You Can Do This: Here’s How

The Business Model for Perioperative Care

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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

FACE REALITY AS IT IS
PROVIDERS MUST LEAD THE WAY IN MAKING VALUE THE OVERARCHING GOAL
BY MICHAEL E. PORTER AND THOMAS H. LEE
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.
## Motivation and PCMH Implementation

<table>
<thead>
<tr>
<th>Higher Implementation Scores</th>
<th>Lower Implementation Scores</th>
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</thead>
<tbody>
<tr>
<td>• Took active role in learning</td>
<td>• Felt a need for external teaching</td>
</tr>
<tr>
<td>• Took the initiative to promote change</td>
<td>• Felt a need for external direction in promoting change</td>
</tr>
<tr>
<td>• All or most team members invested in change</td>
<td>• Placed responsibility on one person; had influential resistors</td>
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## Capability and PCMH Implementation

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

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

thinking

THE BOX

American Society of Anesthesiologists®
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.”

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
Director of Health Policy Research, ASA
6. Review Relevant Non-PSH Material


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.
...And Know the Challenges of Change

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

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

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

4. **Radical Change, the Quiet Way**
   by Debra E. Meyerson

5. **Tipping Point Leadership**
   by W. Chan Kim and Renée Mauborgne

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

7. **The Real Reason People Won’t Change**
   by Robert Kegan and Lisa Laskow Lahey

8. **Cracking the Code of Change**
   by Michael Beer and Nitin Nohria

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

10. **Why Change Programs Don't Produce Change**
    by Michael Beer, Russell A. Eisenstat, and Bert Spector
8. Get to Know One or More Other Performance Improvement Processes

Plan, Do, Study, Act

What Is Lean Six Sigma?

- **LEAN**
  - Reduces waste by streamlining a process.

- **SIX SIGMA**
  - Reduces defects by effectively solving problems.

- **LEAN SIX SIGMA**
  - LEAN accelerates SIX SIGMA; Solving problems and improving processes is faster and more efficient.

Continuous Process Improvement

[Image: goLEANSIXSIGMA - http://GoLeanSixSigma.com]

American Society of Anesthesiologists®
9. Know What’s Up with CMS

The Field Guide to Medicare Payment Innovation

Momentum Building Toward Payment Transformation

Our Perspective: Medicare ACOs and shared savings models
Health Research Institute Analysis

Public Health & Policy

Medicare $$$ May Fuel PCMH Movement
Published: Jul 9, 2013

HCAHPS 30% + Core Measures 70%

VALUE-BASED PURCHASING PERFORMANCE SCORE
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?
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

- 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

Sources: http://www.hospitalmedicine.org/AM/Template.cfm?Section=Home&Template=/CM/HTMLDisplay.cfm&ContentID=25895
12. Review prior ASA commentary and Rovenstine lectures.

13. Follow ASA’s progress via:
   - PSH Learning Collaborative updates
   - PSH website
   - Ongoing communications
GETTING INVOLVED & CONNECTED
“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.
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.

17. Begin to formulate who the PSH project leader should be.

18. Take a “suit” to lunch.


- 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

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*

COLLECTING & SHARING INFORMATION
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
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.
SELECTING A STRATEGIC APPROACH
UC Health’s Journey

Phase I
- Standardized UC Health Wide Preoperative Approach

Phase II
- Joint Replacement Surgical Home

Phase III
- Urological Surgical Home

Locations
- System-wide
- 3 campuses
- 2 campuses

Stage
- Preoperative
- All Stages
- All Stages

Clinical Focus
- ALL Elective
- Elective Orthopedics
- Elective Urological

UC Health’s Process

**Phase I**
UC Wide Steering Committee

- Focused on standardizing preoperative care
- Regular conference calls

**Team Members**

<table>
<thead>
<tr>
<th>Team</th>
<th>Members</th>
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<tbody>
<tr>
<td>Anesthesiologists</td>
<td>Resp Therapy</td>
</tr>
<tr>
<td>Surgeons</td>
<td>PT/OT</td>
</tr>
<tr>
<td>Nurse managers</td>
<td>Discharge planning</td>
</tr>
<tr>
<td>Hospitalists</td>
<td>Quality/safety reps</td>
</tr>
<tr>
<td>Pain Management</td>
<td>Data analysts</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Social work</td>
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**Phase II**
Individual Campus Leadership Group
- Joint Surgical Hospital

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

**Teams**

- Team A: Pre-operative
- Team B: Intra-operative
- Team C: Post-operative
- Team D: Post-discharge
- Team E: Quality Assurance
- Team F: Research

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

**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

Ex: Ortho, Cardiac, Urology
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

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
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.
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
Thank you!

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