Geriatric Consultation and Expertise for the Hospitalized Patient

Laura Perry Fernandez, MD[a], Lindy Romanovsky, MB BCh BAO[a], Houman Javedan, MD[b,*]

KEYWORDS

• Frailty • Elderly • Geriatrics • Consultation • Models of care • Care pathways • System design

HOSPITAL MEDICINE CLINICS CHECKLIST

1. Changing demographics necessitate new models of care that incorporate geriatrics expertise into daily work flow of hospital medicine.
2. Rapid frailty screens can be used to identify the patients at highest risk of iatrogenic complications and greatest need of geriatrics expertise.
3. Targeted patients should receive a Comprehensive Geriatric Assessment, a multidomain evaluation of physical and mental health, functional and cognitive abilities, psychosocial supports, and nutritional status.
4. Frail patients benefit most when geriatrics is involved early in their course, expectations are realistic, and care pathways exist with their vulnerabilities in mind.
5. Geriatricians and hospitalists should collaborate to implement care pathways that anticipate the needs of frail older patients, using successfully tested models as guides.

KEY PRINCIPLES

Do we need geriatric expertise?

With the "oldest old" patients becoming a larger portion of the population of hospitalized patients every year, hospitalists will have to develop a working system that

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[a] Division of Gerontology, Beth Israel Deaconess Medical Center, Suite 1B, 110 Francis Street, Boston, MA 02215, USA; [b] Division of Aging, Brigham and Women's Hospital, Harvard Medical School, 1620 Tremont Street, Boston, MA 02120, USA
* Corresponding author.
E-mail address: hjavedan@partners.org

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incorporates geriatric medicine expertise into their daily work flow.[1] Although published studies have demonstrated that comprehensive geriatric units with multidisciplinary teams of specially trained clinicians (including nursing, physical therapy, and patient care assistants) achieve significantly better outcomes in both morbidity and mortality,[2] hospitals throughout the country have struggled to import the lessons of these teams to other areas of the hospital. The resource-intensive nature of these teams and the pressing need to manage bed flow in busy hospitals make the widespread implementation of these multidisciplinary units often impractical or financially impossible.[3]

As a proxy solution, many systems have attempted to create a consultative service consisting of a geriatrician alone or in concert with other clinical experts such as geriatric nurses and social workers. At first glance, it may seem randomized controlled trials are inconsistent regarding the benefits in morbidity, mortality, or functional status from these consultative services (**Table 1**).[4–14] The investigators of these studies cite a variety of factors as contributors to these negative outcomes, but 2 major trends can be observed. First is the lack of a consistent robust tool to identify patients who need this expertise. Second is the limited implementation of the geriatric recommendations by the primary team due to a variety of factors.

Several questions thus arise from this body of literature. First, what is the role of the geriatric consultative service, and what does it propose to achieve? Second, when should such a service be used as the evidence-based search for the appropriate cohort continues? Finally, how can hospitalists and geriatricians best work together? The authors of this article contend that a geriatric consultative service cannot be thought of as merely an "as-needed" provider of expert opinion, such as a rheumatology consult, nor as the provider of an isolated intervention, such as an interventional radiology consult. It is these utilization patterns that have most likely led to the lack of demonstrable utility.

Rather, the authors offer to provide insight into how care should be delivered to a population of vulnerable elderly patients in high-risk settings. Those population-level interventions can be translated into recommendations for specific individuals. However, without systematic modification of care pathways and protocols under the collaboration of hospitalists and geriatricians, patients will likely experience the same adverse effects repeatedly.

GUIDELINES FOR PRACTICE

Which patients need geriatric expertise?

The most vulnerable patients are at the highest risk of iatrogenic complications: both those that can easily be predicted, such as procedure-associated risks, and those that are more easily overlooked, such as delirium due to overnight vital sign measurement and subsequent sleep disruption. A geriatrics consult can often identify and mitigate some of these harmful factors, but identifying which patients would benefit from such a consult has proven to be a challenging endeavor.[15] Most previously performed studies did not use frailty as a criterion for patient selection; selection criteria have ranged from the following:

1. Age cutoffs only[4,5,7,14]
2. Functional impairment[10,13]
3. Cognitive impairment[12]
4. One or more features such as psychosocial stressors, specific comorbidities, or markers of high service utilization[8,9,11]