What Is a Perioperative Surgical Home?

A roundtable discussion with surgical home participants

The “medical home” is just one of the healthcare reform measures proposed to provide coordinated care and reduce healthcare costs. Best described as a philosophy of primary care, the medical home should be patient-centered, comprehensive, team-based, coordinated, accessible, and focused on quality and safety.

What happens when this primary care concept is applied to a surgical setting? Recently, Peggy L. Naas, MD, MBA, a member of the AAOS Health Care System Committee, discussed the creation of a “perioperative surgical home” with the following four individuals who are familiar with the concept:

- **Ran Schwarzkopf, MD**—assistant clinical professor of orthopaedic surgery, University of California, Irvine (UC Irvine)
- **Mike Schweitzer, MD, MBA**—vice president, healthcare delivery system transformation, VHA Southeast, Inc., and chair of the American Society of Anesthesiologists (ASA) committee on future models of anesthesia practice
- **Zeev Kain, MD, MBA**—chair of the department of anesthesiology & perioperative medicine and associate dean for clinical operations for UC Irvine Health
- **S. Samuel Bederman, MD, PhD, FRCSC**—assistant clinical professor of orthopaedic surgery, UC Irvine Health
Dr. Naas: Can we start by defining a perioperative surgical home?

Dr. Schweitzer: The perioperative surgical home (PSH) is designed to provide coordinated, organized care from the time of the shared decision making for surgery all the way through 30 days postdischarge. It covers the preoperative phase of working with patients to optimize their condition prior to surgery, the interoperative phase, the immediate postoperative phase, and then postdischarge. The concept is to provide team-based, coordinated care to manage the patient’s experience, to improve quality, and to decrease costs.

Dr. Naas: How did the PSH concept get started at UC Irvine?

Dr. Schwarzkopf: My interaction with the PSH began when I joined UC Irvine to help establish the total joint replacement program. I was a new surgeon who wanted to do modern techniques with modern protocols and have everything evidence-based. We also had a very receptive, young, and aggressive anesthesia department. So my anesthesia partners and I, together with the leadership of my chairman Ranjan Gupta, MD, and the other stakeholders in the hospital built the first program.

Dr. Kain: It was a very strong partnership between the orthopaedic surgeons and the anesthesiologists. Under Dr. Gupta’s leadership and due to the success of the total joint replacement PSH, we are expanding the concept to the entire department. I’m the coordinating entity of the PSH at UC Irvine Health, bringing it together, moving the process where it needs to go, and incorporating the various necessary components.

Dr. Bederman: I think Dr. Kain is being extremely modest. He’s a real innovator; without him, none of this would be done. I think joint replacement was the best place to start due to the predictability. The next step is to stay with elective orthopaedics. Most inpatient surgeries at UC Irvine are spine surgeries; my practice is predominantly adult deformities and revisions. These are resource-intensive cases with long lengths of stay and high reported complication rates. So
there’s a lot of room to improve on the delivery of care for these patients.

Dr. Naas: What has the PSH program meant for total joint patients?

Dr. Schwarzkopf: Our total joint replacement PSH took a fragmented system of care—one in which each provider has his or her own segment of care and does it independently, which sometimes can cause conflicts of opinion on the best care—and streamlined the system so that all the pathways are agreed upon in advance, before the first patient enters the process.

All the care is provided mutually as a team. There’s no more conflict of opinion. Everybody is a stakeholder and cares for the patient jointly. Everyone has agreed to the protocols. If a patient has to veer off the regular pathway, you have a team to talk to and discuss the situation. It’s a very different experience than I’ve ever had before.

The patient feels that everybody’s in it together. I didn’t initially think that patients would respond that way, but they do.

Dr. Naas: What about the benefits for surgeons and anesthesiologists? What’s in this program for them?

Dr. Schwarzkopf: From my perspective as a surgeon, it streamlines my work. I don’t have to waste time or resources on things that I’m not proficient in. I have other team members and stakeholders who are better in different parts of the process of caring for the patient and taking that responsibility. So I have more time and resources to do what I know to do best—see my patients in clinics, perform surgeries, and take care of patients.

Because anesthesia, preoperative testing, and postoperative care are performed by people who are best qualified in each group, we see better outcomes and an easier process for everyone.

Dr. Kain: I think there must be a good reporting relationship between the departments of anesthesiology and orthopaedics for this program to work. If that doesn’t exist, the program won’t happen.

From the anesthesiologist’s perspective, we, as anesthesiologists, have to understand that we are physicians, that our practice of medicine should not be limited solely to the intraoperative period. We have to step up to the plate and say that we are perioperative physicians so that we can help optimize patients preoperatively, reduce variability intraoperatively, and help surgeons with the medical management of patients postoperatively to reduce the likelihood of readmissions and shorten the length of stay. We are capable of doing these things, and we need to step up to the plate and actually do them.

Dr. Bederman: From an orthopaedic perspective, a willing anesthesiology department is key to the success of this type of program. But I think that there may be challenges on the anesthesiology side.
**Dr. Schweitzer:** You’re not going to have every anesthesiologist involved in a PSH. But you will have a physician champion who can help lead the PSH team forward, and you may have different champions for various aspects of this project. For example, one anesthesiologist may be involved in the preoperative phase and another who is accustomed to dealing with patients postoperatively.

**Dr. Naas:** With the team approach, what happens in the operating room (OR) itself? Is there a shift in how people work together?

**Dr. Schwarzkopf:** I think it changes the culture, the classical culture between the surgeon and the anesthesiologist, not only in the OR but throughout the entire perioperative period. We’re friends, colleagues, and partners—and it hasn’t always been like that.

For the first time, I’m getting a call the day before surgery from my anesthesia team telling me how busy my day looks and how can they help my day go faster and better.

**Dr. Schweitzer:** It’s primarily a cultural change, one that’s required to take better care of the patient. We have to work together collaboratively and communicate across silos. Once we put the patient at the center of care and focus on that, people start communicating and work better as a team. That makes it more efficient for the surgeon and provides better quality of care for the patient. Those are the two things I think most surgeons want.

**Dr. Schwarzkopf:** Our OR is more streamlined. We did not have any cancellations for the first 2 years, other than a case that I personally cancelled. And I have no fire drills on the morning of surgery.

**Dr. Schweitzer:** Frankly, folks outside the healthcare industry can’t understand why, when a surgery is scheduled for 7:30 a.m., 6 weeks out, we can’t get the patient into the OR at 7:30 a.m. on the day of surgery. Why can’t we have 100 percent of cases be in the OR at 7:30 a.m.? Every case delay affects productivity; a cancellation may create a 2- or 3-hour gap in the surgeon’s schedule that might be hard to fill. As you minimize cancellations and delays, you improve productivity.

**Dr. Naas:** What do you see as the challenges in establishing a PSH program?

**Dr. Schwarzkopf:** We had the opportunity to build a new service line that didn’t exist before, and we had enormous support from the institution and from the chairs of both the anesthesia and orthopaedics departments. It will be harder if more surgeons are involved, if the anesthesia department is not as receptive to this model, or if the hospital doesn’t want to allocate the resources necessary. When you have 10 surgeons, aligning them into a single protocol will be a barrier, but I don’t think it’s impossible.

**Dr. Bederman:** Because we had just one surgeon doing joint replacement—and he agreed with himself 100 percent of the time—consensus was easy to obtain. Now, we have two spine surgeons and three opinions. Consensus may be more challenging. But to be honest, we’re just
getting to the point now where we’re starting to talk about solutions.

We’ve spent a lot of time depicting and characterizing current processes to identify where there are issues and where there are breakdowns. So we haven’t quite hit the hard decisions. But I’m optimistic and I’m sure we’ll be able to work through them.

Just finding the time is very challenging. It really is a huge commitment.

**Dr. Kain:** Keeping the group engaged and communicating nonstop to the institution and the administration is a challenge. You need support from the information technology department because you need to create special dashboards and outcomes delivery. You need all these meetings; we have about 10 a week with various people.

I’m much less concerned about evidence-based protocols and more concerned about reducing variability. So long as we can come up with a solution that’s acceptable to everyone. Not an ideal, but something they can live with.

**Dr. Schweitzer:** The ASA has announced a national PSH collaboration. More than 40 organizations have expressed interest in participating. We’re trying to coordinate and share information about the challenges they faced, how they overcame them, and what payment models they’re using to sustain the effort.

**Dr. Naas: Any last thoughts or comments to share with our readers?**

**Dr. Schwarzkopf:** I can say this is a marvelous experience. We have been able to reduce our length of stay, readmission rates, emergency department visits, and complications to well below national benchmarks.

**Dr. Schweitzer:** There are two parts to the PSH program. One is the delivery model that involves a team providing coordinated care. The other is the payment model. Basically, you have to ask, “Who is saving the money?” The PSH model provides a lot of service and care that’s not billable, even though it is better for the patient. If there’s no payment to sustain that care, it’s not going to continue. Whether you use a comanagement agreement, a bundle payment, or a per member/per month management fee, you really have to look at who’s saving the money and work with them as partners.

**Dr. Bederman:** I think this is a very exciting time, and I am looking forward to seeing how it unfolds and can effect changes. Until then, I’m a little reluctant to make large, sweeping statements about the value of it.

**Dr. Kain:** It was very valuable to start with one surgeon and make a proof of concept in our own institution before moving on. Once you have a track record, it’s a different story. My advice would be to start with one surgeon, make sure it works, find the magic formula, and then expand.
For more information on the perioperative surgical home, see the online version of this article, available at www.aaosnow.org

Additional Information:

1. ASA Perioperative Surgical Home


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