



# Perioperative Medicine Summit

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Evidence Based Perioperative Medical Care

## Building the Perioperative Surgical Home

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# Perioperative Medicine Summit

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## Evidence Based Perioperative Medical Care

1. How do you define the Perioperative Surgical Home? Thompson
2. What are the goals of the Surgical Home? Englesbe
3. What is the current state of the Surgical Home nationally & at your institution? --Edwards
4. How does a health care system approach implementation of a Surgical Home model? Thompson
5. What elements are necessary to make the Surgical Home model successful? Who are the key stakeholders?--- Englesbe
6. What are the challenges to success of a Surgical home model?  
Edwards



# The Medical Home Model

Concept dates to 1967 in pediatrics

Team based health care delivery model intended to provide comprehensive , coordinated, patient-centered care with accessible services to improve quality and safety

Later evolved in family medicine

Patient Centered Medical Home principles released 2007

-Collaborative effort

American Academy of Family Physicians

American Academy of Pediatrics

American College of Physicians

American Osteopathic Association

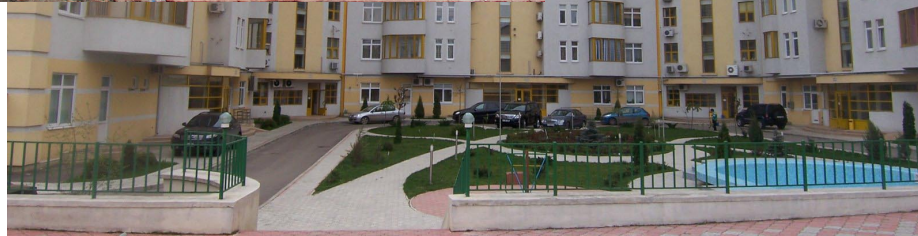
# The Perioperative Surgical Home

Dear Noah,

We could have sworn you said  
the ark wasn't leaving till 5.

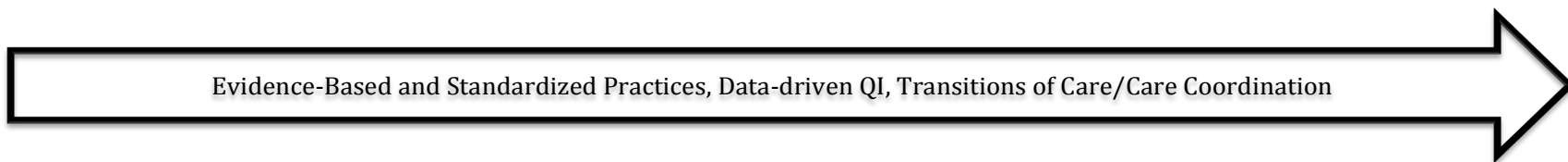
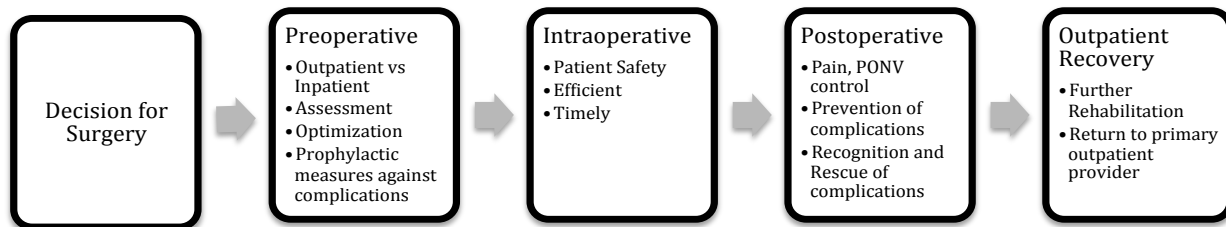
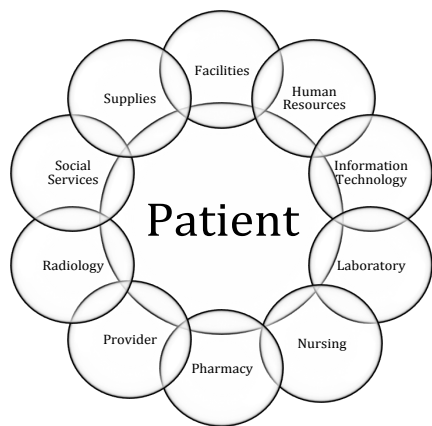
Sincerely,  
The Unicorns

# A Surgical Home?

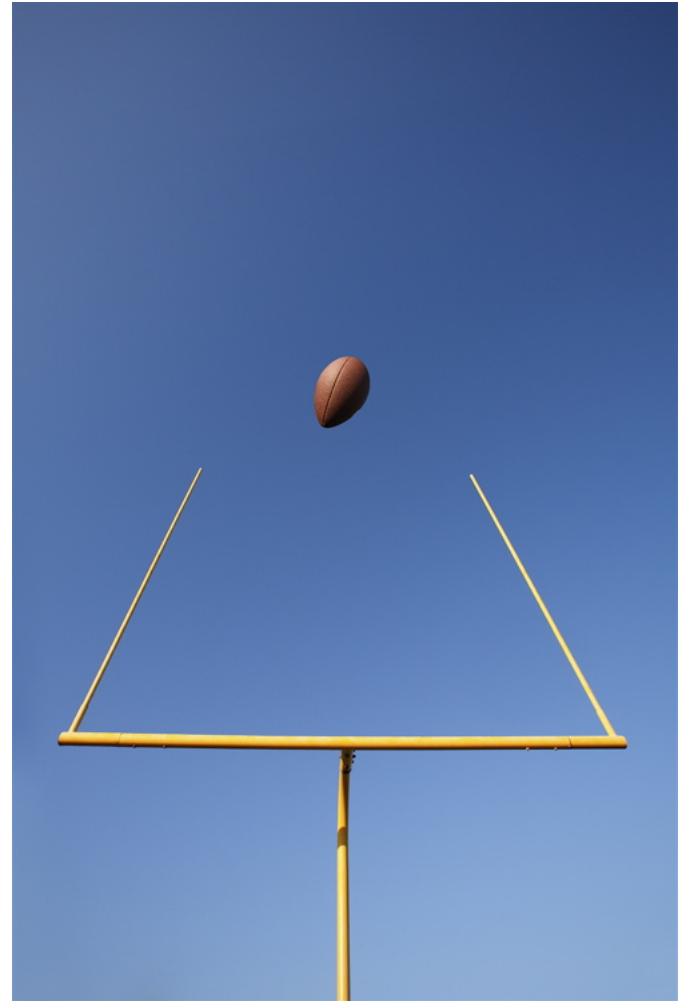




How do you define  
the Perioperative Surgical Home?



What are the goals  
of a surgical home





Appropriateness, communication, trust,  
patient centeredness

# Unique time for engagement



Sitting in a 3.8-metre sea  
kayak and watching  
a four-metre great  
white approach you is  
a fairly tense experience

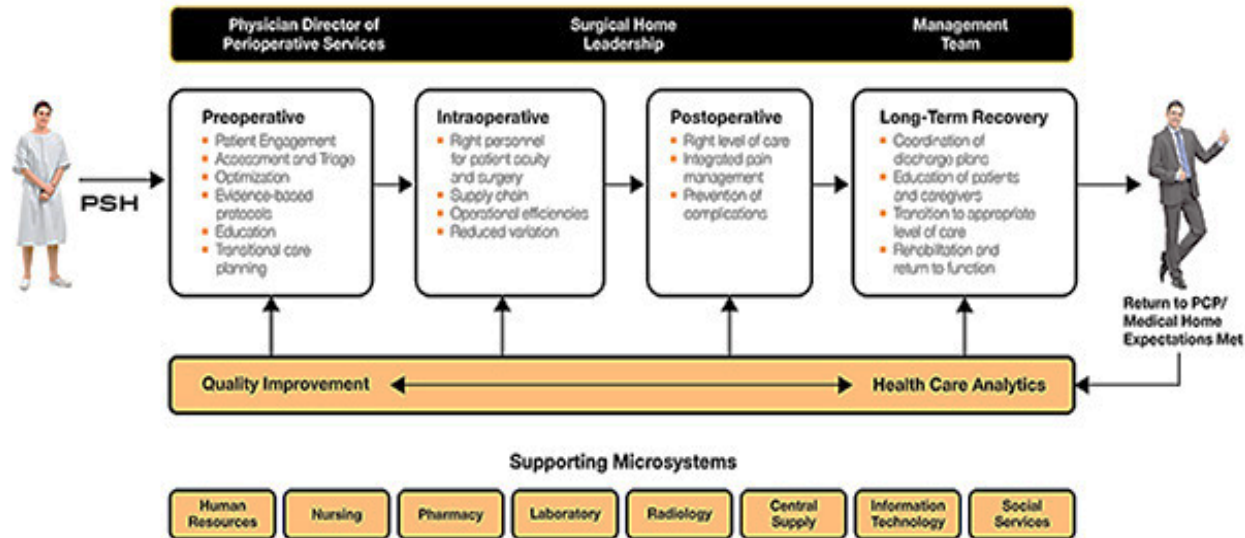
## MOTIVATION

If there is a better reason to paddle, I don't know what it is.

What is the current state of the Surgical Home nationally and at your institution?

## Perioperative Surgical Home Overview

### Perioperative Surgical Home Overview\*



In the PSH model, the patient's experience of care is coordinated by a director of perioperative services, additional surgical home leadership and supportive personnel, which constitutes an interdisciplinary team. The expected metrics include improved operational efficiencies, decreased resource utilization, a reduction in length of stay and readmission, and a decrease in complications and mortality – resulting in a better patient experience of care.

\*Figure developed by Daniel J. Cole, M.D.

With the PSH model, the patient's experience of care is coordinated by a Director of Perioperative Services, additional Surgical Home Leadership, and supportive personnel which constitute an interdisciplinary team. The expected metrics includes improved operational efficiencies, decreased resource utilization, a reduction in length of stay and readmission, and a decrease in complications and mortality-resulting in a better patient experience of care.

# The perioperative surgical home: An innovative, patient-centred and cost-effective perioperative care model

Olivier Desebbe<sup>a, b</sup>

Anaesthesia Critical Care & Pain Medicine



Volume 35, Issue 1, February 2016, Pages 59–66

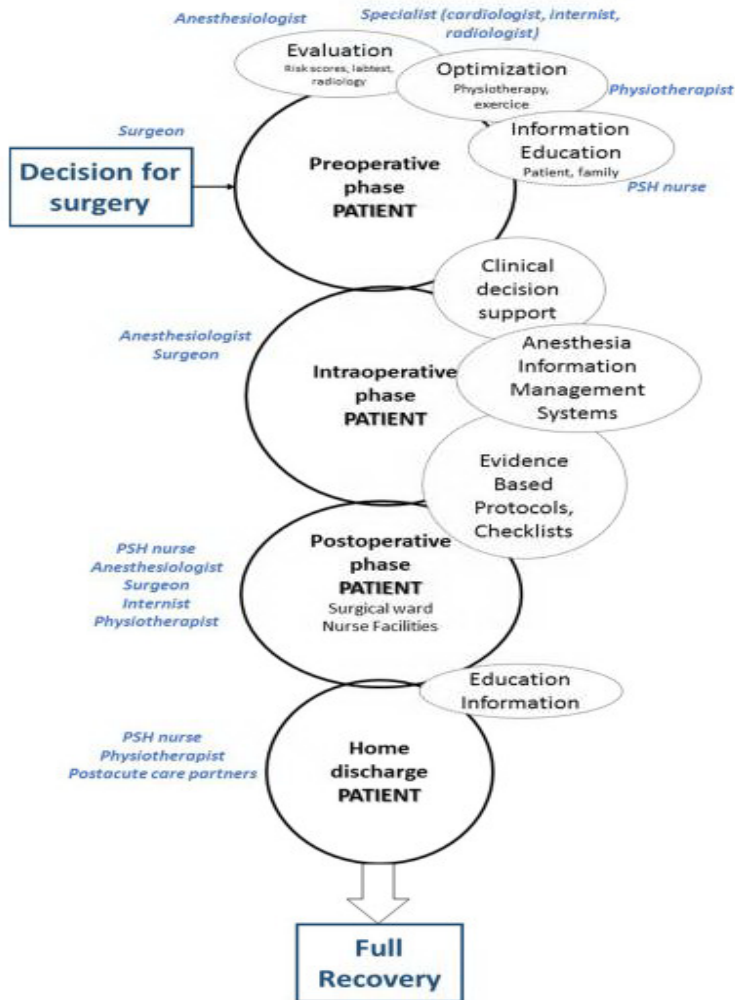
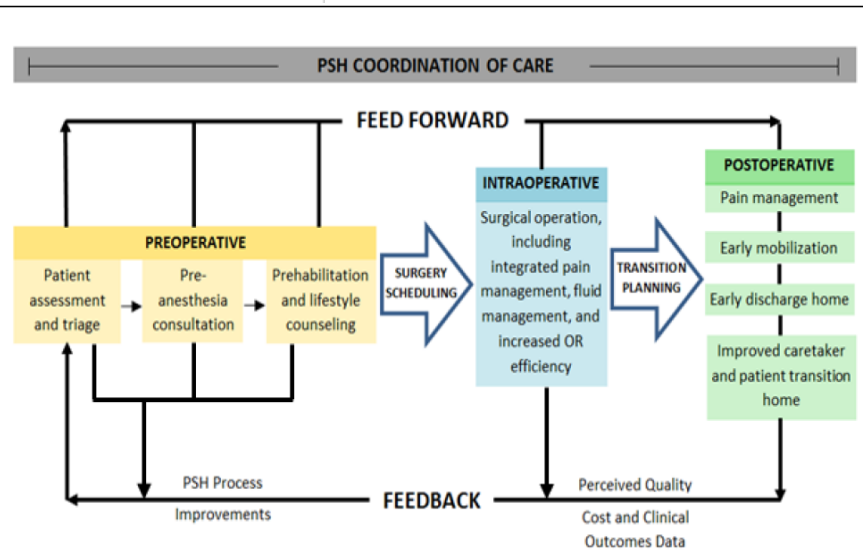


Fig. 2.

The perioperative surgical home model of care. The perioperative surgical home (PSH) is a patient-centred, institution-led, interdisciplinary and team-based system of coordinated care that guides the patient through the entire surgical continuum, from the surgical decision to full recovery; the PSH is provided by a preoperative assessment to generate a ranked and seamless continuity of care. Care providers revolve around the patient; performance measures analyse patient evolution and provide a quality improvement process.



Source: Adapted from Nelson et al. (2011)

## Designing Clinical Pathways in Perioperative Medicine



➤ **First Learning Collaborative** (06/2014)

- **44 leading health care organizations** from across the country to define, pilot and evaluate the extent to which the Perioperative Surgical Home model improves clinical outcomes, cost of care and patient experience.

➤ **Members of collaborative engaged in the following over first 18 months:**

- Four national meetings
- 30 educational webinars
- Numerous committee calls, webinars and activities
- Real-time sharing data through a dedicated online community

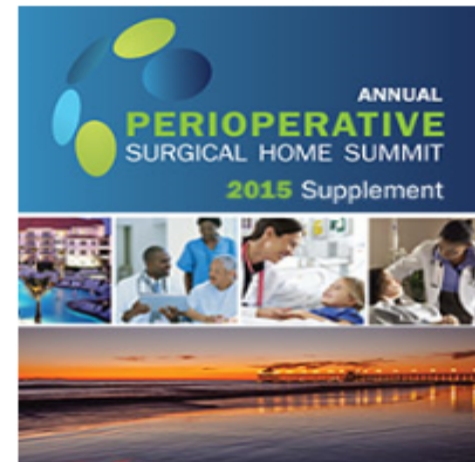
- Participants launched variety of PSH projects within their organizations
- Participated in a Dedicated Partner program; continue on to the 2<sup>nd</sup> Collaborative

➤ **Second Learning Collaborative** (04/2016)

**PSH Learning Collaborative 2.0 Resource Kit**

- All about the PSH Learning Collaborative
- Participant letter
- PSH Learning Collaborative Member Map
- ASA & Premier press release

PSH Learning Collaborative 2.0  
applications due March 15.  
Apply today ▶



**2015 Supplement**

**DOWNLOAD: Annual PSH Summit  
2015 Supplement [pdf]**

Jointly provided by:

American Society of  
Anesthesiologists 

 **UC Irvine Health.**  
Department of Anesthesiology  
& Perioperative Care



## Case Studies on the Perioperative Surgical Home and Related Concepts

# Perioperative Surgical Home: Methodology for Coordinating Pediatric Anesthesia Care



Jill Kilkelly, MD

Clinical Director, Division of Pediatric Anesthesiology  
Medical Director, Pediatric Perioperative Services

Jill Kinch, MSN, MMHC, APRN, CPNP-PC/AC, Assistant Director Advanced  
Practice Nursing

## Clinical Anesthesiology

MAY 22, 2015

# Comments From Readers on Advent Of the Perioperative Surgical Home

**A**nesthesiology News recently published a series of articles highlighting potential benefits of the perioperative surgical home (PSH), in which anesthesiologists are charged with the oversight of care throughout a patient's hospital stay. Whereas some feel this is a logical step to improving clinical care, others disagree with the concept of the "perioperativist."

We have compiled below some of the comments we received on [anesthesiologynews.com](http://anesthesiologynews.com) and via email (with some comments slightly edited for clarity). Where do you stand on this topic? We encourage you to join the conversation.

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### The PSH Saves Money

The American Society of Anesthesiologists (ASA) launched the PSH model to address increasing concerns about costs and outcomes associated with surgery. This patient-focused, multidisciplinary approach has anesthesiologists guiding the perioperative clinical process and overseeing patient care from the moment a procedure is booked to as many as 30 days postoperatively. Researchers cited a study showing that the PSH model can reduce total per-diem costs for total knee arthroplasty (TKA) and total hip arthroplasty (THA); specifically, from literature-reported benchmarks of \$17,588 for TKA and \$16,267 for THA down to \$10,042 and \$9,952, respectively. (See "[Perioperative Surgical Home Promotes Perioperativists](#)"; February 2015, page 8.)

# THE NEED FOR THE PERIOPERATIVE SURGICAL HOME

The PSH is system for **organizing & coordinating care** that is patient-centered, **physician-led and team based**. PSH care extends from the decision for surgery until completion of recovery.

## Main components of the PSH are:

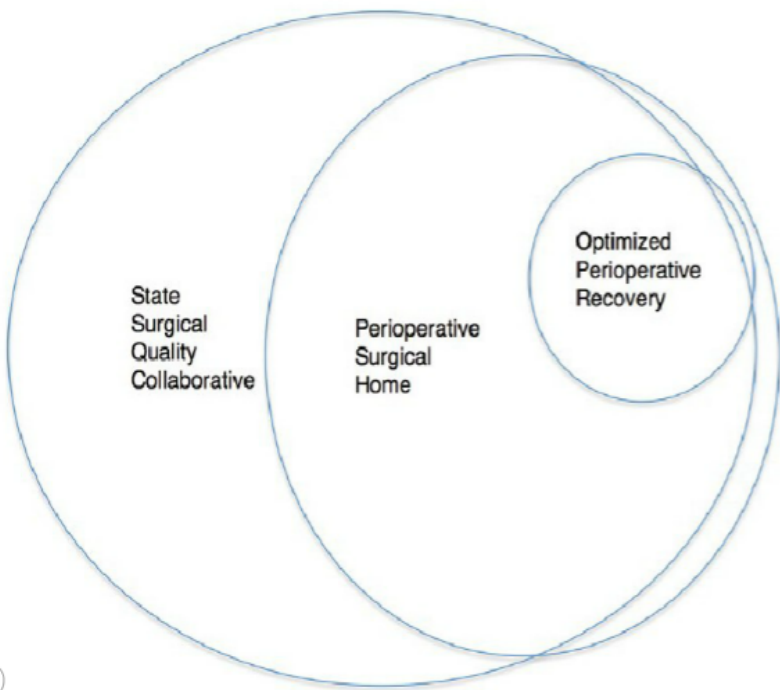
- ✓ Engaged physician leadership,
- ✓ patient optimization for surgery
- ✓ timely scheduling
- ✓ evidence-informed care pathways
- ✓ expert surgical & anesthetic care
- ✓ facilitated prehabilitation/ rehabilitation
- ✓ measurement of patient-centered outcomes
- ✓ continuous performance improvement
- ✓ facilitated return to primary care



Perioperative Surgical Home Elements		
Preoperative Key Elements	Intraoperative Key Elements	Postoperative Key Elements
<ul style="list-style-type: none"> <li>• Admission through a centralized preoperative area/clinic</li> <li>• Early preadmission assessments</li> <li>• Centralized systems to gather health and other information about patients before hospital admission</li> <li>• Preoperative innovations such as “prehabilitation” programs for targeted patients</li> <li>• A triage system to identify which patients need to attend a preadmission clinic or program</li> <li>• Use of a multidisciplinary team based clinical care processed within the hospital to coordinate complex preparation of patients before surgery</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated pain management</li> <li>• Fast-track surgery and discharge home</li> <li>• Precise fluid management</li> <li>• OR delay reduction techniques</li> <li>• Increased OR efficiency through improved OR flow</li> <li>• Scheduling initiatives to reduce cancellations and increase efficiency</li> </ul>	<ul style="list-style-type: none"> <li>• Integrated pain management</li> <li>• Early postoperative mobilization by physical therapy and integrated acute-care and rehabilitation care</li> <li>• Improved coordination of care from postoperative to discharge home</li> <li>• Improved discharge protocol</li> <li>• Increased patient and caretaker education concerning post-discharge care</li> </ul>
<ul style="list-style-type: none"> <li>❖ Early Patient &amp; Family engagement</li> <li>❖ Shared Decision making &amp; appropriate patient selection</li> <li>❖ Cross Continuum Team Collaboration &amp; Integration</li> <li>❖ Health Information Exchange &amp; Shared Care Plans</li> </ul>		

# THE FUTURE OF SURGICAL CARE IN THE U.S.:

State Surgical Quality Collaboratives, Optimized Perioperative Care, and the Perioperative Surgical Home



## The Historical Perspective of Optimized Perioperative Care and the PSH

As described elsewhere in this issue of the ASA NEWSLETTER, optimized perioperative care (OPC), also referred to as enhanced postoperative recovery, or enhanced recovery after surgery (ERAS®), is based upon standardized, evidence-based, interdisciplinary perioperative care pathways including, but not limited to:

- preoperative preparation of the patient with medical optimization
- physical preconditioning
- nutritional supplementation
- intraoperative management involving goal-directed fluid therapy
- transfusion protocols
- minimal use of opioids, NG tubes and drains
- postoperative interdisciplinary care, including:
  - pain and symptom management facilitating postoperative alimentation and mobilization for accelerated convalescence
  - focused, transitional care for 30-90 days post-discharge with structured handoff back to a patient-centered medical home or primary care physician.

# Peri-Op Protocols Enhancing Recovery After Colorectal Surgery

## ERAS protocols

Validated in  
Colorectal surgery

SEPTEMBER 2014 | VOLUME: 40:9

### ❖ Preoperative

- ❖ Formal patient education & prehabilitation
- ❖ Eliminating bowel preparation
- ❖ \*\*Clear fluids up to two hrs before surgery
- ❖ Utilization of **Regional TEA or TAP** blocks preop

### ❖ Intraoperative *JSLs 2014;18:265-272*

- ❖ **Goal Directed Fluid Management**
- ❖ **Goal Directed Ventilator Management**
- ❖ Shortened operative time
- ❖ Reduced blood loss aids recovery

### ❖ Postoperative *Ann Surg 2000;232:51-57*

- ❖ **Opioid sparing modalities**
- ❖ Avoidance of NG tubes & Urethral catheters
- ❖ Early feeding, mobilization, d/c

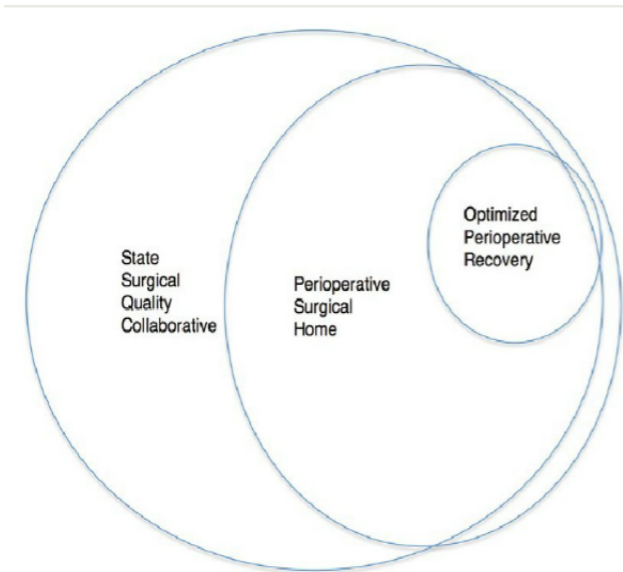
# Perioperative Surgical Home

Current State (Local)

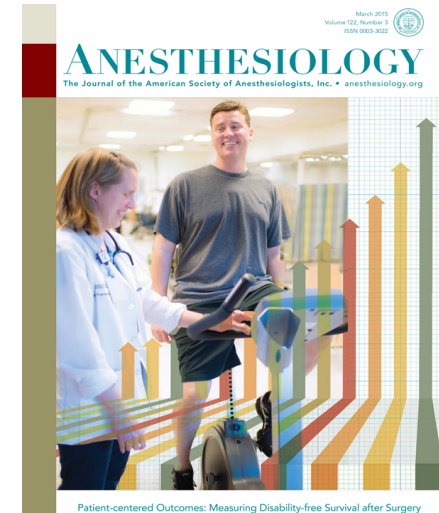
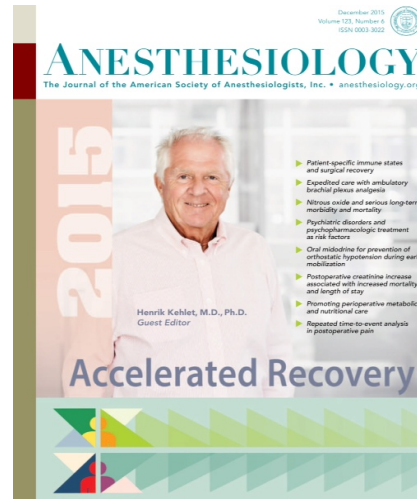


# PERIOPERATIVE SURGICAL HOME

**Optimized Perioperative Care:**  
*Why Is Change So Difficult?*  
*And What Can We Do To Overcome Barriers?*



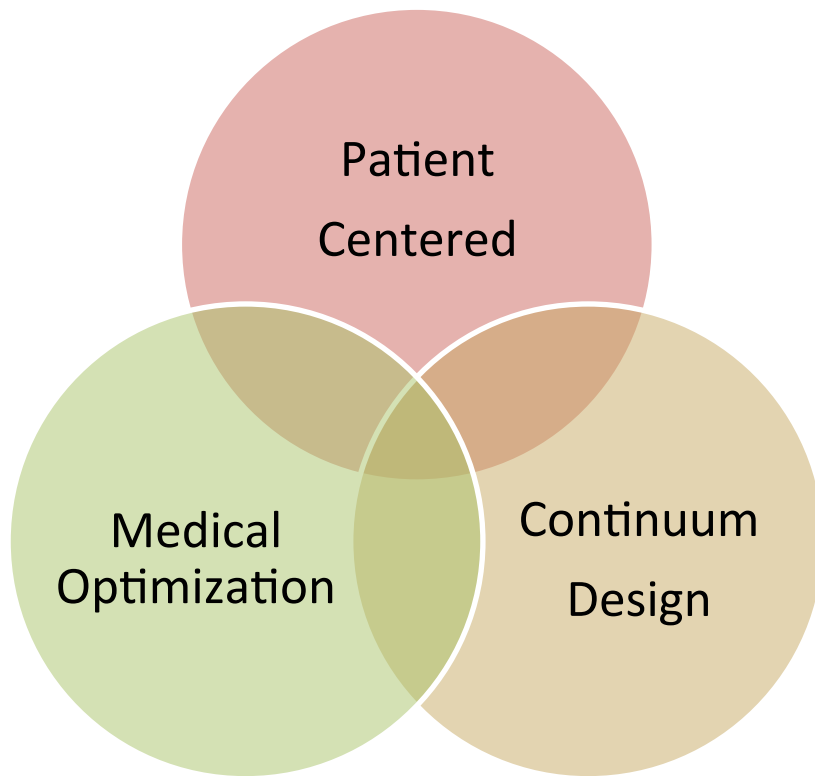
Wake Forest Baptist Medical Center



Enhanced recovery after surgery (ERAS®), "fast-track surgery," or optimized perioperative care (OPC) is an evidence-based perioperative clinical pathway developed to accelerate functional recovery of surgical patients.<sup>1</sup>

# Ideal Vision

## *Continuum Redesign for Surgical Patients @ WFBH*



Patient Centered – Services are brought to our patients, aggregated in the preoperative visit, and coordinated from decision for surgery through day of surgery

Medical Optimization – Development of perioperative care pathways and prehabilitation programs for managing comorbid conditions prior to surgery

Continuum Design – Designed to support and educate patients through transitions in care environments, early identification of patient and family goals and needs throughout the continuum of care

# Implementation

## Surgical Quality Continuum

Quality -> Value



### Quality Metrics

- NSQIP
- Surgical Quality Report
  - Adverse Events
  - Length of Stay
  - Mortality
  - Readmissions
  - Inpatient Experience
  - Outpatient Experience
- Commitment to Excellence
- Medical Director Goals



### Safety

- Wake Wings
- OR Safety & Regulatory Committee



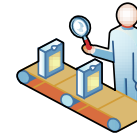
### Surgical Navigation Center

- Validate Case Posting
- Ensure Administrative \ Payor Rules are Met (inpatient-only)
- Financial Counseling
- Care Coordination Assessment
- Pre-Anesthesia Consult
- Pre-operative Medical Management
- OR Scheduling
- QC for All Processes



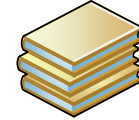
### Costs

- Supply Costs
- Utilization



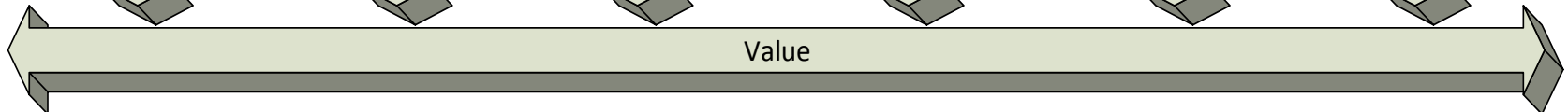
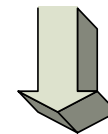
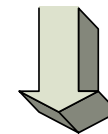
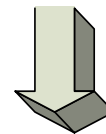
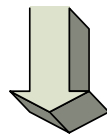
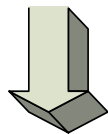
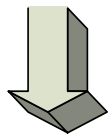
### Retrospective

- Peer Review
- Adverse Events
- Etc...



### Prospective Design & Documentation

- HCC Optimization
- PSI Minimization
- Care Pathway Development (perioperative segments of pathway)



Drive Quality Goals  
Maintain Registries

Reduce surgical errors  
Design for safety  
Ensure safe working environment  
TJC Compliance

Process Owner – Surgery Scheduling  
Process Owner – Medical Clearance  
High Efficient Delivery Vehicle  
Operational Excellence  
Patient Experience

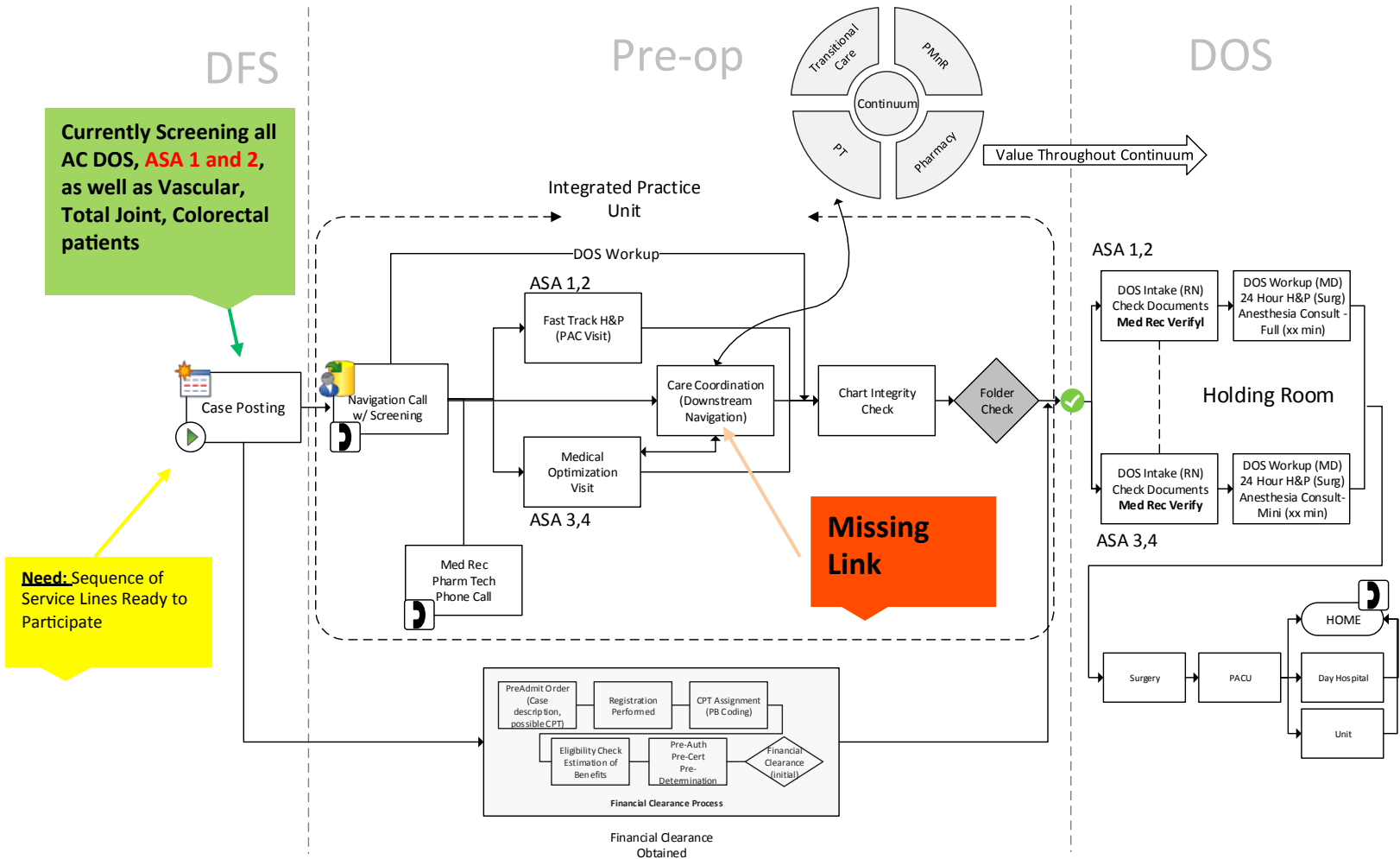
Intraoperative Supply Costs  
Case Time Standardization  
Utilization

Peer Review  
Physician Education  
Systems Improvement

Maximize Reimbursement  
Minimize Penalties  
Evidence Based Care

# WFBH Surgical Navigation Center Process Map

Perioperative Integrated Practice Unit



# WFBH Surgical Navigation Center

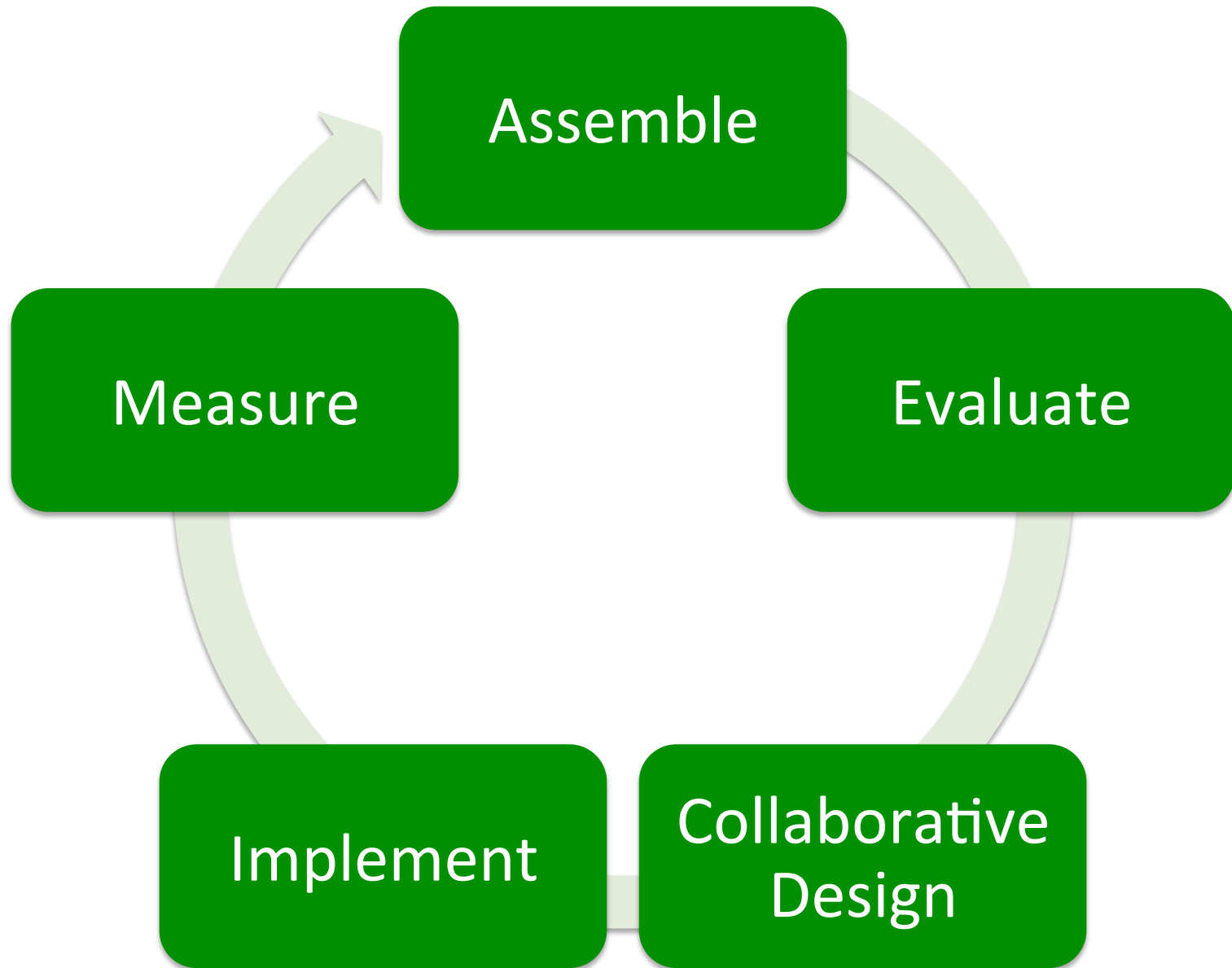
## Initial Challenges

- **Recruitment**
- **Information Technology Enablers** - Required rebuild of IT template to maximize capture of risk factors (aligned with NSQIP), development of a risk registry for all surgical patients, and navigator assessment and communication tools.

## Current Challenges:

- **Service line onboarding**
  - SNC onboarding process has been streamlined and up to three service lines can be in the process of onboarding at a time. Our **greatest challenge** at this point is obtaining the commitment and thoughtful **sequencing of service lines** to ensure that we meet our goal of onboarding all elective surgery cases by the end of FY16 to **maximize program benefit**
- **Care Coordination**
  - Coordination of care across the continuum is a **core programmatic element** of the SNC. Engaging our whole patient, including their social risk factors is a key component to successfully preparing a patient for surgery and recovery. Requires social work/nursing coordinator within SNC

How does a health care system approach implementation of a Surgical Home model?

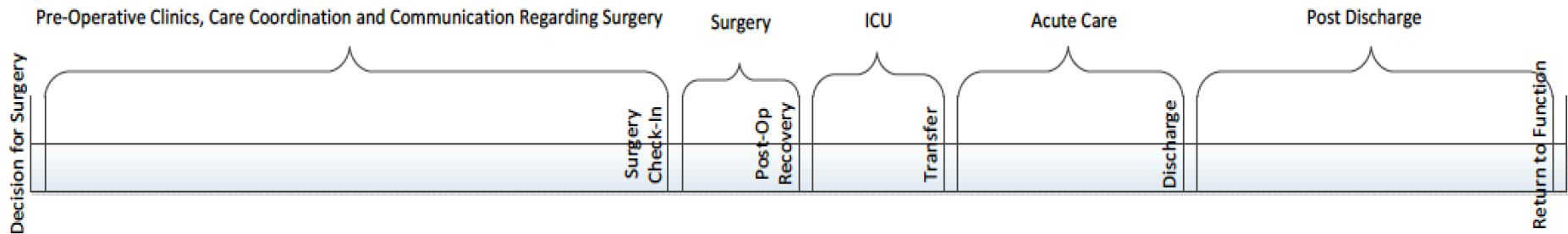


# ENHANCED PERI OPERATIVE CARE PROGRAM

**Scope:** Continuity of care from the time of decision for surgery through to patients' post-operative return to function. Pilot program focus is on spine elective surgery patients, with intent to spread across all elective surgery

**Aim:** Improve patient satisfaction and outcomes. Reduce cost of care, length of stay and complications.

**Function:** Co-Medical Directors will set strategy for interdisciplinary team involvement in the innovation and implementation of efficient & effective (patient, work and information) flows. Will guide and educate clinicians on pathway implementation processes and resources; assuring that work interconnects with other Harborview initiatives and creates no redundancies. Will spread concepts across Harborview, with intention of becoming the reference program for UW Medicine and community.



Surgery Clinic Attending	Surgery Clinic Residents/Fellows	Surgery Clinic Nurses	Surgery Clinic Patient Care Coordinators	Surgery Clinic Business Ops Supervisors	Surgery Clinic Nurse Managers	Pre-Anesthesia Clinic Attending	Pre-Anesthesia Clinic Nurses	Pre-Anesthesia/Surgery PSS's	Acute Pain Service Attending	Acute Pain Service Nurses	Medicine Operative Consult Attending	Medicine Operative Consult Residents	Medicine Operative Consult Pt. Care Specialist
ASU Nurses	ASU Nurse Manager	Surgery Attending	Surgery Residents/Fellows/PA's	Anesthesia Attending	Anesthesia Residents/Fellows	CRNA's	Anesthesia Techs	OR Nurses	OR Scrub Techs	OR Nurse Manager	OR Business Manager	Central Processing Unit	Electro-Physiology Techs
Radiology Techs	Transfusion Services	Lab Medicine	PACU Nurses	PACU Nurse Manager	Nursing Supervisors	Patient Placement Coordinators	ICU Medicine Attending	ICU Medicine Residents	ICU Surgery Attending	ICU Surgery Residents/Fellows	Surgery ARNP's	ICU Nurses	ICU Nurse Manager
Acute Care Medicine Attending	Acute Care Medicine Residents	Acute Care Surgery Attending	Acute Care Surgery Residents/Fellows	Acute Care Nurses	Acute Care Nurse Managers	Clinical Nurse Specialists	Inpatient Therapies	Nutrition Services	Respiratory Therapy	Social Work	Continuity of Care Nurses	Rehab Medicine	IT Services
				EPOC Steering Committee	Becky Pierce and Rick Goss, Executive Sponsors	Arman Dagal, MD Co-Director	Edie Shen, MD Co-Director	Grant O'Keefe, MD ERAS MD Champion	Project Facilitation & Management Team	Finance and Quality Analytic Teams			



- What elements are necessary to make the Surgical Home model successful?
- Who are the key stakeholders?

# Which elements are necessary?

1 S The Sun																	71 Lu The Moon						
2 Fs The First	3 D Dust																	8 Bc Beach	9 Sk Sea	10 Ob Oceans	11 Cl The City	12 Tv The Tower	13 Is Island
4 Dm Dream	5 Y Yacht																	14 Lz Laser	15 Pw Power	16 Ul Ultra	17 Hm Home	18 Ca Cactus	19 P Pillow
20 Ho Hole	21 Fs Fossil	22 Sh Shower	23 T Tide	24 Li Lake	25 Fn Fun	26 Sr Surreal	27 Mg Might	28 Fl Flame	29 Ai Air	30 W Whisper	31 R Rain	32 Ag Just As	33 Tf Tuff	34 Ck Clock	35 Un Unicorn	36 Fy Fairy	37 Fr Friend						
38 Cf Coffee	39 He Heaven	40 Mu Music	41 Jo Joke	42 B Bread	43 O Ocean	44 Ht Hot	45 Au Gold	46 Ma Map	47 Ft Foot	48 Ad Adventure	49 F Fame	50 Pl Planet	51 N Noodle	52 Ch Chick	53 Rb Rabbit	54 Ij Ivy	55 Sc School						
62 Bk Book	63 Co Coffee	64 Pc Pencil	65 Lk Lack	66 V Voice	67 Ec Egg	68 De Desk	69 Aa Aunt	70 Bz Bread	71 Sr Surreal	72 Ov Oval	73 Eg Egg	74 Rr Rabbit	75 Br Bread	76 Lz Laser	77 Dz Dust	78 Cz Cactus	79 Nz Noodle						
80 Za Zoo	81 Dc Dust	82 Tr Tree	83 Li Light	84 Dk Dark	85 Si Sea																		

86 Gz Gone	87 Gh Ghost	88 Do Dog	89 Kr Kite	90 Di Die	91 Su Super	92 Pa Pain	93 Sk The Sky	94 X X-ray	95 Fe Fence	96 S Shut	97 Lv Love	98 H Hub	99 M Memory
100 N The Nose	101 Dy Daisy	102 Mi Mitten	103 No Nose	104 Lf Life	105 B Bread	106 Sn Sneeze	107 Hv Haven	108 Rw Round	109 Rp Rabbit	110 Fo Forget	111 Sl Slime	112 Co Cactus	113 Sb Sneezing

## Shared Decision Making

### Risk assessment and patient empowerment



Risk Score **76**  
Of 100

## Patient Training

### Move



- Goal to increase **walking** distance each day
- Patients given a pedometer to track **progress**

### Breathe



- Incentive **spirometer** given to patients with training goals
- **Smoking cessation** resources/classes offered

### Eat



- Resources for **improving nutrition** given to patient
- Healthy **weight loss** goals

### Relax

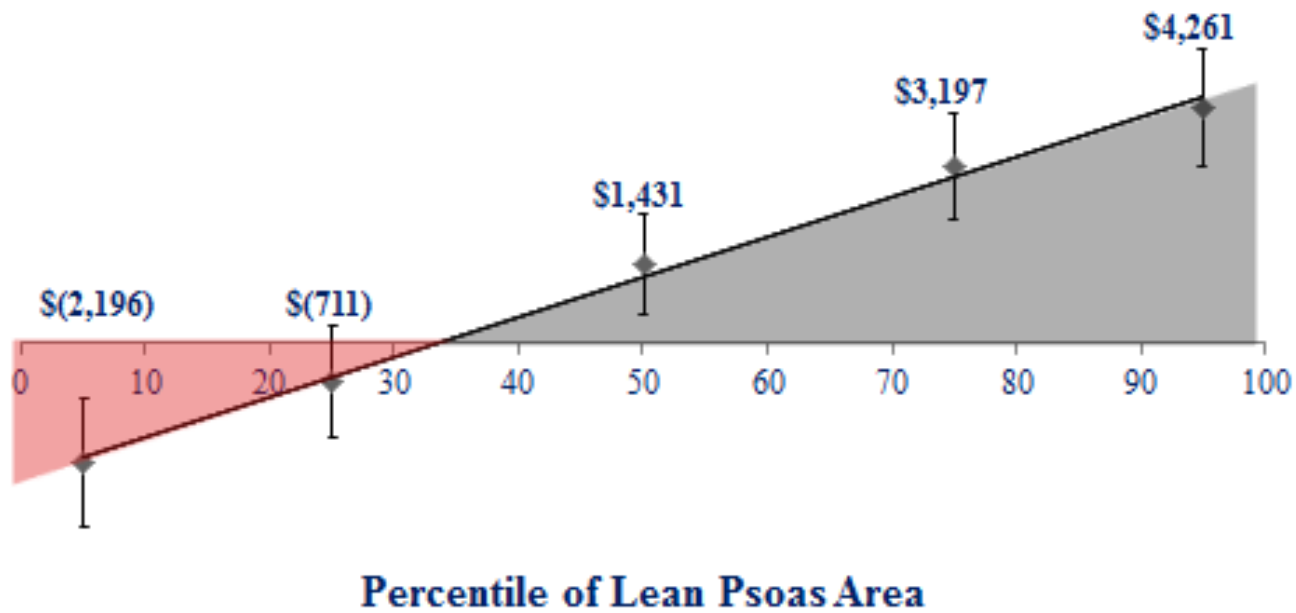


- Relaxation techniques and **sleep training**
- Resources for alternative **relaxation** classes

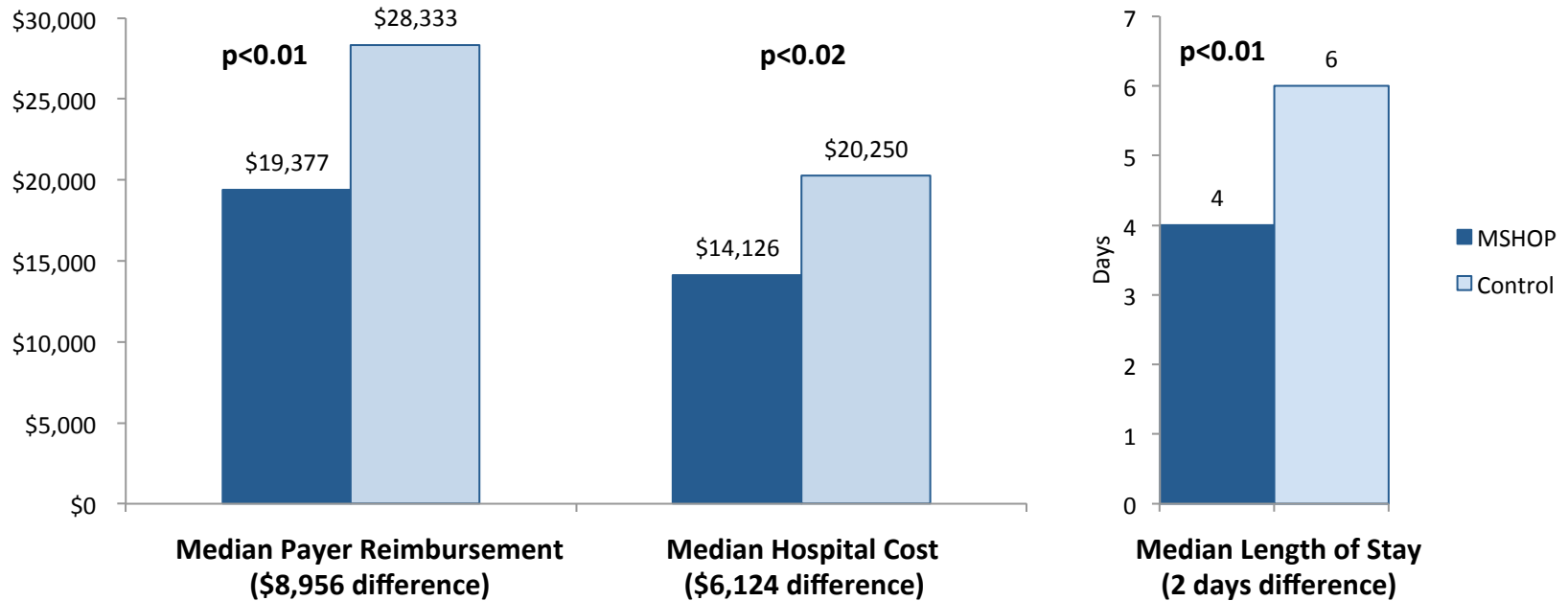
## Patient Reported Outcomes

Collect patient-specific recovery data

# Adjusted Hospital Margin

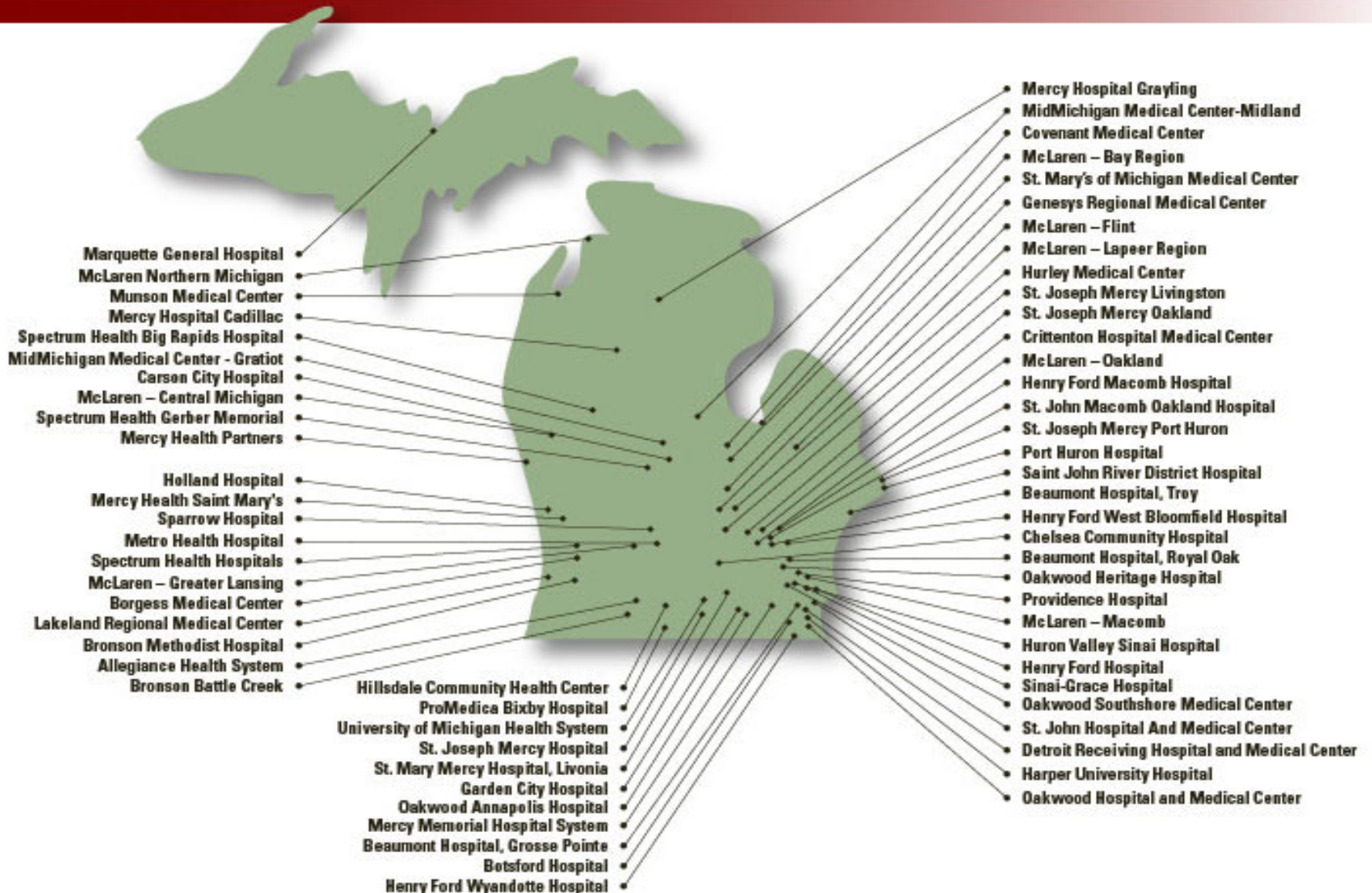


# Phase 3 Data - MSHOP



# MSQC

Michigan Surgical Quality  
Collaborative



- What are the challenges to the success of a Surgical home model?

# Getting Started Implementation



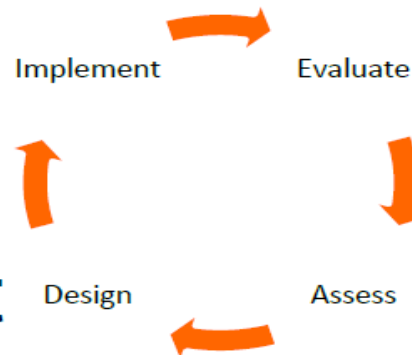
SELECTING A STRATEGIC APPROACH



GETTING INVOLVED & CONNECTED



**C**ontinuous  
**P**rocess  
**I**mprovement





# Success of a Value-based Clinical Pathway depends upon a careful implementation strategy

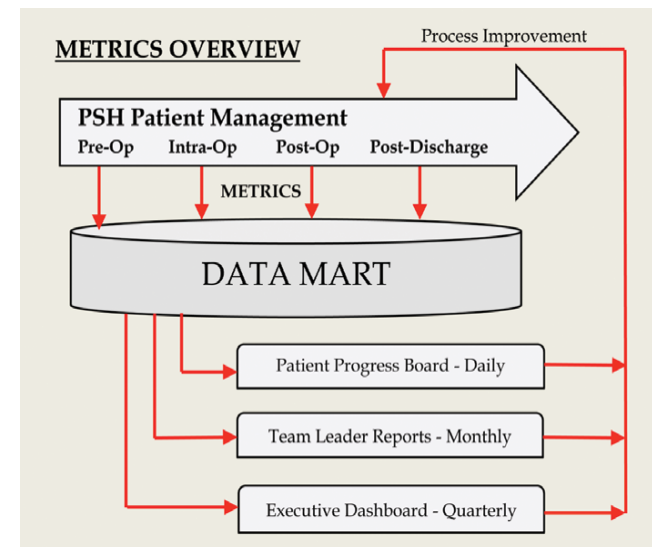
## Key Elements should include:

1. Multidisciplinary involvement
2. Communication across teams: realigning to a single goal of value
3. Real time access to best practice & newer evidence
4. Patients involvement in their own care
5. Incentives aligned to Value Agenda
6. Full transparency
7. Supportive Leadership that demands a culture of continual learning

National Academy of Sciences, IOM Wash DC: The National Academies Press 2013  
Best Care at lower cost: The Path to Continuously Learning Health Care in America

## Success of a Value-based Clinical Pathway depends upon Performance Metrics

- ✓ Clinical Process Measures
- ✓ Safety Outcome Measures
- ✓ Patient Centered Outcomes
- ✓ Internal Efficiency Process Measures
- ✓ Economic Outcome Measures



*“In order to be successful, metrics must be used to demonstrate to the hospital & third party payers the benefit of this innovative clinical framework”*

# Performance Metrics

**Table 1: Clinical Process Measures Domain – Examples**

Pre-Op	Intra-Op	Post-Op	Post-Discharge
Patient name	Cancellation within 24 hours of planned procedure	Timing of antibiotic discontinuation	Date discharge summary completed
Patient contact info	Date of surgery	Surgical site issues	Date primary care provider is contacted
Primary care provider contact info	Anesthesia team members	Lowest post-op hemoglobin level	Date of 2- to 3-day post-discharge phone call
Surgeon	Type of anesthesia	Post-op transfusion	Date of surgical follow-up visit
Date of surgical evaluation	Actual procedure	Hemoglobin at time of discharge	Date of 30-day follow-up phone call
Date of planned procedure	Thromboembolism prophylaxis	Post-op pain management methods	Post-discharge pain scores
Planned procedure	Prophylactic antibiotic agent and timing	Post-op pain scores	Post-discharge complications
Date of anesthesia evaluation	Patient warming used	PONV scores	Readmission
Patient age, weight, height, BMI	Total fluids administered	Meets ambulation benchmarks	Reason for readmission
Pre-op pain scores	Blood loss	Meets nutritional benchmarks	Mortality
Opiate tolerance	Blood products administered	In-hospital complications or issues	
Coexisting diseases		Return to O.R.	
Preop hemoglobin level	Transfer to floor/tele/ICU	Discharge date	
ASA Class			
Risk index for PONV			
Risk index for post-op pulmonary issues			
Risk index for post-op acute renal failure			
Risk index for post-op delirium			
Pre-op anemia therapy			
Nutrition education			
Physical therapy education			

The PSH: Clinical Safety, Internal Efficiency, and Economic & Patient Centered Metrics”, Schwid et al. Oct 2014 Volume 78

# Performance Metrics

## ❖ Data collected from multiple sources

- » Patient scheduling
- » Preoperative Assessment
- » Order sets
- » Drug administration records
- » Nursing flow sheets
- » Anesthesia records
- » Inpatient & outpatient progress notes
- » Patient feedback forms
- » Ideally directly from Electronic record

# Perioperative Surgical Home

- I. Coordination of care
  - II. Active participation of all stakeholders
  - III. Establishing institution specific Evidence Based Protocols
  - IV. Intraoperative management (enhanced recovery protocols, Surgery, Nursing)
  - V. Immediate postop management (PONV, Pain Control)
  - VI. Information Technology - clear documentation of effort
- ❖ Protocols will vary significantly across institutions
    - will depend on the surgical services & local environment
  - ❖ Successful models will include components of Enhanced Recovery & coordinated postoperative management



# Additional Questions

- What is the future of the surgical home model?
- How do you think surgical, anesthesiology and medical societies will be able to collaborate to produce an effective model?
- How will reimbursement models (bundled care vs. fee for service) affect the future of the surgical home?