SURGICAL DIRECTIONS

Overcoming common obstacles to implementing a perioperative surgical home

Realize the benefits of a standardized and optimized approach

Consulting • Assessment • Interim Management

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Over the last 5 years, the perioperative surgical home (PSH) model has attracted increasing interest from OR directors, anesthesiologists, and surgeons. This team-based, patient-centered approach coordinates all phases of surgical care, from preoperative assessment through intraoperative care and postdischarge recovery. According to the American Society of Anesthesiologists, PSH initiatives have resulted in lower surgical complication rates, fewer readmissions, higher patient satisfaction, and lower episode costs.

Surgical Directions, a Chicago-based healthcare consulting firm, has seen similarly positive results from systems with a PSH in place. Despite growing interest in this model, however, many surgery department leaders are unsure how to launch a PSH, and even those who have started one tend to face stumbling blocks.

Pioneering hospitals have encountered most of these problems and developed effective solutions. Here are six of the most common obstacles to implementing a PSH, along with tested strategies for optimizing performance.

Lack of support from hospital executives

The PSH model requires an investment in staff and process change, and it can cause disruption for key perioperative stakeholders. As a result, it can be difficult to gain agreement from hospital executives. To overcome this obstacle, OR leaders should learn how to make the financial case for a surgical home.

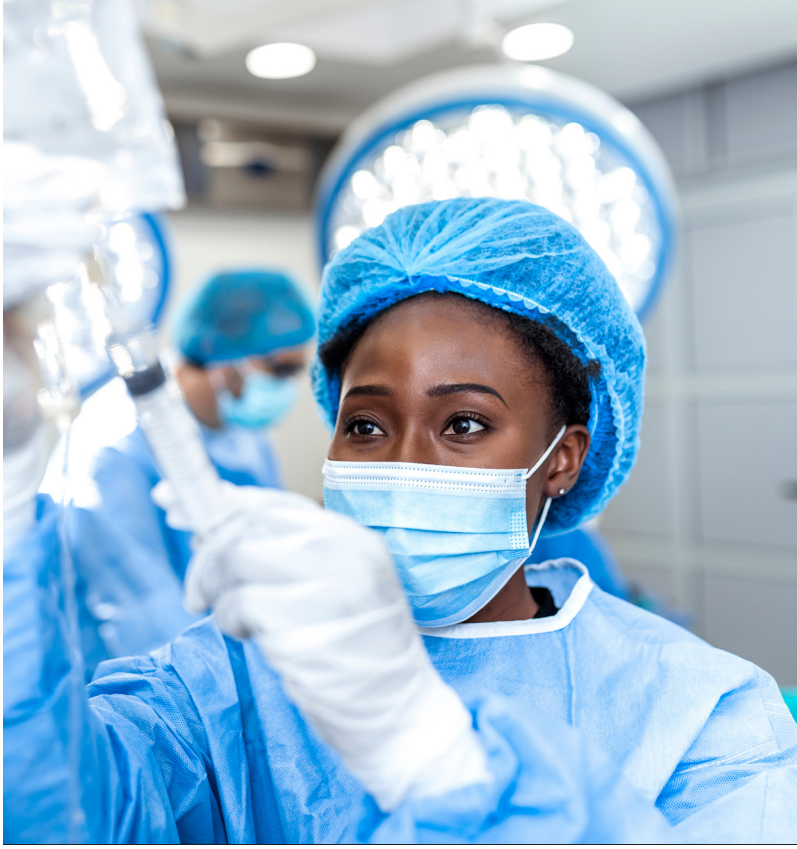
Start by providing the payment analysis. Under value-based care, hospital diagnosis related group (DRG) payments are increasingly at risk for quality, clinical outcomes, total cost, and patient satisfaction. Key drivers of payment risk include:

- High complication rates (1% penalty under the Hospital-Acquired Condition Reduction Program)
- High readmission rates (up to 3% penalty under the Hospital Readmissions Reduction Program)
- Overall clinical quality, safety, cost performance, and patient satisfaction (up to 2% penalty or incentive payment under the Hospital Value-Based Purchasing Program)

The potential losses for low-quality care can be significant. One hospital we recently visited lost $12.5 million over 6 years because of poor performance under these three programs alone.

Value-based payment penalties are tied to hospital results across all departments, not just surgery. However, perioperative services drive a significant share of these results. And when you consider that surgery and surgery-related care account for approximately 60% of hospital spending, perioperative performance is a critical element of overall cost control.

With a demonstrated ability to reduce complications, cut readmissions, improve patient satisfaction, and control costs, the PSH model represents a hospital's best overall opportunity



to achieve several value-based goals with one comprehensive approach.

From a payment viewpoint, PSH results can be impressive. A few years ago, an East Coast hospital was struggling with Medicare payment penalties tied to readmissions and other measures. Perioperative leaders responded by implementing a surgical home model for joint arthroplasty. Within 2 years:

- Readmissions were cut in half
- Surgical complications decreased by more than one-quarter
- Cost per case decreased by more than $1,700
- Patient satisfaction increased to above the 90th percentile

These improvements allowed the hospital to avoid millions of dollars in value-based payment penalties. They also helped cut length of stay by more than one-third, which enabled the hospital to increase OR volume significantly. In subsequent years, the hospital rolled out the surgical home model to multiple service lines. In 2018, total savings attributed to the hospital's PSH program exceeded $10 million.

Uncertainty about where to begin

Leading hospitals have surgical homes in place for multiple services. Although this is the ultimate goal, an initial PSH launch should focus on one well-selected specialty or procedure. Here are some key considerations:

• Which service lines are the focus of hospital strategy? It will be easier to gain executive support and physician buy-in for a PSH initiative that could help optimize a strategic department or procedure.

• Do any surgeons already support the surgical home concept or its components? A strong surgeon champion is a critical success factor for a PSH initiative. Surgeon leadership can quickly win executive support and get staff behind the surgical home vision.

• Which service lines have a strong enhanced recovery after surgery (ERAS) program? Teams that have already seen solid ERAS results will understand the value of a protocol-driven approach to optimizing surgical care.

• Which services have the biggest room for improvement? Where performance is lagging, there is often a big opportunity to show a gain quickly. Scoring an “early win” can energize a PSH initiative and set the stage for rapid growth.

It is helpful to understand how pioneering hospitals have launched a PSH. Common starting points include orthopedic surgery (especially for joint replacement), colorectal surgery, gynecological surgery, cardiac surgery (especially for bypass procedures), and bariatric surgery. Other PSH programs have begun with a focus on general surgery, pediatric surgery, urology, gynecological oncology, spine surgery, or neurosurgery. Recently, we have also seen several hospitals target elective Caesarean delivery for their initial foray into the surgical home model.

Difficulty with designing PSH protocols

A surgical home initiative might involve dozens of units and hundreds of individual stakeholders. It can be challenging to get everyone on the same page regarding clinical protocols and pathways.

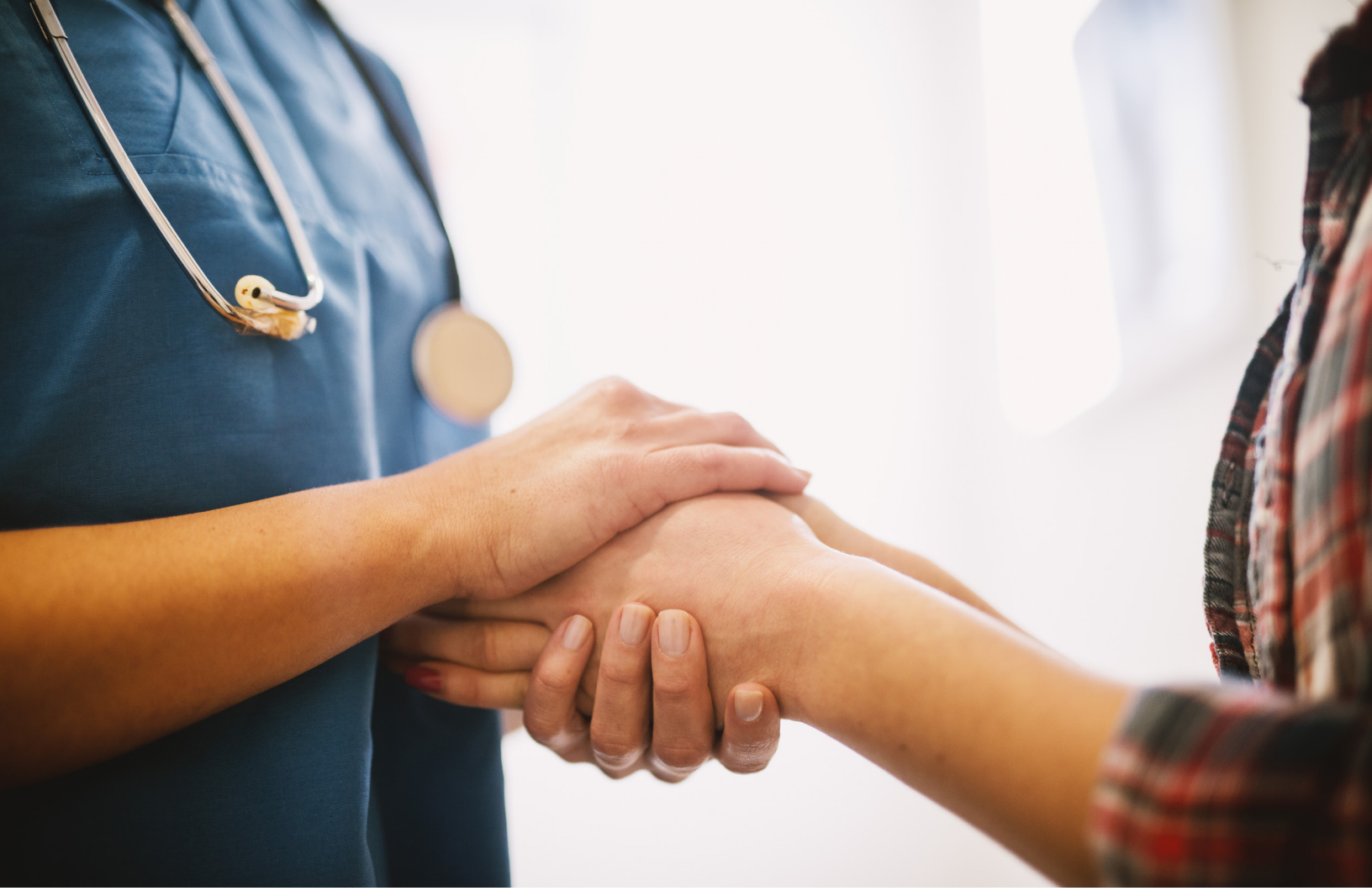
The best way to overcome this obstacle is to establish a PSH Steering Committee (PSHSC) to lead all clinical decision-making. An effective PSHSC includes clinical stakeholders—surgeons, anesthesiologists, and nursing leaders—plus representatives from key support systems, such as presurgical testing, pharmacy services, laboratory services, radiology, central sterile processing, information technology, human resources, and social services.

The main job of the PSHSC is to develop standardized protocols covering the entire spectrum of perioperative care for the targeted service line. For example, clinical protocols for a joint replacement surgical home might include:

- Standard preoperative processes that cover scheduling, lab testing, prehabilitation classes, medication management, and nutrition orders.
- Intraoperative protocols such as multimodal pain control, regional anesthesia, nausea prophylaxis, normothermia safeguards, and a joint-specific infection prevention bundle.
- Optimized postoperative care, including early ambulation and opioid-sparing pain management.
- A standard postacute pathway that ensures early discharge, physical therapy, consistent communication, and fully integrated joint-specific home care.

The PSHSC should also establish metrics for monitoring surgical home processes and outcomes. A sample dashboard illustrates how a PSHSC could use a key indicator report to monitor PSH performance.

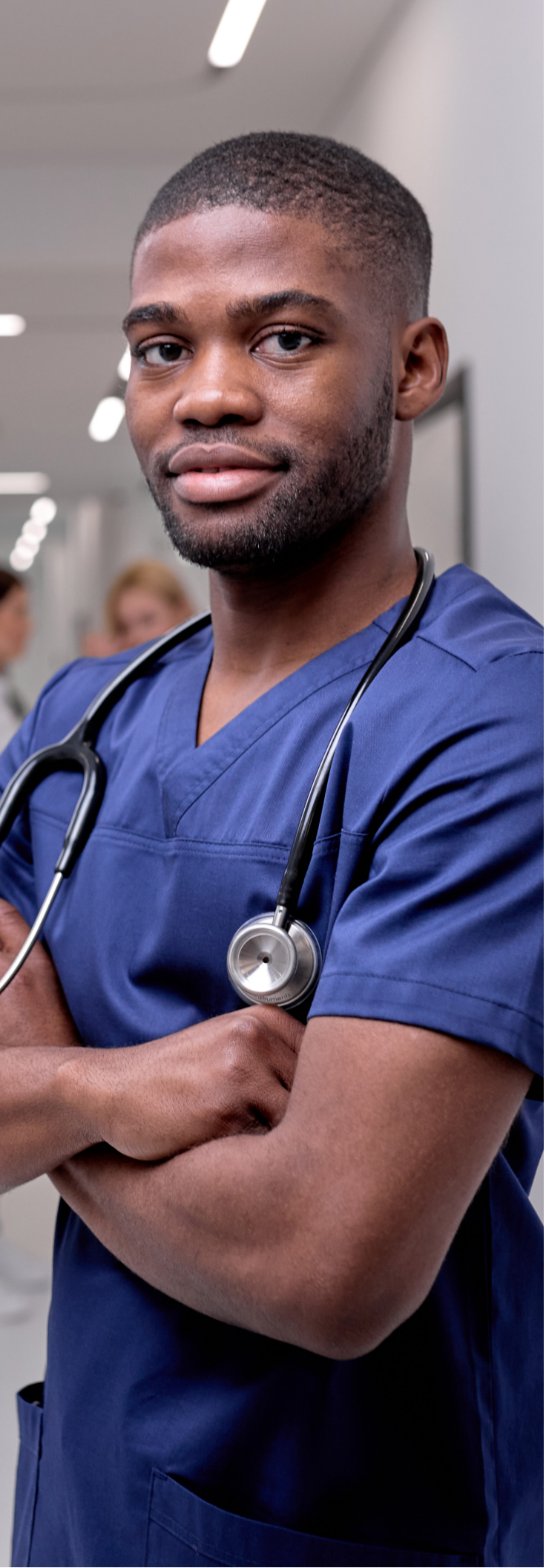
Although it may seem as though the surgical services executive committee (SSEC) could take charge of a PSH, launching a surgical home is a big enough project that a separate committee is needed. In addition, a surgical home requires involvement from stakeholders who are not part of a traditional SSEC (e.g., pharmacy). Further, we recommend launching a PSH with just one service, so putting it under the charge of a multiservice SSEC can lead to confusion. In short, the PSHSC can report to the SSEC, but it should always be a separate entity.



Uncertainty about how to roll out the model

In some hospitals, the prevailing change-management culture favors large-scale rollouts. For a complex surgical home initiative, however, a large-scale “go live” is not advisable. The PSH model is a very hands-on approach to patient care that requires a lot of flexibility. Initiatives that start small and scale slowly have the best chance of success.

We recommend a “rule of one” approach. After PSH clinical protocols have been established, test the model with one surgeon and one patient, and review the results. Data from even a single patient will show how the pathway works in real life and generate insights on how to improve the model. Continue to test, review, and iterate with successive patients. Once the model is working successfully for one surgeon’s practice, expand it to other members of the surgeon staff.



Difficulty with getting surgeon buy-in

A surgical home initiative will usually require some changes in clinical practice and patient time commitment, so surgeons may resist participating in the model.

One solution is peer education, especially from the surgeon champion who is spearheading the surgical home initiative. If coaching fails to persuade a surgeon to adopt a key protocol, PSH leaders may consider escalating the issue to the SSEC. Ultimately, however, surgeon buy-in will stand or fall based on clinical results. As a surgical home begins to deliver better outcomes and prevent complications, even skeptical surgeons will willingly adopt new protocols.

Another solution is to establish a comanagement agreement. Comanagement can be complex, but it is essentially a contract that allows physicians to be rewarded for improving patient care and reducing costs. One component of a comanagement agreement would be hourly compensation for taking part in PSH management activities, such as planning protocols, reviewing performance, and working on continuous improvement. (Hourly compensation is based on independently determined fair market value for physician work input.) The other component would be a performance incentive tied to improvement on baseline metrics for quality, outcomes, and costs.

A comanagement agreement is a flexible way to align physicians with the PSH model. Performance metrics can be customized to the particular goals of the surgical home. Quality and cost metrics can change yearly to ensure physicians are always engaged with new performance targets. In addition, PSH comanagement contracts can eventually be expanded to include other programs and/or bundled payment agreements.

Difficulty with “tying it all together”

An effective surgical home depends on tight choreography of services and staff. Failures in one area can affect performance throughout the system. PSH coordination can break down in several ways, but many problems can be resolved by answering three questions.

1. Are patients getting into the system at least 2 weeks before their procedure? A strong preadmission testing (PAT) process is a critical component of the PSH model. This should include screening all patients for risk, using an evidence-based lab matrix, and referring the highest-risk patients for medical optimization. One common problem is that surgeon office staff are not scheduling patients with enough time to benefit from the process. If the ultimate cause is poor surgeon buy-in, use the physician engagement strategies described above to resolve the roadblocks. If office staff are simply unaware of the new surgical home processes, explain the importance of using correct scheduling processes, ordering appropriate labs, sending clearances in a timely manner, and other key practices.

2. Are you maintaining communication with patients following discharge? Patient commitment is critical to ensure the best surgical outcomes, so make sure your PSH pathways include plans to engage and educate patients. Several technological tools can be useful. For example, the successful colorectal PSH at Advocate Lutheran General Hospital near Chicago uses a digital platform to automate key patient communications before and after surgery.

3. Is one person responsible for steering day-to-day operations? All successful surgical homes that we have encountered include a nurse navigator. The PSH navigator acts as a liaison between the patient and perioperative services and is responsible for the overall choreography of the program. What should you look for when hiring a PSH navigator? A good candidate is highly organized, is willing to take charge, has both a systems perspective and emotional intelligence, and has earned the trust of physicians.

Strong foundation

There are several obstacles to implementing the surgical home model, but overcoming the barriers is well worth the effort. ORs that adopt PSH successfully are able to establish a strong foundation for high performance in value-based care.

Barbara McClenathan, MBA-HCM, BSN, RN, CNOR, is director of perioperative nursing and Lisa Branding, MHSA, is director of strategy and value-based care at Surgical Directions, a healthcare consulting firm specializing in operating room transformation.