A Beginning Thought

“The immediate challenge to improving the quality of surgical care is not discovering new knowledge, but rather how to integrate what we already know.”

Urbach DR, Baxter NN. BMJ 2005
Perioperative Consult Service Collaborations: Current State

~3,200 patients/year

Average LOS 1.2d

COST $ 15-20%

Opioids

>80% intraoperatively
>80% postoperatively
>66% at discharge

*of note: no change over time with surgical services where a collaboration with PCS does not exist (urology/ENT/vascular)

Mean LOS across multiple services: No PCS = 5.17d (N=1664) v. PCS 3.94d (N=2260)

Average LOS 1.2d

COST $ 15-20%

Opioids

>80% intraoperatively
>80% postoperatively
>66% at discharge

*of note: no change over time with surgical services where a collaboration with PCS does not exist (urology/ENT/vascular)

VUMC ERAS and Perioperative Medicine Program

THE NEW OLD AGE

The Elderly Are Getting Complex Surgeries. Often It Doesn’t End Well.

Complication rates are high among the oldest patients. Now a surgeons’ group will propose standards for hospitals operating on the elderly.

By Paula Span

June 7, 2019
Optimize?

15% HI-RISE
85% ERAS

Evolution of Perioperative Medicine

- Highly Skilled, Uncoordinated Chaos
- Enhanced Recovery After Surgery (ERAS)
- Specialist Consult Service Implementing ERAS
- Hi-RISE (High-Risk Surgical Encounter) Service;
  ERAS for all others
ANEMIA

SMOKING
(Pop Health: 27% of TN residents)
ERP + Hi-RISE: Clinical Pathway
One team with one shared goal from Decision to Discharge:
Enhanced Recovery After Surgery
Safe, Effective, Efficient, Coordinated, and Co-Managed Care Across the Entire Perioperative Period

Hi-RiSE* Preop Clinic in VPEC
Collaborating with surgeons and medical specialists as a primary point of contact, care coordination, and medical management for Hi-RiSE patients pre/perioperatively.

*High-Risk Surgical Encounter

If elective surgical patients with these conditions are not optimized:

↓Outcomes  ↑LOS  ↑Cost