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ANAESTHESIA
Editorial

"How far are you willing to walk up the river bank?" The Additional Value of an Acute Pain Service

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Historically, the primary aim of Anesthesiologists might have been stated as 'getting patients safely across this river'; that is, get them through the surgery without major or minor adverse events. Today, with our advanced monitoring, better medications and equipment, along with preparation and vigilance, we most often meet this goal. There are still strides to be taken in the patient safety arena and complications will continue to occur despite our best efforts, but we are regularly doing bigger surgeries on sicker patients, yet the rate of anesthesia-related deaths has decreased dramatically [1]. More often than not, when we've signed the patient out of the PACU or when they are tucked in on the wards or loaded into their car for the trip home, we say: "You made it across the river safely. My job is done here Mission Accomplished!"

We have found that by extending ourselves 'up the bank of the river a little' prior to surgery to evaluate patients and confirm that they are medically optimized, it results in better outcomes, financial benefit and fewer cancellations [2-4]. This has positive financial implications for the hospital, results in fewer disgruntled patients and demonstrates an additional value of our particular service.

Some have ventured up the opposite 'bank of the river' after surgery to improve post-operative pain control for patients. Though thoracic and lumbar epidurals for post-operative pain control have been staples of anesthesia services for decades, the challenge of expanding from 'single shot' (SS) peripheral nerve blocks to continuous peripheral nerve blocks (CPNB's) for post-operative pain control has proved vexing for many providers. Epidurals extend analgesic benefit to patients similar to CPNB's, but they are encumbered by a number of side-effects and limitations of use that are not shared by CPNB's [5-6].

Performing SS nerve blocks over CPNB's has become the more common practice for most Anesthesiologists. They are relatively easy to administer and do provide a temporary benefit to the patient. The problem with SS nerve blocks is that they are far less likely to translate into significant outcome differences or into reliable changes to downstream processes for larger surgeries because their effect is too short-lived. The inflammation from moderate or significant surgical trauma will outlasts the bolus of the SS bolus. It is like a parachute that works great until you are 100 feet from the ground. It isn't as bad a fall as it would have been, but it is still going to be a rather unpleasant landing! This results in returning to high dose opioids, slowing bowel function again, hindering recovery, added interventions and cost, plus we lose the ability to send patients home early.

I have trained enough people in different locations to know why most attempts to begin performing CPNB's fail or why they never get off the ground in the first place. Tell me if any of these sound familiar:

1. Administration will not support us
2. Surgeons won't let us perform CPNB's on their patients
3. The learning curve is too steep
4. It is too much trouble for little or no benefit at all
5. We are not set up to do that here

There is not time in this editorial to discuss these responses that I hear most often, but I can assure you that each of these concerns can be effectively addressed in essentially any environment. I would also say that there are a number of factors in the evolving U.S. health market that make the reality of creating a well-supported, profitable and successful Acute Pain Service a 'no-brainer' for hospital administrators and for others if properly presented and implemented. An Acute Pain Service can improve patient satisfaction and safety, optimize and shorten patient recovery, decrease length of stay and opioid use, convert inpatient surgeries to outpatient surgeries, and even influence patient decision-making about where to have their surgery. These factors can drastically affect the financial bottom line for the hospital and make the life of our colleague surgeons much better. Beyond organizing a service that generates financial capital for your group, it can generate an enormous amount of 'political' capital within the hospital for the Anesthesiologists.

Although there are certainly other avenues for Anesthesiologists to demonstrate their ability to add (or prove their) value within the hospital and to various insurers, my experience would indicate that there are few opportunities for Anesthesiologists that will translate into substantial positive physiologic and financial outcomes as much as using CPNB's to optimize post-operative pain control within an Acute Pain Service. Developing a well-organized Acute Pain Service exemplifies the Triple Aim (better patient experience, better health care, reduced costs) of the Perioperative Surgical Home advocated by the American Society of Anesthesiologists [7]. As the landscape of reimbursement within medical practice continues to change from a fee-for service to a more merit-based system, we will be continually pushed to actively demonstrate our value to Medicare and other insurers. Beyond this, changing our practices in order to provide improved service within our facilities and better care to our patients beyond the walls (or the 'banks') of the operating room is important for our profession as it earns and maintains respect from surgeons and administrators and promotes our profession within our communities. Beyond this, if we have the ability to significantly help patients, it is just the right thing to do!

Our profession has always been recognized as a leader in patient safety. We are not well known for influencing where a patient will choose to have their procedure. In fact, we are more often considered a 'cost center', Than a 'revenue center' by administrators. With the implementation of an Acute Pain Service, we have new opportunities to become leaders in our hospitals by demonstrating our ability to influence patient referral patterns and to greatly influence tangible financial outcomes. At the same time, we further improve physiologic outcomes for our patients.

I believe this opportunity to change and expand our influence within the medical community is essential for our profession to grow and to flourish in the coming years. Change is always difficult at first and is often met with resistance, but an Acute Pain Service provides an exciting opportunity and challenge for willing Anesthesiologists to forge new paths and lead our profession in directions that have previously been unconsidered or were unavailable.

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