laskow Lahey

Cracking the Code of Change
by Michael Beer and Nitin Nohria

The Hard Side of Change Management
by Harold L. Sirkin, Perry Keenan, and Alan Jackson

Why Change Programs Don't Produce Change
by Michael Beer, Russell A. Eisenstat, and Bert Spector

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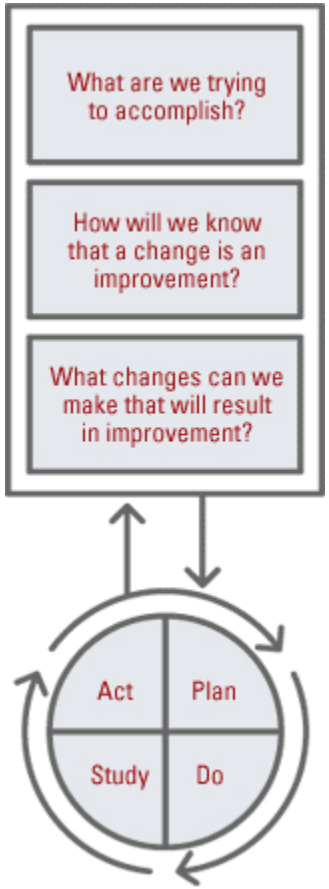
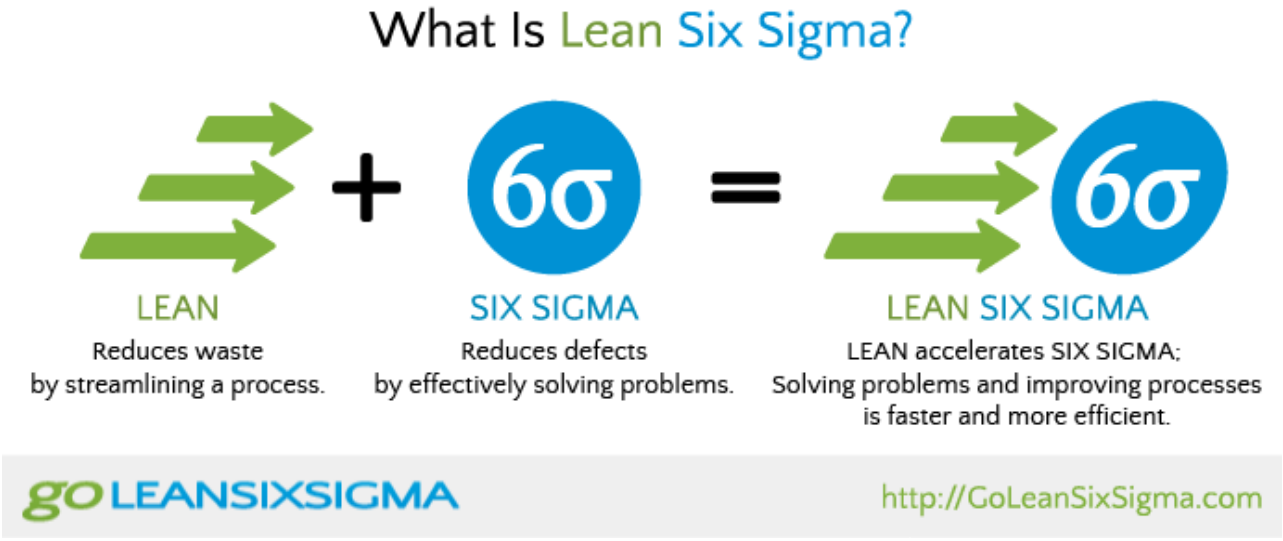
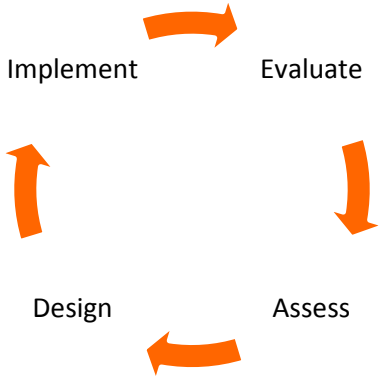
8. Get to Know One or More Other Performance Improvement Processes

Plan, Do, Study, Act





Continuous
Process
Improvement



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9. Know What's Up with CMS

The Field Guide to Medicare Payment Innovation

Momentum Building Toward Payment Transformation

The Advisory Board Company

www.pwc.com/us/healthindustries

Our Perspective: Medicare ACOs and shared savings models

Health Research Institute Analysis

pwc

Public Health & Policy

Medicare $$$ May Fuel PCMH Movement

Published: Jul 9, 2013

HCAHPS 30% + Core Measures 70%

= VALUE-BASED PURCHASING PERFORMANCE SCORE

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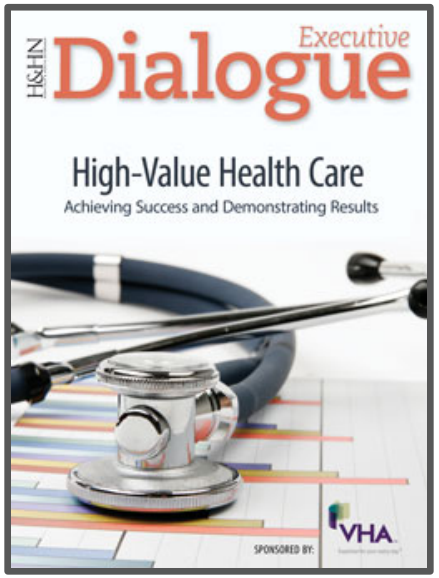
10. Know Your HCO's Strategic Position

- **Environmental Assessment/ Situation Audit**
  - SWOT analysis
    - Quality and cost performance
    - Priority service lines, centers of excellence
  - Physician groups, structures, utilization
    - Use of hospitalists
  - Relationships with payers & HCOs
    - Competitive positioning
    - PCMH and ACO initiatives
- **Goals and Strategic Priorities**
  - What's really important to your HCO governance and leadership?



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11. Review What Others Are Saying/Doing

SHM's guide to building a co-management program:

- ☑ Identify Obstacles and Challenges
- ☑ Clarify Roles and Responsibilities
- ☑ Identify a Champion
- ☑ Address Financial Issues
- ☑ Measure Performance

shm Society of Hospital Medicine
Hospitalists. Transforming Healthcare. Revolutionizing Patient Care.

- Michigan Bariatric Surgery Collaborative
- Michigan Society of Thoracic and Cardiovascular Surgeons Quality Collaborative
- Michigan Surgical Quality Collaborative
- Michigan Trauma Quality Improvement Program
- Perioperative Outcomes Initiative

Blue Cross Blue Shield Blue Care Network of Michigan

Sources: http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&Template=/CM/HTMLDisplay.cfm&ContentID=25895
http://www.bcbsm.com/providers/value-partnerships/collaborative-quality-initiatives.html

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Review and Follow ASA's Progress

12. Review prior ASA commentary and Rovenstine lectures.

- Miller RD: Report of the Task Force on Future Paradigms of Anesthetic Practice. 2005.
- Warner MA: Who Better than Anesthesiologists? 2006.
- Kapur PA: The Future Practice of Anesthesiology. 2008.
- Miller RD: The Pursuit of Excellence. 2009.
- Kapur PA: Leading Into the Future. 2012.

13. Follow ASA's progress via:

- PSH Learning Collaborative updates
- PSH website
- Ongoing communications

Getting Involved & Connected

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It Is Now Time for The Team

“The past 50 years have been marked by advances in the science of medicine.

The next 50 will be marked by improvements in the organization and teamwork of how health care is delivered.”

- Charles H. Mayo
January 1913

Source: Joe Damore, VP of Population Health Premier Inc. 9/11/2013.

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14.-19. Get Involved.
Know: Relationships Matter

14. Join the PSH collaborative.

15. Participate in HCO-wide QI and efficiency initiatives.

16. Take another clinician to lunch to strategize about the PSH.

14.-19. Get Involved.
Know: Relationships Matter

17. Begin to formulate who the PSH project leader should be.
18. Take a “suit” to lunch.
19. Become an effective and “wanted” leader.

- The C-suite: CEO, COO, CFO, CNO, CIO, CSO
- Other VPs: Service line/COE leadership

What does HCO administration seek in physician leadership?

Desired Characteristics from One Health System's Physician High-Potential Leadership Program

1. Collaborative and cooperative
2. Strong listening skills
3. Communication skills
4. Self-confidence and mental resilience
5. Humility
6. Lack of arrogance
7. Appreciative of others
8. Mentoring
9. Values life balance — "Real doctor, real person"
10. Vision

Source: North Shore-LIJ Health System, Manhasset, New York. http://www.beckershospitalreview.com/hospital-physician-relationships/10-characteristics-of-physician-leaders.html

20. Recognize Management-Speak ☺

- *It's a paradigm shift*
- *ROI [used in any sentence]*
- *I'm a team player/we only hire team players*
- *We think outside the box here/color outside the lines*
- *It's like the book "Crossing the Chasm"/"Blue Ocean"/ "Good To Great"/"Tipping Point"/"Outliers"*
- *We need to monetize/strategize/analyze/incentivize*

Source: http://www.forbes.com/sites/ericjackson/2012/06/19/89-business-cliches-that-will-get-any-mba-promoted-to-middle-management-and-make-them-totally-useless/

Collecting & Sharing Information

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21. Know PSH Measurement Goals

- Measure patient/family experience
- Measure achievement of clinical goals for the indicated procedure.
- Measure and track the cost of care
- Demonstrate continuous quality improvement
- Report (joint) performance externally

How to Get There with Information

22. Willingly share whatever your practice has regarding Cost and Quality of anesthesia and perioperative care.
23. Develop selected targets/benchmarks and monitor.
24. Develop joint outcome measures (initiate, participate).
25. Be willing to pilot efforts; use manual processes.
26. Know where to get relevant data within your HCO and start getting it (e.g., util. trends by type of surgery).
27. Help “fix” data problems; be a part of the solution.
28. Join the Anesthesia Quality Institute (AQI).

Selecting a Strategic Approach

UC Health's Journey

UC HEALTH

Davis • Irvine • Los Angeles • San Diego • San Francisco

	Phase I	Phase II	Phase III
	• Standardized UC Health Wide Preoperative Approach	• Joint Replacement Surgical Home	• Urological Surgical Home
Locations	System-wide	3 campuses	2 campuses
Stage	Preoperative	All Stages	All Stages
Clinical Focus	ALL Elective	Elective Orthopedics	Elective Urological

Source: Adapted from CHQI Quality Enterprise Risk Management Proposal, "Looking into the Future: A UC Wide Innovative Preoperative Assessment and Surgical Home."

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UC Health's Process

UC HEALTH

Davis • Irvine • Los Angeles • San Diego • San Francisco

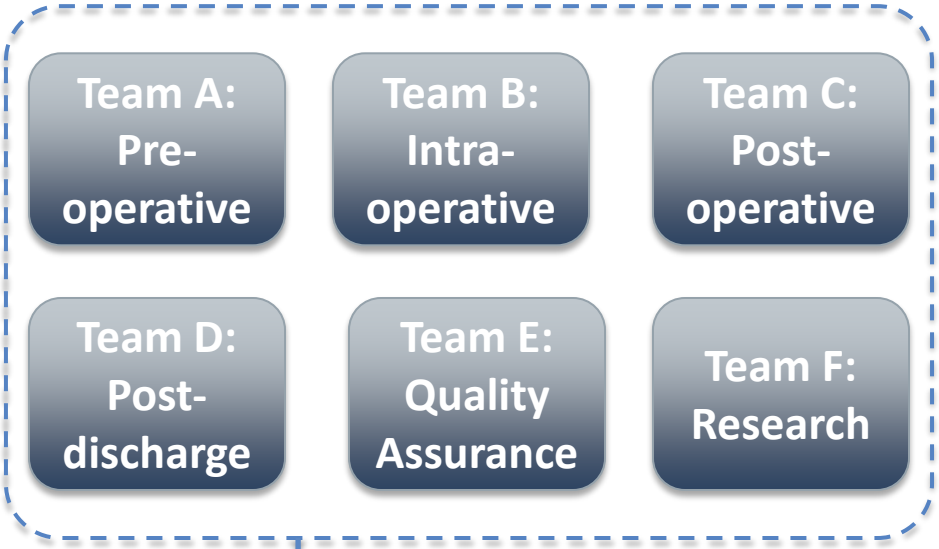
Phase I
UC Wide Steering Committee

- Focused on standardizing preoperative care
- Regular conference calls

Phase II
Individual Campus Leadership Group
- Joint Surgical Hospital -

- Leadership group with reps from 6 teams
- Meets weekly; trained in Lean Six Sigma

Team Members	
Anesthesiologists	Resp Therapy
Surgeons	PT/OT
Nurse managers	Discharge planning
Hospitalists	Quality/safety reps
Pain Management	Data analysts
Pharmacy	Social work



Source: Adapted from CHQI Quality Enterprise Risk Management Proposal, "Looking into the Future: A UC Wide Innovative Preoperative Assessment and Surgical Home."

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When Specialty-Specific vs. Hospital-Wide Makes Sense

Specialty-Specific

- High-volume, high cost specialties
- Elective cases
- Cases with multiple morbidities/complications
- Established center of excellence exists
- Global/bundled payment pilots in place
- Surgeon interest/champion
- Evidence-based practices exist for specialty
- Team-based care is prevalent in specialty

Ex: Ortho | Cardiac | Urology

Hospital-Wide

- Wide-scale service line structure
- Wide-scale efficiency training in place
- Very active quality improvement committee and evidence-based practice development
- Robust, enterprise-wide data warehouse and analytics function available
- ACO model or wide-scale risk contracts in place

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The “How”s Become More Difficult

29. **Think/discuss/decide among practice.**
30. **Should be connected enough to form PSH committee or task force.**
    - Change name if needed: Surgical Home, Enhanced Perioperative Services (EPS), etc.
31. **Conduct formal meeting of a broad multidisciplinary group (clinical and administrative).**
    - Employ “best practices” in conducting a meeting
    - First meeting: Begin to discuss common vision of “why,” goals, work groups, surgical focus, specific follow-up action steps (e.g., funding/finance, additional information needs)
    - **LISTEN**.

Getting Started & Moving Forward

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Getting Started

First, do all (most) of the above #1 – #31.

32. **Identify a project leader/champion.**
    - It need not be you, but that would be great.
33. **Continue team building/vision development & sharing.**
34. **Conduct an honest self-assessment of HCO readiness.**
35. **Attend 2-3 relevant conferences/sessions.**
    - Not just anesthesiology sponsored.
    - Bring a new friend or two (e.g., surgeon, CNO, CFO, CSO, COO, service line administrator, or even an HCO board member).

Readiness Assessment (*draft* sample)

Subject Matter Readiness

- Surgical Home Concepts
- Regulatory/ Payment Trends
- Quality/Change Management

Organizational/ Cultural Readiness

- Organizational Structure
- Provider Structure/Team Based Care
- Leadership Engagement in Quality

Programmatic Readiness

- Preoperative Elements
- Intraoperative Elements
- Postoperative Elements

Getting Started – *continued*

36. **Begin to nail down program goals and metrics.**
    - Use the S.M.A.R.T. guidelines
37. **Develop formal timeline and primary responsibilities.**
    - Remember, human resource capacity is often more constrained than capital resources.
38. **Develop a preliminary description, including specific components and processes to be part of the PSH.**
    - Identify any funding requirements (initial investment) for new "unpaid" services.
39. **Develop weekly and daily checklists.**
    - DO SOMETHING DAILY to help move the PSH forward.

And Before Payment Reform…

40. **Work with HCO finance staff to use chargemaster to track "uncompensated" PSH activities.**
    - Outside of CPT world (where changes will take a while)
    - Chargemasters (or charge description masters [CDM]) are HCO-specific
    - Disastrous PR recently; yet listed charges essentially irrelevant
    - Some states require posting of CDMs (e.g., CA)
    - CDMs also used for cost accounting, and tracking of physician-hospital joint ventures and pilot clinical programs
    - Can be used to track (proposed) PSH activities

Use of Chargemaster or CDM…

- **Strategy may not be viable in some HCOs.**
- **Why track utilization even if not *directly* paid for activity?**
- **What type of activity?**
  - In or not in PSH?
  - Preoperative assessment(s)
  - Consultations
  - Review of medical records
  - Post-operative pain plans
  - “Extra” performance improvement action items
  - Special, selected outcomes tracked

You CAN Do This!

Thank you!

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