LEADERS: SYLVIA MCKEAN, M.D.

Hospitalist Puts Spotlight on Comanagement

BY MARY ELLEN SCHNEIDER

Dr. Sylvia McKean was on the ground floor of the hospitalist movement in the mid-1990s, and now she is helping to spearhead a new trend: comanagement of patients with surgeons and other specialists.

"This is really, I think, the critical direction for hospital medicine," said Dr. McKean, who founded the hospitalist program at Brigham and Women's Hospital in Boston. She chairs the Comanagement Task Force and Advisory Board for the Society of Hospital Medicine (SHM), and is editing a comprehensive textbook on hospital medicine to be published in 2010 by McGraw-Hill.

As the patient population ages and develops complex medical problems, hospitalists are increasingly being asked to care for patients on other inpatient services, such as neurosurgery or orthopedics. Acute medical issues, rather than surgical considerations, may determine the timing of surgery, risk of postoperative complications, resource utilization, and hospital length of stay, Dr. McKean said.

When Dr. McKean was director of the SHM's annual meeting in 2008, she heard from attendees seeking education on comanagement as well as benchmarking data on what other hospital groups were doing. With that in mind, the SHM chartered a new task force to examine the educational needs and scope of practice issues involved in comanagement. The SHM also created an advisory board of interdisciplinary team leaders to develop an approach for establishing comanage-

ment services with orthopedic surgeons.

Drawing on the experience of hospitalist services that have already ventured into comanagement, the task force has sought to develop a framework for hospitalists in both community and academic settings. The key is to agree on the "rules of engagement," Dr. McKean said. "It's really critical to make sure everybody's on the same side of the page to prevent problems down the road."

For example, everyone involved should recognize that it's "truly" comanagement. This means that hospitalists, most of whom were trained in internal medicine or family medicine, should not function as surgical residents managing surgical issues such as wound care, which requires additional training.

Every hospital will have its own approach, Dr. McKean said, but it is critical for the two services involved in comanagement to agree on job descriptions specifying who does what—for example, when preparing discharge summaries. Those agreements should be reevaluated on a regular basis.

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Measurement also is essential for a successful comanagement program. Creating a "report card" with the most important metrics allows for "strategic planning at a glance," she said, and lets the administration see when the service needs more resources.

But Dr. McKean cautioned physicians not to look at any of the comanagement measures in isolation.

For example, there might be more delirium identified in the comanagement service than in the traditional consultation service, but that does not necessarily mean that hospitalist care is deficient, she said. Instead, it might indicate earlier identification of delirium, the admission of sicker patients to the comanagement service, or the need to target multidisciplinary efforts to improve the hospital setting for vulnerable patients. ■