

The Evolution of Co-Management

— *In Hospital Medicine* —

Co-Management Workgroup 2016-2017 Roster

Chair:

Hardik Vora, MD, MPH
Riverside Medical Group

Members:

Bill Atchley, MD
Sentara Medical Group

Stephen Behnke, MD
Med One

Chris Cockerham, MD
Marietta Memorial Health System

O'Neil Pyke, MD
Medicus Healthcare Solutions

Roy Sittig, MD
Sound Physicians

Staff:

Patrick Vulgamore, MPH
Society of Hospital Medicine

The charge of the Co-Management Work Group of the Practice Management Committee is to define the roles of hospitalists within co-management systems while articulating what a successful co-management system looks like.

© Copyright 2017 by Society of Hospital Medicine. All rights reserved.

No part of this publication may be reproduced, stored in retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording, or otherwise, without prior written consent. Unlawful scanning, uploading and distribution of this book via the Internet or via any other means without the permission of the Society of Hospital Medicine may be punishable by law. For more information or to obtain additional copies contact SHM at: Phone: 800-843-3360.

Website: www.hospitalmedicine.org/practicemanagement

Introduction and Background

Per data extrapolated from the 2015 American Hospital Association survey, 92% of hospitals with more than 200 beds utilized hospitalists (penetration has steadily risen since 2003, when it stood at 46%). One of the myriad reasons that hospital medicine has grown so quickly in both the number and compensation of providers (10.2% increase in compensation from 2014 to 2016) is due to the value that hospitalists bring in the co-management of patients. The Society of Hospital Medicine (SHM) recognized this synergy and, in 2006, produced best practices, toolkits, sample agreements and case studies on hospitalists' roles in co-management. Given the evolution of hospitalists' scope of services and the ever-growing specialization of hospitalists, SHM's Board requested that the Practice Management Committee form a workgroup to provide an update on co-management in hospital medicine. The following document should be used as a guide while establishing the co-management agreement between the hospitalist team and the non-hospitalist specialty team to provide clarity and set expectations for the entire care team.

92%
of hospitals with more than
200 beds utilized hospitalists

Over the past two decades, hospital medicine as a specialty has grown and evolved rapidly, resulting in various hospital medicine models. As predicted,¹ Hospital Medicine Groups (HMGs) were found to bring significant value in the care of hospitalized patients, while simultaneously improving the efficiency of health systems and hospitals. Hospitalists were utilized to streamline the flow of patient care and provide improved clinical access for patients in the hospital. One way that hospitalists have increasingly been utilized, particularly over the last decade, is in a co-management role alongside subspecialty partners in ways that are considered non-traditional to primary care trained physicians, such as in neurosurgical, orthopedic, oncologic or other subspecialty patient groups.² Co-management models have shown significant positive effects on patient care with decreases in hospital mortality rates, improved patient safety and improved pain scores.³ Not only has it been proven to be preferential among clinicians,⁴ co-management has been associated with significant cost savings per hospitalization.⁵ Most recently, Rohatgi, et al. (2016) found that intervention by surgical co-managing hospitalists was associated with a significant decrease in medical complications, length of stay (LOS), 30-day readmission rates, number of medical consultants and cost of care, and a nonsignificant increase in patient satisfaction.⁶

Often, co-management arrangements are coordinated as a solution for subspecialist staffing or coverage issues, medical complexity in surgical patients or for the efficiency of the emergency department. An unintended consequence of co-management arrangements can be inconsistent interpretation of the roles and responsibilities to the patient between the hospital medicine inpatient generalist and the subspecialists.⁷

Over the past two decades, hospital medicine as a specialty has grown and evolved rapidly, resulting in various hospital medicine models.

Pearls of Wisdom

- **Programs that have bi-directional agreements in place are more successful.**
 - Hospitalists and subspecialists should have equal stake/say in the structure of the agreement.
- **There should be solid conflict resolution plans. Conflicts are broadly divided in two major categories: operational and clinical.**
 - Operational conflicts should be escalated to the leadership of both groups for resolution. If no resolution is reached, the conflict should be escalated to hospital administration, medical staff leadership or medical group leadership, depending on the governing structure of the groups.
 - Clinical conflicts are typically handled by the attending physician. If one remains concerned about clinical practice, the conflict should be escalated to leaderships of each group, and possibly the quality review committee at the hospital.
- **All providers must function within a well-defined and appropriate scope of practice based on their training and experience — e.g., hospitalists should not be expected to or be responsible for determining timing of procedure (surgery or intervention) and/or postprocedural care and monitoring, even if they are the attending of record.**
 - Similarly, specialists should not be expected to or be responsible for managing chronic medical issues or identifying and managing acute medical issues, even if they are the attending on record.
- **Incorporate systematic review of co-management agreements in the workflow to examine the outcomes (positives and negatives) of co-management and adjust as and when necessary.**

Co-Management Models

There are two primary models that incorporate hospitalists as co-managers. The first model assigns the hospitalist as the patient's primary attending, utilizing the subspecialist as a consultant. The second model assigns the hospitalist to serve as a consultant to the patient while the subspecialist is the patient's primary attending.

Either model can work effectively in the right circumstances, with agreement and support from the collaborating parties. However, if the co-management structure is not clearly defined, inconsistent expectations or frequent misinterpretation of roles may develop for key hospital stakeholders, such as the nursing staff, other medical staff members and often for the co-managers themselves. The factors involved with the roles in the co-management program will vary depending upon the type of model chosen.

Collaborative Practice Agreements

Regardless of the model chosen, co-management programs need to provide clear guidance for all parties through a comprehensive written policy known as a Co-Management Agreement or Service Line Agreement (also known as a Memorandum of Understanding [MOU] in some institutions). Such an agreement should be designed with all engaged parties that outlines the roles and responsibilities of each provider type involved in patient care. Particularly, an agreement should ensure continued provider engagement throughout the patient care episode, with focus around handoffs and sign-offs during the episode.

A well-crafted agreement should also identify critical communication processes and clinical expectations to avoid compromising patient safety and putting patients and providers at risk. If the co-managers cannot come to agreement of an appropriate level of engagement, then a co-management program should NOT be developed for the service lines.

Due to the unique characteristics and locations of our healthcare systems around the country, a one-size-fits-all approach to co-management does not exist. Roles/responsibilities and scope of practice of hospitalists in a co-management model must consider “local factors” to develop an effective and sustainable co-management program. Even the best-defined agreements and programs cannot foresee or account for all contingencies. All parties should recognize that changes may need to occur in the agreement over time based on the co-management experiences and patient and staff satisfaction/clinical outcomes. Best practice would suggest having co-management set up as collegial arrangements with open lines of communication. A conflict resolution pathway, as stated above, will help to mitigate patient safety concerns in the involved service lines as unintended or unforeseen conflicts often arise.

Things to Look Out For

The most significant concern for co-management programs is ensuring that all parties involved are functioning within the scope of their clinical training and expertise. A high-quality co-management model will develop and incorporate appropriate clinical boundaries and clear pathways for provider coordination and communication. Scope creep can occur, for example, when a hospitalist is designated as the attending physician of a patient with a primary clinical issue that falls outside of the scope of traditional hospitalist training. Without adequate engagement of the consultant, there is increased risk and frustration for the hospitalist and likely poorer clinical outcomes for the patient.

A challenge in this situation could arise if staff and/or patients direct inquiries toward the hospitalist that are best answered by the subspecialist involved in the patient’s care. This type of situation may place the hospitalist in an awkward position of having to make decisions about a medication or treatment plan with which they’ve had limited exposure or experience. Consequences then may result in provider (both hospitalist and subspecialist) dissatisfaction and burnout, increased redundancy of care and inefficient resource utilization, along with increased medical-legal risk. Skill sets and subspecialty expertise of hospitalists vary widely depending on experience, and a well-defined agreement ensures appropriate clinical expectations for all roles.

Things to Look Out For

There is, however, a rationale for having hospitalists serve as the primary attending on surgical or other subspecialty hospitalized patients where the hospitalist does not have detailed training on that type of subspecialty patient. This is related to hospitalist expertise in standardization of processes within the workflow of the hospital. Hospitalists bring the following strengths to this type of agreement:

- emergency room (ER) flow
- electronic medical record (EMR) and order set usage
- clinical processes
- social work/case management connection
- patient/family discussions

As some surgeons or medical subspecialists may have less time to dedicate to the minute-to-minute inpatient care, while spending daytime hours in the operating room (OR) or outpatient clinic, hospitalists may have more time to dedicate to hospital processes, helping generate standardized management streams that could improve patient satisfaction, hospital care transitions and overall hospital flow.

When designing a co-management program or agreement, here are some considerations:

- The current **culture of your organization** is an important contributor. If you have traditionally cared for a group of patients, should you continue to provide that care or did it spring from a previous need and is no longer in the patient's best interest? For example, if the staffing for subspecialists was limited and the hospitalists agreed to admit their patients, and now they become fully staffed, should the arrangement continue?
- In certain **practice settings** (e.g., rural, suburban vs. urban, academic vs. community hospitals) with limited available resources (e.g., size of specialty group may influence structure of co-management program), the HMG might be tasked with more responsibilities. An example of this occurs when specialist group size is too small to provide sustainable 24x7 coverage.
- **Training, knowledge base and experience of hospitalists:** Do your hospitalists have the training, knowledge base and skills to take on additional responsibilities that come with being the attending physician in a co-management agreement? Do you have resources available for ongoing skill development for your providers?

Things to Look Out For

- **Provider engagement** is the single most important factor influencing success of co-management programs. Co-management programs are unlikely to succeed if providers are not truly engaged. Risk of provider disengagement is higher when the co-management program is an arrangement of convenience for specialists and not driven by goals of adding value and improving the quality and efficiency of patient care.
- **Impact of staffing and provider satisfaction:** Do you have adequate staffing for additional patient volume? Unstructured growth of a HMG's patient volume through co-management agreements can lead to significant staffing shortages and instability within the HMG.
- **Role of nurse practitioners (NPs) and physician assistants (PAs):** Consider optimizing NP and PA expertise while developing co-management programs. NPs and PAs can play a vital role in building sustainable co-management programs when appropriately trained and deployed.
- **Financial impact** of co-management program: Co-management can have both positive and sometimes negative impacts on the hospital, the hospitalists and the subspecialists, especially if not carefully designed. A carefully designed co-management program can have a positive financial impact by improving documentation, and LOS (e.g., optimal management of chronic comorbidities and early recognition/management of acute medical issues, improving medication management).
 - As we move to a value-based healthcare delivery system, it is critical that we carefully examine and remove redundancy in healthcare. Do you have two providers managing the same problem? Would your co-management program be viable as transition away from a fee-for-service approach?
- **Medical-legal risk** of both co-management models.
- Considerations for different models:
 - If using the **hospitalist as consultant**, at what point should the hospitalists sign off; what is the role of the hospitalist in managing coordination of care?
 - If using the **hospitalist as primary**, how does the program ensure engagement by the subspecialists throughout the patient stay? How does the program ensure that hospitalists' responsibilities are within their scope of practice and clinical training?

It is important to consider and develop a co-management program that works for your practice setting. Regardless of the hospitalists' role (e.g., consultant vs. attending) in the co-management program, they must function within a well-defined and appropriate scope of practice, based on their training and experience. It is critically important to set clear expectations and define roles and responsibilities of each provider that are within their scope of practice and consistent with their training and expertise.

No matter how your co-management practice is set up, it is important that you always ensure that patient safety is at the cornerstone of the agreement. While provider convenience may be a central motivator, it is paramount that the patient be placed at the center of all negotiations. A successful co-management agreement allows providers to deliver high-quality, cost-efficient care for our patients.

Metrics for Successful Co-Management Program

Here are some suggested metrics to determine the value of a co-management program. The success of co-management programs can be defined and measured in various ways, with the following three broad categories serving as a foundation.

- **Quality** metrics are key to proving how hospitalists are adding value to patient care, and co-management agreements make it clear on how to most effectively disperse expertise. A few examples include:
 - Medication reconciliation accuracy
 - Readmissions
 - Hospital-Acquired Infection (HAI) reduction
 - Order set compliance
 - Timing to surgical intervention
- **Engagement** metrics will help articulate the effectiveness of co-management agreements, as imprecision or lack of co-management agreements can cause misinterpretation of roles and dissatisfaction, leading to burnout. Consider the following measures when examining the effect of a co-management agreement:
 - Provider satisfaction
 - Ancillary services satisfaction
 - Recruitment and retention (for both specialists and hospitalists)
 - Patient satisfaction
- **Financial** components are important to track for the purpose of program sustainability, especially considering the shift to value and stewardship of limited resources. Here are a few examples of data points:
 - Clinical documentation accuracy
 - Length of stay
 - Resource utilization

Innovations in Co-Management

Over the past 20 years, the concept of co-management has evolved and will continue to evolve. In the early years of hospital medicine, hospitalists were primarily the attending physician for primary care physicians' hospitalized patients. As hospital medicine evolved, hospitalists became involved in co-management of medical subspecialty patients, then on to the co-management of surgical patients. What does the future hold for other areas of co-management? Already, hospitalists are being asked to co-manage pregnant patients with medical illness and interventional radiology patients requiring overnight stay. In some parts of the United States, hospitalists are being asked to co-manage psychiatric patients as well as patients being evaluated for coronary bypass surgery. There is a logic behind the present and the future states of co-management, as it plays an integral role involving the management of acute and chronic medical issues and facilitating care coordination. The future development of co-management will now be driven by issues that, if dealt with proactively, will only lead to better patient care, more efficient healthcare delivery and subsequent further expansion.

Over the past

20 Years,

the concept of co-management has evolved and will continue to evolve.

Presently, hospitals are facing potential payment penalties regarding Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and readmissions. With the growth of alternative payment models (APMs) such as accountable care organizations (ACOs) and bundled payments for care improvement (BPCI), well-functioning co-management arrangements will be in even higher demand. The focus on high value will be the reality that all physicians will face in the 21st century. The success of the co-management evolution will depend on understanding the drivers behind it. Understanding the rationale for the request from subspecialists and the hospitals will help to develop programs that meet the needs of the subspecialists, patients, hospitals and hospitalists.

Co-Management Toolkit

As stated in the introductory paragraph, SHM built a **comprehensive toolkit for co-management in 2006**. The current workgroup updated that toolkit to reflect the evolution of co-management over the last 10 years. In the toolkit, you'll find a guide to building a co-management program; case studies; sample co-management service agreements; and tips on documentation, coding and billing. If you have any specific questions, ideas, suggestions or experiences in co-management at your hospital, please post to the **Practice Management Community on HMX**.

References

1. Wachter RM, Goldman L. The emerging role of “hospitalists” in the American health care system. *N Engl J Med.* 1996;335:514-516.
2. JACC: Heart Failure. *J Am Coll Cardiol HF.* 2013;1:445-453.
3. Tadros et al. Society of Clinical Vascular Surgery - 2015 pgs 1550-1555.
4. Huddleston JM, et al. Medical and surgical comanagement after elective hip and knee arthroplasty: a randomized, controlled trial. *Ann Intern Med.* 2004 Jul 6;141(1):28-38.
5. Auerbach AD, et al. Comanagement of surgical patients between neurosurgeons and hospitalists. *Arch Intern Med.* 2010 Dec 13;170(22):2004-2010.
6. Rohatgi N, Loftus P, Grujic O, Cullen M, Hopkins J, Ahuja N. Surgical comanagement by hospitalists improves patient outcomes. *Ann Surg.* 2016;264(2):275-282.
doi:10.1097/sla.0000000000001629
7. Cheng HQ. Comanagement hospitalist services for neurosurgery. *Neurosurg Clin N Am.* 2015 Apr;26(2):295-300.