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Practice Management

Keeping Up With the Business Side of Our Practices

The Role of Anesthesiologists in the Perioperative Surgical Home™ Model

I read with great interest the September 2012 *ASA NEWSLETTER* article "Can Anesthesiologists Survive Under Accountable Care?" by David Young, M.D. and Jeffrey Peters, M.D.[1] It is an example of a successful story of the Perioperative Surgical Home™ concept of care. They demonstrated that by driving improvements in quality, efficiency and surgeon service, anesthesiologists can make themselves indispensable to organizations focused on improving patient outcomes, controlling costs and maximizing O.R. revenue.

The Perioperative Surgical Home™ concept would more actively integrate anesthesiologists into the patient continuum by increasing their involvement in all parts of the perioperative period, including preoperative assessment, intraoperative stabilization and safeguarding of all body systems and vital organs, and postoperative optimization and pain relief.[2] By coordinating the services provided by other health care professionals in the perioperative period, the anesthesiologist also would improve communication and address system issues that frequently contribute to suboptimal outcomes.[2]

The authors[1] proved that the Perioperative Surgical Home™ model can help anesthesiologists survive under accountable care. The Perioperative Surgical Home™ helped increase surgery volume and hospital revenue under current fee-for-service payment systems. In fall 2011, the Center for Medicare & Medicaid Innovation (CMMI) introduced a bundled payment demonstration program. A bundled-payment program generally would work as follows: A group of physicians and a hospital get together, propose a lump-sum payment for some episode of care and divide the payment according to an internal formula.[3] Anesthesiologists may see substantial and undesired changes in compensation.[4]

The role of specialists in an ACO can be either as an owner, an ACO CEO, an ACO participant, a member of the ACO governing body, a senior-level medical director, or part of the physician-directed quality assurance and improvement program.[5] Therefore, the role of anesthesiologists in the Perioperative Surgical Home™ concept of care can be the same as the role of specialists in the ACO. Anesthesiologists must actively fulfill these roles and become leaders in many of these bundled payment initiatives and share in the increased payments to minimize reduction in compensation.

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References:

1. Young D, Peters J: Can Anesthesiologists survive under accountable care?" *ASA Newsl.* 2012, 76(9):40-41
2. American Society of Anesthesiologists (ASA): The Perioperative or Surgical Home: An emerging draft proposal for pilot innovation demonstration projects (May 2011).
3. Johnstone R: A new way to lose a bundle CMS innovation. *Anesthesiology News*. 2011, 37:10.
4. Cohen, Norman: Medicare accountable care organization and anesthesiology. *ASA Newsl.* 2012; 76(6):40-41
5. American gastroenterological Association (AGA): Role of specialists in the Medicare Shared Saving Program (MSSP) establishing accountable care organizations (ACOs).

MOCA® Saves a Life

Maintenance of Certification in Anesthesiology (MOCA®) has many critics who have questioned the value of simulation-based practice performance and assessment (Part IV). To those skeptics, I offer a personal account where the skills I learned during a MOCA® course saved a patient's life. I was called to a "Code Blue" and arrived to find chest compressions in progress for pulseless electrical activity (PEA). The patient had no I.V. access (despite many attempts) and we were unable to administer ACLS medications. Knowing this patient needed immediate vascular access, I obtained an intraosseous (IO) needle and placed an IO line in the tibia. I then administered epinephrine and fluid and quickly achieved a sustainable cardiac rhythm with a return of peripheral pulses.

The most interesting part of my encounter is that I had never before placed an IO line. I participated in the MOCA® course at Penn State Hershey Medical Center in 2010. As part of the curriculum, we learned the fundamentals of IO placement and had hands-on practice in a simulator. It can be very daunting to try a new procedure for the first time on a real patient, but I knew this was a "do or die" situation. The training I received in the simulation center enabled me to take that leap from simulation to "real life' with confidence.

The 2010 American Heart Association guidelines for cardiopulmonary resuscitation advocates early use of IO access if I.V. access is not obtainable. This is just one example of how our practice can change. Without my simulation training I would not have even considered placing an IO line in this patient. I believe it is critically important that we maintain and utilize educational opportunities such as MOCA® so that we can adapt with future changes that come our way.

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