Weight Management & Bariatric Surgery Clinical Focus Group

In Person Retreat

April 28, 2016

Burbank, CA

Weight Management/Bariatric Surgery CFG

Name	Title	Region
Justin Clark MD	General Surgeon	AK
Amy Myers	Director of Digestive Health	AK
Eric Becker	Providence Partners for Health Manager	CA
Mary Kingston	Chief Executive So Bay Communities	CA
Anne Lemaire	Assoc Adminstr Ops	CA
Rosanne Morrison	Regional Director Women/Childrens	CA
Philippe Quilici MD	Program Director Weight Loss/Bariatric Surgery	CA
Julie Sprengel	Chief Executive, Providence Saint Joseph Medical Center	CA
Betsy Hart RN	Chief Nursing Officer	CA
Janet Klaudt RN	RN Care Coordinator, Bariatric Surgery	MT
Andy Peasley	Manager Physician Practice	MT
Bradley Pickhardt MD	Program Director Weight Loss/Bariatric Surgery	MT
Alana Chock MD	Medical Director	NW WA
Mitesh Parikh	Vice President, Service Line Development	NW WA
Joanne Roberts MD	Chief Medical Officer, Liason to Clinical Council	NW WA
Eric Werttemberger Pharm.D	Director, Pharmacy & Digestive Health Services	NW WA
Diana Collinson	Director of Operations	OR
Mihai Onofrei Pharm.D	Manager, Population Health	OR
David Pass MD	Medical Director, Quality Providence Health Plan	OR
Robert Quinton	Executive Surgery Program	OR
Kevin Reavis MD	Surgeon, Gastroenterology and Minimally Invasive Surgery	OR
Barb Reinhardt RN	Senior Director, Physician Practice	PHC
Kasia Konieczny	Director, Oncology Service Line; Director Digestive Health	SW WA
Fina Araya	Senior Product Manager, Marketing	System - Marketing
Heather Cook	Senior Healthcare Intelligence Analyst	System - Analytics
Rich Snader	Senior Director, Chief Contract Officer	System – Payor Contracting
Jon Younger MD	Vice-President Primary Care	System-Primary Care
Jimmy Chung MD	Director, Medical Products Analysis	System-Surgery
Mike Horrigan	Program Manager Clinical Value Analysis	System: Value Analysis
Troy Hanninen	Clinical Business Intelligence Analyst	System - Analytics
Chris Bowler	Value Analysis Program Coordinator	System – Value Analysis
Geoffrey Martin	Director of Finance	System - Finance
Spenser Troiano	Senior Business Development Specialist	WWR
Marc Horton MD	Executive Medical Director, Advanced Surgical	WWR
Jennifer Misajet RN	Exec Dir Sys Periop Svcs, Administration	WWR
Brian Sung MD	Medical Director, Bariatric Surgery, Bariatric Surgeon	WWR

Agenda

Time	Topic	Speaker
10:00am	Introductions & Logistics for the day	Lynda Baxter
10:10am	Welcome/Reflection/Patient Safety Story	Julie Sprengel Chief Executive, PSJMC Dr Nick Testa Chief Medical Officer, PSJM
10:15am	Weight Management/Bariatric Surgery Overview: PSJMC, CA	Dr Philippe Quilici
10:30am	Weight Management/Bariatric Surgery Overview: PSPH, MT	Dr Brad Pickhardt
10:45am	Weight Management/Bariatric Surgery Overview: SHS, WA	Dr Brian Sung
11:00am	Weight Management/Bariatric Surgery Overview: PRMCE, WA	Dr Alana Chock Eric Werttemberger
11:15am	Weight Management/Bariatric Surgery Overview: PAMC, AK	Amy Myers
11:30am	Tour: Providence Saint Joseph Medical Center (PSJMC)	Dr Nick Testa Chief Medical Officer, PSJM
12:00pm	Working Lunch- OMADA Health presentation	Mike Payne Chief Healthcare Development
12:45pm	Introducing System QA Standards for PHS Bariatric Surgical Services	Dr Philippe Quilici Rob Quinton
1:45pm	Journey to Center of Excellence	Dave Kennedy (facilitator)
2:45pm	Wrap Up and Next Steps	Lynda Baxter, Dr Philippe Quilici Rob Quinton
3pm	**Adjourn**	

Welcome/Reflection/Patient Safety Story

Julie Sprengel
Chief Executive, PSJMC
Nick Testa MD
Chief Medical Officer, PSJMC

Weight Management/Bariatric Surgery Overview:
Providence Saint Joseph Medical Center, Burbank CA

Philippe J. Quilici, MD
Director, MIS Services

Overview agenda

SITE: Regional Service – Providence Saint Joseph Medical Center – Regional Bariatric Surgery Service

- Site profile
- Type of Procedures
- Volume & Core Data
- Effort on Resource Utilization Analytics
- Two year site plan
- Wrap up

PSJMC MIS-BS Site Profile

- **A Mature, Regional Bariatric Service for LA Area – Started in 2001 Cedars – Moved to PSJMC in 2003.**
- **Inpatient Service** with two, other affiliated in-patient services [contracting issues]:
  - **Regional** – Main Campus: PJSMC – Burbank
  - **Affiliated Services [Contracts]**: Cedars Sinai, LA and Huntington Med Center, Pasadena.
- No OP or Surgery Center. Part of our Minimally Invasive Service. Approved MIS Fellowship [Paused PSJMC site since 2013]
- Historically partnered with Affiliated Medical Programs – In 2016, fully integrated medical weight loss program.
- **Practice Environment:** Private Practice with a 38% Managed Care Group penetration.
- **Surgical Team**: 2 Surgeons, 3 Nurse Practitioners, 2 FT OP Dietician, 2 FT Psychologists
- **Center of Excellence Status**: Dual Certification SRC & ACS Since 2005 / Since 2013: ACS

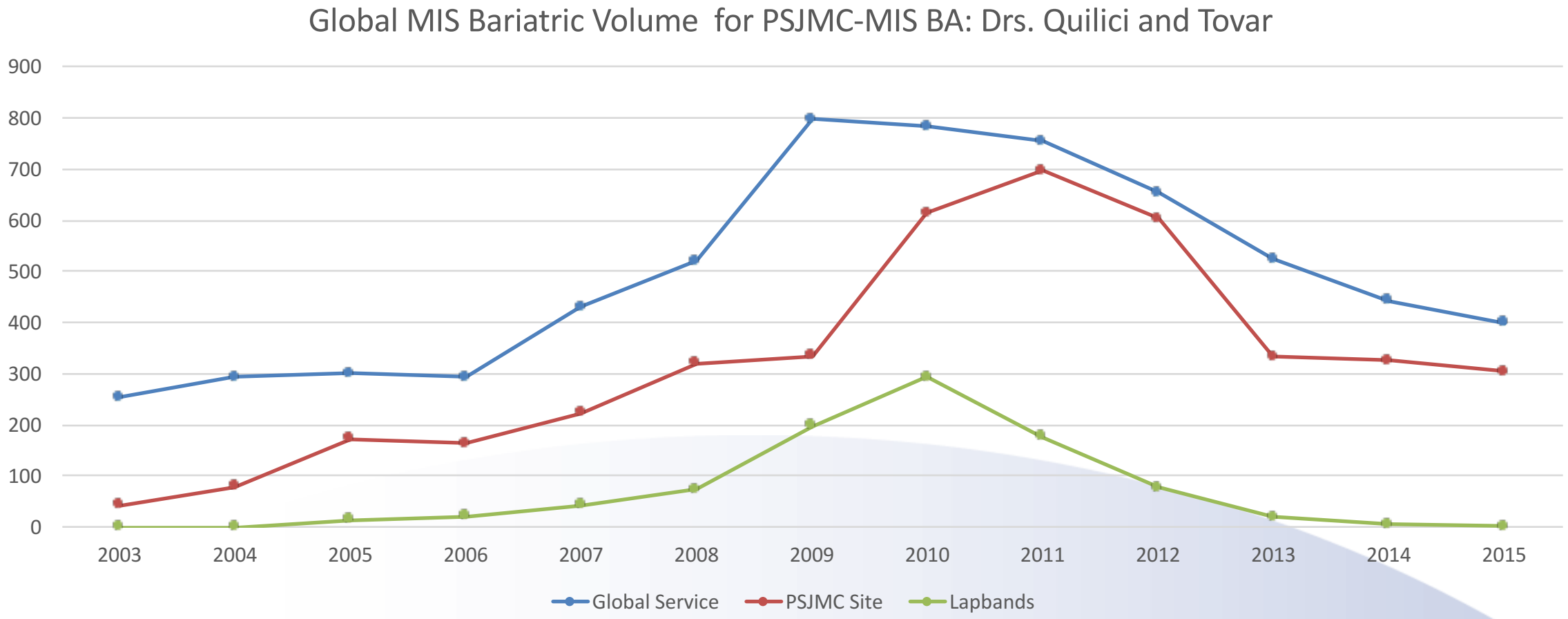
PSJMC MIS-BS Site Productivity

- Remains the busiest IP Bariatric Service in LA Area.
- Most Aggressive competitor: Marketing and Advertising supported multi-sites, free-standing surgery centers [1-800LAPBAND/ WestMedical, etc.]
- Damaged by Lack of Marketing & Advertising

Types of Procedures

- **Laparoscopic Procedures are 100% of our volume**: Conversion Rate has been 0% since 2004.
- **Robotic**: Discontinued in 2015 – High Costs without Performance Improvement / Assessing experimental, Robotic Technology in June 16.
- **Referred Revisional Bariatric Procedures:** 14% [2016 Est 17%]
- **Center Type:** Regional Center – Comprehensive – Full Care / Inpatient Centers / No Transfer OUT – Transfer IN ONLY.
- Currently NO Outpatient Centers. Part of our future strategy.
- **Pricing Format in place for 5 years**: Bundled, Integrated, FFS.

Historical Global Bariatric Case Volume - Snapshot



Core STATS: Rev. Sg14% - GABMI: 47 [35-73] – GAORT: 34 - Mort 0% - ReAd 2% - ReExp 1.4% - RUo/eT:0.86 – Ruo/eG:0.54

Morbidity Summary / Analytics / Yr. 2013-2014-2015

Morbidity Event	2015	2014	2013
Mortality	0	0	0
Event [356T]: Re-Exploration / 30 from Index Procedure	5	5	6
• I A Bleeding	3 [R1]	4 [R2]	2 [R1]
• Ischemic Tip Gastric Pouch on Vband Conversion	1 [R]		
• I A Abscess – LGRBY / Sleeve	1 [R]		2 [1R]
• Conversion to LGBRY From Revisional Sleeve		1 [R]	
• Post Band removal > LGBRY with IA Abscess			1 [R]
• Band Surgery – N/V			1
ThromboEmbolic Event - DVT	0	0*	1
Global Average OR Time - Minutes	35	34	36

Morbidity Summary / Analytics / Yr. 2013-2014-2015

Morbidity Event	2015	2014	2013
Mortality	0	0	0
Event [35R]: Re-Admissions / 30 from Index Procedure / Include Re-Explorations / Other Dx	8	4	6
Raw Rate	2	1.8	1.1
• Dehydration	1	1	2
• TBEE: DVT			1
• TBEE: Portal vein thrombosis		1 [R-AO]	
• Wound Infection – Port Site	1 [R]		1 [R]
• Abdominal Pain – No Etiology	1	2	1
• GI –Bleed Iatrogenic –[AC started by PMD]	1 [R]	0	1
• Abdominal Wall Hematoma	1 [R]		

Resource Utilization Analytics

- **Current Resource utilization analysis**: Tracking CPE and CPE-D
  - TransMed, an in-house Certified EHR-Outcome Engine system tracking costs through the continuum of care. Looking at EPIC.
- **Developing and Deploying**: IT Innovative, Partnership with Medtronic.

Two years site plan

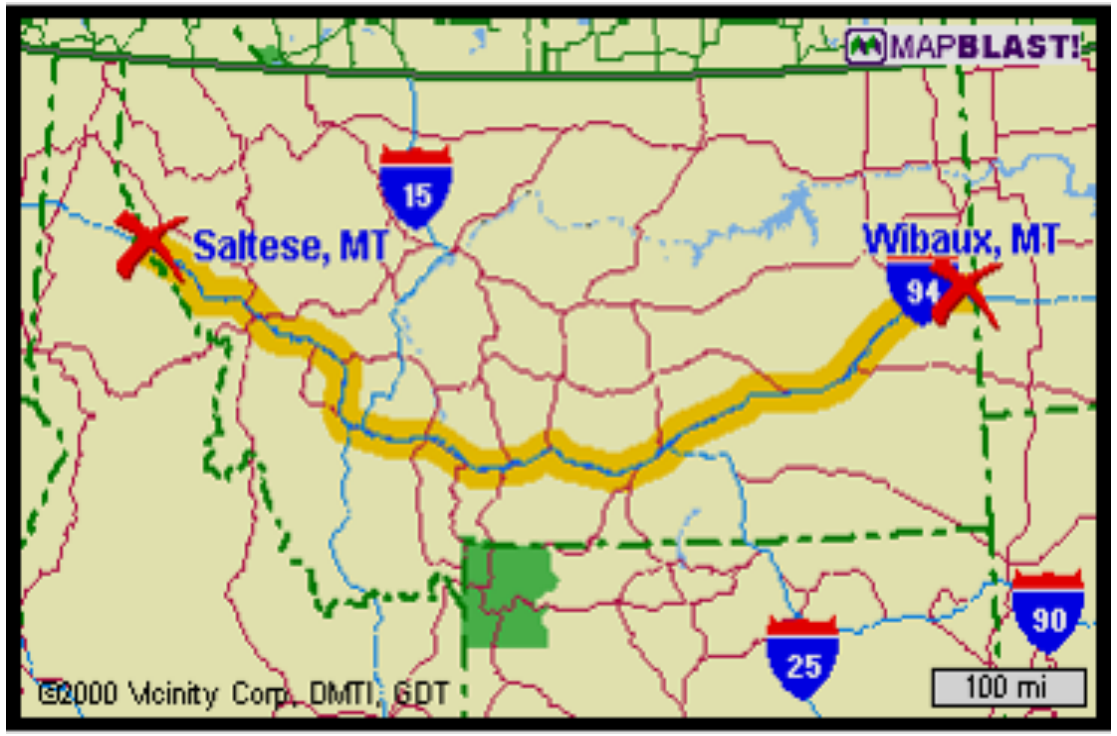
- **Procedural outlook**
  - Local Growth impaired – damaged by aggressive marketing by surgery center-based surgical groups. Severe lack of marketing funds.
  - Adjustable Banding procedures vanishing.
  - Contract driven outlook
- **Quality initiatives**
  - All newer quality initiatives are driven by “Strict Standardization” and “Cost Savings”.
- **Expansion**
  - Expanding our Medical Weight Loss Program & Outreach.
  - No Structural Expansion: Facility is 1000 cases/yr capable.

Questions, Feedback & Web-platform

Weight Management/Bariatric Surgery Overview:
Providence Saint Patrick Hospital, Missoula MT

John Bradley Pickhardt, M.D., F.A.C.S.

Medical Director Bariatric Services



Bring Snacks

Driving distance across Montana is about the same as the distance from Washington,D.C. to Atlanta, GA

Overview agenda

Providence Saint Patrick Hospital Bariatric Services

- Site profile
- Validated site data
- Quality data
- Miscellaneous
- Two year site plan
- Wrap up

Site Profile

- Location type: Inpatient
- Practice type: Employed staff, surgeons
- # of surgeons: 2
- Medical program: No medical weight loss program
- Surgical program only
- COE: No

Site profile, continued

- Patient demographics:
  - 2009-present 78% Insurance /18% Cash Pay / 4% Medicare
  - 81% Female / 19% Male
  - 22% in their 40's / 33% in their 50's / 25% in their 60's
- Nearest competition:
  - St Vincent Healthcare, Billings, Montana (343 miles east of Missoula)
    - Services offered: MBSAQIP designation, Roux en Y, Sleeve Gastrectomy, Medical Weight Management, Pediatric Weight Management.
    - # of surgeons: 3
  - Billings Clinic, Billings, Montana
    - Services offered: Roux en Y, Sleeve Gastrectomy
    - # of surgeons: 2

Validated site data

- Volumes: over 1200 surgeries since 1999, 422 total patients from 01/01/2007 (includes Lap Bands)
- LOS: 2015 = 1.4 days
- Re-admissions:
  - Sleeve Gastrectomy 2%
  - Roux 3.9%
- Re-exploratory volume and accompanying indications:
  - Sleeve gastrectomy: 0%
  - Roux: Internal Hernia Repair 1.5%
  - Evacuation of abd hematoma 0.5%
- Mortality: One patient death in program history (Since 1999)

Quality data

- Procedure types performed:
  - Open: no
  - Laparoscopic: all primary cases
  - Robotic: not currently
  - Volumes: 422 surgeries since 2007, 41 in 2015.
- Where performed:
  - Inpatient
- Outcomes
  - Roux: Avg preop BMI 46, 2 year post op BMI 29.7 and avg 70% EWL
  - Sleeve Gastrectomy: Current data: 61% EWL at 1 year. No long term data available

Miscellaneous

- Resource utilization and cost per case: unable to obtain cost per case
- Bundle Pricing with 30 day warranty
- What resources is this site utilizing? – Dedicated staff: Practice Manager, 2 part time Patient Service Rep's and 1 full time Certified Bariatric Registered Nurse
- Opportunities for collaboration: Providence Medical Group Endocrinology
- Surgeon feedback:
  - Obstacles, most difficult local issue
    - Local and state payers not covering (BCBS), Medicaid
  - Opportunities, wish list:
    - Non-surgical weight management
    - Dedicated dietician (working with Endocrinology to make this happen)
    - Medicaid reimbursement

Two year site plan

- Procedural outlook
  - Growth: 20 surgeries 2014, 42 surgeries in 2015, on track to exceed for 2016
  - Referrals – Strong referral base established, insurance coverage is the limitation.
- Quality initiatives
  - Improvement – High Reliability Organization. CMS Inpatient Quality Reporting programs, Value-based purchasing, Readmission Reduction programs, Hospital-Acquired Condition Reduction program, NHSN (CDC) registries.
- Expansion
  - Services – Collaboration with Endocrinology for a non-surgical weight loss program
  - Facility – Providence Medical Group Bariatric Services is an ambulatory clinic. There are no plans for expansion on the facility side of the hospital, however, we will require system/facility assistance in order to qualify for MBSAQIP

Wrap up

- Questions?
- Feedback
- WWW & next steps

Weight Management/Bariatric Surgery Overview:
Swedish Weight Loss, Seattle WA

Brian Sung, MD
Medical Director, Bariatric Surgery

SWEDISH
DIGESTIVE HEALTH
NETWORK

PROVIDENCE
Health & Services

Overview agenda
Swedish Weight Loss

- Site profile
- Validated site data
- Quality data
- Miscellaneous
- Two year site plan
- Wrap up

SWEDISH
DIGESTIVE HEALTH
NETWORK

PROVIDENCE
Health & Services

Program Overview – Swedish Weight Loss

Comprehensive MBSAQIP Center of Excellence

Weight Loss Physician Team (Employed)

Dr. Brian Sung, Med. Dir, Bariatric Surgery
Dr. Judy Chen, Bariatric Surgeon
Dr. Richard Lindquist, Med Dir, Weight Loss

Weight Loss Provider Team (Employed)

PA, ARNP, PsyD, ABPP,
RN, MSW, RD

SWEDISH DIGESTIVE HEALTH NETWORK

PROVIDENCE Health & Services

Site profile, continued

- Patient demographics (2015 First Hill):
  - Avg Inpt. BMI: 44
  - Avg Inpt. Age: 51
  - Inpt. Gender: 81% Female, 19% Male
- Nearest competition:

	CHI Franciscan St. Joseph	Overlake	University of Washington	Virginia Mason	Seattle Weight Loss	Eviva (PS Bariatrics)
# Surgeons	3	1	2	4	1	5
Surgical Services & Procedures	Band, Sleeve, Bypass, Switch	Band, Sleeve, Bypass	Band, Sleeve, Bypass	Band, Sleeve, Bypass, Balloon	Band, Sleeve, Bypass, Overstitch, Balloon	Band, Sleeve, Bypass, Balloon, vBloc

2015 Site Data

- Volumes (FH & Issaquah):

Bypass	Lap Band	Sleeve	Other	Total
187	9	144	41	381

- Average LOS: <2
- Re-admissions: 2.2%, 0.37 O/E
- Re-operative/Revision: 12 (Includes non-Swedish index cases)
- Mortality: 0

Quality data

- Procedure types performed:

Laparoscopic	Open	Robotics
>99%	<1%	N/A

- 2015 Volumes (First Hill & Issaquah):

Bypass	Lap Band	Sleeve	Other	Total
187	9	144	41	381

- Where performed?
  - IP: 93%
  - OP: 7%

Miscellaneous

- Resource utilization and cost per case:
  - Insights costing tool available spring/summer 2016

- What resources is this site utilizing?
  - Clinical staff: PA, ARNP, PsyD, ABPP, RN, MSW, RD
  - Office/Program staff: Ops Director, Supervisor, Pt. Coordinators (front desk/schedule/referrals), MBSAQIP Program Coord., MBSAQIP Registry Coord.
  - System: Quality, Marketing/Communication, Strategy/Business Development, Periop. Operations, Endoscopy, Finance, IS, etc.

- Surgeon feedback:
  - PHP: outdated criteria for Bariatric surgery candidacy
  - Increased system marketing resources

SWEDISH
DIGESTIVE HEALTH
NETWORK

Two year site plan

PROVIDENCE
Health & Services

Program Expansion

- Recruiting 3rd surgeon
- New clinics open fall 2016
- Issaquah COE accreditation
- Services: Balloon systems, overstitch

Procedural Outlook

- 20% procedure growth forecasted over 5 years
- Referral growth from Healthy Planet and collaboration opportunities
- Bundles

Collaboration Initiatives

- Swedish Digestive Health Network
- Primary Care
- Endocrinology & Diabetes
- Gynecology
- Multicultural team

Quality Initiatives

- Clinical pathway updates
- Cost & Resource utilization
  - Selective Endoscopy
  - Gastroscope utilization
  - Selective Labs

SWEDISH
DIGESTIVE HEALTH
NETWORK

PROVIDENCE
Health & Services

Wrap up

- Questions?
- Feedback
- WWW & next steps

Weight Management/Bariatric Surgery Overview:
Providence Regional Medical Center, Everett, Everett WA

Alana Chock, MD, FACS
Bariatrics Medical Director
Eric Werttemberger, PharmD
Digestive Health Service Line Director

Overview agenda
Providence Regional Medical Center Everett

- Site profile
- Validated site data
- Quality data
- Miscellaneous
- Two year site plan
- Wrap up

Site Profile

- Location type: IP & Physician Owned ASC
- Practice type: Aligned
- # of surgeons: 3
- Medical program: Yes at ASC
- Surgical program: Yes at Hospital and ASC
- COE: Hospital Current Accredited as Low Acuity Center

Site profile, continued

- Patient demographics: By Zip
- Nearest competition:

		Services	
	Surgeons	Surgery	Medical
I. ASCs			
Puget Sound Bariatric Center (Eviva)	5	X	X
II. Accredited Hospitals			
Facility Name			
Swedish Medical Center	2	X	X
Northwest Weight Loss Surgery	3	X	X
Overlake Hospital Medical Center	2	X	X
Evergreen Hospital	9*	X	X
Virginia Mason Medical Center	3	X	X
University of Washington Medical Center	2	X	X

Patient Demographics – By Zip

Validated site data

- Volumes: 73
- LOS: 25 hrs
- Re-admissions: TBD
- Re-exploratory volume and accompanying indications: None
- Mortality: None

Volumes

Type Surgery	Hosp Admit 2015 Jan	Q1 Feb	Mar	Apr	Q2 May	Jun	Jul	Q3 Aug	Sep	Oct	Q4 Nov	Dec	Grand Total
LAPAROSCOPIC GASTRIC BAND REMOVAL	1						1	2		1	1		6
LAPAROSCOPIC GASTRIC BANDING							1						1
LAPAROSCOPIC GASTRIC BYPASS/GASTRECTOMY		1			1		1		1				4
LAPAROSCOPIC SLEEVE GASTRECTOMY	2		2	1	1	3		2	3	4	3	5	26
ROBOTIC ASSISTED XI ROUX-EN-Y					1	1			1	1			4
ROBOTIC ASSISTED XI SLEEVE GASTRECTOMY		1	3		1	2	5		7	2	2	6	29

LOS Breakdown

Prim Surg..		Hosp Admit 2015 Q1	Q2	Q3	Q4
Provider #1	# of Pts	6 pts	5 pts	11 pts	12 pts
	Median MD_OR_Time_Min	74 mins	108 mins	95 mins	92 mins
	Avg. MD_OR_Time_Min	72.3 mins	124.0 mins	104.2 mins	110.3 mins
	In - Out Room Avg	2.0	3.0	2.4	2.5
	Out Room - Disch (hrs) Median	26.5 hrs	23.0 hrs	26.0 hrs	27.0 hrs
	Overall LOS Average	29.5 hrs	25.8 hrs	31.5 hrs	41.6 hrs
	Overall LOS Median	30.5 hrs	30.0 hrs	30.0 hrs	31.0 hrs
Provider #2	# of Pts	3 pts	7 pts	12 pts	12 pts
	Median MD_OR_Time_Min	74 mins	91 mins	118 mins	60 mins
	Avg. MD_OR_Time_Min	81.7 mins	138.7 mins	141.8 mins	67.1 mins
	In - Out Room Avg	2.0	3.0	3.1	1.8
	Out Room - Disch (hrs) Median	27.0 hrs	29.0 hrs	29.5 hrs	24.0 hrs
	Overall LOS Average	31.3 hrs	84.7 hrs	46.7 hrs	24.9 hrs
	Overall LOS Median	31.0 hrs	33.0 hrs	33.5 hrs	28.0 hrs
Provider #3	# of Pts	2 pts	1 pts	1 pts	1 pts
	Median MD_OR_Time_Min	138 mins	66 mins	116 mins	231 mins
	Avg. MD_OR_Time_Min	137.5 mins	66.0 mins	116.0 mins	231.0 mins
	In - Out Room Avg	3.0	2.0	2.0	5.0
	Out Room - Disch (hrs) Median	57.0 hrs	27.0 hrs	3.0 hrs	18.0 hrs
	Overall LOS Average	62.0 hrs	31.0 hrs	9.0 hrs	27.0 hrs
	Overall LOS Median	62.0 hrs	31.0 hrs	9.0 hrs	27.0 hrs

Quality data

- Procedure types performed:
  - Open - Usually Emergent Admits
  - Laparoscopic - 1 Surgeon
  - Robotic – 2 Surgeons
- Volumes 73 in 2015
- Where performed? Hospital Data Only

Miscellaneous

- Resource utilization and cost per case (tracked in Burbank, should also be tracked System-wide?) – Not pursued yet
- What resources is this site utilizing? NA
- Opportunities for collaboration – Exploring Stronger ASC/Hospital Alignment
- Surgeon feedback:
  - Obstacles: Room Turnover
  - Opportunities: Volume Growth, Other Specialty Referral

Two year site plan

- Procedural outlook
  - Growth: Goal 90-100 Cases 2016
  - Referrals: Growth from Specialties, Primary Care
- Quality initiatives
  - Improvement: Diet Order Coordination
  - New metrics: IR Advance Procedure Collaboration
- Expansion
  - Services: No plans at this time
  - Facility: None

Wrap up

- Questions?
- Feedback
- WWW & next steps

Weight Management/Bariatric Surgery Overview:
Providence Alaska Medical Center, Anchorage, AK

Amy Meyers

Director of Digestive Health, PAMC

Overview for PAMC

- Site profile
- Validated site data
- Quality data
- Miscellaneous
- Two year site plan
- Wrap up

PAMC Site Profile

- Location type- Inpatient services for bariatric surgery and outpatient services to be provided. Current OP is from independent MD
- Practice type- Two independent physicians credentialed and privileged
- # of surgeons- None at PAMC
- Medical program- Inpatient services, outpatient family medicine. One MD has a medical program in office.
- Surgical program only- Yes
- COE- Pursuing *(designated in past)*

PAMC Site Profile Cont.

- Patient demographics:
  - Age 20-40 at 40%; 40-60 at 50 %; 60 + at 10%
  - Sex Females 91 % Males 9 %
  - BMI 45.38
- Nearest competition:
  - Alaska Regional Hospital – IP Services
  - Alaska Native Medical Center – IP Services
  - # of surgeons - 2

PAMC Validated Site Data

- Volumes to increase last quarter 2016
- LOS was not calculated
- No re-admissions noted
- Re-exploratory volume and accompanying indications are prevalent in the population that have had bariatric surgery outside the US
- No mortality found for 2015 at PAMC

PAMC Quality Data

- Procedure types performed:
  - Open 5
  - Laparoscopic 30
  - Robotic- XI SI (To be utilized by new physicians coming to AK)
- Volumes lower currently due to competing hospital
- Number of surgeries- 35 total 35 AM Admit as inpatients
- Outcomes- No readmissions or complications at PAMC 2015
- Pathways- One post op order-set. Will need updated.

PAMC Miscellaneous Information

- Resource utilization and cost per case is not currently being tracked. Track supplies and medications (ie.16,101.77)
- Resources utilized- Staff, equipment, & supplies
- Opportunities for collaboration are in the near future. Gaining 2 bariatric surgeons that are opening up a practice in AK
- Surgeon feedback:
  - Patient compliance is challenged without a consistent way to offer support throughout the continuum of care, Physician participation limited but future opportunities exist

PAMC's Two Year Site Plan

- Procedural outlook
  - Build a strong bariatric program starting in June 2016 with a Bariatric Medical Director to lead. Work in collaboration with 2 physicians for care throughout the continuum
  - Start certification* process first quarter 2017 (CBC)
- Quality initiatives
  - Decrease complications from surgery that originated at PAMC
  - Patient compliance post operatively (Providing the support needed)
- Expansion
  - Increase bariatric surgical & procedural volumes for IP/OP
  - Increasing bariatric support (structural, OP services, community)

PAMC Bariatric Service Line Director Contact:

- Please contact Amy Myers with questions and feedback

  907-212-3138

  Amy.myers@providence.org

- http://alaska.providence.org/locations/p/pamc

  **Bariatric site currently under construction*

Tour: Providence Saint Joseph Medical Center

Dr Nick Testa

Chief Medical Officer, PSJMC

OMADA Presentation

Working Lunch

Mike Payne, Chief Healthcare Development

Introducing System QA Standards for PHS Bariatric Surgical Services

Philippe Quilici MD
Program Director Weight Loss/Bariatric Surgery
Rob Quinton
Executive Surgery Program

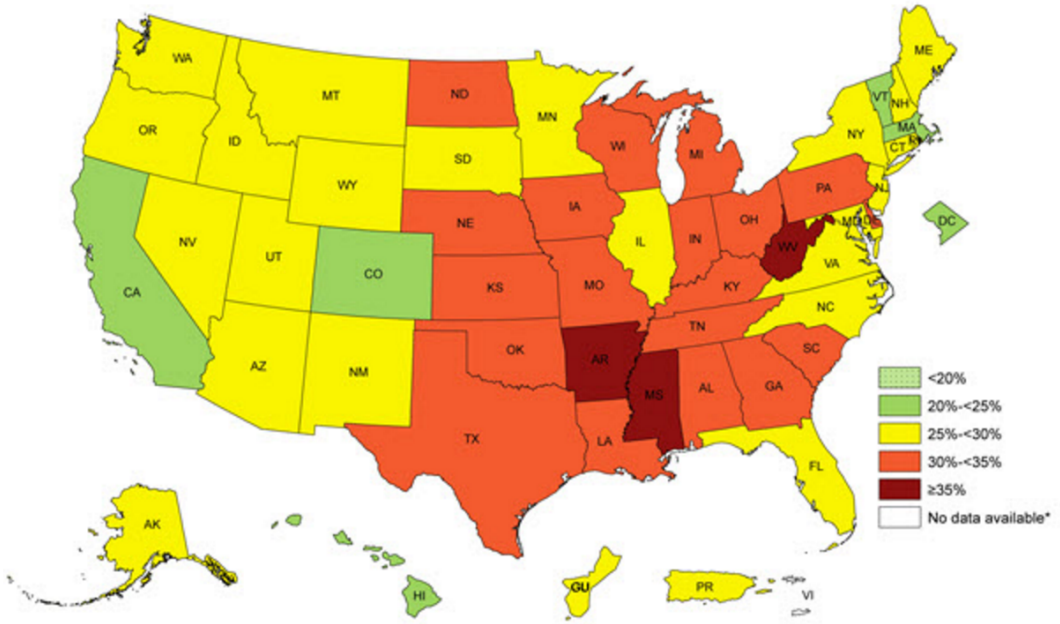
Overview agenda

- Mission
- Market
- Coding
- Standards of Performance
- Clinical Pathways
- Questions

"American Health care is a platform subject to the business pressures of well-run, for-profit corporate entities. To be sustainable, Health Care must become, function and behave as a true, accountable business entity… to do so, it must generate, understand and control its performance and productivity data."

Laurence Fink, CEO, Blackrock, A Multi-national Investment Company

Understanding the US and our Market



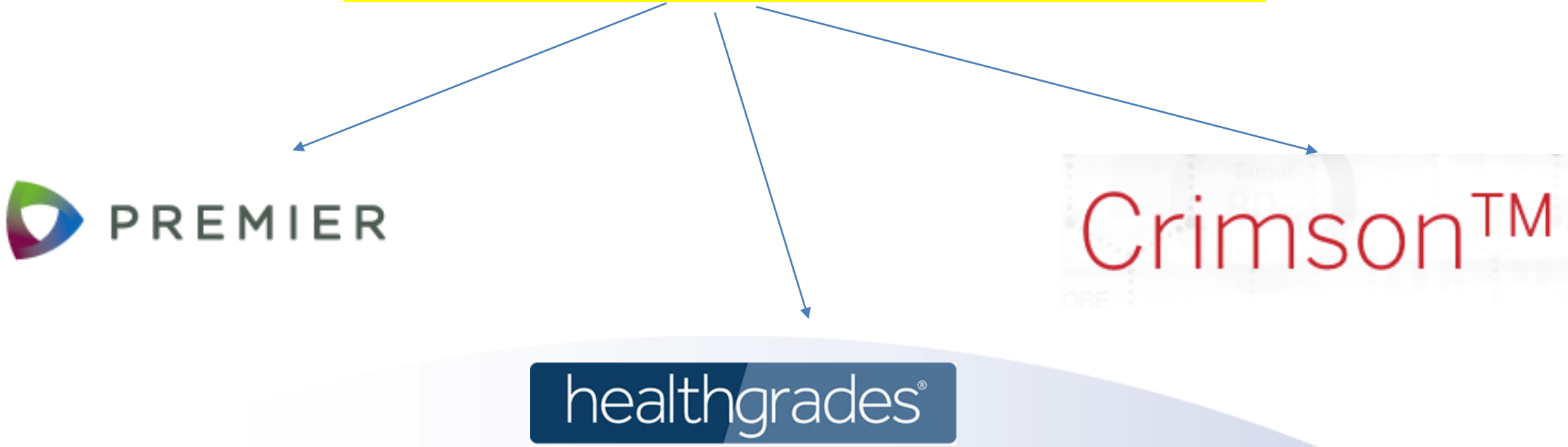
- > 60% of US overweight.
- 35,7% BMI > 30
- 6.7% BMI > 40
- Medical and self-promoted weight loss regimen: 97% failure rate.
- Surgical weight loss management continues to be the best management.

Why should we accumulate Performance Data?

1. Monitoring Quality essential in Health Population Management Environment.
2. Delivering Universal Quality of Care across our network of medical centers.
3. Performance Data is the best marketing tool.
4. Resource Utilization Analytics is the path to Sustainability in Heath Care and Health System's fiscal fitness.
5. Performance Data must include Patient Satisfaction Analytics.
6. An evolving Pay for Performance Landscape.

Knowing the Current Analytics Environment

A WORLD OF CLAIM-BASED DATABASES AND ANALYTICS



Learning from our Past Mistakes: the Power of Data

- 2001 Need of Data Collection System – Repository
- 2003 TransMed Deployed
- 2006 HealthGrades begins rating Bariatric Services / Not the results we expected.
- 2007 Learned and Master Claim-based Analytics
- 2008 HealthGrades published non-concordant rating
- Using our production data, demonstrated Healthgrades analytics were flawed.
- HealthGrades suspends reports – Ask us to re-craft their analytics
- Since then ranked top Bariatric Service.
- In CA – OSHPD removed gender and certain ID in datasets – Rating for bariatric services suspended in 2015.

The Value of Real Time Quality Data

- Certified Services enter data into ACS Database which will give comp. data with other certified services.
- ACS – So called SAR [reports] are delayed a year later. Last SAR released April 20, 2016 reports from 7.2014 to 6.2015 and analyses 127,514 patients or records.
- Real time quality data [60 days post Index Procedure] across the system will help monitor our clinical and fiscal production more efficiently.
- Benchmark quality data is needed.

Learn, Know & Master the Coding of your Bariatric e-claims

Essential ICD10 & CPT Codes [Weight Order]

- Always AUDIT the code inserted in your procedural e-claim.
- Bariatric Revision or Previous Bariatric Procedure – include ICD10: **Bariatric Status Z98.84.**
- BMI entry by ICD10 – enter in your diagnosis list for your electronic claim [Ex: ICD10 CODE: **Z68.36** Body mass index (BMI) 36.0-36.9, adult].
- **BMI is essential in Medicare/CMS claim**: Omission = Rejection. Use BMI with listing of at least 1 Co-morbid condition if BMI<40.
- **Co-morbidities**: Include them on admission as ICD 10 codes.
- **Post-op Management**: Clearly identify your indications for any Non-Routine studies or Procedures. [Ex: CXR ordered for R/o Pneumothorax > ends up with Complication: Pneumothorax].
- **Re-admission:** Inpatient vs Observation vs Day Admission: Use carefully.

Core Quality Data Set for PSJMC Bariatric Services

Core Set 1: General Patient Data Accumulation	Notes
Demographic Area	By address / ZIP
Referring Source	Self / PMD / Insurance / etc.
Gender	
Weight + Weight	
BMI Pre-op	
Major Co-Morbid Conditions: Diabetes, HTN, CAD, etc	Enforce ICD10 coding
Pre-op Education classes	Length of classes / Mandated?
Patient Satisfaction Data [Press Ganey]	Must decide on a new method

Procedural Data Set

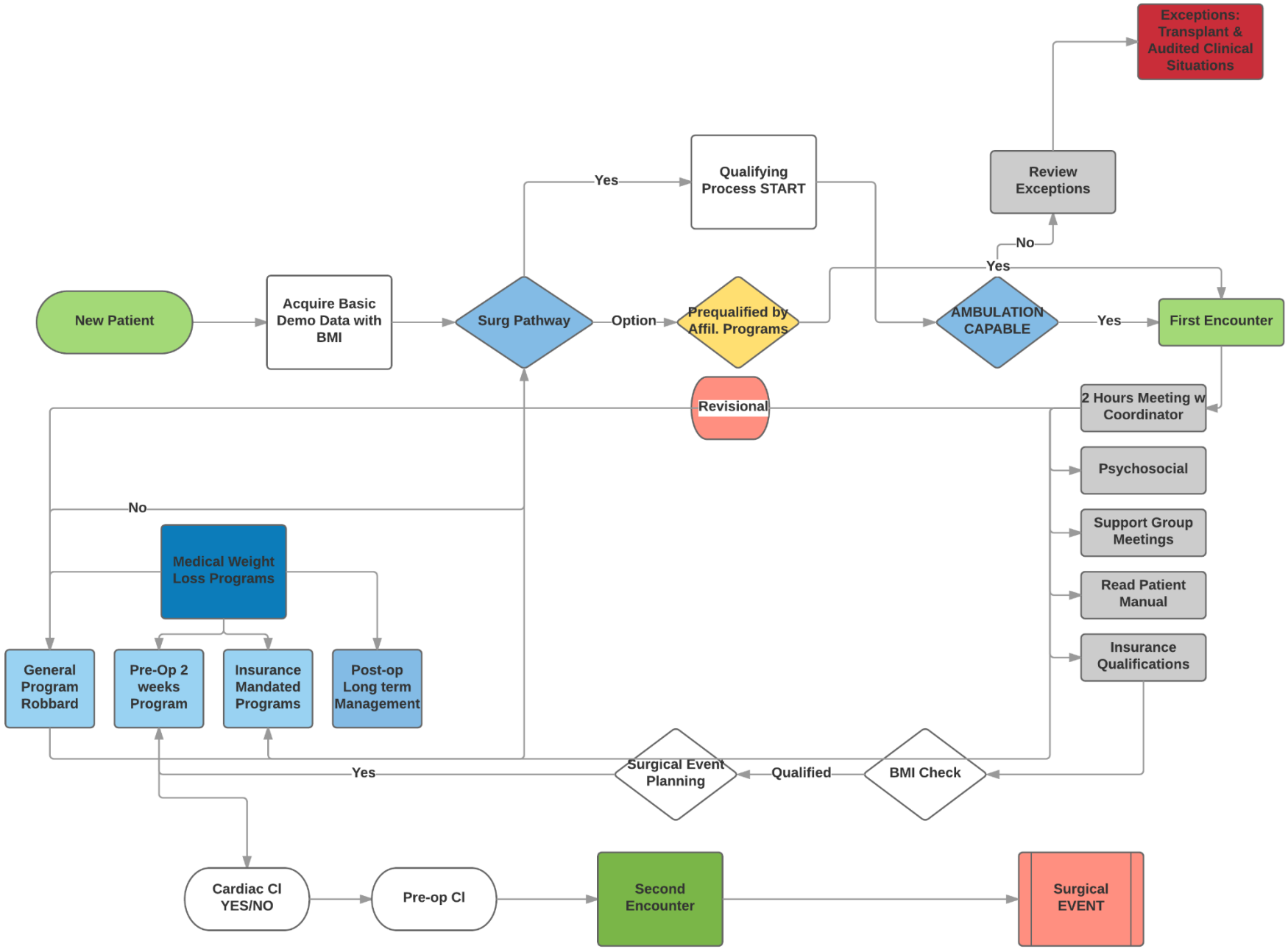
Core Set 3: Procedural Data Set	Details
Procedure Type	CPT-ICD
A1 C Pre-op for diabetic patients	LOINC
Previous Major TBEE	Manual
IVC Filter Pre-op	Manual
Previous Bariatric Procedure	ICD10
Length of Stay	Days / Hours
Operating Time	From EPIC - TM
Re-exploration	CPT – ALL SITES - CB
Re-exploration Indication - Findings	ICD10
Re-admission	Obs/InPatient/Day – ALL SITES - CB
Re-admission Indication-Findings	ICD10
Weight - BMI Serial	Merge with Remote Patient Entry

Resource Utilization Data Set

Core Set 5: RU Data Set	Details
Procedure Type	CPT-ICD
OR Time	Time / Prod.
In OR EndoMechanical / Disp / Implant Cost	Epic
LOS / Hour	Hours
LOS / Unit Stay BD	Epic
CPE [Cost per Event]	Calculated
CPE-D [Cost per Clinical Diagnosis]	Multi-databases Calculation

The Need for Clinical Pathways

- **A Must for ACS Certification**
- **A Must for standardization protocols across the system and enhancing outcomes.**
  - For All Primary Bariatric Index Procedures
  - For All Revisional Bariatric Index Procedures
  - Point of Entry
  - Post-op Management


Exceptions: Transplant & Audited Clinical Situations
Review Exceptions
Yes
Qualifying Process START
No
Yes
New Patient
Acquire Basic Demo Data with BMI
Surg Pathway
Option
Prequalified by Affil. Programs
AMBULATION CAPABLE
Yes
First Encounter
Revisional
2 Hours Meeting w Coordinator
Psychosocial
Support Group Meetings
Read Patient Manual
Insurance Qualifications
No
Medical Weight Loss Programs
General Program Robbard
Pre-Op 2 weeks Program
Insurance Mandated Programs
Post-op Long term Management
Yes
Surgical Event Planning
Qualified
BMI Check
Cardiac Cl YES/NO
Pre-op Cl
Second Encounter
Surgical EVENT

PROVIDENCE Health & Services

PSJMC CLINICAL PATHWAY: LAPAROSCOPIC GASTRIC BYPASS Updated: 12/2015 [Quilici-Tovar]

Date	Day of Admit/Surgery- SAU	Day of Surgery -PACU	Day of Surgery- Bariatric Unit POTENTIAL DISCHARGE	POD #1 DISCHARGE	POD #2 DISCHARGE
Assessments	Adult Admission History & Assessment Pre-Op Checklist Baseline VS, O2 Sat, pain score	VS per PACU routine Pain assessment/management I&O	VS q 1h x4, q4h x24 Assess for pain and nausea per routine orders I&O - Straight cath prn Notify MD for ↑ Temp, unmanaged N/V, pain, ↑ BP and Pulse per MD parameters Check drain and Op sites Qshift ASSESS DISCHARGE STATUS	VS routine Assess pain and nausea per routine orders Straight cath prn Notify MD for ↑Temp, unmanaged N/V, pain, ↑ BP and pulse per MD parameters Check drain and Op sites Qshift	VS routine Assess pain and nausea per routine orders
Tests	Accucheck if diabetic –contact surgeon if blood sugar abnormal	Accucheck if diabetic –contact anesthesia if BG <80 or >200 CBC w diff/ BMP	Obtain MD order for insulin sliding scale if diabetic	Obtain MD order for insulin sliding scale if diabetic, CBC,CMP	Obtain MD order for insulin sliding scale if diabetic
Consults	If CPAP or BiPAP indicated: RT to set-up post op Pt may use own CPAP or BiPAP as per RT policy	If CPAP or BiPAP is indicated: RT to set-up Pt may use own CPAP or BiPAP as per RT policy	Psych, Social Worker, Wound Care consults prn RT, PT, OT, Dietitian per MD order Eval to inpatient nutrition	Psych, Social Worker, Wound Care consults prn RT, PT, OT, Dietitian per MD order	Psych, Social Worker, Wound Care consults prn RT, PT, OT, Dietician per MD order
Activities	Admission weight		Ambulate 30 laps – 1 MILE CPAP or BiPAP as ordered per RT policy. HOB up for comfort	Ambulate 30 laps – 1 MILE Begin increasing as tolerated.	Ambulate 30 laps – 1MILE – Begin increasing as tolerated.
Perioperative and Anesthesia	Activate Perioperative clinical pathway PC laparoscopic gastric bypass	Airway and Post Anesthesia care management	Airway and Post Anesthesia care management	Airway and Post Anesthesia care management	
Medications/ Treatments	Insert IV Void prior to OR Check if patient is on Antihypertensive Meds and Hypoglycemic agents / Insulin [Note if taken this AM].	Antiemetics per N/V guidelines: Glucose management per anesthesia Pain - Nausea Management – SCD per MD orders Oxygen prn	PCA, pain medication, SDC & antiemetics, Heparin per MD orders CPAP or BiPAP per order-RT protocol Wean oxygen as tolerated to maintain O2 Sat >90% IS q1hr while awake Check if Pre-op ANTICOAGULATION – If YES, Orders or Call MD.	Manage pain/nausea per MD orders CPAP or BiPAP per RT protocol IS q 1hr while awake Check if Pre-op ANTICOAGULATION – If YES, Orders or Call MD.	Manage pain/nausea per MD orders Pain managed on oral elixirs D/C SCD when ambulating JP drain dc'd if ordered
Nutrition	NPO	NPO	2 Hours post-op may have sips of water then advance to bariatric clear liquid as tolerated	Bariatric clear liquids Add protein shake	Bariatric clear liquid diet and High protein shake as tolerated
Discharge Planning/ Instruction	Orient patient to environment Orient family to surgery waiting room Pre-Op Teaching:		Post op IS use Post op ambulation progression Review discharge instructions/ handouts and discharge meds. Diet progression. Start post op training	Review discharge instructions/Handouts and discharge meds. Diet progression	Review discharge instructions/Handouts and discharge meds. Diet progression
Outcomes	Adm. History & Assessment complete Bariatric Qualifications Checked Pre-Op Checklist complete Pre-Op Meds given H&P on chart	Pain Management Oxygenation Level Drain: Non Bloody	VS WNL, Sats >92%, N/V managed Pain managed Absence of calf pain, DVT, SOB Ambulation progressed as tolerated Determine Discharge status - level of support D/C	VS WNL - Amb progressed. Pain managed. Drain: Non Bloody Ready for Discharge	Return to Pre-Surg ambulation activity Intact skin & healing

CLINICAL PATHWAY LAPAROSCOPIC SLEEVE GASTRECTOMY SURGERY

Updated: 12/2015 [Quilici – Tovar]

Date	Day of Admit/Surgery- SAU	Day of Surgery -PACU	Day of Surgery- Bariatric Unit POTENTIAL DISCHARGE	POD #1 – Discharge DISCHARGE	POD #2 - Discharge
Assessments	Adult Admission History & Assessment Pre-Op Checklist Baseline VS, O2 Sat, pain score	VS per PACU routine Pain assessment/management I&O	VS q 1h x4, q4h x24 Assess for pain and nausea per routine orders I&O Notify MD for ↑ Temp, unmanaged N/V, pain, ↑ BP and Pulse per MD parameters Check drain and Op sites Qshift	VS routine Assess pain and nausea per routine orders straight cath prn Notify MD for ↑Temp, unmanaged N/V, pain, ↑ BP and pulse per MD parameters Check drain and Op sites Qshift	VS routine Assess pain and nausea per routine orders
Tests	Accucheck if diabetic –contact surgeon if blood sugar abnormal	Accucheck if diabetic –contact anesthesia if BG <80 or >200 CBC w diff/ BMP	Obtain MD order for insulin sliding scale if diabetic	Obtain MD order for insulin sliding scale if diabetic	Obtain MD order for insulin sliding scale if diabetic
Consults	If CPAP or BiPAP indicated: RT to set-up post op Pt may use own CPAP or BiPAP as per RT policy	If CPAP or BiPAP is indicated: RT to set-up Pt may use own CPAP or BiPAP as per RT policy	Psych, Social Worker, Wound Care consults prn RT, PT, OT, Dietitian per MD order	Psych, Social Worker, Wound Care consults prn RT, PT, OT, Dietitian per MD order	Psych, Social Worker, Wound Care consults prn RT, PT, OT, Dietitian per MD order
Activities	Admit weight		Ambulate 30 laps – 1 MILE CPAP or BiPAP as ordered per RT policy. HOB up for comfort	Ambulate 30 laps – 1 MILE	Ambulate 30 laps – 1 MILE
Perioperative and Anesthesia	Activate Perioperative clinical pathway PC laparoscopic gastric bypass	Airway and Post Anesthesia care management	Airway and Post Anesthesia care management	Airway and Post Anesthesia care management	
Medications / Treatments	Insert IV Void prior to OR	Antiemetics per N/V guidelines: Glucose management per anesthesia Pain Management per MD orders SCD's Oxygen prn	PCA, pain medication & antiemetics, heparin per MD orders SCD per MD order CPAP or BiPAP per order-RT protocol Wean oxygen as tolerated to maintain O2 Sat >92% IS q1hr while awake	Manage pain/nausea per MD orders CPAP or BiPAP per RT protocol IS q 1hr while awake Check if Pre-op ANTICOAGULATION – If YES, Orders or Call MD.	Manage pain/nausea per MD orders Pain managed on oral elixirs D/C SCD when ambulating JP drain dc'd if ordered
Nutrition	NPO	NPO	Start sips of water 2 hours after arrival to floor, advance to Bariatric clears	Bariatric clear liquids Add protein shake	Bariatric clear liquid diet and High protein shake as tolerated
Discharge Planning/ Instruction	Orient patient to environment Orient family to surgery waiting room Pre-Op Teaching:		Post op IS use Post op ambulation progression Review discharge instructions/ handouts and discharge meds. Diet progression Start post-op training	Post op ambulation progression Review discharge instructions/ handouts and discharge meds. Diet progression	Review discharge instructions/Handouts and discharge meds. Diet progression
Outcomes	Adm. History & Assessment complete Bariatric Qualifications Checked Pre-Op Checklist complete Pre-Op Meds given H&P on chart	Pain Management	N/V managed VS WNL, Sats >92% Pain managed absence of DVT's Ambulation progressed as tolerated Determine DISCHARGE READINESS and level of support D/C	VS WNL Ambulation progressed Pain managed DISCHARGE	Return to Pre-Surg ambulation activity Intact skin & healing DISCHARGE

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CLINICAL PATHWAY: LAPAROSCOPIC OUTPATIENT LAPBAND SURGERY

Updated: 12/2015 [Quilici – Tovar]

Date	Day of Admit/Surgery- SAU	Day of Surgery -PACU	Day of Surgery- Bariatric Unit DISCHARGE – SHORT STAY	POD #1 - Discharge	POD #2 - Discharge
Assessments	Adult Admission History & Assessment Pre-Op Checklist Baseline VS, O2 Sat, pain score	VS per PACU routine Pain assessment/management I&O	VS q 1h x4, q4h x24 Assess for pain and nausea per routine orders I&O Notify MD for ↑ Temp, unmanaged N/V, pain, ↑ BP and Pulse per MD parameters	VS routine Assess pain and nausea per routine orders straight cath prn Notify MD for ↑Temp, unmanaged N/V, pain, ↑ BP and pulse per MD parameters	VS routine Assess pain and nausea per routine orders
Tests	Accucheck if diabetic –contact surgeon if blood sugar abnormal	Accucheck if diabetic –contact anesthesia if BG <80 or >200 CBC w diff/ BMP	Obtain MD order for insulin sliding scale if diabetic	Obtain MD order for insulin sliding scale if diabetic	Obtain MD order for insulin sliding scale if diabetic
Consults	If CPAP or BiPAP indicated: RT to set-up post op Pt may use own CPAP or BiPAP as per RT policy	If CPAP or BiPAP is indicated: RT to set-up Pt may use own CPAP or BiPAP as per RT policy	NONE	Psych, Social Worker, Wound Care consults prn RT, PT, OT, Dietitian per MD order	Psych, Social Worker, Wound Care consults prn RT, PT, OT, Dietitian per MD order
Activities	Admission weight		Ambulate 30 laps [Short stay – 7 NEB] CPAP or BiPAP as ordered per RT policy. HOB up for comfort	Ambulate 30 laps around Nurses station	Ambulate QID With a minimum of 1 mile per day
Perioperative and Anesthesia	Activate Perioperative clinical pathway PC laparoscopic gastric bypass	Airway and Post Anesthesia care management	Airway and Post Anesthesia care management	Airway and Post Anesthesia care management	
Medications / Treatments	Insert IV Void prior to OR	Glucose management per anesthesia Pain Management per MD orders Nausea Management per MD orders SCD's Oxygen prn	Pain medication & antiemetics, heparin, SCD per MD orders CPAP or BiPAP per order-RT protocol Wean oxygen as tolerated to maintain O2 Sat >92% IS q1hr after awake Check if Pre-op ANTICOAGULATION – If YES, Orders or Call MD.	Manage pain/nausea per MD orders CPAP or BiPAP per RT protocol IS q 1hr while awake	Manage pain/nausea per MD orders Pain managed on oral elixirs D/C SCD when ambulating
Nutrition	NPO	NPO	1 hours post-op may have sips of water then advance to Bariatric clear liquids as tolerated	Bariatric clear liquids Add protein shake	Bariatric clear liquid diet and High protein shake as tolerated
Discharge Planning/ Instruction	Orient patient to environment Orient family to surgery waiting room Pre-Op Teaching:		Post op IS use, ambulation progression Review discharge instructions/ Handouts and discharge meds. Diet progression Start post op training		Review discharge instructions/Handouts and discharge meds. Diet progression
Outcomes	Adm. History & Assessment complete Pre-Op Checklist complete Pre-Op Meds given H&P on chart	Pain Management	N/V managed VS WNL, Sats >92% Pain managed, absence of DVT's Ambulation progressed as tolerated **Determine DISCHARGE READINESS, DISCHARGE and level of support D/C TRANSFER to 7NEB If admission required**	VS WNL Amb progressed Pain managed	Return to Pre-Surg ambulation activity Intact skin & healing

Questions, Feedback & Web-platform

Journey to Center of Excellence- 2018

Preparing for COE

Dave Kennedy, Program Manager CPS

COE Development

- Objective: Preparing for COE Accreditation by 2018
- Accreditation standards change October 1, 2016

COE Development - Workout

- What are the critical must haves to begin the COE journey?
- Are there specific standards that are more difficult to achieve?
- What assistance does your site need to achieve COE by 2018?
  - Develop COE toolkit to prepare 1 year in advance of application
  - COE mock audit teams
- Other questions?

Wrap Up and Next Steps

- Pathway development, Epic optimization and implementation
- Cross walk existing COE standards w/new standards
- COE toolkit and mock audit teams
- Formation of workgroup for registry development