Comanagement Works Best With Clear Boundaries

BY DOUG BRUNK
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SAN DIEGO — As a hospitalist, the best approach to the comanagement of patients is to define your boundaries from the start and revisit those boundaries frequently.

Ask other members of the care team specific questions, such as: What parts of this patient's care are your responsibility? What parts of the care are mine? How are we going to decide who does what?

"If you don't know what you're doing when you're seeing the patients, if you don't have a coherent and mutually agreed upon vision for how you're going to make the care better, I'm not sure that you're actually doing anything other than showing up," Dr. Eric M. Siegal said at the annual meeting of the Society of Hospital Medicine.

Comanagement relationships can be fraught with ambiguity, so he offered the following "existential questions" to ask in an effort to achieve clarity:

- Why are we being asked to comanage this patient's care?
- What are the "rules of engagement"? Do I make suggestions or decisions?
- What responsibilities are mine vs. yours?
- Where do our responsibilities overlap, and how do we manage those overlaps?
- What happens if we disagree?
- Who makes the final call?

"If you haven't at least thought these through and talked these over with the people with whom you're working, you're setting yourself up for a problem, a conflict at some point down the road," Dr. Siegal warned.

In terms of protocol, "you absolutely have to insist on uniformity," said Dr. Siegal, a hospitalist who is regional medical director of Cogent Healthcare, Nashville, Tenn. "You can't have orthopedist A doing it his way and orthopedist B doing it her way and hospitalist C doing it a third way. If this is how we're going to do it, then this is how everybody does it." This applies to hospitalists as well, who need to be vigilant that they are all practicing consistently. Because board certification in hospital medicine is not yet available, hospitalists often have significantly different skill sets.

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DR. SIEGAL

For example, if all of the members of your hospitalist program are adept at managing mechanical respiratory ventilation, that's great. But if only one member of your program can manage mechanical respiratory ventilation, "then you either have to pull that person out of the rotation to cover the vents, or nobody can manage the vents," he said. Don't have a two-tiered system "because nothing drives specialists and nurses more crazy than to see one hospitalist come in and do one thing and then see the next hospitalist either unable to do it or do it radically differently."

If you need help defining a reasonable role for a hospitalist, Dr. Siegal recommended reviewing the core competencies published in the January/February 2006 supplement of the Journal of Hospital Medicine (www3.interscience.wiley.com/journal/112396185/issue). "One size doesn't fit all, but it at least provides some framework for what the archetypical hospitalist should be able to do."

Dr. Siegal recommends negotiating your expectations with other members of the comanagement team and developing guidelines when ambiguity exists. When he was director of the hospitalist program at Meriter Hospital, an affiliate of the University of Wisconsin, Madison, he sat down with cardiologists at the hospital and devised cardiology admission guidelines so everyone would be on the same page. They agreed that the cardiologist would admit patients with specific conditions that included ST-segment elevation, myocardial infarction, and advanced heart block requiring or potentially requiring emergency temporary pacing, while the hospitalist would admit patients with a different set of conditions that included chest pain of uncertain etiology and atrial arrhythmias.

"Does this cover every possible permutation? No," Dr. Siegal said. "But the point was, we agreed on a basic set of rules up front. We disseminated them, put them in the emergency department, and it lowered the number of confusing calls and decreased the amount of angst. It's worked really nicely. As much as you can, cookbook this stuff up front so you know what the rules are."

Revisiting the comanagement relationship after the first few months is a good idea, he noted, "because perspectives change, sometimes for the better, and sometimes for the worse." As a case in point he described a surgeon he worked with who was initially skeptical of hospitalists. One day Dr. Siegal was called to stabilize one of the surgeon's patients who was crashing in the postanesthesia care unit. The surgeon was busy with a case at another hospital when this occurred.

"I took care of that patient and the next thing I knew, I could do no wrong," Dr. Siegal recalled. "I'm not sure how I went from being marginally competent to very competent based on one case, but from his perspective I was and that was good enough. The point is, relationships change, but they may not always change for the better. One screw-up can radically change the relationship for the worse as well."

He acknowledged that there will be people in comanagement relationships whom you won't get along with despite your best efforts. "So you have to be thoughtful about what you're getting yourself into in the first place," he said. ■

Hospitalists Are Ideally Suited to Lead Quality Improvement

BY DOUG BRUNK
San Diego Bureau

SAN DIEGO — The way Dr. Mark Novotny sees it, hospitalists are uniquely qualified to lead hospital-based quality improvement projects because they encounter inefficiencies on a daily basis such as missing lab specimens, lost chest x-rays, or a patient they've been asked to see who has been moved to another room.

"The inefficiency and waste of hospital processes are not just an observation on a spreadsheet, they're your day," he said at the annual meeting of the Society of Hospital Medicine. "Those inefficiencies and waste in your day are multiplied by every other caregiver, and the patient. Most estimates are that 30% of health care dollars are completely wasted. That's a lot of money."

A key factor to leading a quality improvement project is the willingness to accept accountability for managing resources, said Dr. Novotny, a hospitalist who is chief medical officer of Southwestern Vermont Health Care, a not-for-profit consortium of services based in Bennington, Vt. The goal of your project might be to align resources to accomplish performance improvement, reduce harm to patients, achieve reliable processes, or reduce waste of time and money. Whatever it is, "choose an issue about which you're passionate," he advised. "Volunteer to lead a task force, understand the resources, and pick a measurable goal and time frame. Get the training you need to understand how to set a goal, measure, and improve."

It also helps to "think like the administrators" in your practice setting and be able to articulate how the project will save money and improve quality. "The cost of poor quality is something that you can identify and take to the administrators for support of your project," said Dr. Novotny, who became a physician leader after starting out as a general internist 26 years ago. "There are reimbursement issues that are now tied to quality measures. Find out what quality issues the administration is already worried about."

When starting a quality improvement project, 'choose an issue about which you're passionate.'

DR. NOVOTNY

He offered the following tips for leading quality improvement projects:

- **Use your clinical knowledge to bring forward system problems.** "You know where the problems are out there," he said, adding that efficient data capture and data management are common challenges in today's practice environment.
- **Acquire the performance improvement skills you need.** Take the Society of Hospital Medicine's Quality Improvement Pre-Course, courses at the Institute for Healthcare Improvement or Intermountain Health Care, or learn the tools from your own quality department.
- **Find partners who will work with you and support your goal.** These may include nursing leaders, the chief medical officer, the chief operating officer, or case managers. "They're out there, and they can advocate the goal that you have," he said. "They don't have to work for you, but they can support your goal."
- **Use the politics of your organization to help you.** "To me politics means the informal organizational chart," Dr. Novotny said. "It's knowing who has influence, and being able to anticipate who's going to get in your way at your next meeting. It's knowing how to move something through your organization using influential people."
- **Get someone from finance on board with the project.** "You can get a finance manager or the chief financial officer to look at your data or your proposal before you take the project to the next level," he said.
- **Get somebody with experience in quality/safety issues to help you design the project.** "I've only recently begun to understand how complicated this is, because most of the processes you work in are chaotic," he said. "They need design to become standardized, and it's not easy."
- **Learn to run a meeting efficiently.** "When you do this well, people will come to your next meeting," he said.

If your quality improvement project is successful, don't take sole credit for the success. "Always credit the team and be quiet," Dr. Novotny said. "When you credit the team, they'll come back for more, and then you'll get something else done. If you credit yourself, your team feels devalued. That was your last group project."

He acknowledged that the hardest part of spearheading a quality improvement project is balancing the amount of time you spend on it. Hospitalists "have so much energy and passion for this work that people are using their own personal time," he said. "I don't think that's a sustainable model. People are going to burn out. Don't do this without resources. You need an administrative assistant or someone to help you. You need to negotiate" for those resources. ■