Co-Management & Consultation

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Agenda

• Large group with case discussions
• Small groups with brainstorms elements of a co-management program from your institution
• Report out
Namrata’s Case

• 10 year old with FUO and extensive lymphadenopathy
• Thorough infectious workup negative; lymphoma top of differential
• Oncology recommended excisional lymph node biopsy of cervical or axillary lymph node
• Surgery consulted and oncology’s recommendation for site of excisional biopsy communicated
• 10 minutes prior to procedure, surgery attending informed mother that cervical lymph node excision wasn’t needed and worse cosmetically
• Proceeded with inguinal lymph node excisional biopsy without discussing with hospitalist or oncology teams
• Inguinal lymph node biopsy negative; oncology and pathology agreed cervical lymph node biopsy was needed to exclude lymphoma
• Mother asked to talk to surgeon before considering repeat biopsy
• Surgeon stood by original opinion that cervical lymph node biopsy was unnecessary and that is what he would communicate to mother
Jennifer’s Case

- 12 mo with Dandy-Walker malformation, hydrocephalus, dysgenesis of the corpus callosum, developmental delay
- VP shunt placed at 4 mo, shunt infection at 7 mo, needing replacement
- Presented with vomiting and lethargy for 2 days, afebrile, no infectious symptoms
- Day 1 - Admitted to Neurosurg, shunt series done and felt to be normal
- Day 2 - Peds consulted to work up vomiting
- Concerned for increased ICP (HR 120 > 80, BP 80 >100, lethargy, occasional apneas)
- Peds team d/w Neurosurg fellow re: concern for raised ICP and Peds team told not concerned about shunt malfunction
- Day 3 - Peds team again raised concerns for increased ICP with Neurosurg
- Patient then became bradycardic, unresponsive, apneic, pupils assymetric and code called
- Neurosurg took directly to OR for emergency EVD
Basic Rules About Consultation

1. Tell the consultants why you are consulting them.
2. The quality of the consult is directly proportional to the quality of the questions that are asked.
3. Never badmouth another physician to a family – it just makes everyone [including you] look bad.
4. The medical record is for documentation, not communication.
5. All involved physicians should speak to the family/patient with one voice.
6. Don’t forget that the radiologist is also a consultant.

[Hentel and Khorasani J Amer Coll Radiol 2012; 9:231]
What You Should Expect From Consultants

- **Appropriateness**: no fighting off consults
- **Timeliness**: correct pace of consult and evaluations
- **Thoroughness**: both recommendations and rationale
- **Consistency**: especially among members of the same specialty
- **Narrow Focus**: just address their own issues
- **Communication**: with the requesting physician and the family, including the appropriate use of translation services
10 Commandments of Effective Consultation

• Determine the question/customer
• Establish urgency
• Look for yourself
• Be as brief as appropriate
• Be specific, thorough, and descend from your ivory tower to help

10 Commandments of Effective Consultation

- Provide contingency plans and discuss their execution
- Honor thy turf, but (in some cases) negotiate joint title
- Teach...with tact and pragmatism
- Talk is cheap, effective, and essential
- Follow-up

Becky’s Case

• You are working as a community hospitalist whose job it is to “co-follow” all surgical patients < 12 to help with mgmt of meds, pain, and to be first call (surgeons are often stuck in OR)
• The surgeons recently switched to a 24-hr call system, where there is a different surgeon each day
• You admit a child with ruptured appendicitis for IV antibiotics with the hope of a delayed surgery in a few weeks then go off service
• When you return 4 days later he looks worse with persistent fever, increasing inflammatory markers, and worsening pain
• While you were gone, the surgeon each day had a similar opinion: “Let’s wait and see if he gets better in the next 24 hrs”
• You speak to a nearby children’s hospital’s pediatric surgeon who requests the patient be transferred
• The chief of general surgery at the community hospital apologizes, acknowledges the child’s suboptimal care, and that the team approach needs to be improved upon
Case

- 5 yo healthy child admitted post-op S/P CRPP of type IV supracondylar fracture to hospitalist team with orthopedics consulting
- Pediatric resident responsibilities – place orders, complete paperwork
- Patient arrived to floor without any pass-off from Orthopedics
- Ortho resident ordered antibiotics in PACU that weren’t part of standard order set
- Ortho resident communicated to family they would be discharged after arrival to floor
- On eval by Peds team, family expecting d/c despite poor PO and inadequate pain control
- Roles and responsibilities of Ortho team addressed with Ortho resident, Ortho chief resident, and Department Chair
- Antibiotics order discontinued and event report placed in electronic error reporting system
Co-Management

shared responsibility, authority, and accountability for the care of a hospitalized patient across clinical specialties
• In practice, co-management varies widely, ranging from a model of care indistinguishable from traditional medical consultation to one where hospitalists admit and assume primary responsibility for surgical and specialty patients.
• Variability makes it difficult to study and make generalizations about role and impact of hospitalist co-management.
• Recent evidence suggests that hospitalist consultation and co-management may not be as effective as originally anticipated.
Co-Management Outcomes

• Hospitalist Orthopedic Team (HOT) trial – Huddleston et al: RCT 526 joint replacement pts
  – Hospitalist co-management reduced minor complications such as UTI, fever, hyponatremia
  – No effect on moderate or major complications
  – Modestly reduced adjusted LOS defined as the point at which patients were deemed stable for discharge, by 0.5 days, but had no impact on actual LOS or cost per case

• Simon et al: retrospective study of pediatric spinal fusion patient
  – Hospitalist co-management of high risk pts only (12%)
  – Low-risk pts mean LOS decreased by 21% vs. for high-risk, hospitalist-comanaged pts where LOS decreased by 28%
Current State of Co-Management in PHM

- 92% of PHM providers care for surgical patients through consultation
- 65% report working on co-management models
- Often collaborate with surgical residents, midlevels, and attending surgeons to provide care to surgical pts
Pitfalls

• Families left in middle when medical and surgical providers disagree
• Resident education may suffer from attending level conversations and withholding of experience from surgery residents in basic medical care post-op
Community Hospital Pediatric Surgical Co-Management

Challenges
• Predominantly healthy children
• Non-pediatric trained staff
  – Surgeons
  – Anesthesiologists
  – Nurses (OR, PACU, Floor)

Opportunities
• Clinical
  – Pain
  – Fluids
  – Medication dosing
  – Medical co-morbidities
• Communication
  – Family
  – Primary care provider
  – Care team

Rationale for Co-Management Program Development

**Specialist or Surgeon**
- Medical Complexity
- Specific Knowledge Base
- Time Constraints

**Administration**
- Sentinel Event
- Administration Concerns
- Outcomes Data
- Marketing

**Hospitalist**
- Quality and Safety
- Clinical Diversity
- Expand Practice / Enhance Skills
- Facilitate Communication
SHM Co-Management Task Force
5 Keys to Success

1. Identify Obstacles and Challenges
   – Stakeholders, goals, risks, assumptions

2. Clarify Roles and Responsibilities
   – Whose service?, hospitalist role/delineation of responsibilities, communication, documentation
   – Document these in a statement of understanding or service agreement!

3. Identify a Champion

4. Measure Performance
   – Length of stay, hospital cost and ancillary utilization, satisfaction, readmission rates, quality/safety metrics

5. Address Financial Issues

The Society of Hospital Medicine’s Co-Management Task Force. Hospitalist Co-Management with Surgeons and Subspecialists
Michelle’s 6\textsuperscript{th} Key to Success: Understand Culture

Intermountain Riverton Hospital

\textit{I can and I will...}

Intermountain Primary Children’s Medical Center

\textit{The Child First and Always}