Employer Learning Collaborative (ELC)
Enhanced Recovery After Surgery (ERAS)
Session #1
A Patient's Journey

April 19, 2022

1:30 pm – 3:00 pm Eastern

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Agenda

- Overview of what an ELC (formerly collaboratives) is and how it operates
- What we are going cover over the next 12 months
- Session #1 – A patient's journey

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TO ASK QUESTIONS

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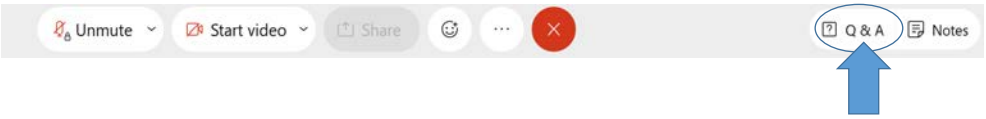
QUESTIONS?

For most devices, the **Q&A function** can be found by clicking on Q & A at the bottom of your screen on the far right.



- With the Q&A window open, type in your question and send to **HOST** or **Ashley Tait-Dinger.**
- There is a 512-character limit for questions.
- While we would like this to be interactive, we understand sometimes that is not possible. Maybe the lawn people are outside the window!

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Rules of Engagement for the ELC

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- This is a new topic for most people. We are going to level set during the first 3 sessions.
- Dialogue is meant to be bi-directional. Please ask questions! Comments are great also!
- The sponsors are also thought partners and will be very engaged.
  - We all want to hear your thoughts, concerns, and reactions.

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Enhanced Recovery After Surgery (ERAS) / Enhanced Recovery After Delivery (ERAD)

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- 12-month long collaborative focusing on the following topics:
- ERAS focused session – A patient's journey. What is it? Why is it effective?
- ERAS focused session - An employer's journey. What impact it has on health plan costs (both medical and pharmacy), return to work, patient satisfaction/quality of life goals, patient safety, quality?
- ERAD focused session – A patient and employer journey for delivery.
- Both - Development of a cost strategy to encourage use with providers.
- Both - Wrap up employer/plan design focus and discussion of appropriate quality measurement and reporting organizations to encourage them to add ERAS/ERAD measurements and/or to encourage use of ERAS/ERAD as part of an opioid reduction policy at the facilities and providers in their networks.
- Both - How to engage employees/members to seek out providers who utilize ERAS and ERAD.

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Thought Partners

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- A BIG Thank you!
- These partners were purposefully invited.

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- The ERAS® Society described it as: *ERAS is short for Enhanced Recovery After Surgery. ERAS represents a **new way of thinking** about how we look after patients undergoing major surgery. It helps patients recover from their operation sooner, so that life can return to normal as quickly as possible. ERAS is a treatment program made up of a number of different elements based on the best available medical science. **It also focuses on making sure you are actively involved** in your recovery.*

- *The main aspects are **planning and preparation before admission** (including improving your nutrition and physical fitness before surgery); reducing the physical stress of the operation; a structured approach to the management during your hospital stay (including pain relief and early nutrition); and getting you moving as soon as possible. (https://erassociety.org/patients/)*

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Session #1
A Patient's Journey

Brand Newland – Goldfinch Health

Dr. Luke Elms – Orlando Health

Ryan Burke – Surgery Plus Powered by Employer Direct Healthcare

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The Perfect Storm
Escalating healthcare costs
Pandemic delayed healthcare
Workforce challenges

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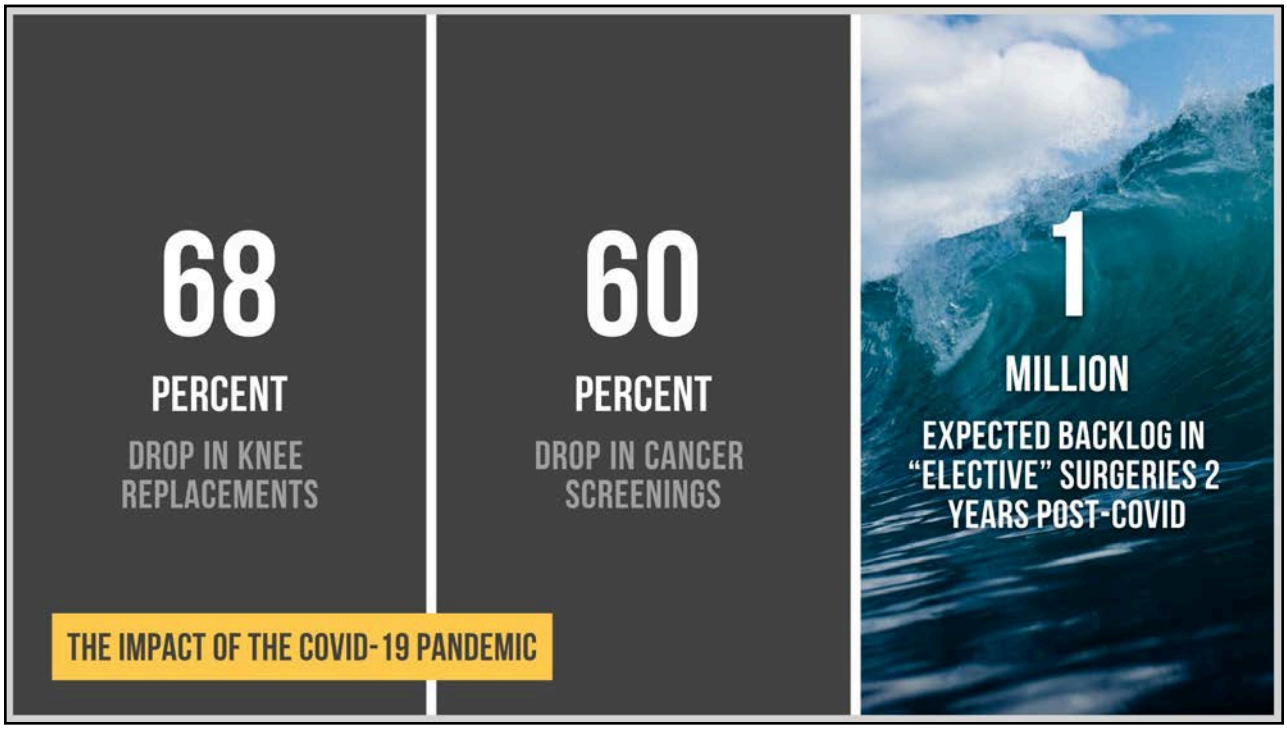
68
PERCENT
DROP IN KNEE REPLACEMENTS
60
PERCENT
DROP IN CANCER SCREENINGS
1
MILLION
EXPECTED BACKLOG IN "ELECTIVE" SURGERIES 2 YEARS POST-COVID
THE IMPACT OF THE COVID-19 PANDEMIC

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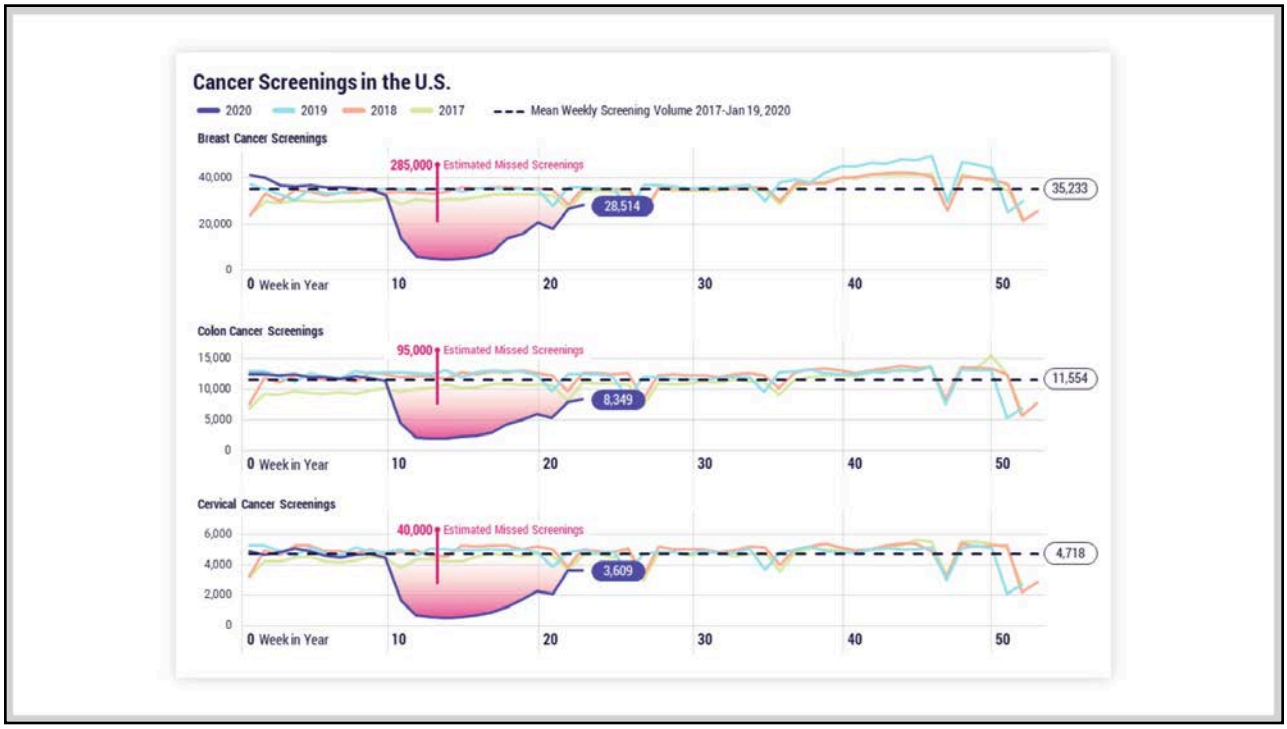
Cancer Screenings in the U.S.
2020
2019
2018
2017
Mean Weekly Screening Volume 2017-Jan 19, 2020
Breast Cancer Screenings
285,000 Estimated Missed Screenings
40,000
20,000
0
28,514
35,233
0 Week in Year
10
20
30
40
50
Colon Cancer Screenings
95,000 Estimated Missed Screenings
15,000
10,000
5,000
0
8,349
11,554
0 Week in Year
10
20
30
40
50
Cervical Cancer Screenings
40,000 Estimated Missed Screenings
6,000
4,000
2,000
0
3,609
4,718
0 Week in Year
10
20
30
40
50

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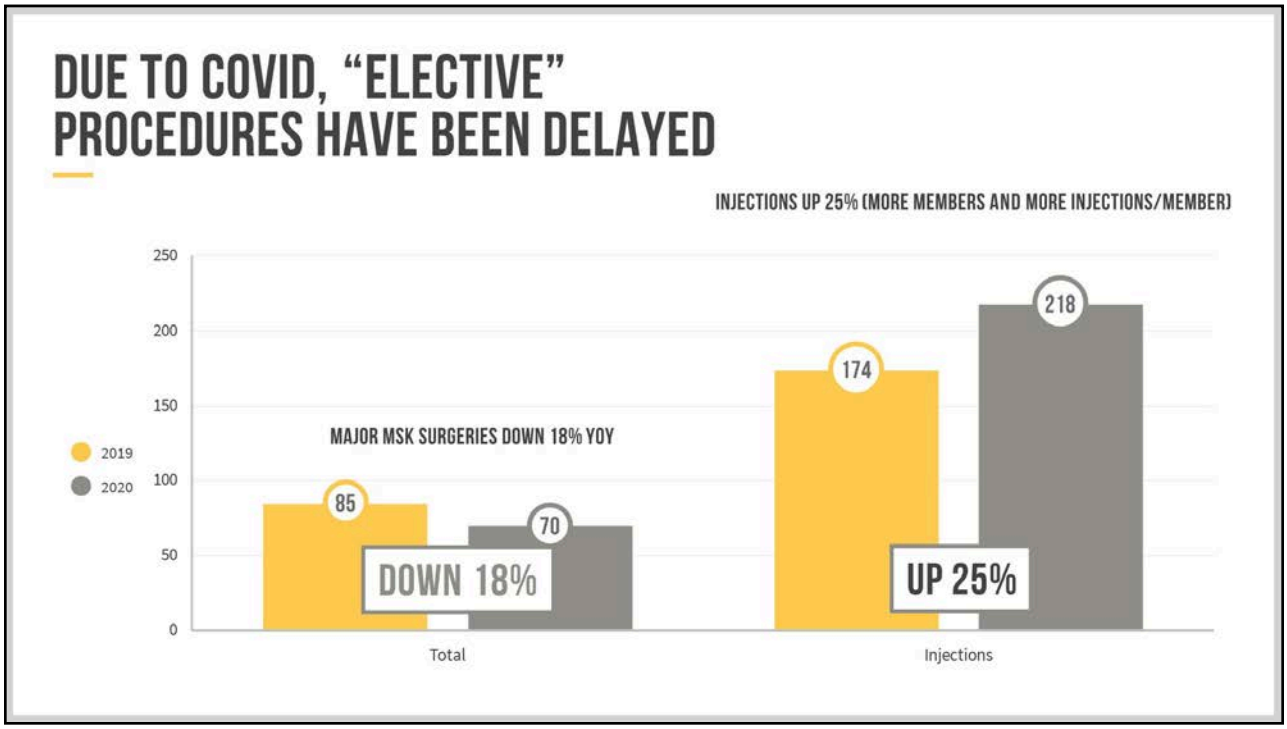
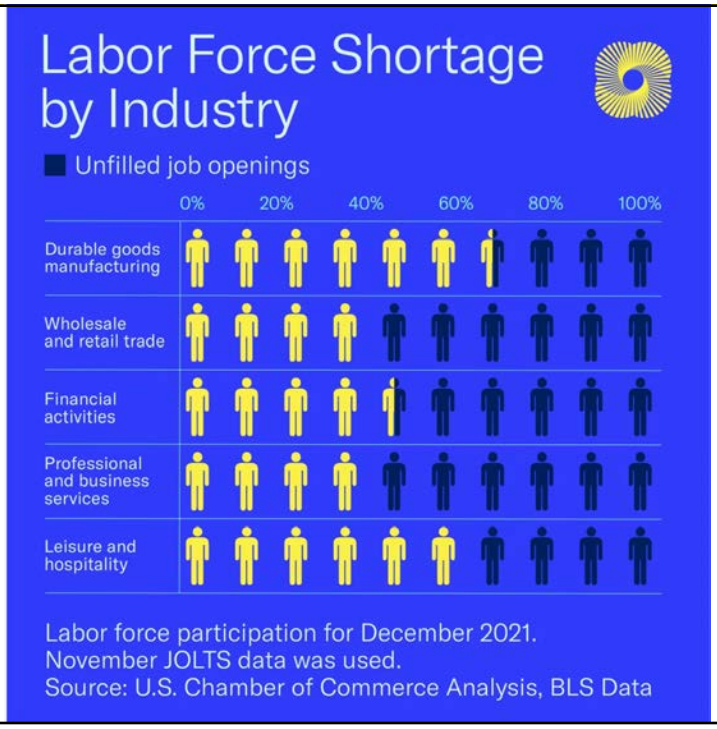

DUE TO COVID, "ELECTIVE" PROCEDURES HAVE BEEN DELAYED
INJECTIONS UP 25% (MORE MEMBERS AND MORE INJECTIONS/MEMBER)
MAJOR MSK SURGERIES DOWN 18% YOY
2019
2020
250
200
150
100
50
0
85
70
DOWN 18%
174
218
UP 25%
Total
Injections

12



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OUTPATIENT, MINIMALLY-INVASIVE SURGERY IS THE FUTURE (AND THE PRESENT)

- **INVASIVENESS OF SURGERY**
  - >60% of surgeries performed via large incision approach
  - <10% should be
- **SITE OF CARE**
  - 93% of hip and knee replacements eligible for outpatient, ambulatory

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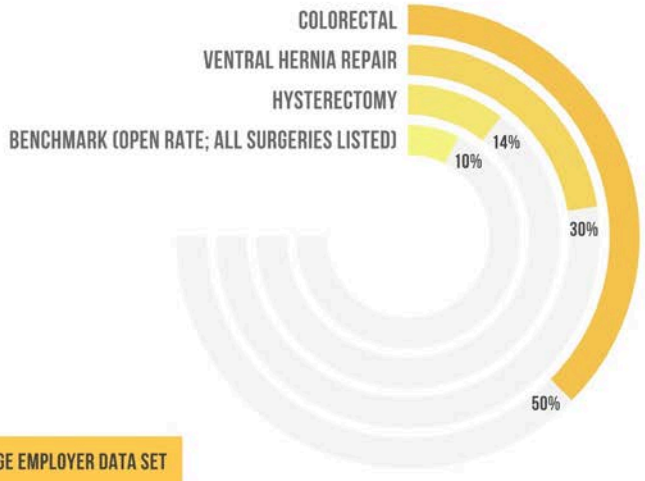
INVASIVENESS OF SURGERY - TECHNIQUE

Large-incision, "open" surgeries are the opposite of high-quality, low-cost care.



OPEN OPERATIONS LEAD TO HIGHER COSTS, LONGER LENGTH OF STAY & RETURN TO WORK, HIGHER INFECTION RATES, AND MORE OPIOID USE.

SAMPLE ANALYSIS OF LARGE EMPLOYER DATA SET

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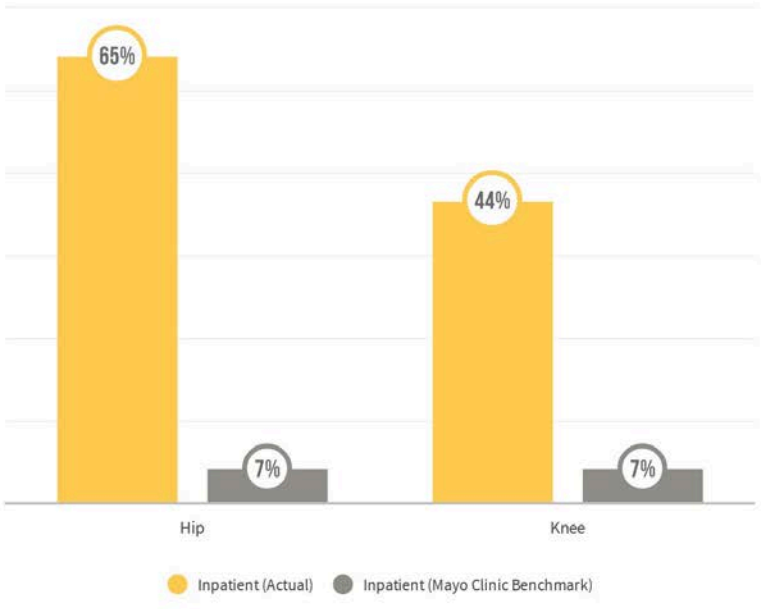
SITE OF CARE

HIGH RATES OF OUTPATIENT PROCEDURES DRIVE HIGHER COSTS

INPATIENT CARE REPRESENTS A MORE EXPENSIVE SITE OF CARE THAN OUTPATIENT AS IT OFTEN INCLUDES A MULTI-DAY HOSPITAL STAY



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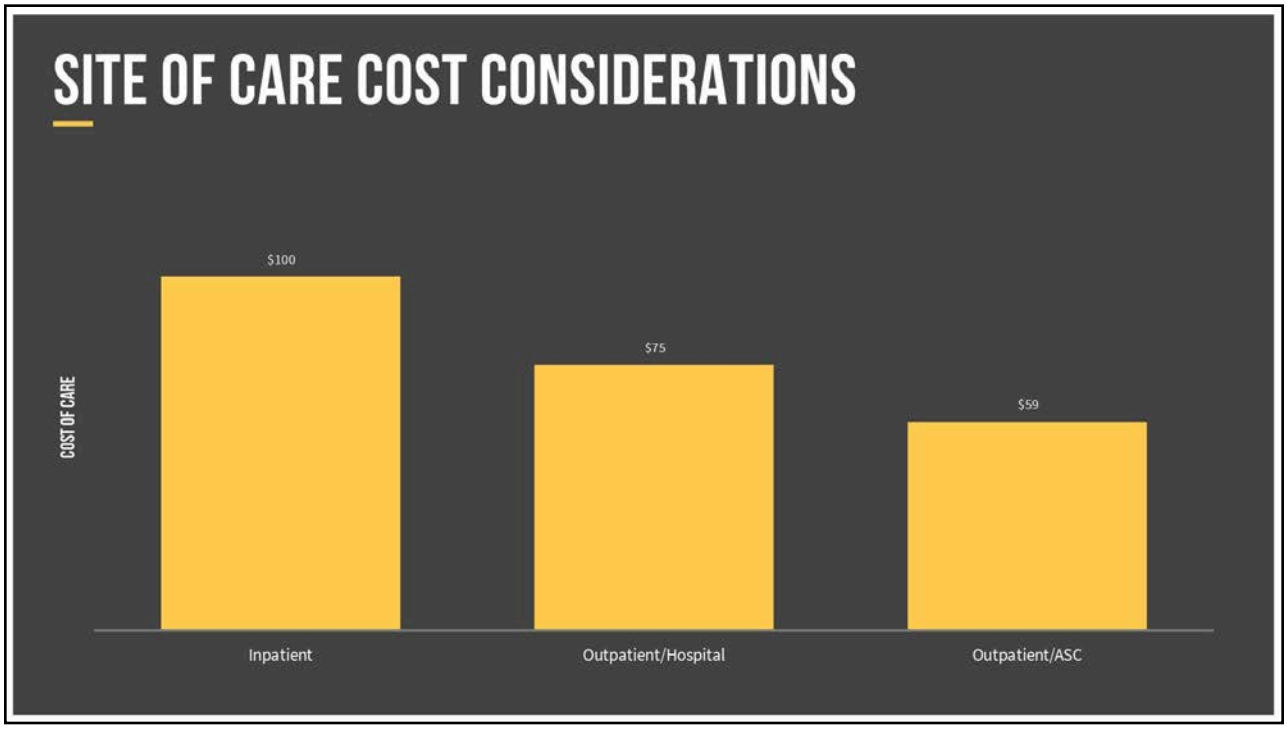
SITE OF CARE COST CONSIDERATIONS
COST OF CARE
$100
$75
$59
Inpatient
Outpatient/Hospital
Outpatient/ASC

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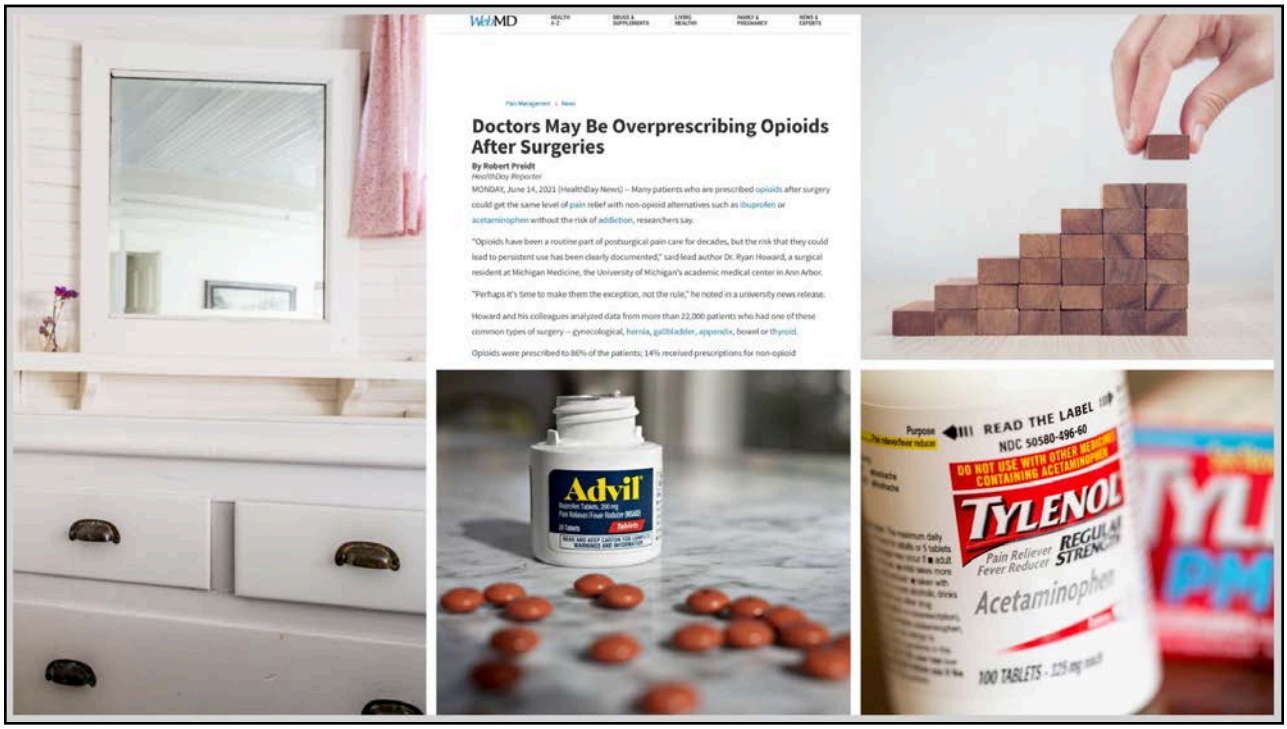
WebMD
Doctors May Be Overprescribing Opioids After Surgeries
By Robert Preidt
HealthDay Reporter
MONDAY, June 14, 2021 (HealthDay News) -- Many patients who are prescribed opioids after surgery could get the same level of pain relief with non-opioid alternatives such as ibuprofen or acetaminophen without the risk of addiction, researchers say.
"Opioids have been a routine part of postsurgical pain care for decades, but the risk that they could lead to persistent use has been clearly documented," said lead author Dr. Ryan Howard, a surgical resident at Michigan Medicine, the University of Michigan's academic medical center in Ann Arbor.
"Perhaps it's time to make them the exception, not the rule," he noted in a university news release.
Howard and his colleagues analyzed data from more than 22,000 patients who had one of these common types of surgery -- gynecological, hernia, gallbladder, appendix, bowel or thyroid.
Opioids were prescribed to 86% of the patients; 14% received prescriptions for non-opioid
Advil
READ THE LABEL
NDC 50580-696-60
DO NOT USE WITH OTHER MEDICINES CONTAINING ACETAMINOPHEN
TYLENOL
Pain Reliever
Fever Reducer
Acetaminophen
100 TABLETS

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THERE IS A BETTER WAY!
• "ENHANCED RECOVERY AFTER SURGERY" (ERAS)
• CLINICALLY-VALIDATED OVER 20 YEARS
• PATIENT-CENTRIC
• 4,000+ JOURNAL ARTICLES SUPPORTING THE BENEFITS
• 30% shorter hospital stays
• 50% few complication (like infections)
• 90% less opioid use
• Promotion of health equity
• 5% ADOPTED ACROSS SURGERY TYPES

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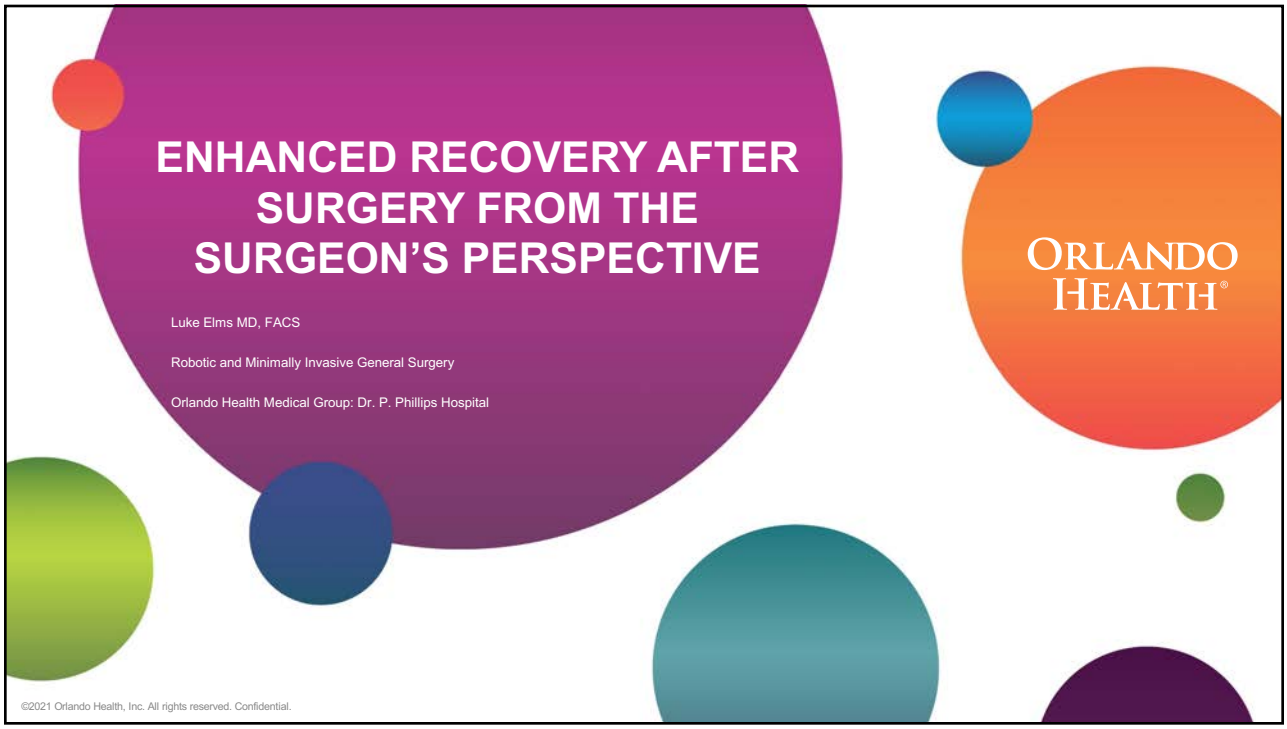
ENHANCED RECOVERY AFTER SURGERY FROM THE SURGEON'S PERSPECTIVE
Luke Elms MD, FACS
Robotic and Minimally Invasive General Surgery
Orlando Health Medical Group: Dr. P. Phillips Hospital
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BACKGROUND

- ERAS – Enhanced Recovery After Surgery
  - Colon and small bowel surgery
  - Reduce complications, speed recovery, improve outcomes
  - Orlando Health ERAS Right Care Initiative – 2016
- Multiple Pillars of ERAS
  - Minimally invasive approach
  - Changes to traditional management of perioperative nutrition
  - Early advancement of activity and goal-directed discharge criteria
  - Focus on ileus reduction
  - **Multimodal Pain Control (MPC)**

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MY PRACTICE

- Adopted ERAS for bowel surgery
- Expanded to all surgeries
- Standardized utilization of MPC and nerve blocks
- Reduced quantity of opioid prescriptions
- Reduced power of the opioids being prescribed
- Identified failures and performed a deep dive:
  - Compliance was primary cause of failure

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Patient Education

How pain will be managed after your operation or procedure:

Surgery is a traumatic experience for the body and you may feel different types of pain such as: inflammatory pain, nerve pain, and muscle spasms. As a result, we will use several different medicines that will work together to reduce your pain. Our goal is to help you manage your pain. This **does not** mean that the surgery will be pain free. Experiencing a normal amount of postoperative pain is expected and acceptable after a procedure or surgery. In the past, pain has mostly been treated with narcotic pain medications. These cause many side effects such as drowsiness, nausea, vomiting, constipation, slowed bowels, and a potential for addiction. Because of this, and the new Florida Law regarding narcotics, we have made the decision to use a multi-modal pain management approach where we prescribe several types of medication that work together so you won't need as much narcotic pain medication. This provides a safer and more effective postoperative pain management plan for our patients.

Here is a list of medications that you may be sent home on when you are discharged. Your surgical team will place a check mark next to the medicines recommended for you to use at home.

- **Acetaminophen**

-Treats standard pain but do not take if you have liver problems.
-We recommend taking 1000mg every 6 hours while awake for the first week after surgery (Do NOT exceed 4000mg in 24 hours).
-This should be the last pain medication weaned after surgery and can be taken as needed after the first few days
-This medicine is available over the counter at your pharmacy if your prescription runs out.

- **Ibuprofen – To be added to Acetaminophen if pain is not controlled.**

-Treats standard pain but at higher doses it also treats inflammatory pain. This medicine can cause an upset stomach, so we recommend taking it with food.
-Do not take if you have kidney problems or a history of gastric ulcers.
-We recommend taking 800mg every 6 hours while awake or as written for the first week after surgery and should be weaned second to last. Ibuprofen/Motrin/Advil is available over the counter at our pharmacy if your prescription runs out.
-Because this medicine can cause a stomachache, we recommend taking Famotidine 40mg twice daily while taking Motrin/Ibuprofen more than twice daily. Pepcid can be bought over the counter at your pharmacy.
If you start experiencing a painful stomachache while taking this medication, please stop taking it and seek medical evaluation.

- **Methocarbamol – To be added to Acetaminophen or Ibuprofen if pain is not controlled.**

-This medication is a muscle relaxant that can be used to treat muscle spasms after your surgery.
-Do NOT drive while taking this medication because it can make you drowsy.
-We recommend taking 1000mg every 8 hours as needed for pain unrelieved by the other two medications. This medicine is only available by prescription and a refill can be called in over the phone if necessary. It is your third line agent for pain control.

- **Tramadol – To be added to Acetaminophen, Ibuprofen, and Methocarbamol if pain is not controlled.**

-These are narcotic pain medicines and the strongest pain reliever in the regimen/group. You may be prescribed one of these but NOT both. New Florida law only allows us to prescribe a 3-day supply of these medications. You should not make important decisions or operate a motor vehicle or other machinery while taking these medicines. Do NOT drive while taking this medication.
-Side effects to watch for: drowsiness, nausea, vomiting, constipation, slowed bowels, as well as the potential for addiction in long term use.
-This medicine will cause constipation, so we recommend taking two tablets of Senna/Docusate twice a day while you are taking the narcotic pain medicine. Senna/Docusate can be bought over the counter at your pharmacy. Stop taking if you have diarrhea.
Important Oxycodone/Tramadol should be weaned first when coming off your pain medications. Only take this medication if you have taken the other pain medications and they have not lowered your pain to a tolerable level. These medications are narcotics and cannot be refilled over the phone.

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RESULTS

- Patient satisfaction scores increased
- Patient calls, readmissions, LOS, and return to work decreased
- Converted inpatient procedures to outpatient procedures
- PACU nurses and CRNAs reported requiring minimal opioids
- 600 surgeries from January to August of 2021
  - <5% failure rate: escalation from Tramadol or request of a refill
- Patients recover faster with quicker return to normal life!

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PATIENT EXAMPLE

- 60 y/o otherwise healthy female
- Episodes of gallstones causing pain and nausea
- Decided to have gallbladder removed rather than wait on it to become an emergency
- Underwent robotic assisted cholecystectomy as an outpatient
  - Drank carbohydrate drink 2 hours prior to surgery
  - Preop Acetaminophen, Ibuprofen, Methocarbamol, Gabapentin
  - Minimal opioid use in surgery/PACU
  - Used Acetaminophen, Ibuprofen, Muscle relaxant at home
- Did not require any opioids at home though they were available if needed
- Returned to work the next day
- Seen in office postoperative day 11 doing great.

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ERAS VS. PRE-ERAS

- ERAS
  - No solid food 8 hours before surgery
  - Drink carbohydrate drink 2 hours prior
  - Multiple preoperative medications
    - Non-opioid
  - Minimized use of opioids during surgery
    - Used only as needed
    - Not withheld
- Pre-ERAS
  - No food or drink 8 hours before surgery
  - Fentanyl in preop
  - Fentanyl/Toradol in OR
  - Morphine or Percocet in PACU

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ERAS VS. PRE-ERAS

- ERAS
  - Continue multimodal medications postoperative
  - Minimally invasive approach
  - Focus on ambulating early and
  - Returning to normal diet early
  - Return to work ASAP and shorter lifting restrictions in many cases
- Pre-ERAS
  - Discharged on Percocet
  - No preference on open vs minimally invasive approach
  - Slowly advance diet as tolerated
  - Ambulate as tolerated
  - 6 weeks out of work with lifting restrictions

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WHY ISN'T THIS USED EVERYWHERE?

- It is spreading!
  - Slowly
  - Piecemeal
- Medicine can be very slow to adopt new practices without external forces
- Not always the path of least resistance for the provider or the patient
  - Clear benefits outweigh the increased efforts
- Its financial benefit depends on the parameters used to determine cost
  - Dramatic cost saving to patient and payer

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ERAS: A call to action

> "ERAS is the current surgical revolution to improve clinical outcomes and economic efficiency in health care systems, far beyond surgical techniques and technologies. The main questions remaining are – what are managers and leaders waiting for? And how long will patients still accept treatment at a non-ERAS hospital?"

"Beyond surgery: clinical and economic impact of Enhanced Recovery After Surgery programs", BMC Health Services Research, December 2018

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COST OF SUBOPTIMAL SURGERY

Yearly costs of suboptimal surgery are significant for every 1,000 employee lives.

TOTAL EMPLOYEES	1,000
POTENTIAL SUBOPTIMAL SURGERIES	75

- **ORTHO**
  - Knee/Hip/Spine
- **WOMEN'S HEALTH**
  - Hysterectomy
  - C-Section
- **GENERAL**
  - Colorectal
  - Hernia repair
  - Gallbladder removal

4,200	wasted days of recovery time (16 FTEs)
$1.2M	wasted labor costs alone ($98 PEPM)
$171K	healthcare cost savings
7	persistent opioid users that could have been avoided

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Top Quality Approach is Defined by the Experts

Clinical Leadership

Carolina Escobar, MD – CMO, EDHC
Dr. Escobar is board certified in Internal Medicine, Oncology, and Hematology, and is fellowship trained in bone marrow transplant. She is an active member of the American Board of Internal Medicine, the American Society of Clinical Oncology, the American Society of Hematology, the American College of Physicians / American Society of Internal Medicine, the American Medical Association, and the American Society of Bone Marrow Transplant.

Marty Makary, MD – Lead Clinical and Quality Advisor
Dr. Makary is a surgical oncologist and chief of the Johns Hopkins Islet Transplant Center. In addition to serving as a clinical lead for the Johns Hopkins Sibley Innovation Hub, he also serves as Executive Director of Improving Wisely, a Robert Wood Johnson Foundation project to lower healthcare costs in the U.S. by creating measures of appropriateness in healthcare.

Jennifer Cook, MD – Co-Chair of Medical Advisory Board
Dr. Cook owns private practice in the Tampa Bay area where she specializes in joint replacement and complex knee revision procedures. In addition to being an active member of the American Association of Hip and Knee Surgeons and the Arthroscopy Association of North America, Dr. Cook founded the Women's Orthopedic Global Outreach program, performing over 200 free joint replacements in underprivileged countries.

Marc Dean, MD - Co-Chair of Medical Advisory Board
Marc Dean, MD is a board-certified ENT Surgeon, specializing in ear and sinus disease. Dean also serves as the President and CEO of the Otorhinologic Research Institute, a non-profit organization focusing on the development of new treatments for ear, sinus and eustachian tube disorders. New endeavors for Dr. Dean include the development of a cochlear implant program in northern Iraq and a head and neck program in Vietnam.

Christi Walsh, MSN, CRNP – Lead Nurse, Quality & Clinical Protocols Advisor
Christi is an Acute Care Nurse Practitioner in the Department of Surgery and Transplant Coordinator at Johns Hopkins Hospital. She practices as an NP for the surgical oncology department specializing in pancreatic surgery, NP for the Pancreatitis Center, and coordinator for Pancreas Islet Cell Auto-transplantation Program. She also plays a significant role in the Robert Wood Johnson Foundation, studying quality metrics and developing navigational support to patients.

Our Advisory Board

Keith Berend
Orthopedics, Total Joints
Columbus, OH

Shane Seroyer
Orthopedics, Knee/Hip
Dallas, TX

Steve Lucey
Orthopedics, Total Joints
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Indianapolis, IN

Stan Hoehn
Bariatric Surgery
Lenexa, KS

Sean Garber
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New York, NY

Robert Masson
Spine & Sports Medicine
Orlando, FL

Daniel Cottam
Bariatric Surgery
Salt Lake City, UT

Farhan Siddiqi
Spine
Tampa, FL

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Quality & Credentialing - Driven by Experts, not Algorithms

A best-in-class medical advisory board uses verifiable data and industry expertise that the common consumer does not have

In network with major carrier

Surgeons passing Stage 1

Stage 1: Pre-Screening

- + Licensed — 98%
- + Board Certified — 60%
- + Fellowship Trained — 34%
- + No State Sanctions — 28%
- + Reputational Review — 27%
- + Malpractice Review — 25%

These surgeons move on to Stage 2

Stage 2: Interview / On-Site

Review of Programs
- Years and outcomes
- Alignment with best practices

Optimization Requirements
- Modifiable risk factors
- Educational programs/support

Enhanced Recovery
- Established ERAS program
- Opioid reduction / Rx trends

Surgical Volume
- Procedure specific

Interview / References
- Practice & outside practice
- Peer-to-peer phone screening

Stage 3: Facility Evaluation

Venue Appropriateness
- Hospital vs. ASC vs. in-office
- Patient selection criteria

CMS Outcomes Data
- HAC scores, readmissions
- Complications / outcomes

Program Reviews
- Established program units
- Accreditations / awards

Leapfrog Data
- Key surgical metrics

Patient Perception
- HCAHPS scores
- Site visit

These criteria have resulted in venue optimization and significantly reduced complications / readmissions

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Improved Patient Outcomes in the Right Hands

When a member has the tools to make the right surgeon choice

Procedure Averages	Hand Selected Surgeons	Industry Average Surgeons
Joint Replacements		
Procedures 2020-21	1,560	NA
Complication Rate	0.32%	8.0%
Other Ortho		
Procedures 2020-21	3,110	NA
Complication Rate	0.10%	4.8%
Spine		
Procedures 2020-21	973	NA
Complication Rate	0.81%	13.7%
Bariatrics		
Procedures 2020-21	2,058	NA
Complication Rate	0.92%	8.4%
General		
Procedures 2020-21	1,726	NA
Complication Rate	0.34	9.4%

Complications include readmissions, ER visits, any unplanned second surgery related to the initial procedure

Surgical Avoidance

Defined

Documented evidence that another surgeon recommended surgery prior to the member seeing an S+ network surgeon

~30% of Spine

Members who had been diagnosed by a non-S+ surgeon as needing surgery, that after seeing our surgeon, were determined to not be surgical candidates

~20% Joints

Members who were told they need joint replacement surgery by a surgeon, who then saw our surgeons and it was determined they don't need or were not a candidate for the surgery

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Venue and Patient Optimization

Shifting site of service decreases risk and optimizes outcomes

"Analysis of 1.2 million hip and knee replacements – 90% of commercial insurance patients had procedure in a hospital, 90% of these were inpatient, with 2.5% contracting surgical site infection requiring readmission to hospital, compared to 0.3% of joint replacements performed in an ASC." -United Healthcare

Opioid Epidemic by the Numbers 2019

10.1M	People who misused opioids
70,630	Deaths from drug overdoses
48,006	Deaths from opioid overdose (68% of all drug related overdoses)
14,480	Deaths from heroin overdoes

Surgery is the #1 gateway to opioid addiction

ASC/Outpatient TJAs reduce the risk of opioid dependence

Venue Optimization and ERAS

- Optimization pre-op, ERAS, and novel non-narcotic pain protocols
- Study of 574,375 joint replacements, 3.15% of outpatient TJA had adverse outcome compared to 7.45% of inpatient TJAs
- Study of 92,506 opioid naïve TJA patients, outpatient TJAs had significantly shorter duration of opioid use

SurgeryPlus Surgeons Optimize Patients Prior to Surgery Allowing for Venue Optimization & Shorter Length of Stay

2021 SurgeryPlus Joint Replacement Summary

Completed Procedures	Outpatient Procedures	Ambulatory Surgery Center	Hospital (due to Patient Condition)	Same-Day Hospital Discharge	Re-Admit or Direct Admit (Same-Day Discharge)
1,562	1,257	953	609	305	0

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34