Demands of Integrated Care Delivery in Interventional Medicine and Anesthesiology

Interdisciplinary Teamwork and Strategy

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KEYWORDS

• Strategy • Nonoperating room anesthesia • Clinical operations anesthesia
• Integrated care delivery • Interventional medicine • Anesthesiology
• Interdisciplinary teamwork

KEY POINTS

- Evolving financial constraints for nonoperating room or services.
- New noninvasive approaches to treatment and implications for operations.
- Financial silos and implications for care integration.
- Increasing scope of patient comorbidities for nonoperating room patients.
- Collaborative practice for nonsurgeons and anesthesiologists.

There is no longer any doubt that the growing array of noninvasive procedures performed outside of the operating room offers substantial benefit and increased value over traditional surgical alternatives. Interventional medical procedures performed by cardiologists, gastroenterologists, pulmonologists, and radiologists now offer effective alternatives to traditional surgery.[1]

In fact, nonoperating room procedural volume exceeds operating room surgical case volume in many hospitals.[2] As volume grows, the scope of cases expands as well. Older and more complex patients increasingly undergo technically sophisticated treatments performed in procedural suites with the support of anesthesiologists.[3]

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Although there continues to be a place for sedative administration by trained nurses, nurse-administered moderate sedation is inadequate for procedures that require minimal patient movement or complex hemodynamic and respiratory control. The role of anesthesiologists in setting standards and determining the conditions for which moderate sedation is acceptable will advance the safety, efficiency, and quality of delivered care. As technological advancement continues, intricate techniques demand the full attention of proceduralists. Thus, the need for anesthesiology services beyond the operating room is escalating rapidly. Unfamiliar and unique work environments, new procedures, and moribund patients make expanded anesthesiology practice even more difficult yet more critical to accomplish.

Although this is a predictable consequence of medical evolution, strategic planning for the extension of anesthesiology services beyond the operating room has been slow to take shape. Because significant complications are relatively low-frequency events, complacency has prevailed. Muddled by misinformation, cultural barriers, poor communication, infrastructure deficits, and financial shortsightedness, the transition has been uneven and inefficient for patients, anesthesiologists, and proceduralists alike. Awareness of the need for collaborative, multidisciplinary financial, and medical planning is growing; the process is slow and difficult, however, because it involves intradisciplinary, multilevel infrastructure change, as well as cultural change among administrative and medical providers.

Disparities between operating room and nonoperating room practice standards are becoming increasingly obvious. Interventionalists and anesthesiologists alike are concerned. The Center for Medicare and Medicaid Studies (CMS), the Joint Commission (TJC), and the American Society of Anesthesiologists (ASA) all mandate preprocedural patient evaluation for high-risk patients and high-risk surgeries in the operating room.[4] Often, hospitals recognize and underwrite the cost of clinics that perform timely assessments of surgical patients. However, the provision of such services for interventional medicine patients, even as recommended by the ASA, is inconsistent at best. Clear pathways for financing those services are lacking, and medical guidelines for provision of such services are variable or nonexistent. Many hospitals seek to engage a broad base of primary cares providers by offering direct access scheduling; little if any preprocedural triage occurs. Assessments and workups are done immediately prior to the case, and planning does not occur. Comorbidities discovered at the last minute increase the likelihood of delays, cancellations, and suboptimal and excessively costly care.

In addition, inadequate screening leaves decisions about who needs an anesthesiologist undecided until immediately prior to the case. Scheduling becomes imprecise, and resources may not reflect need. Anesthesia providers and medical proceduralists are forced to wait for each other as a result of inaccurate scheduling, and overtime becomes necessary even when there is excess capacity during the day. Although the goal is for all scheduled operating room patients to undergo either a phone screen, a preoperative evaluation, or surgical contact prior to surgery, this is not always the case for patients scheduled for nonoperative procedures. Interventional medicine patients often present for their procedures having never seen the proceduralist and lacking any preoperative information.

Operating rooms generate significant revenue streams for hospitals, and they are expensive to maintain. Operating room management groups therefore prioritize efficient multidisciplinary function. Operating room utilization rates not only reflect the percentage of available time in use, but also the degree of practice integration that surgeons, anesthesiologists, and ancillary care providers achieve. In order to maximize utilization, central scheduling is utilized to coordinate operating room bookings and anesthesia resources. To minimize excess capacity, operating rooms are often closed

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