Comanagement Hospitalist Services for Neurosurgery

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KEYWORDS

• Comanagement • Medical consultation • Hospitalists • Physician satisfaction • Cost effectiveness • Care coordination • Perioperative management

KEY POINTS

- Comanagement is a rapidly growing care model that lets the hospitalist share the responsibility, authority, and accountability for the care of the surgical patient.
- Features of comanagement include advance negotiation of an agreement between hospitalists and surgeons, criteria for automatic hospitalist engagement, and broad scope of practice and for the hospitalist.
- Implementation of comanagement enhances provider satisfaction and the efficiency of care, but has not been shown to improve clinical outcomes.
- Potential pitfalls of comanagement include fragmented care and disengagement of the surgeon; careful planning prior to implementation of comanagement can reduce these risks.

INTRODUCTION

Surgeons have long depended on medical specialists (either general internists or subspecialists) to provide advice and assistance in caring for their patients. In this traditional consultation relationship, medical specialists have limited roles and responsibilities. They saw patients only at the surgeon's request and focused on the narrow topic of the consultation question. They left recommendations for care but deferred to the surgeon to implement them. While traditional consultation still exists, a more collaborative comanagement model is gaining popularity.

EMERGENCE OF HOSPITALIST COMANAGEMENT

Growth of Comanagement

Comanagement is a negotiated relationship that lets the medical specialist share the responsibility, authority, and accountability for the care of the surgical patient. Although any medical specialty can comanage surgical patients, this role has largely fallen to hospitalists. Hospital medicine emerged in the 1990s and has become the fastest growing medical specialty.[1] Because of their availability to care for inpatients, familiarity with the hospital's operations, and capability of managing a broad range of medical problems, hospitalists are the natural providers of perioperative care. As a result, comanagement of surgical patients by hospitalists increased by over 11% per year between 2001 and 2006.[2] Factors contributing to this growth include:

- Patients once deemed too old or medically complicated to undergo elective surgery are now routinely having operations. This requires more frequent and intensive involvement of physicians able to provide perioperative medical care.
- Competing responsibilities and financial incentives reduce the time surgeons can spend

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taking care of postoperative patients on the wards. In teaching hospitals, duty hour restrictions also limit resident availability.

- Surgeons are more willing to share responsibility for the management of their patients' medical problems. A 2007 study found only a minority of surgeons believed that consultations should be limited to a specific question or that consultants should not write orders without prior discussion. A majority of surgeons desired a comanagement relationship.[3]
- Medical centers have promoted hospitalist comanagement, hoping to improve efficiency and patient safety, as hospitalists have demonstrated in the care of medical patients.[4]

Features of Comanagement

The specific features of a hospitalist comanagement service depend on the needs of the surgeons and resources available to the hospital medicine group. However, comanagement differs from consultation in several aspects (Table 1).

Comanagement relationships are negotiated in advance

The surgeon and hospitalist must have a prior understanding of their respective roles and responsibilities. These are described in a comanagement agreement. This is particularly important for management issues that require shared responsibility, such as discharge planning.

Comanaging hospitalists can select which patients to see and what problems they will manage

The hospitalist can automatically see patients who meet predetermined clinical criteria, which were negotiated as part the comanagement agreement. These might include admitting diagnoses (eg, all patients with subarachnoid or subdural hemorrhage), medical comorbidities (eg, coronary artery disease or diabetes), or demographic features (eg, age over 70 years or admission to a critical care unit). Instead of depending on the surgeon to formulate a specific question, comanaging hospitalists have broad latitude to address most medical issues they identify.

Comanagement allows the hospitalist to write most orders without the surgeon's approval

Exceptions to the hospitalist's order writing privileges, such as initiation of anticoagulation, are delineated in the comanagement agreement.

Comanagement may include nonclinical collaboration

Although comanagement focuses on direct patient care, a successful relationship often evolves into a broader alliance between surgeons and hospitalists. Hospital medicine groups often play key roles in patient safety and hospital quality improvement endeavors. Surgeons who may have less experience or availability to address these concerns have collaborated with hospitalists to optimize their systems of care. Surgeons and hospitalists may also provide reciprocal education through conferences. In academic settings, comanagement relationships have also yielded joint research and publication.

Comanagement can occur whether a patient is under the care of the surgeon or hospitalist as the attending physician of record. In teaching hospitals, the surgeon typically remains the primary attending physician, with the hospitalist charting and billing as a consultant. In community hospitals, however, these roles are sometimes reversed. The hospitalist may have primary

Table 1
Differences between consultation and comanagement

	Traditional Consultation	Comanagement
Relationship between surgeon and consultant	Informal, ad hoc	Formal, negotiated in advance
Patient selection	Only at surgeon's request	Hospitalist sees all patients who meet predetermined clinical criteria
Consultant's focus	Narrow consultation question chosen by surgeon	Comprehensive care of medical issues determined by surgeon or hospitalist
Consultant's scope of practice	Leave recommendations	Write orders without prior approval in most circumstances
Discharge planning	Surgeon's responsibility	Shared responsibility
Nonclinical roles	None	Surgeon and hospitalist may collaborate on quality improvement, research, and education projects