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Development of a Screening System to Identify Patients Preoperatively Who May Benefit from a Postoperative Hospitalist Consult

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Background: While pure consultative and co-management models are common in hospitalist consultation, both have their weaknesses. Pure consultative models likely select for sicker patients, but patients who would benefit from consultation may be missed and also may miss opportunities to prevent medical complications. Strictly co-management models cast a wide net and therefore patients are followed who may not need the care of a hospitalist. This model may not best match clinical need with the additional resource of hospitalist consultation.

Purpose: Our group operates under a pure consultative model and does not participate in a perioperative clinic. Review of our administrative data indicates that the primary services may be calling consults later into the patient's clinical course when earlier consultation would have been indicated. We sought to develop a system to better identify patients who would benefit from a hospital medicine consult.

Description: We developed our pilot system in conjunction with our two highest-volume orthopedic attendings who care mostly for total joint replacement patients. While these patients tend to be older and have more comorbidities, not all of these patients require hospitalist input. To identify patients, the consulting hospitalist reviews the list of patients scheduled for the operating room and screens for preselected indications for consultation by reviewing the electronic medical record: age > 75 years, stage 3 kidney disease, diabetes mellitus, hypertension, congestive heart failure, patients on chronic anticoagulation, and subjective selection by our group or by the surgeon. Once identified, we notify the surgeon the week of the planned surgery that their patient may benefit from a hospitalist consult and plan to follow up postoperatively unless the surgeon feels otherwise.

Results and Conclusions: To date, 75% of the patients screened have required inpatient consultation. Difficulties have arisen during the pilot, including inconsistent communication within our group regarding the patients to be seen and inconsistent consultative practice by our group. Overall, satisfaction level has been high among the surgical teams. We are working to refine our criteria to create a more effective service. We also hope to expand our program to other surgical services, including vascular surgery and neurosurgery.