Surgical Comanagement: Look Before You Leap

BY PATRICE WENDLING

CHICAGO — Hospitalists are increasingly being asked to comanage patients with their surgical colleagues, but experts contend that this role should be carefully developed.

Some hospitalists may start comanaging patients as a collegial enterprise or because they've received "an offer they can't refuse" from their hospital CEO or department chair, Dr. Jeffrey Glasheen, director of hospital medicine at the University of Colorado, Denver, said at the annual meeting of the Society of Hospital Medicine.

For other hospitalists, comanagement evolves gradually. For example, if an increasing number of hip fracture patients are admitted to the hospitalist service via the emergency department, hospitalists eventually may find themselves comanaging almost every orthopedic patient.

Before getting into comanagement arrangements, hospitalists should consider what they're trying to accomplish and pay close attention to the potential for intended and unintended consequences, said copresenter Dr. Eric Siegal, of the University of Wisconsin, Madison.

"We should use some selection criteria to determine when to comanage," Dr. Siegal said. " 'Just do it' is a great slogan—if you're a shoe company."

Comanagement can improve patient care, but it isn't a panacea. Potentially, comanagement can delay appropriate care, bypass established protocols, and disengage subspecialists. Conflicting orders and reports given by hospitalists and other physicians can confuse patients and the care team about who is doing what, ultimately increasing the risk of medical error.

The presenters agreed that the first step is to nail down the goal of comanaging a patient population. Ideally, hospitalists should focus on patients who will benefit the most from their involvement, such as those with significant medical comorbidities, Dr. Siegal said. Hospitalists should ask what problems they're expected to fix, whether their involvement is the best solution, what their involvement might jeopardize, and how to determine if comanagement has been successful.

There is no standard used to define the role of the hospitalist, Dr. Siegal acknowledged. Comanagement varies within institutions and even between groups of physicians, ranging from traditional medical consultation to a model in which hospitalists admit and assume primary responsibility for patients requiring surgical or subspecialty care.

Hospitalists should make it clear at the outset that their relationship with surgeons or subspecialists is one of equals, and should avoid becoming the hospital "admitologist" or "dischargologist." Attempts should be made to decide who owns what aspects of care, agree when subspecialists must come in to see a patient, and define which patients should go to which service, Dr. Siegal said.

Audience members noted that financial considerations often drive the decision to expand hospitalist comanagement services, thereby freeing up higher-revenue providers. Some hospital leaders may view comanagement as a way to protect overstretched surgeons and subspecialists. This can result in overextended hospitalists who make mistakes, deliver poor care, and burn out professionally, Dr. Glasheen said.

Defining the scope of hospitalist practice is another challenge. The Core Competencies developed by the Society of Hospital Medicine define in broad terms what hospitalists do, but not what they can't do, Dr. Siegal said. Hospitalists should be wary if they find that comanagement evolves into a substitute for subspecialist care; if they are doing things on nights, weekends, or holidays that they wouldn't do on weekdays; or if the emergency department sends inappropriate patients to them because it's easier than calling the surgeon or subspecialist.

After rules of engagement are clearly defined and mutually agreed upon, they must be applied consistently. Problems can arise if hospitalists have different skill sets and apply them inconsistently. For example, one hospitalist on the team manages vents, but the next day another team member won't. If asked to comanage patients outside the scope of their training, hospitalists should negotiate for additional skills training, support, or equipment to allow them to do so competently and safely, Dr. Siegal said.

Hospitalists often ask if it matters if they are the attending physician of record for a patient. Theoretically, hospitalists are not legally responsible for a surgeon's decisions or problems that may arise during surgery, but they will inevitably be named in a lawsuit if their name is on the chart, Dr. Glasheen said. He advised hospitalists to document carefully if they disagree with the management of a patient.

Ultimately, Dr. Siegal said, comanagement may be best defined by a simple rule. If it "matters" who the attending physician of record is, then one service is by definition subordinate. As far as he is concerned, that is not comanagement.

Whether listed on a chart as an attending, a consultant, or a comanager, a hospitalist remains ethically and morally responsible for the patient, Dr. Glasheen added.

Dr. Siegal and Dr. Glasheen disclosed no relevant conflicts of interest. ■

CMS Adds Readmission Data to Hospital Compare Web Site

Nearly 20% of Medicare patients who are admitted to the hospital after an acute myocardial infarction will be readmitted within 30 days, according to historical data released by the Centers for Medicare and Medicaid Services.

The all-cause, 30-day readmission rate for acute MI (19.9%) is similar to rates for patients originally admitted for heart failure (24.5%) and pneumonia (18.2%). The figures, which are based on 3 years of data, were posted to Medicare's Hospital Compare Web site. The 30-day readmission rates were produced using statistical models that rely on Medicare claims and enrollment information, according to the CMS.

The Web site (www.hospitalcompare.hhs.gov) provides consumers with quality information on local hospitals. The analysis of readmission rates is part of the Obama administration's larger health reform efforts, including his proposal to bundle payments for inpatient services and postacute care within 30 days of discharge.

"The President and Congress have both identified the reduction of readmissions as a target area for health reform," Health and Human Services Secretary Kathleen Sebelius said in a statement. "When we reduce readmissions, we improve the quality of care patients receive and cut health care costs."

The Hospital Compare readmissions data include individual hospital information, as well as national figures. It allows consumers to learn if a hospital's readmission rate is better, the same, or worse than the national rate.

The readmission data do not include planned hospital treatments such as a readmission for a scheduled heart bypass or coronary angioplasty. The data also exclude readmission of patients who left the hospital against medical advice.

Launched in 2005, the Hospital Compare Web site also includes mortality data and scores on patient satisfaction measures, 25 process of care measures, and 2 children's asthma care measures.

—Mary Ellen Schneider