FEATURE

Surviving and Thriving in a New Health Care Paradigm: The PSH

Written by Dennis Bittner

The face of medicine is changing rapidly in the United States and abroad. The opening session of the 2014 annual meeting of the American Society of Anesthesiologists (ASA) addressed game-changing "disruptive innovations" that challenge the health care status quo. Although change provides risk and is rarely a comfortable process, the transformations currently occurring in medicine also present opportunities for anesthesiologists to assume leadership in the new paradigms that are unfolding, because of the unique role their discipline occupies in perioperative patient care. A central concept of these new paradigms is called the perioperative surgical home (PSH). The concept of a "medical home" has been proposed as a patient-centered, team-based approach for providing coordinated and accessible health care focused on quality and reduced costs. Applying this concept to a surgical setting has led to the creation of the PSH model, an idea that has gained considerable traction within the ASA. This model places anesthesiologists at the head of a health care process that seeks a better patient experience, improved outcomes, and reduced costs of care.

Speakers at the opening session provided real-world examples of recent PSH successes supporting their assertions that the changing health care paradigm offers extraordinary opportunities for physician anesthesiologists to become the perioperative leaders of the future. Jason Hwang, MD, MBA, PolkaDoc, Sunnyvale, California, USA, led off the session by warning the audience that changes for payment models are on the horizon that shift more risk onto anesthesiologists and create threats to physician autonomy, as health care systems and payers attempt to manage decision making. Dr Hwang drew analogies to the current situation in health care with examples from the history of information technology (IT), in particular the transition that occurred when mini-computers, as represented by Digital Equipment Corporation, were supplanted by the personal computer (PC). Dr Hwang said that Certified Registered Nurse Anesthetists and automated conscious sedation devices are symptoms, not the cause, of disruptive innovation. The cause is complacency with the status quo.

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Discussing solutions to the challenges facing anesthesiologists, in further analogy to the computer market, Dr Hwang contrasted the modular approach seen in the assembly of PCs with the Apple's integrated system. Dr Hwang said that the PSH represents an example of an integrated approach, as opposed to the traditional patient care silos. As with transformative change in other industries, the core is providing what customers want, which in health care means continuing to improve quality of care and outcomes, but also increasing value. Delivering on the promise of the PSH means coordinating care teams that collaborate with other types of providers. Sounding a cautionary note, Dr Hwang said that in some instances, the optimal set of components that provide the best possible solution may not include an anesthesiologist.

Mark Warner, MD, Mayo Clinic College of Medicine, Rochester, Minnesota, USA, expanded on the PSH concept, detailing it as a physician-led, team-based care model. The anesthesiologist's role is to help lead the team in providing better patient care. The ASA has helped to expand the role of the anesthesiologist for decades, making the PSH concept a natural extension of those efforts. In terms of disruptive innovations, Dr Warner said that truly great organizations are willing to change just about anything in order to improve—except their core values. There are 2 core values held by anesthesiologists. The first is an unrelenting commitment to 2 types of patients, that is, those who are critically ill and those who are faced with acute and chronic pain, including those undergoing procedures. The second core value is a compelling commitment to always improve the safety and the care of patients. Everything else, including where care is provided, how it is provided, and how anesthesiologists are recognized for that care, is likely to change. Driving this change, said Dr Warner, is the growing belief in the United States that physician skills are not

required in anesthesia care of most patients, evidenced by 17 states having opted out of physician oversight of anesthesia care. Anesthesiologists must be prepared to adapt to the changing environment.

Zeev Kain, MD, MBA, Department of Anesthesiology and Perioperative Care, University of California, Irvine, California, USA, delivered the perspective of an academic department with "perioperative" in its name. Presenting real-world examples of PSH successes, Dr Kain offered suggestions on why anesthesiologists need to incorporate the elements of the PSH into their own practices. Dr Kain agreed with the previous speakers that anesthesiology needs to move from a modular perioperative approach to a methodology that is more integrated, and he identified PSH as an integrated delivery care model. The major underlying tenet of PSH is better coordination of care across the entire perioperative period, said Dr Kain, from the initial meeting of a patient with a surgeon until 30 days after discharge. Reducing variability and standardizing care is key, as variability leads to errors and increased costs. The work environment is inclusive and collaborative, especially in regard to the partnership of anesthesiologists with their surgeon partners, but also with every other group that interacts with the patient, including nurses, hospital aides, IT, and hospital administration.

Describing the PSH as patient centric, Dr Kain said that the biggest conceptual change for anesthesiologists in PSH is the delivery of care during the postoperative period. Postoperative complications (pneumonia, urinary tract infection, delirium, etc.) represent a huge contribution to health care costs, with each of these complications adding on average $10 000 to the hospital bill. Another impact from better postoperative care is reduced readmission rates, now as high as 8% to 10%. Dr Kain drew parallels to Darwin's comments that survival of the fittest meant survival of those best adapted to their environment. The environment for anesthesiology is undergoing dynamic change, such that the future of the discipline hangs in the balance. Dr Kain concluded his talk with a warning to the audience that if as anesthesiologists they did not become more involved in the preoperative and especially postoperative stages of treatment in their own practices, they might "go the way of the dinosaurs."

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