

Transcript: Preparing for MACRA Part One featuring Dr. Gary Loyd, Anesthesiologist at Henry Ford Health System

Jay Bhatt: Hello and welcome to the American Hospital Association and American Society of Anesthesiologists podcast series on preparing for MACRA. I'm Doctor Jay Bhatt, chief medical officer and president of the Health Research & Educational Trust. The American Hospital Association and the American Society of Anesthesiologists are collaborating on three part series to examine how physicians and hospitals are working together to prepare for the payment changes coming in 2019 as part of MACRA.

This series will feature three sections. The first will be a discussion with Dr. Gary Loyd, Anesthesiologist at Henry Ford Health System, sharing his perspective on preparing for MACRA.

Our second section will feature Ann Marie Creed, Vice President of Operations sharing her views on preparing for MACRA with Gary and his team.

The third section will include a discussion with both of them about what they learned and how they are moving forward.

With that, I'll ask Gary to start us off with a story from the physician perspective.

Gary Loyd: Thank you Dr. Bhatt. I think as a background people have to understand that Henry Ford is in a unique position because we've been an integrated health system. The facility and the physicians really being integrated as one since its inception in the 1920's. But that doesn't mean that we don't have anything to offer because we have used that and leveraged it to our advantage to be able to move forward and prepare for MACRA.

We have our own accountable care organization, ACO, and so therefore we're going for the next gen advance payment model. To tell you something about our accountable care organization we have about 28,000 CMS lives, more than 1,000 physicians, more than 800 mid level providers, 5 hospitals, 142 and 10 home health agencies. That sets us up to have a good provider network and be ready to tackle the challenges for the ACO and next gen payments.

When we look at the components and what we aim to target as our pin points for the next gen we divide it into a primary care initiative and then there's a surgical specialty care initiative as well. I think originally it was just a primary care initiative but the surgical specialty care was added on as we were looking at trying to look at our costs and increase our performance. Under the primary care initiative that will be talked about with Ann Marie Creed, I'm going to be talking more about the surgical specialty care initiative. What has started out with several system service line council, such as a joint council, because having five hospitals that are not that close to one another you've got a lot of private practices and some high bred practices and some academic practices so, everybody is having to learn how to get along with one another.

We also have 22 initiatives, which are funded initially by Blue Cross Blue Shield but they are collaborative quality initiatives that allow us to share data and look for best practices. The one thing I want to concentrate on is the perioperative surgical home. Which I was recruited here to Henry Ford to initiate and we've been going for a little bit more than a year now.

The goals of the perioperative surgical home mirror those of the internal institute of medicine. They are improving outcomes with quicker recovery, which means we're going to decrease complications and confounding factors. We're going to increase our efficiency and efficacy of care and at the same time reduce the cost and the waste that's in the system. The third big component is improving patient and provider satisfaction, which means we have to decrease the frustration and barriers in providing the care.

We have a complex system and if you look at the slide that will be made available to go with this podcast you'll be able to see some colorful arrows, which we call the interplay matrix. We picked six service lines to start out with as pilots and criteria for those service lines was we had to have the surgeons in those service line pilots being willing to change their practice based upon the data, both evidence based data in the literature and also our internal data we're able to create. Those lines are crossed by the low hanging fruit of the co morbidity lines that are nine that we looked at in the literature that promise to give us the greatest yield and those were around anemia, cardio pulmonary pre head, glucose control, hyper tension control, nutritional support, sleep apnea, pain control, post operative cognitive dysfunction, and post operative nausea and vomiting.

With those, both the service lines and the co morbidity lines is we're looking at doing surgery, the patient has to take those pieces and walk through the individual phases such as the intake clinic, the optimization preparation phase, the inter operative procedure phase, post op earlier restoration phase and a post discharge reestablishment phase. The extra wording was added to decrease the amount of confusion between the different phases because of as it turned out nurses, anesthesiologists, surgeons, and support personnel all had different definitions of what these phases meant and when they started and when they ended. We had to create some unique wordage with exact definitions to keep everybody on the same page.

Then crossing all these lines are the functional aspects, which are compliance data analysis, finance, quality components and research perspective. If you look on the graph it looks like they all completely cross one another but when you start getting into the details and you start talking to people that are represented in each one of these colorful lines you find out that nobody is really talking to anybody else. They talk to their own teams and when they have to they talk to the other teams to transfer information. But really not talking about how to transfer care and so that no one really knows what the next silo of people is actually doing. One of the main emphasis of using the perioperative surgical care approach is to get people to talk, get them on the same line, create type protocols but add to the type protocols, measurable lead and lag metrics so that you can actually create data that will help you make decisions. That's extremely important.

The detail is really what makes this work. The slide that you'll see a little cartoon so that all the goals is on one end and the other end is that colorful slide that I put on. In the middle it says, "A miracle occurs." That's where we have to get into the weeds of how does the perioperative surgical home make the miracle occur. When you're dealing with lots and lots of detail and you've got an end point it's finding that it worked to have a really robust, strategic plan. We spent two, three months creating a robust, strategic plan and then in the last 10 months we have actually succeeded in doing a lot of things.

The first of which is we integrated with a patient education engagement program they have here, which is supported by a grant and we acquired other grant funding to help us take the 14 patients who volunteered to be our advisors in this process and start creating patient oriented patient education material. Most of the education material that is produced, and I mean the vast majority, is really what the clinician or the facility wants the patient to know. It isn't necessarily what the patient wants to know. And when they're inundated in small segments of intense education they usually forget to ask their questions, or they don't have time to think of their own questions, so their questions usually get unanswered. This is an approach where we're trying to be proactive and give the patients what they want.

We've had success with multiple meetings enhancing what we're already doing and in creating brand new material. We're also creating a patient education portal on our website to be able to decimate all this other information. Another bucket of work that we are doing on our strategic plan revolves around the clinical pathways and those involve both the six service lines and the nine co morbidity teams that we've put together. We've been able to institute some enhancements to our electronic health record and we have another one that we are trying to launch, which is a clinical pathways support module for the electronic health record, which bridges across all the silos of the phases and also makes it easy for everyone to understand what everybody else is doing and to provide one level of education and one level of care for the patient.

We have developed an intranet website where we can house these materials and have a SharePoint type of system on the intranet where team members can work together collaboratively and create these written pathways and also be able to put our data up that helps make it in the decision making as we're moving forward. We've involved finance departments, financial management. We brought in decision support and we've also brought in supply chain. Previously they had not talked to one another and we now have them all in the same room and we regularly meet and we talk about what advances we can make and where can we go to the next level. I've got to talk a little bit here about the progress that we've made in that arena because all the cost accounting when we were originally asking, you do cost accounting and they said, "Yes." When they gave us the data it was all charge accounting.

So with the cost is what is the cost to the payer, but not necessarily what is the cost to the facility or the institution to supply the services that it is supplying. We have one example in the slide when you're looking at it is that the readmission rates for hips and knees and you'll see on the slide that they have peaks and valleys over the last several years. The peaks are usually explained by doing all patients and when the readmission rate goes up and the alarms go off they stop doing the really sick patients and only do

the healthier patients. And readmission rates go down. You see that cycle over and over and since we started the perioperative surgical home that cycle has been broken and we're now at the lowest levels for readmissions for hips and knees that we've ever been at.

At the very bottom of that you look at it and say, "Well, we started asking about the cost accounting pieces of that." The initial data that came back, there was absolutely no relationship between the cost accounting data and that graph. And readmission is a major component to providing care to patients. They were sent back to the drawing board and when you get to the net flight and the slide you'll see that on the second pass it got a lot better. But if you compare the two graphs you see there, the readmission rate actually goes down at the very end of March and April 2017. Yet the cost accounting starts to go up.

They are back working on another version to try and improve it and make it even better. We're trying to get it down to the episode of care and eventually to the point where we'll know what the cost of making a decision will be but that is going to be awhile to get there because it's something that doesn't currently exist.

We've also got integrated data and we've been big on lead and lag metrics. Most of the people in the country that, and we work in a learning collaborative with perioperative surgical home, which is a fantastic organization to be able to share with other institutions that are trying to work with this. It's through the American Society of Anesthesiology. It's also supported by the orthopedics group and some other groups as well. We had to create some data marks where we could put information that wasn't in our EHR, such as finance data, but also as we're creating patient satisfaction surveys and outcome surveys and other things that are not present in the area of EHR, we have to have a place to put them so that we can start putting all the data together and start looking at what are the actual outcomes. The perioperative surgical home starts at the time of decision to refer the patient to the specialist. And then it ends when the patient is fully functional sometime way after discharge. For a spine surgery it may be a year or two whereas for hips it may be 90 or 120 days.

That data that we need to gather will help us determine where the patient is going to end up going. We combined this information and try to make the perioperative surgical home accentuate all the processes that are currently going on in the institution. So, it's not trying to occur separate but actually integrate and augment all the good work that is happening in the perioperative surgical home collaborative, learning collaborative. All the 60 plus institutions that are there all have different people trying to do good things in their own institution but they've run into the same problems that we've run into is that the groups don't talk to one another.

When you have a common data mart or enterprise data warehouse in which people can put their data then you can start doing some real analytics. Where, applying some machine learning and neuro network techniques to try and tease out what are the correlations between the different aspects of care and what makes the different pieces work? As we're being able to get to the granularity of the financial data we will then be able to also predict if we make alterations what's going to give us our greatest return on

investment. What area should we actually be focusing the limited resources and every healthcare institution I know has limited healthcare resources to apply to this. You have to have the knowledge and information to be able to judiciously apply it.

If you want to get your perioperative surgical home started how would you do it? Well, first you're going to have to have a common platform for communication and we did that, something we call The Team E-Room, where the documents can be stored. But then, there's also, you've got to get an idea of how can you get your first win? We started with something that wasn't particular to any of our service lines but it was room turnover. Room turnover in the operating room usually doesn't have a huge impact on the bottom line, it has some. But, it is a major satisfier for surgeons and for patients and for workers and for everybody else and most administrators are familiar with it. It was a good place to start.

If you get to look in the slide deck you'll see we had as we started applying the lean technique to the turnovers, the perioperative surgical home uses lean and six sigma and a host of other techniques to get to the end point. It's not a tunnel vision approach to how to solve problems. But as you look at the first part, as we're doing the value stream mapping, uncovering what the problems are the improvements immediately start and that happened even if you go back and look at the slide about the hips and knee readmissions, the real improvement started just to having people talk and when they are things that they can personally do, things just start to get instituted.

Many people have the misconception that the perioperative surgical home is a plan that you write up and you flip a switch and it goes on. That's not how it works. It starts from the very beginning of the conversation and improvements start to happen and you might want to call it the Hawthorne Effect but there's actually a real change in how things are being done. It's more than just the Hawthorne Effect, and it seems to be carrying on through.

If you can go back and look at the slide about turnover times, you'll see there is improvement, improvement, and then you get to the point where we have to do a full implementation. The full implementation where some harder pieces that require some extra resources and those got put in as well and there was continuation in improvement. Then, it flattens out, doesn't quite hit its goal, but it turns out that we ended up doing a root cause analysis and finding out that a big part of the reasons for the turnover is actually related to the patients. There is a redesign of how patients work through this system and a significant number of patients decide at the last minute that they want to go to the bathroom and have to get up. Well, that takes a few minutes and all of a sudden your room turnover doesn't look as good.

There's different ways to look at this but it causes the redesign but improvement still happens. You will eventually get to the slide deck to a slide that I like to borrow from premier whose helping support the PSH learning collaborative. It has to do with collaborative methodology. Most of the people that I talk with and have talked with in the learning collaborative, their institutions are just really learning how to cooperate. If you get these silos to talk to one another, if you only get them to cooperate you're probably not going to achieve your full potential. This collaborative methodology is

where you use the synergy to create something greater than just what cooperation will get you to. They have a loop that goes there and then on the slide you'll see where it says Henry Ford PSH is here. Of the eight steps there we're approaching six and this is just in our pilot. Once we get our pilots at our one main hospital finished and we will be spreading it out to the entire health system.

The spreading is already starting because one doesn't stop and the other begin, they work on the back of one another and as some pilots are starting to move along, they're getting ready to move system wide. But really understanding the difference between collaboration and cooperation and going for the higher level of collaboration tends to have the biggest benefit. Then we get to the point of, well, if we do the co morbidities and we get the type protocols there we will achieve the low hanging fruit. Then you have to move to the concept of aggregate of marginal gains. The aggregate of marginal gains is that each little gain by itself may not be statistically significant but when you put them all together they make a big difference. That's where the future is going to lie and being able to pull the data and look through best practices in the normal variation in your own systems you'll be able to share that data back to the providers with the practitioners and let them change their own behaviors to the higher order.

That's been our approach and so far we're having success with it but again, we still have a ways to go. I feel very fortunate that we're going to be able to contribute to lower our cost increase and increase the efficiencies and be successful in the new MACRA environment. MACRA didn't drive the whole perioperative surgical home approach but it was a major determining factor of pushing the right resources in the right direction to speed our progress up.

I think that's the end of what I have to say so far.

Jay Bhatt: Fantastic. Thank you Gary, appreciate your perspective and candor in showing the challenges and successes along the way. I think this was wonderful information and will be really useful as practitioners and clinicians and leadership are considering how might they meet the challenges of MACRA. Please tune in to part two of this series where we will hear from Ann Marie Creed, vice president of operations at Henry Ford.