The Surgical Home Model: Value Streams for Community Hospitals
Today’s Speakers

Mary Ouimet, DNP, RN
Vice President, Patient Care/CNO

Sonya Pease, MD
Chief Medical Officer, Anesthesia Division
Sonya Pease, MD

“Simply put, safer, higher quality care can be more cost effective.”

Having received her Masters of Medical Science in Anesthesiology from Emory University and an MD from the Medical College of Georgia, Dr. Pease has served as CMO of TeamHealth Anesthesia since 2008 and a diplomate of the ABA since 1998. She completed her residency in anesthesiology at Jackson Memorial Medical Center in Miami, and she is a past President of the Florida Society of Anesthesiologists and serves on several national committees with the American Society of Anesthesiologists (ASA), including the Committee on Economics and the Committee on Future Practice Models. Dr. Pease is a clinically active anesthesiologist and has been intimately involved in the development of the Perioperative Surgical Home model and is currently engaged with several healthcare organizations within TeamHealth that are part of the ASA’s Perioperative Surgical Home Learning Collaborative 2.0. The surgical Home model addresses the triple aim of healthcare reform by improving OR efficiency and perioperative processes focused on improving patient outcomes and engagement and reducing costs per episode of care.
Mary Ouimet, DNP, RN

“Innovation is critical to the delivery of high quality care”

Having served as senior vice president and chief nursing officer at Ascension-All Saints Medical Center since 2006, Mary Ouimet, DNP, RN, is a senior level nursing executive with more than 25 years of experience in health system leadership and nursing services administration. Her proven track record includes leading the development of clinically integrated care across the continuum, leadership in clinical operations, labor and workforce management, service line leadership and professional development. Mary was awarded her bachelor of science in nursing in 1986 from Marquette University in Milwaukee, WI, and her master of science in nursing from the University of Wisconsin-Madison in 1990. She received her doctorate of nursing practice from Marquette University in 2015. Her professional affiliations include membership in the American Organization of Nurse Executives (AONE), the Wisconsin Organization of Nurse Executives (WONE) and Sigma Theta Tau International.
For the 2018 performance year, we anticipate that the following models would be Advanced APMs (in addition to the list above).

- ACO Track 1+
- New Voluntary Bundled Payment Model
- Advancing Cardiac Care Coordination through Episode Payment Models (Cardiac and Joint Care)
Overview of CMS Bundled Payment Joint Proposal

The Participants

Included:
- IPPS Hospitals in 75 MSAs\(^1\), including rural
- Medicare beneficiaries in the MSAs

Excluded:
- BPCI Model 1, risk-bearing Model 2 and 4 for joint replacement
- Medicare Advantage, ESRD\(^2\) beneficiaries

The Episode

- Triggered by MS-DRG 469, 470 discharge
- Anchor hospitalization plus all services 90 days post includes all relevant Medicare Part A and B payments
- All episode spend attributed to anchor hospital
- Retrospective: paid fee-for-service as usual

Comprehensive Care for Joint Replacement

Spending Requirement
- Every year CMS calculates your episodic spend
- Target price is a mix of historical pricing and regional pricing with a 2% discount factor
- If spend < target price, hospital eligible for Medicare reconciliation payment (year 1-5).
  If spend > target price, hospital repays Medicare the difference (years 2-5)
- Spending performance alone is insufficient to receive reconciliation payment

Quality Requirement
- 3 quality measures assessed:
  - HCAHPS;
  - THA/TKA Readmissions;
  - THA/TKA Complications;
- To receive reconciliation payment, performance in years 1-3 must exceed 30th percentile nationally on all measures, years 4-5 exceed 40th percentile nationally
- Successful submission of voluntary patient reported outcomes (PRO) measure lowers target price discount factor from 2.0% to 1.7%

\(^1\) Metropolitan service area.
\(^2\) End stage renal disease.

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Source: CMS, Financial Leadership Council analysis.
Major Joint Surgery

Episode Costs for Hip & Femur Procedures Except Major Joint (2014)
30 Days After Index Admission

- **Index**: $13.07K
- **Physician**: $1.05K
- **Readmissions**: $1.24K
- **Rehab**: $177.11
- **LTAC**: $13.28K
- **Skilled Nursing Facility**: $159.99
- **Hospital Outpatient**: $64.09
- **Hospice**: $937.82
- **Home Health**: $30.06K
- **Total**: $40K

**SNF**
Reconciliation Based on Payment and Quality

Two Requirements Must Be Fulfilled to Receive Reconciliation Payment

1. Medicare Payment Below Target
   - CCJR episode payments must be below CMS' target

2. Meet Quality Standards
   - Hospital outperforms national threshold on 3 mandatory measures

Hospitals can only receive reconciliation payments if they meet quality measures. If hospitals come in below target price but do not meet quality threshold, they will not be eligible for reconciliation payment.

Source: CMS, Financial Leadership Council analysis.
Common threads to all proposed alternative payment models are…

- Better coordination of care for patients
- Lower rates of infections and complications for patients
- Lower total spending for purchasers and payers
- Higher payment for physicians by reducing costs for hospitals or reducing unnecessary services, tests, and procedures
- Improved patient satisfaction and engagement
Demonstration Project

PSH Collaborative 1.0 Hospital Partnerships:
- Total of 44 Healthcare Organizations Nationwide
- Ascension All Saints Hospital, Racine, WI (Core Collaborative)

PSH Collaborative 2.0 Hospital Partnerships:
- Total of 56 Healthcare Organizations Nationwide
- Legacy Good Samaritan Medical Center, Portland, OR (Advanced Cohort)
- Ascension All Saints Hospital, Racine, WI (Core Collaborative)
All Saints - Current State

- Surgical Volumes Down
- Patient Satisfaction not at goal
- Desired growth and Improvement in hip fracture care
- Decrease surgical length of stay
- Decrease complication rates
Perioperative Surgical Home

Preoperative
- Patient engagement
- Assessment & triage
- Optimization
- Evidence-based protocols
- Education
- Transitional care plan

Intraoperative
- Right personnel for patient acuity & surgery
- Supply chain
- Operational efficiencies
- Reduced variation

Postoperative
- Right level of care
- Integrated pain management
- Prevention of complications

Long-term Recovery
- Coordination of discharge plans
- Education of patients and caregivers
- Transition to appropriate level of care
- Rehabilitation & return to function
- Reduced variation

Quality Improvement

Database

Supporting Microsystems
- Nursing
- Pharmacy
- Laboratory
- Human Resources
- Central Supply
- Social Services
- Radiology
- Info Technology

# Lean Surgical Home Value Stream

## Sponsor Team

### Executive Team:

<table>
<thead>
<tr>
<th>Role</th>
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<tbody>
<tr>
<td>Hospital Chief Operating Officer</td>
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<tr>
<td>Hospital Chief Operating Officer</td>
</tr>
<tr>
<td>Hospital VPMA – Primary Care</td>
</tr>
<tr>
<td>Hospital Administrative/ Nursing Champion</td>
</tr>
<tr>
<td>Chief of Surgery</td>
</tr>
<tr>
<td>Chief of Anesthesia</td>
</tr>
<tr>
<td>Hospital Administrative/ Nursing Champion</td>
</tr>
<tr>
<td>Director of Surgery</td>
</tr>
<tr>
<td>Clinical Educator</td>
</tr>
<tr>
<td>Chief of Anesthesia</td>
</tr>
<tr>
<td>Perioperative Director</td>
</tr>
<tr>
<td>Director of Quality</td>
</tr>
<tr>
<td>Pharmacy Director</td>
</tr>
</tbody>
</table>

### Clinical Focus Team:

<table>
<thead>
<tr>
<th>Role</th>
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<tbody>
<tr>
<td>Chief of Surgery</td>
</tr>
<tr>
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<tr>
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<tr>
<td>Director of Surgery</td>
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<tr>
<td>Clinical Educator</td>
</tr>
<tr>
<td>Perioperative Director</td>
</tr>
<tr>
<td>Pharmacy Director</td>
</tr>
</tbody>
</table>
# Ascension All Saints: Surgical Home Project Update

## Clinical Initiatives

<table>
<thead>
<tr>
<th>Initiative</th>
</tr>
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<tbody>
<tr>
<td><strong>ERAS</strong></td>
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<tr>
<td><strong>Rapid Hip</strong></td>
</tr>
<tr>
<td><strong>Pain Management</strong></td>
</tr>
<tr>
<td><strong>OSA</strong></td>
</tr>
<tr>
<td><strong>Capnography Monitoring</strong></td>
</tr>
<tr>
<td><strong>CVL Protocol Improvement</strong></td>
</tr>
</tbody>
</table>

### ERAS
- Initiated March 2015 with General and Colorectal surgery
- Preliminary data shows 1 full day reduction in LOS post protocol implementation

### Rapid Hip
- Iliaca fascia nerve blocks for fractured hips

### Pain Management
- Responsible for total pain management of post-op patients for general/colorectal pts & Ortho
- Increased use of epidurals, blocks, intrathecal narcotics, Exparel in general surgery patients.
- Addressing chronic pain patients

### OSA
- Stop-Bang Assessment for all pre-op patients.
- Opiate sparing for OSA Pts
- Monitoring protocols for PACU and Phase 2

### Capnography Monitoring
- Purchased equipment to monitor post-op patients on the floor at high risk of respiratory depression

### CVL Protocol Improvement
- Intraop fields for documentation of sterile ultrasound protocol compliance
- Checklist to support adherence to and documentation of CVL placement protocol

## Data and Metrics

### Data Collection Status:
- ERAS data manually collected. PSH Primary Metric data collection on hold awaiting Epic’s completion of the PSH metric build for the anesthesia registry

### EMR System:
- Epic – Live January 2016

### Metrics Currently Collected:
- ERAS patient tracking

### Method of Data Abstraction:
- Currently manual. Epic anesthesia registry configured

### Comments:
- Epic PSH Metrics expected January 2017

## Deliverables Status Report

<table>
<thead>
<tr>
<th>Key Deliverable</th>
<th>Target</th>
<th>Status</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSH Primary Metric data collection</td>
<td>01/2017</td>
<td>H</td>
<td>On hold pending completion of PSH metric configuration by Epic team, for automatic abstraction by the anesthesia registry</td>
</tr>
<tr>
<td>EPIC Registry Solution</td>
<td>01/2016</td>
<td>C</td>
<td>Configured prior to Epic go-live January 2016</td>
</tr>
</tbody>
</table>

## Overall Status
- Green: Clinical initiatives are progressing successfully, with multiple underway concurrently. Previous clinical initiatives have successfully transitioned to become standard practice. Strong clinical leadership and active engagement from hospital leadership and surgeons.

## Sponsor
- Sonya Pease, MD
- Physician Champion: David Samanie, MD
- Date: 10/11/2016

## Notes
- Surgeon champion: Steven Ryder, MD
- Performing blocks in patients in ED
- Pain management consult to anesthesia for all hip fracture patients in ED
- Tracking pain score, pre-op opiate administration and time to OR
- P&T approved ordering of Hydromorphone for PCA December 2014
- Additional focus on management of chronic pain patients at direct request of hospital administration
- Patients identified at high risk of OSA given letter prior to discharge to provide to their Primary Care MD for ongoing management

## Status
- Green: On track
- R: Action Req’d
- C: Complete
- H: On hold
- Y: Focus Needed
Project Targets

**Case-Specific Protocols:**
- Orthopedics: Total Joints, Hip Fractures (Rapid H.I.P.)
- Colorectal Surgery (Enhanced Recovery After Surgery)

**Disease-Specific Protocols:**
- Pain: Comprehensive pain team, multimodal pain management
- Anemia: Patient Blood Management, Anemia Clinic
- Glycemic Control: A1C and perioperative glucose
- Cardiac: Stents, AICD, CHF

**Standardization and Technology Enabled:**
- Pathway Templates
- Best Practice Advisory Builds
- Quality measure tracking and standard reporting dashboards
Leveraging IT Infrastructure

- Best Practice Advisories (BPAs)
- Standardized Order Sets
- Hardwiring Clinical Pathways
- Quality data element capture through registry
# ERAS Order Set

## Post-op Nausea & Vomiting

<table>
<thead>
<tr>
<th>Order</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ IP Order: scopolamine (TRANSDERM-SCOP) 1.5 mg external patch</td>
<td>1 patch. Transdermal. As needed</td>
</tr>
<tr>
<td>☐ IP Order: dexamethasone (DECADRON) injection</td>
<td>8 mg Intravenous. Once as needed</td>
</tr>
</tbody>
</table>

## ERAS (Enhanced Recovery After Surgery)

<table>
<thead>
<tr>
<th>Order</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ IP Order: acetaminophen (TYLENOL extra strength) tablet</td>
<td>1,000 mg Oral Once Pre-Op</td>
</tr>
<tr>
<td>✔ IP Order: celecoxib (CELEBREX) capsule</td>
<td>200 mg Oral Once Pre-Op</td>
</tr>
<tr>
<td>☐ IP Order: celecoxib (CELEBREX) capsule</td>
<td>300 mg Oral Once Pre-Op</td>
</tr>
<tr>
<td>☐ IP Order: gabapentin (NEURONTIN) capsule</td>
<td>600 mg Oral Once Pre-Op</td>
</tr>
<tr>
<td>☐ IP Order: gabapentin (NEURONTIN) capsule</td>
<td>900 mg Oral Once Pre-Op</td>
</tr>
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</table>
What You Don’t Measure, Doesn’t Change

Average Relevant Costs after Severity-Adjusting
Typical Costs: PCMH vs. non-PCMH

The Patient Centered Medical Home (PCMH) practices involved in a pilot have been reporting clinical measures on patients with Diabetes, CAD and Asthma. Not on hypertension, GERD or COPD.

HCl^3 Analysis of a regional health plan using the PROMETHEUS ECR Analytics, 2012
Creating Actionable Data
# Measure Episodes of Care

<table>
<thead>
<tr>
<th>Metric #</th>
<th>Metric Domain</th>
<th>Primary Metric Name</th>
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<tbody>
<tr>
<td><strong>Pre-operative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSH-IE2</td>
<td>Internal Efficiency</td>
<td>PSH Day-of-Surgery Case Cancellations (IP and OP)</td>
</tr>
<tr>
<td><strong>Intra-operative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSH-IE1</td>
<td>Internal Efficiency</td>
<td>PSH First Case Delayed on Day of Surgery (IP and OP)</td>
</tr>
<tr>
<td><strong>Post-operative</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PSH-IE3</td>
<td>Internal Efficiency</td>
<td>Timeliness of Outpatient PSH Surgical Case Discharge</td>
</tr>
<tr>
<td>PSH-IE4</td>
<td>Internal Efficiency</td>
<td>Average Length of Stay for Inpatient PSH Surgical Cases</td>
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<tr>
<td><strong>Episode (All Phases Combined)</strong></td>
<td></td>
<td></td>
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<tr>
<td>PSH-CS1</td>
<td>Clinical &amp; Safety</td>
<td>Outpatient PSH Surgical Case Mortality</td>
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<tr>
<td>PSH-CS2</td>
<td>Clinical &amp; Safety</td>
<td>Discharge Disposition of Inpatient PSH Surgical Cases</td>
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<tr>
<td>PSH-CS3</td>
<td>Clinical &amp; Safety</td>
<td>Unplanned Upgrade of Care for Inpatient PSH Surgical Cases</td>
</tr>
<tr>
<td>PSH-CS4</td>
<td>Clinical &amp; Safety</td>
<td>Unplanned Upgrade of Care for Outpatient PSH Surgical Cases</td>
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<tr>
<td>PSH-CS5</td>
<td>Clinical &amp; Safety</td>
<td>Non-Mortality Complications for Adult Inpatient PSH Surgical Cases</td>
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<td>PSH-CS6</td>
<td>Clinical &amp; Safety</td>
<td>Non-Mortality Complications for Pediatric Inpatient PSH Surgical Cases</td>
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<td>PSH-CS7</td>
<td>Clinical &amp; Safety</td>
<td>Inpatient PSH Surgical Case Mortality</td>
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<tr>
<td>PSH-PC1</td>
<td>Patient Centered</td>
<td>PSH Patient Experience at Discharge</td>
</tr>
<tr>
<td>PSH-PC2</td>
<td>Patient Centered</td>
<td>PSH Patient Experience 30 days Post Discharge</td>
</tr>
</tbody>
</table>
Rapid Hip Value Stream

- 9% Reduction in Imaging per case
- 22% Reduction in average tests per case
- 87% Reduction in Red Blood Cell Use
- 0.6-Day reduction in length of stay
- Improve pain management/ Avoid delirium
- Reduce time from diagnosis of acute hip fracture to surgical incision
- Reduce perioperative complications
- Reduce Post Acute facilities length of stay
Rapid Hip: Acute Hip Fractures - Short comparison Before and After fascia Iliaca peripheral nerve blocks in the ED as soon after diagnosis as part of a multi-modal pain approach to avoid post-op narcotic use and improve patient pain control.

- **77% Reduction** in pain medication administration within the first 12 hours post-operatively (156 vs. 36)
  - Includes both narcotic and non-narcotic medications

- **51% Reduction** in average post-operative pain scores within the first 12 hours after surgery (6.53 vs. 3.3)
Enhanced Recovery After Surgery Value Stream

- Improved patient education and engagement
- Decreased PCA use (narcotic sparing techniques)
- Reduced post-op complications: Ileus
- Decreased LOS
- Decrease readmission rate
- Reduce costs per episode
Pre-Operative Care of the ERAS Patient:
Preadmission Counseling:
GOALS: Prepare patients for active role in their recovery, set reasonable patient and caregiver expectations, get more patients home post-discharge, reduce pre-op anxiety.
Patients receive oral and written preadmission information describing:
- What will happen during hospitalization
- What they should expect
- Their role in the recovery process
- Discharge Planning
- Patient and a family member or caretaker meet with Surgeon, Anesthesiologist and Nurse Navigator
Preoperative Optimization:
GOALS: Optimize medical co-morbidities, reduce post-operative pulmonary and wound complications, minimize length of stay
- Exercise: Encourage daily exercise prior to surgery. Consider pre-op physical therapy.
- Smoking Cessation & Abstinence. Smoking should be stopped at least 4-8 weeks before surgery and instructed not to smoke day of surgery.
- Selective use of Bowel Preparation:
GOALS: Prevention of dehydration, post-op ileus
- Left sided surgeries only
- Enemas may be used at the surgeon’s discretion

Pre-Operative:
- Preadmission risk assessment, patient education, engagement and optimization: ERAS, anemia, HbA1c, smoking abstinence, pre-habilitation therapy
- Fluid and carbohydrate loading
- Immunonutrition
- No prolonged fasting
- No or selective bowel prep for resections
- Antibiotic prophylaxis
- Thromboprophylaxis
- Premedication – PONV and Multimodal Pain Management

Pre-Operative Care of the ERAS Patient:
Fluid and Carbohydrate Loading:
GOALS: Decrease pre-op hunger, thirst, and anxiety.
- Reduced post-op insulin resistance, loss of nitrogen and protein
- Patients instructed to drink 12.5% carbohydrate clear drink 3 hours pre-operatively (ex. ClearFast)
Reduced Fasting Duration:
GOALS: Reduction in post-op insulin resistance, loss of nitrogen and protein, reduction in pre-operative anxiety levels
- Solid foods: up until 8 hours pre-op
- Full liquid diet: up until 6 hours pre-op
- Clear liquids: up until 2 hours pre-op
Immunonutrition:
GOALS: Improve wound healing and decrease post-operative inflammation
- Impact AR nutrition drink provided to patients to consume pre-operatively
- Contains arginine which helps promote immune function and recovery

Thromboprophylaxis:
GOALS: Prevention of deep vein thrombosis and pulmonary embolism
- Patient education regarding when last dose can be taken pre-operatively; the majority of patients will receive regional anesthesia perioperatively
Enhanced Recovery After Surgery
Enhanced Recovery: For patients who received care per the ERAS protocol...

✓ **0.8-Day Reduction** in length of stay (3.3 vs. 4.1)

✓ **78% Reduction** in opioid doses administered post-operatively (81 vs. 365 doses)
  - 29% increase in doses of non-narcotic pain medication administered
  - 33% reduction in average pain scores reported post-operative days 0 – 3 (2.6 vs. 3.9)
### Sibley Memorial Hospital Collaborates With Better to Extend Care Beyond Hospital Walls

<table>
<thead>
<tr>
<th>Number of Cases</th>
<th>Total Patient Days</th>
<th>Median Length of Stay</th>
<th>Median Direct Cost</th>
<th>Median Indirect Cost</th>
<th>Median Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY2015 Q1</td>
<td>36</td>
<td>185</td>
<td>3</td>
<td>$5,045</td>
<td>$4,215</td>
</tr>
<tr>
<td>CY2014 Q1</td>
<td>38</td>
<td>271</td>
<td>4</td>
<td>$6,695</td>
<td>$4,924</td>
</tr>
</tbody>
</table>

**Savings per patient:** $2,296
Enhanced Recovery After Surgery
TeamHealth Anesthesia
Surgical Home Model

What is ERAS?
Enhanced Recovery After Surgery (ERAS), sometimes referred to as “fast track surgery”, are multimodal perioperative care pathways designed to achieve early recovery after surgical procedures by maintaining pre-operative organ function and reducing the profound stress response following surgery.

The key components of ERAS programs are a set of 20 guidelines that encompass all areas of the patient’s journey through the surgical process. [Figure 1]

A successful ERAS program implementation requires multidisciplinary collaboration among surgeons, nursing staff, anesthesia providers, pharmacists, operating room staff, clinics, and preadmission services.

How will ERAS help our patients?
The key factors that keep patients in the hospital after surgery include:

• need for parenteral analgesia
• need for IV fluids secondary to gut dysfunction
• bed rest caused by lack of mobility.

The central elements of the ERAS pathway address these key factors, helping to clarify how they interact to affect patient recovery. In addition, the ERAS pathway provides guidance to all involved in perioperative care, helping them to work as a coordinated team to provide the best possible care to patients.

Key to the success of the program are clear and consistent communication about expectations for patients regarding activity, diet, and pain management before, during, and after their hospital stay. Postoperative goals are communicated on a daily basis with the patient and multidisciplinary care team, with the goal of discharge by postoperative day 3, if the patient meets all discharge criteria.

How does it work?
Use of the ERAS pathway has been shown to reduce care time by more than 30% and reduce postoperative complications by up to 50% in meta-analyses.

In 2010, colorectal surgeon Dr. Joseph Frankhouse, MD and a team from Legacy Good Samaritan Hospital and Medical Center in Portland, OR, in collaboration with OHSU, implemented ERAS protocols, and by 2011 the program was in full practice. A prospective study was conducted to assess the impact of the ERAS protocols on outcomes affecting patient experience and safety in patients undergoing colorectal surgery.

Dr. Frankhouse and his team found a 3-day reduction in average length of stay post-implementation, with no increase in the readmission rate, which resulted in up to a $4800 savings per patient. The team also found a significantly lower incidence of postoperative ileus following protocol implementation. The use of multimodal pain management tools in the ERAS pathway also resulted in a significant reduction in use of PCA narcotics. [Table 1]

How can I do my part?
By familiarizing yourself with the ERAS Pathway protocols that affect your role to modify your practice as necessary, attending in-services and education sessions offered, and collaborating as a unified team with other disciplines towards a successful ERAS Program, we can ensure our patients are receiving safe, efficient, and effective care.

For more information please go to:
http://www.erasociety.org/index.php/eras-guidelines

Legacy Good Samaritan Hospital

Perioperative Home Success:

- Decreased PCA Use (Narcotic-sparing techniques)
- Reduced Post-op Ileus
- Reduced Deep Organ Space Infection (Average $16,000 to $30,000 per patient)
- Decreased LOS (6.7 days to 4.7 days @ $2,100 per day)
- Increased savings over “average” outcomes ($1.5 Million)
- No increase in Readmission
Missed Opportunities

- **Imminent Surgery Protocols –** Rapid H.I.P.
- **Perioperative Clinic**
  - ✓ Anemia Management – Reduce Blood Utilization
  - ✓ Prescribe Pre-op Physical Therapy
  - ✓ Smoking Abstinence and Cessation
- **Multimodal Pain Management**
  - ✓ Narcotic sparing techniques
  - ✓ Less delirium
  - ✓ Less post-op ileus
- **Glycemic Control**
  - ✓ Less post-op surgery site infections
- **Goal Directed Fluid Therapy**
  - ✓ Less post-op respiratory complications
Key Messages Summary

- Administrative and clinical alignment of value streams
- Clinical leader empowerment
- Smarter technology
- Actionable metrics and data
- Rapid cycle performance Improvement Initiatives
- Reset baselines and repeat
Questions?