

Quality improvement

Orthopedic PSH a prime model for value-based care—Part 1

Uncertainties pepper the healthcare landscape, but the shift to value-based care is expected to continue, even though momentum may slow under the current administration. That means perioperative services leaders must continue to explore new care delivery options such as the perioperative surgical home (sidebar, p 17).



*Peggy Naas, MD,
MBA*

“The demand for value and value-based payments based on specific performance metrics and directly tied to reimbursement is a huge driver in care now and will continue to be so in the future,” says Peggy Naas, MD, MBA. “The PSH is an excellent pathway to increase the value delivered to patients by caregivers.” Naas and Jeffery Angel, MD, represent the American Academy of Orthopedic Surgeons (AAOS) on the American Society of Anesthesiologists (ASA) PSH Collaborative Steering Committee.

Orthopedic PSHs have a proven track record in coordinating care of patients from the time they decide to have surgery until they return to function. But a team approach is essential for success.

“CMS’s [the Centers for Medicare & Medicaid Services] quality payment program requires us to work together as a team, which is ideal under any circumstances,” 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. The CMS quality payment program has two tracks for clinicians—the merit-based incentive payment system (MIPS) and advanced alternative payment models, with most choosing MIPS.



*Christopher Steel,
MD*

Although physician payments won’t be decided until October 2017, surgeons are looking ahead. Now is the ideal time to develop an orthopedic PSH, which can yield significant benefits for patients, physicians, and hospitals.

This first part of a two-part series on the orthopedic PSH discusses its value and steps for setting up this model. Operational strategies will be covered in a future issue of OR Manager.

PSH power

Benefits of the PSH for patients undergoing orthopedic surgery include reductions in length of stay, readmissions, and costs, and increases in patient satisfaction scores.

The PSH at WRHS reported the following achievements from 2013 to 2016:

- average total savings of \$3,200 per case for lower extremity joint replacements in the organization’s first bundled payment program
- reduction in readmission after total knee arthroplasty (TKA) from 6.3% to 3.7%
- reduction in readmission after total hip arthroplasty (THA) from 11.6% to 1.9%
- decreased length of stay for TKA from 2.9 to 1.65 days.

A 2016 study by researchers at Tampa General Hospital in Florida found that patients who were part of a PSH had lower lengths of stay, better pain management, improved patient satisfaction, and fewer blood transfusions and laboratory and imaging tests than those not in a PSH.

And improved efficiency was reported in a 2017 study from researchers at the University of Alabama at Birmingham (UAB), who found that a PSH increased on-time surgery starts by 7.2% and reduced anesthesia-related delays by 5.8%.

Beyond total joints

It's not just total joint patients who benefit from PSH.

"We're seeing dramatic decreases in length of stay for shoulder arthroscopy and ACL [anterior cruciate ligament] repairs," Dr Steel says. Overnight stays for patients undergoing shoulder arthroscopy dropped from 42% of cases in 2013 to just 7% in 2016.

Other orthopedic procedures that can fall under a PSH include hip fractures. "It's a challenge, but you can create a protocol and standardization and get patients more conditioned to help them with healing," Dr Steel says (sidebar, p 19).

For example, patients receive oral hydration instead of nothing by mouth, and multiple pain regimens are used—including, but not limited to, oral acetaminophen, anti-inflammatory agents, opioids, and injected local anesthetics to reduce or eliminate the need for IV narcotics.

Tampa General uses a "rapid hip protocol" for patients with fractures:

- The emergency department (ED) physician confirms a hip fracture and immediately consults with the anesthesia and hospital medicine teams.
- The hospitalist admits the patient while the anesthesiologist notifies the orthopedic surgeon and schedules the surgery.
- The anesthesiologist conducts a preoperative risk assessment in the ED.



Devanand Mangar,
MD

"You need to get the patient to the OR right away," says Devanand Mangar, MD, chief of anesthesia at Tampa General and regional medical director for TEAMHealth Anesthesia. The protocol, which minimizes the number of preoperative tests required, speeds the process.

Addressing hip fractures now will help hospitals down the road. "The federal government has shown interest in embedding hip fractures into bundled payment programs," Dr Naas says. "It has been put on hold for now, but we'll know more in October [2017]."

She adds that much can be done to support patients with this acute problem, including preventing complications such as urinary tract infections and determining the best value-added location for rehabilitation, whether home or in a facility.

No matter what the ultimate scope of the PSH, OR leaders have to start somewhere. Here are some tips from the experts.

Profile of the perioperative surgical home

The perioperative surgical home (PSH) is a patient-centric, team-based model of care created by leaders of the American Society of Anesthesiologists (ASA).

Purpose: The ASA says the PSH is designed to "help meet the demands of a rapidly approaching healthcare paradigm that will emphasize value, patient satisfaction, and reduced costs."

Time frame: The PSH guides patients through their complete surgical experience, from their decision to undergo surgery, through surgical care, and concluding with planned discharge and return to function. It addresses four phases:

- preoperative
- intraoperative
- immediate postoperative
- postdischarge (usually 90 days postop).

The collaborative: Currently, 57 organizations are participating in the second PSH Collaborative (PSH 2.0), a partnership be-

tween ASA and Premier, Inc. Of these, 25 organizations are planning, launching, or expanding orthopedic PSH efforts, and six are in the Centers for Medicare & Medicaid Services' Comprehensive Care for Joint Replacement program. Learn more about the collaborative, which started April 1, 2016, and ends March 31, 2018, at <https://www.asahq.org/psh/learning%20collaborative/an%20overview>.

Enhanced recovery after surgery (ERAS) is an important PSH component. The American Association of Nurse Anesthetists defines ERAS as "patient-centered, evidence-based, multidisciplinary team-developed pathways for a surgical specialty and facility culture to reduce the patient's surgical stress response, optimize their physiologic function, and facilitate recovery." ERAS addresses preoperative, intraoperative, and postoperative phases.

Build a business case



Jimmy Chung, MD,
FACS, CHCQM

“Before starting a perioperative surgical home, you first have to make sure it aligns with your organizational goals,” says Jimmy Chung, MD, FACS, CHCQM, senior director for perioperative services at Providence St Joseph in Renton, Washington. “Then you have to make the business case to the executives by showing them the opportunities based on their own data.”

First, identify key players, which typically include an administrator, at least one physician champion (it’s ideal to have both an anesthesiologist and a surgeon), and a nursing champion.

“We always talk about a physician champion, and that’s vital, but you need a strong nurse leader, too,” says Thomas Vetter, MD, MPH, department of surgery and perioperative care at Dell Medical School, University of Texas at Austin. Dr Vetter previously co-lead the PSH at UAB.



Thomas Vetter,
MD, PhD

“You want a nursing champion who is able and willing to work alongside his or her anesthesia and surgical colleagues to help develop, implement, and sustain a PSH,” he says. At UAB, a nurse director managed the Preoperative Assessment, Consultation, and Treatment Clinic: “She had tremendous credibility with all of her nursing colleagues and was an invaluable ally and partner.”

Another key nursing player is the chief nursing officer (CNO), who influences how strategic programs are prioritized, Dr Vetter says. OR leaders can share the potential value of a PSH with the CNO, offering to find physicians interested in developing the program so a pilot can be completed.

The champions will need data, and collecting that data can be challenging. Dr Naas says participation in CMS programs such as the Bundled Payments for Care Improvement and the Comprehensive Care for Joint Replacement (CJR) pays off.

“CMS gives you the ability to download claims-based data for your patients that looks longitudinally through the entire episode of care, including rehabilitation and return to another hospital for a complication,” she says.

Organizations that haven’t signed up for CJR could contract with private payers to obtain non-Medicare data. Another option is to use deidentified data from the organization’s own employer-paid insurance coverage.

“There are multiple successful variants of the perioperative surgical home concept,” Dr Vetter says. “Different organizations will approach it in different ways depending on resources, priorities, and political forces; there is not just one way.”

For example, a high first-case delay and cancellation rate on the day of surgery prompted the UAB team to start with the preoperative phase. Staff at the Preoperative Assessment, Consultation, and Treatment Clinic now assess patients using evidence-based testing protocols, which has resolved the problem.

Any organization building a PSH uses the available local resources, which will differ among facilities, but evidence-based protocols for improving the quality of care for surgery patients are universal, Dr Chung says. “Most programs want to do the same thing: Create a coordinated experience for the patient that ends with optimal outcomes and cost savings,” he says.

Another decision is where the PSH will fall in the organizational chart. “We moved it (from surgery) to under quality, which has allowed us to not just focus on surgery, but to standardize care for other conditions such as myocardial infarction and pneumonia,” Dr Steel says.

Build your team

Most PSHs run with existing staff. “Many are volunteering within their role because they know we can do better, and it frustrates them when we don’t,” Dr Naas says.

Involving as many stakeholders as possible early on will improve chances for success. “Large meetings are very inefficient, and they represent tremendous opportunity costs, but being inclusive initially is vitally important,” Dr Vetter says.

In addition to champions, Dr Naas identifies other members of a PSH dream team: discharge planner, hospitalist, respiratory therapist, occupational therapist, physical therapist, pharmacist, nutritionist, social worker, and nurses who care for the patient throughout the continuum of care.

Dr Naas says few teams include a rehabilitation medicine physician, yet the role is key for facilitating return to function. The rehab physician can help determine if a patient can go home or needs a rehab facility.

“Adding value isn’t randomly adding resources,” she says. “You want to have appropriate resources in place.”

Others interviewed for this article provided additional suggestions for team members. Dr Vetter recommends organizations add someone who can address patients’ psychological issues.

“If a psychological condition such as depression or anxiety is underdiagnosed or undertreated, patients won’t be able to effectively rehabilitate after surgery,” he says.

Dr Chung notes that information technology staff should be involved from the start. “They will give you the data, so they have to understand what you need.”



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

Colleen Walsh, DNP, RN, ONC, ONP-C, CNS, ACNP-BC, immediate past president of the National Association of Orthopaedic Nurses, says a nurse navigator is essential for a successful orthopedic PSH.

“The nurse navigator can propel the patient through the entire episode of care,” says Walsh, who serves on the advisory board of the American College of Perioperative Medicine. The navigator can ensure patient-centered care by serving as the consistent contact during the hospital stay.

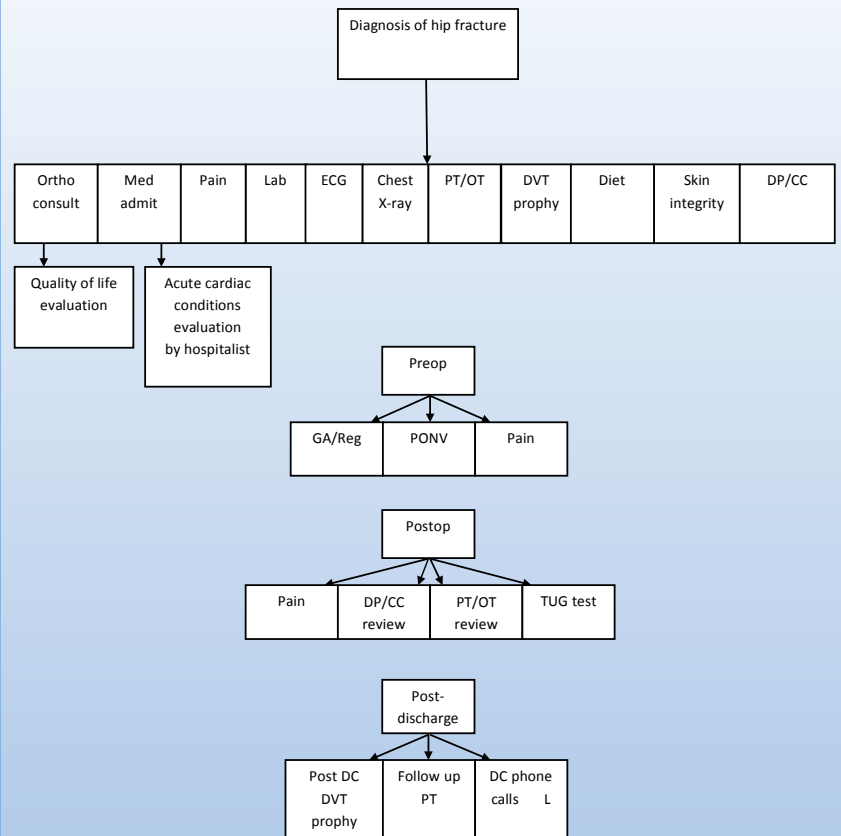
“The navigator should be with the patient the morning of surgery, when the patient wakes up, and when moved through different areas of care,” she says.

With this large a team, ground rules are crucial. “It has to be an equal partnership where everyone is on the same playing field,” Walsh says. “You have to treat everyone with respect and dignity,” Dr Mangar adds.

Once your team is onboard, Dr Steel says the biggest step is to simply get started.

Hip fracture pathway

The hip fracture pathway from White River Health System (Batesville, Arkansas) provides an overview of how to manage patients. Most steps include a link to a protocol, which contains more details.



Source: White River Health System. Reprinted with permission.

“You can’t learn to ride a bicycle by reading a book,” he says.

WRHS has two teams: The precision team, which develops the protocols, and the quality team, which then follows outcomes measures and performs gap analysis when goals aren’t met. (For more information about the teams, see “PSH provides affordable, reliable care for adult and pediatric patients,” *OR Manager*, June 2016, 14-17.)

Many resources exist for starting an orthopedic PSH, but the most important resource is a strong team. “The ability to work as a team has never been more critical,” Dr Naas says.

“We cannot underestimate the vital role that perioperative nursing plays in the successful development, implementation, and sustaining of a perioperative surgical home model,” Dr Vetter says. ❖

Cynthia Saver, MS, RN, is president of CLS Development, Inc, Columbia, Maryland, which provides editorial services to healthcare publications.

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