Anesthesiologists Play Key Role in Delivering PSH Concept for Hip Replacement Patients

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Powerful forces driving health care in the United States have challenged health care providers to increase the quality of patient care that they deliver while providing that care at lower costs with higher levels of patient satisfaction. The concept of a medical home has been proposed as a patient-centered, team-based approach for providing coordinated and accessible health care focused on quality and reduced costs. Applying this concept to a surgical setting has led to the creation of the perioperative surgical home (PSH) model, an idea that has gained considerable traction within the American Society of Anesthesiologists. Anesthesiologists are a logical choice to play a central role in any such multidisciplinary approach to caring for patients throughout the entire perioperative experience. Matthew Patterson, MD, Ochsner Health System, New Orleans, Louisiana, USA, and colleagues presented a pilot PSH program developed at Ochsner for patients undergoing elective hip arthroplasty. Goals of the project were to establish preoperative, intraoperative, and postoperative protocols based on PSH principles that would improve patient outcomes while reducing costs and length of stay.

A total of 74 patients undergoing primary total hip arthroplasty enrolled in a PSH program managed by multidisciplinary teams of health care providers, each led by an anesthesiologist. The preoperative workup for patients included a comprehensive triage oriented to identifying and remediating risks while reducing unnecessary testing and maximizing patient education. Patients attended classes on their upcoming surgeries that emphasized the benefits of discharge as early as postoperative day (POD) 1. Patients at risk for longer stays were identified and counseled regarding a perioperative timeline appropriate to their personal circumstances. This approach enabled use of "prehabilitation" protocols that included physical therapy (PT), nutritional support, and anemia correction to better prepare patients for a quick recovery from surgery.

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Combined spinal epidural with dosing of neuraxial block was performed whenever possible to best enable a PT protocol that typically began in the recovery room. Following surgery, daily rounds were made by the team's anesthesiologist to oversee patients' postoperative care. Anesthesiologists were then followed by a multidisciplinary team that included an acute pain nurse, an anesthesiology resident, and physical therapists—all of whom collaborated on managing patients' pain while meeting their PT goals. Pain management was multimodal. Epidural analgesia was discontinued the morning of POD 1 to facilitate PT. Opioid and nonopioid analgesics were both used as needed for breakthrough pain. PT was conducted twice daily following its initiation in the recovery room on the day of surgery. Patients who did well in PT were eligible for discharge on POD 1, while those who stayed longer underwent 2 additional sessions on POD 2 and were then discharged to either home or a skilled nursing facility. Case managers continued to stay in touch with patients' circumstances to allow coordination of payer approvals and to provide efficient transition to outpatient care.

The researchers concluded that their PSH model achieved its aim of reducing overall cost of care. They estimated that their institution could realize an additional net income of >$200 000 per year based on the additional hospital capacity available, owing to the length-of-stay reductions experienced by arthroplasty patients. No baseline measurements were available to compare patients' assessment of care quality or their satisfaction scores.