

Conference abstract

Redesigning Pulmonary Embolism Response Team Coverage: Early Evaluation of an Alternating Interventional Radiology–Cardiology Model

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INTRODUCTION

This quality improvement project evaluated the implementation of an alternating Interventional Radiology–Cardiology Pulmonary Embolism Response Team (PERT) coverage model at our institution. The project was initiated to address concerns regarding sustainability, workload distribution, and provider burnout associated with the prior Interventional Radiology-only consult structure. The goal of the intervention was to improve multidisciplinary coordination, optimize workflow efficiency, and enhance provider satisfaction while maintaining effective pulmonary embolism care delivery. Expected benefits included improved communication, more balanced consult coverage, reduced burnout, and streamlined patient management.

METHODS

An alternating monthly Interventional Radiology–Cardiology coverage model for PERT consults was implemented at our institution. To assess the impact of this intervention, an anonymous electronic survey was distributed to Interventional Radiology physicians, residents, advanced practice providers, and nursing/technical staff. Survey domains evaluated perceived effectiveness, care coordination, workflow organization, consult routing accuracy, educational impact, and provider burnout. Responses rated as “Agree” or “Strongly Agree” were categorized as positive responses. Descriptive statistical analysis was performed to evaluate perceptions and identify operational barriers associated with the new coverage structure.

RESULTS

Fifteen survey responses were collected, including residents (67%), nursing/technical staff (20%), and advanced practice provider/attending physicians (13%). Eighty percent of respondents agreed that the alternating coverage structure was effective, while 64% preferred it over the previous Interventional Radiology-only model. Sixty percent reported improved coordination and clinical decision-making, and all respondents agreed that the alternating schedule reduced burnout. However, workflow challenges remained, as only 33% perceived improvement in workflow organization and timeliness of pulmonary embolism care. Respondents also identified frequent consult misrouting during Cardiology-covered months, likely related to provider unfamiliarity with the alternating structure.

CONCLUSIONS

The alternating Interventional Radiology–Cardiology PERT coverage model was perceived positively overall and demonstrated benefits in provider satisfaction, multidisciplinary coordination, and reduction of burnout. Despite these improvements, operational inefficiencies such as consult misrouting and inconsistent workflow organization were identified as important barriers to optimal implementation. These findings suggest that while the intervention improved sustainability of PERT coverage, additional system-level refinements are necessary. Future QI cycles will focus on provider education, electronic medical record optimization, broader stakeholder engagement, and objective assessment of patient-centered outcomes before and after implementation to further improve pulmonary embolism care delivery.



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