ACP Meeting

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Leader of the Medical Team

"We always cover the ears of the patient whenever we need to ask the nurse how to do something."

Hospitalist Co-Management

- Definition - shared responsibility, authority and accountability for the care of a hospitalized patient across clinical specialties
- "While there are opportunities for hospitalists to add real value as co-managers of surgical patients (e.g., in optimizing the medical care of patients with significant co-morbidities such as heart failure and diabetes, and reducing post-operative complications such as venous thromboembolism), the general definition of co-management is vague and varies markedly from one hospital to another."
- SNF - A white paper on a Guide to Hospitalist/Orthopedic Surgery Co-management

Co-Management

- Medicine
  - Cardiology
  - Oncology
  - Hospice/Palliative Care
  - Endocrinology
  - Nephrology
  - Neurology
- Surgical
  - Orthopedics
  - General Surgery
  - Urology
  - ENT

Hospitalist Roles

- Leader of the Medical Team
  - Multi-disciplinary Rounds
  - Documenting, Rounding, Communicating, Facilitating, Consulting
  - Co-Management
- Education
  - Medical Student
  - Resident
- Quality Improvement
  - Core Measures
  - Mortality, LOS, Pt Satisfaction
  - Readmissions
  - Management
- Transitions of Care
  - Pre-operative Evaluation
  - Transition Clinic
  - LTAC
  - SNF

Co-Management

- The Classic Question for Physicians???
Co-Management

- The Classic Question for Physicians???
  - Who is admitting and who is consulting?

- What the surgeon says:
  - “I need your help managing the medical issues”

- What the hospitalist hears:
  - “I need you to do the discharge summary”

Benefits of Co-Management

- Increased prescribing of evidence-based treatments
- Reduced time to surgery
- Fewer transfers to an ICU for acute medical deterioration
- Lower post-operative complications
- Increased likelihood of discharge to home
- Reduced length of stay
- Improved nurse and surgeon satisfaction
- Lower readmission rates

Comanagement of geriatric patients with hip fractures: a retrospective, controlled, cohort study.

- Implementation of a comanagement protocol for care of geriatric patients with hip fractures:
  - Admission to a geriatric primary care service
  - Standardized perioperative assessment regimens
  - Expedited surgical treatment
  - Continued primary geriatric care postoperatively

- Results:
  - Reductions in lengths of stay, ICU admissions, and hospital costs per patient
**Issues with Co-Management**

- Inconsistent definition from hospital to hospital
- Increases demand for hospitalists and with it a critical and potentially destabilizing hospitalist manpower shortage
- Facilitates surgeon/specialist disengagement
- Hospitalist career dissatisfaction and burnout
- Unclear delineation of responsibilities places patient at risk for conflicting/contradictory orders

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**Opportunity missed: medical consultation, resource use, and quality of care of patients undergoing major surgery.**

- **METHODS:** Observational cohort of patients undergoing surgery at a university-based hospital. The outcome measured was hospital 30-day readmission rate.
- **RESULTS:** Patients who received a medical consultation were less likely to be readmitted (6.0% vs. 10.3%; P < .001).
- **CONCLUSIONS:** Medical consultation can improve patient outcomes, and hospitalists should be encouraged to provide care in a new model of care.

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**Medical and surgical co-management after elective hip and knee arthroplasty: a randomized, controlled trial**

- **INTERVENTIONS:** A comanagement Hospitalist-Orthopedic Team compared with standard postoperative care.
- **RESULTS:** The hospitalist group had lower rates of complications (11.8% vs. 22.7%; difference, 11.8 percentage points [95% CI, 2.8 to 20.7 percentage points; P = .009]) and shorter hospital stay (5.1 days vs. 6.0 days; difference, 0.9 days [95% CI, 0.5 to 1.3 days]) compared with the standard group. The nurses preferred the hospitalist model.
- **CONCLUSIONS:** The hospitalist model improved patient outcomes and was preferred by nurses.

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**Co-Management**

- The question isn't if Hospitalists should or should not provide surgical co-management but with how, with what patients, and with what goals?

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**Building Co-Management**

- What is administration's expectations?
- One service at a time
  - Ortho’s different from Gen Surg which is different than Urology
- Define the population of patients that will benefit
  - ASA Guidelines
  - Low, moderate, high risk

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**Hospitalist Co-Management**

- **Checklist for Starting a Co-Management Service:***
  - Identify program champions
  - Identify program stakeholders
  - Hold committee meetings
  - Determine stakeholder goals
  - Develop service agreements
  - Define key program metrics
  - Address financial considerations
  - Select patients appropriate for co-management
  - Establish staffing model and communication plan
  - Develop program support materials
  - Pilot program

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ASA Classification

<table>
<thead>
<tr>
<th>ASA-PS</th>
<th>Category</th>
<th>Preoperative Health Status</th>
<th>Comments/Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Normal healthy patient</td>
<td></td>
<td>No organic, psychologic or psychiatric disturbance; the patient is not in any way incapacitated</td>
</tr>
<tr>
<td>2</td>
<td>Patients with mild systemic disease</td>
<td>Some functional limitations that is a constant threat to life</td>
<td>Has at least one severe disease that is partly controlled or at end stage; predicts a high risk of death within two years; advanced cardiovascular, respiratory, renal or other systemic diseases with intercurrent infections</td>
</tr>
<tr>
<td>3</td>
<td>Patients with severe systemic disease</td>
<td></td>
<td>Has at least one severe disease that is partly controlled or at end stage; predicts a high risk of death within two years; advanced cardiovascular, respiratory, renal or other systemic diseases with intercurrent infections</td>
</tr>
<tr>
<td>4</td>
<td>Moderate risk patients</td>
<td></td>
<td>Mixed evidence on improving LOS and functional status</td>
</tr>
<tr>
<td>5</td>
<td>High Risk</td>
<td></td>
<td>Most convincing evidence that hospitalists improve outcomes, decrease complications</td>
</tr>
</tbody>
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**Examples:**
- Decompensated Heart Failure
- Moderate COPD exacerbations
- Acute MI
- Acute CVA
- DKA
- Active Arrhythmias

**Building Co-Management**

- Put it in writing and stick to the script
  - Miscommunication between providers increases risk to patient
  - Define who manages what

- Common Questions that need addressed:
  - Who manages:
    - Post op complications?
    - Who does the nurse call for Fever? Hypotension? Low UOP?
    - Medication Reconciliation - Admission and Discharge?
    - Discharge Summary

**References**


Comanagement of hospitalized surgical patients by medicine physicians in the United States

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### References


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