The Anesthesiologist-Directed Perioperative Surgical Home: A Great Idea That Will Succeed Only if It Is Embraced by Hospital Administrators and Surgeons

John F. Butterworth, IV, MD, and Jeffrey A. Green, MD

Health care in the United States, although unsurpassed in technical advancements, is more expensive, less efficient, more fragmented, and no more likely to produce high-quality outcomes than the less expensive health care provided in other Western democracies. The United States spends nearly 18% of its gross domestic product on health care. Specifically, in 2010, the United States spent $8233 per person on health care; Norway, the Netherlands, and Switzerland, our closest competition, all spent less than $3000 per person on health care. Meanwhile, the United States has fewer licensed physicians and fewer licensed hospital beds per person than other Western democracies.

This leads to the most fundamental problem: health care in the United States delivers inadequate value for its cost, relative to our competition. The problem is not unique to surgical and perioperative care. However, the “Perioperative Surgical Home (PSH)” is the focus of this issue of Anesthesia & Analgesia. Three articles identify defects in our current system and conclude that the anesthesiologist-led PSH offers a means by which to improve patient experiences and patient outcomes, thereby increasing value. Indeed Vetter et al. propose that the PSH can accomplish the triple aim of “… (1) improving the individual experience of care, (2) improving the health of populations, and (3) reducing per capita costs of care.” A skeptical reader might pose the question: Can I with my colleagues and my hospital establish a PSH that will improve the cost-value ratio and patient and population outcomes?

“In this world, you get what you pay for.”

—Kurt Vonnegut, Cat’s Cradle

Those who wonder why health care in the United States remains fragmented and expensive need look no further than at the systems in which it is provided and at the methods by which the “agents” providing health care (e.g., physicians, ambulatory surgery facilities, hospitals) are compensated for their labor and material costs. Although there are some well-known examples of integrated health care delivery systems (e.g., Mayo Clinic, Virginia Mason Clinic), these are the exceptions, not the rule. Moreover, in many institutions and practices, the decision as to how to deploy and compensate physicians is tied directly to individual or departmental productivity as measured by fee-for-service revenue or some surrogate metric such as production of work Relative Value Units (wRVUs) or American Society of Anesthesiologists units. Recent attempts by insurers and others at “controlling health care costs” have focused on reducing per service compensation. The typical overall result was that utilization of services increased, and any overall cost savings was small. Production increased because increased production was rewarded. Why would anyone expect a different result?

“Every system is perfectly designed to get the results it gets.”

—Paul Batalden, MD

As Dexter and Wachtel point out, to reduce cost in a PSH anesthesiologists can reduce unnecessary interventions and improve operating room efficiency. However, most current payment systems reward exactly the opposite behavior. We offer an example. When a hypertensive patient receiving hydrochlorothiazide and metoprolol undergoes laparoscopic cholecystectomy in the United States, typically neither the referring physician nor the surgeon will have an electronic system for medical records in their offices. While the imaging facility and the ambulatory surgery center may have electronic medical record systems, there is no guarantee that either will interact with the other, or with the electronic system (if present) in the physician offices. Due to systems’ incompatibilities and fragmentation of care, the anesthesiologist who sees the patient on the day of surgery may fail to find all the preoperative data that have already been collected by the patient’s physician and surgeon. Unnecessary duplicate testing may result. If the medication reconciliation has not been completed at the time of anesthesiologist’s preoperative assessment, the “system” may not maintain perioperative β blockade. As pointed out by Dexter and Wachtel, appropriate use of better integrated information systems can be the cure for much of this fragmentation.
agree. Does that prove that an anesthesiologist-led PSH will offer greater value to the patient?

At the present time, the surgeon, internist, and anesthesiologist are likely to be paid in a fee-for-service system in which each one derives financial benefits only from his or her own production, and none will receive revenue (or wRVUs or American Society of Anesthesiologists units) for “coordination of care.” Nevertheless, we and the authors of all 3 of the cited manuscripts agree that our patient undergoing cholecystectomy would benefit from coordination of care. The question remains as to who should coordinate the care? All 3 articles opine that anesthesiologists should be well qualified to lead this effort. We agree that anesthesiologists should be qualified, but we speculate that some are either “deconditioned” or otherwise not qualified for this activity at the present time. Even if we accept that anesthesiologists are qualified, is the type of activity anticipated in the PSH likely to be attractive to the great majority of practicing anesthesiologists whose primary interest lies in the intraoperative care of patients undergoing surgery and other procedures?

Is the anesthesiologist the most cost-efficient specialist to oversee all perioperative care? Under the current fee-for-service system, the anesthesiologist would be exceedingly cost-efficient: there are no American Society of Anesthesiologists billing units attached to care coordination! It is hard to improve cost efficiency if costs (at least when estimated by potential fee-for-service collections) approach zero! Kain et al. propose that “...in the current fee-for-service model, anesthesiologists could be compensated for their role in PSH just like family practitioners get reimbursed for their role in patient-centered medical home.” We speculate that some readers will not find comfort in this vision for the future.

Vetter et al. opine that to pay for the PSH, anesthesiologists must be financially “aligned” with the institution. If the chief executive of your health system decides that care coordination through a PSH-like organization is needed, how will this chief executive get physicians and surgeon who receive their compensation from another entity to provide this service? We assume that the physicians who will be working in the PSH will want to receive fair market compensation within the range that others in their profession receive. If that chief executive must pay physicians to lead the PSH in his or her hospital, why would the executive choose an anesthesiologist rather than a lower paid medical specialist who is available, competent, and willing?

Kain et al. implemented a PSH model utilizing LEAN and Six Sigma techniques to standardise protocols and reduce variability in perioperative processes. Anesthesiologists tend to be systems-oriented, data-driven, and motivated to improve patient throughput and patient outcomes; however, we cannot claim to be the only physicians with these characteristics and skills. We must prove not only that the PSH delivers value but also that anesthesiologists deliver incremental value over that which might be provided by other physicians. Our comments and comparisons will remain valid even if the entire fee-for-service system is scrapped and accountable care organizations (or PSHs) are paid a global fee for an episode of care.

“When you come to a fork in the road, take it!”
—Yogi Berra

In summary, we agree with both the diagnosis and the treatment prescribed by the authors of these 3 articles. We share their enthusiasm for improving perioperative systems and patient and population outcomes. We agree that anesthesiologists-in-training must acquire the necessary knowledge and skills to join in these efforts upon the completion of their residencies. We agree that the costs of having anesthesiologists administer and provide care in a PSH represent mere “budget dust” when compared with the benefits of having more cost-efficient and patient-focused surgical care. It will be up to anesthesiologists to provide the evidence that it will make sense for a health system to have anesthesiologists administer and provide care in its PSH rather than another specialist who is equally bright, equally information-technology-savvy, but potentially less expensive. Finally, we agree with the authors of the 3 articles and recommend that when we anesthesiologists get the chance to lead PSHs or other systems-based, patient-focused clinical entities, we need to do the hard work to make it happen.