

Whether you pronounce Accelerated Recovery PSH or ERAS it's its time to put our foot on the gas!

Background

The ASA has championed the Perioperative Surgical Home (PSH) for the past three years, investing a lot of volunteer and staff time and well over a million dollars on the first PSH Learning Collaborative. Hundreds of articles have been published; all the major anesthesiology journals have devoted an entire issue to the PSH. But we in the United States are late to the game. In 1992 Dr Henrik Kehlet a Danish surgeon was talking about some radical ideas to improve surgical outcomes (1). It was to be 15 years before Accelerated Recovery became mainstream in England—and almost 25 years in the US. Cannesson et al (2) described the convergence of the PSH and ERAS initiatives in the British Journal of Anesthesia last year; this article will focus on the financial and political environment that shapes the adoption of Accelerated Recovery in the US and United Kingdom (UK).

UK vs US health care organization

The UK treasury funds the National Health Service (NHS) which operates the health care system—there is a small (15%) private sector that is not significantly involved in population health care. In the USA the financing is more heterogeneous; not only are there many payer sources but facilities and professionals are paid in entirely different ways. There are pros and cons to the American way that are beyond the scope of this article, but our huge historic differences are shrinking and America is moving closer to the English model. The organization of the NHS is incredibly complicated but you can learn more from this six and half minute video(<http://www.kingsfund.org.uk/projects/nhs-65/alternative-guide-new-nhs-england>) or explore the NHS website that explains it in thousands and thousands of pages.(<http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx>).

Simplified, the NHS funds Clinical Commissioning Groups (CCG) that fund the hospitals within their service area with a preset amount of money each year. This is Population Health writ large. If a hospital runs out of money before the end of the year it must draw from next years budget and cut down on services provided. This draconian control mechanism demands that the people in charge pay attention. In 2008 the system was (again?) running out of money and action was required. Of interest to us, the NHS Enhanced Recovery Partnership identified the opportunity represented by decreasing variance in length of stay (LOS) and sold the concept of Enhanced Recovery as a money saving opportunity. Reducing average LOS and LOS variance represented an opportunity to enable more surgeries to be done with the same resources. Given population health responsibilities of the CCG, the commonly played (in the US) shell game of shifting the costs to another party was not an

option—the English had to actually reduce morbidity to affect the quality of outcomes—or costs would simply move to another place in the system. (Figure 1).

Figure 1 shows that hospitals in England regardless of case volume had a huge variance in LOS (5-18 days) for colorectal resection –they set a goal is to get average hospital LOS to between 5 and 8 days.

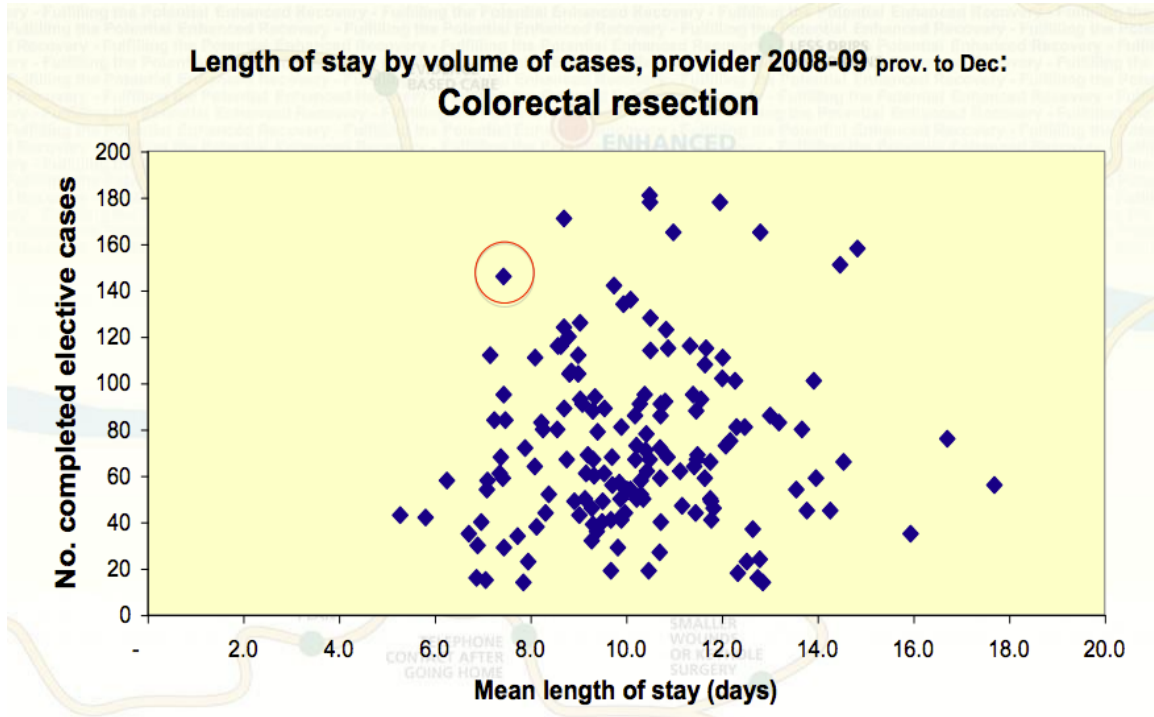


Illustration courtesy of NHS England

The program saved over 170,000 patient days in the first four years (<http://www.nhs.uk/8846.aspx>) of its existence. Success on this scale was very challenging even in a centrally funded system of care but the results have definitely affected health of the population. The example in the box of a 550 bed hospital that serves a local service population of 330,000, and a specialty cancer service population approximately 2.8 million)

The Royal Surrey County Hospital experience. It is by no mere chance Royal Surrey is seen as a flagship for Enhanced Recovery Pathways. It's because we are delivering the best evidence based perioperative and cancer care from point of referral to 5 year survival. The journey started 14 years ago when a small group of like-minded surgeons and anesthetists started changing dogma. WE were the first group in the UK to give oral preload, not use nasogastric tubes routinely, avoid surgical drains if not needed. We conducted studies on analgesic techniques and their effect on mobility and bowel function/reduction of ileus rather than focus on a patient centric pain score. Outcomes were the driver(3). The surgeons focused on minimizing primary injury and reducing blood loss using

laparoscopic techniques and making the most of new technology where open surgery was still necessary. As anesthesiologists we have focused on optimizing fluid therapy and analgesia throughout the perioperative period such that it is continued post operatively for at least 6 hours on a surgical high dependency area on ICU. The big change in mindset came when surgeons realized that the perioperative care after surgery had a bigger impact on improving outcomes than the surgery itself (unless there is unexpected issues or significant blood loss). ERAS has empowered anesthesiologists - no longer can surgeons insist on 'doing it their way' unless there is a reasonable evidence base to support them. Standardizing post operative orders for patients under the care of different surgeons for the same operation does not only make common sense it means it is easier for nurses to ensure compliance with the treatment points improving the care delivered. Nurses are also empowered as they can take out drains and catheters and move patients' care on without the need for a ward round and without fear of criticism. In this system you can predict what a patient should be doing - both physically and from a treatment point perspective on any day after surgery. If a patient is not completing these targets there is a high index of suspicion that recovery is not going according to plan and we look for the reason why - is there a complication?

Meanwhile back in the USA

I will assume that everyone reading this is already has their own opinion of how US healthcare is organized. There are a lot of great things about practicing medicine in the USA—and the fact we never seem to run out of money is top of the list—but one price we pay is that we work in a system where innovation is possible but the change difficult to implement.

Change is difficult because there are so many stakeholders. Since nearly 20% of the GDP goes through health care—even the smallest change to the smallest stakeholder causes huge economic disruption to thousands or even millions of people. This translates into modifications of our health care system - always meeting with political resistance at the state and federal level. Failure to understand this may explain the frustration encountered by folks (from both parties) who live in the White House and talk only to partisan “experts”.

Notwithstanding the Federal government is a huge and supremely important payer for health care services through the programs and can modify incentives via Centers for Medicare and Medicaid Services (CMS). Major changes in these incentives seems to occur every 25 years or so (Merrick personal communication) so its not surprising to me that we are seeing the major changes described elsewhere in this edition.

ASA role

In 2007 a group of ASA Directors described how the misalignment of payment incentives was not rewarding physicians for improving quality. This implied that the status quo, while profitable in the short run was not going to be sustainable in the long run. After many discussions and two white papers ASA Board defined Perioperative Surgical Home in 2013. In parallel with these ASA leadership conversations there were three other major trends under way;

1. The almost universal implementation of preop-clinics, acute pain and other ancillary services in both academic and private practices.
2. Anesthesiology researchers looking at the Henrik Kehlet's work and other ideas related to ERAS (see Aronson's article on page ##)
3. Passage of Affordable Care Act Payment forced the discussion of payment changes

Last year the pace of change accelerated because MACRA is forcing providers to work with facilities through "Alternative Payment Models" or be punished through the Merit-based Incentive Payment System (MIPS). On April 1 2016 CMS mandated bundled payments for hip and knee replacements in 68 metropolitan areas.

The recent evidence (4,5) suggest the economic arguments for accelerated care are valid. As noted by Dr's Schweitzer and Naas, ASA is reaching out to our medical and surgical colleagues—we need them fully engaged as equal partners for the greater challenge may be working with the hospitals and other facilities.

Accelerated Care is here and its our future whether it be called PSH or ERAS, and in the US we are getting a late start. As Dr. Scott's colleagues did 14 years ago we all need to work with our colleagues and our facilities for the good of our patients and our communities. That is population health for the 21st century.

References

1. Kehlet H. 1993 John J. Bonica Lecture. Postoperative pain relief. A look from the other side. *Reg Anesth.* 1994 Nov-Dec;19(6):369-77.
2. Cannesson, M. Ani, F. Mythen, M M. Kain, Z. Anaesthesiology and perioperative medicine around the world: different names, same goals. *Br J Anaesth.* 2015 Jan;114(1):8-9.
3. Levy BF, Scott MJ, Fawcett WJ, Rockall TA. 23-hour-stay laparoscopic colectomy. *Diseases of the Colon & Rectum.* LWW; 2009;52(7):1239-43.
4. Grocott MP, Mythen MG. Perioperative Medicine: The Value Proposition for Anesthesia?: A UK Perspective on Delivering Value from Anesthesiology. *Anesthesiol Clin.* 2015 Dec;33(4):617-28.
5. Thomas R. Vetter TR. Jones, KA. Perioperative Surgical Home Anesthesiology Clinics, 2015-12-01, Volume 33, Issue 4, Pages 771-784