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DISCLOURES

NONE

ALTHOUGH, I AM WILLING TO BE PAID OFF!

THE HOSPITAL MEDICINE CONSULT

Where we were

where we are

and where we are going

AN BHFUIL AN TEANGA CHÉANNA Á LABHAIRT AGAINN?

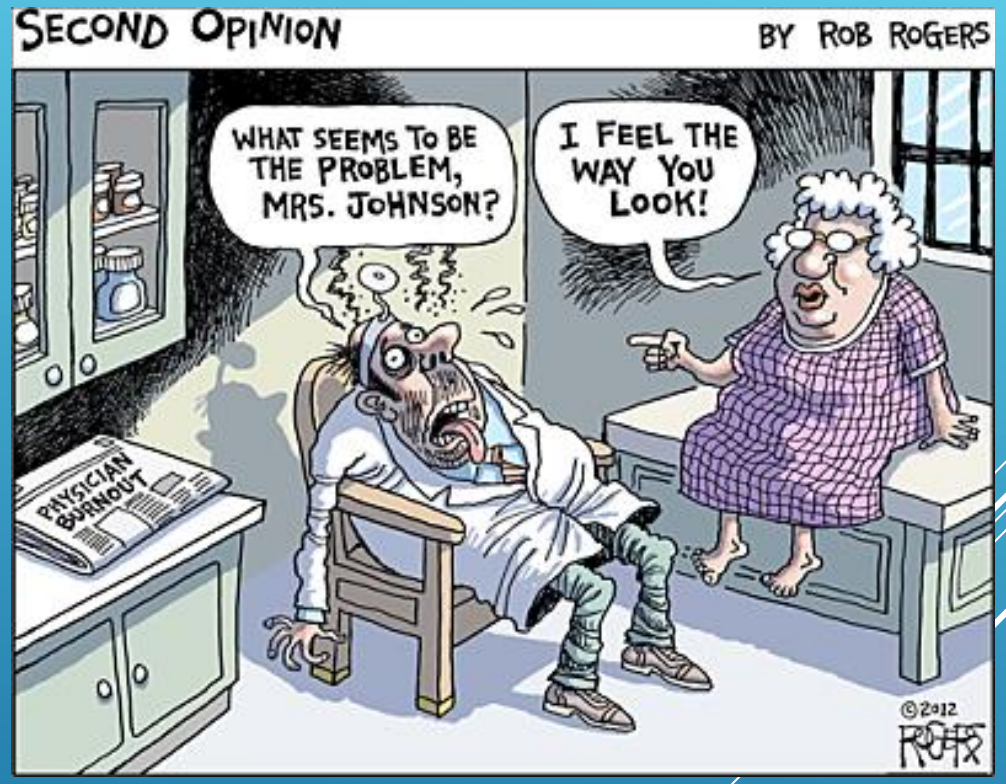
Consult VS Co-comanagment

Consult – a formal request to address a specific problem and limited to recommendations

Co-management – a more "egalitarian division of responsibilities, often with more frequent and dynamic communication

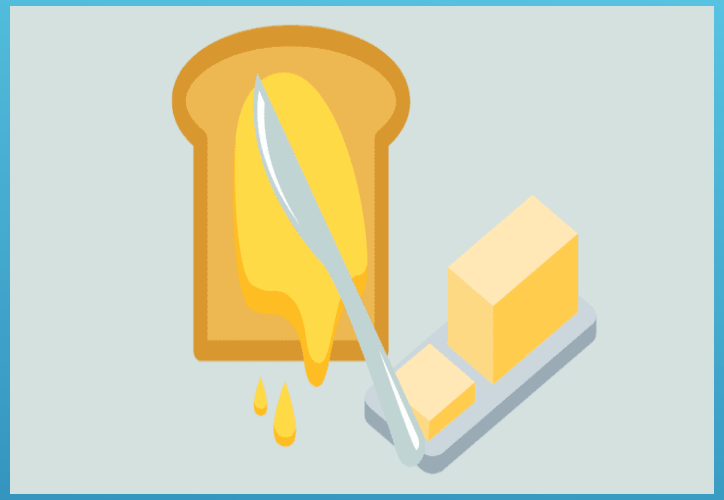
[cost-effectiveness of surgical co-management]. The Surgeon. 2021;19(2):119-127

Where we were



- "Hospitalsits" coined in 1996 by Dr. Robert Wachter and Dr. Lee Goldman
- Society of Hospital Medicine founded in 1997 by Dr. John Nelson and Dr. Winthrop Whitcomb

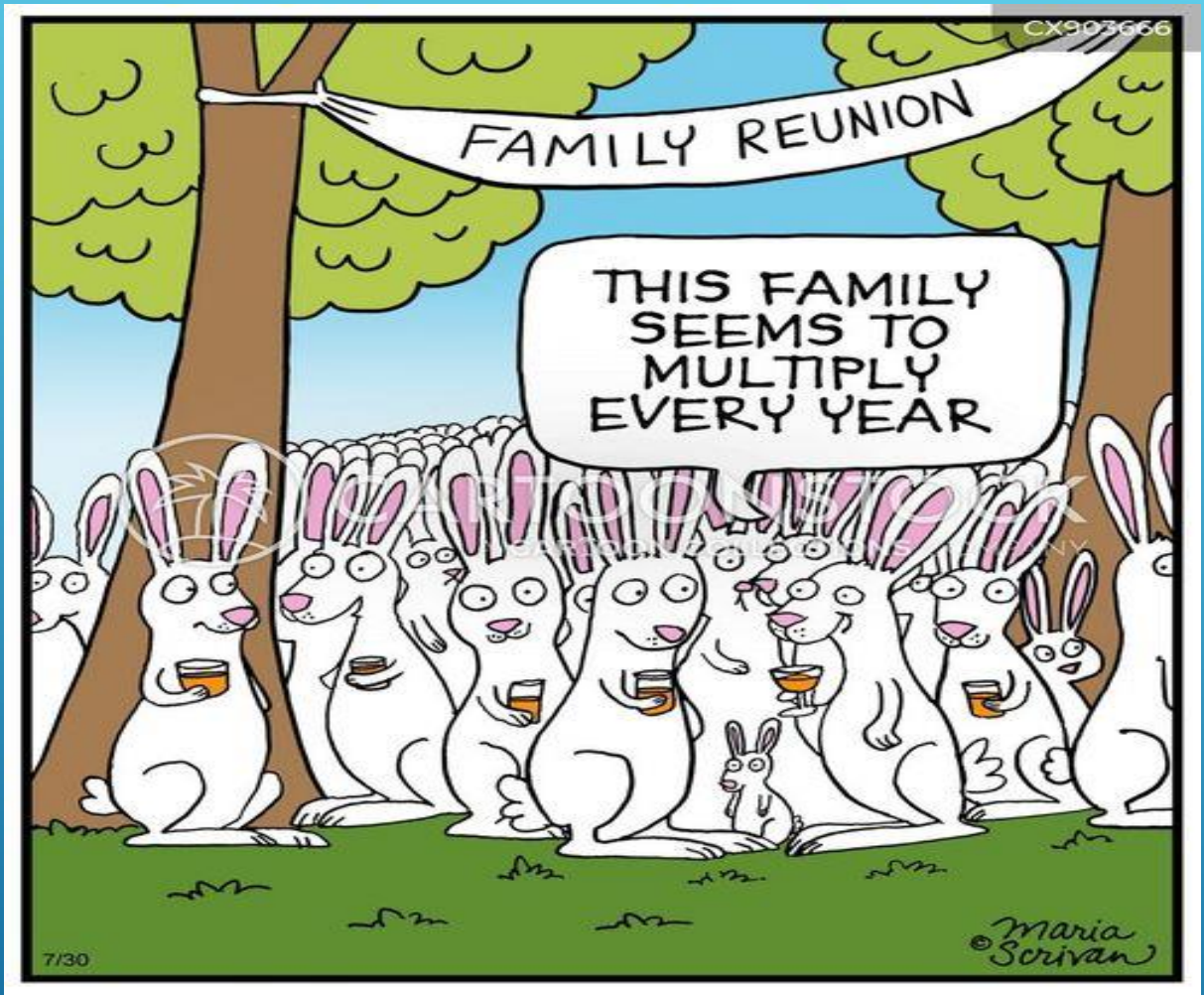
In Lexington, hospital medicine started to emerge around 1999-2000 with KIMA, followed by Lexington Clinic in 2000.



- Early on, the "bread and butter" of a hospital medicine practice where those cases of pneumonia, cellulitis and the like
- Renal pt went to nephrology, cardiac patients went to the cardiologist.

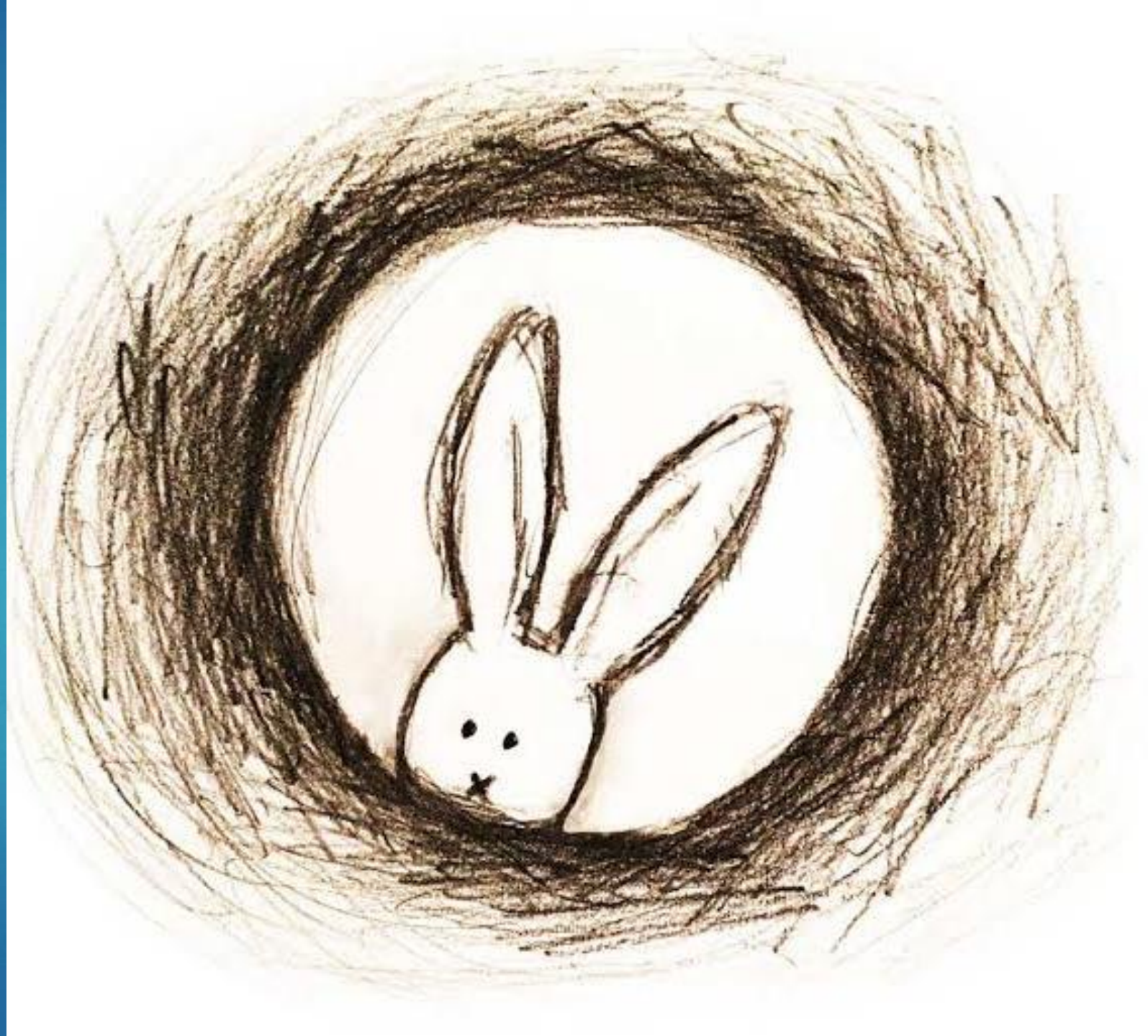
- Hospital administrator, and specialists alike, realized that having internist in the hospital focusing on length of stay / cost made more sense and slowly moved to the Hospital Medicine Model


Where Are
We Now?



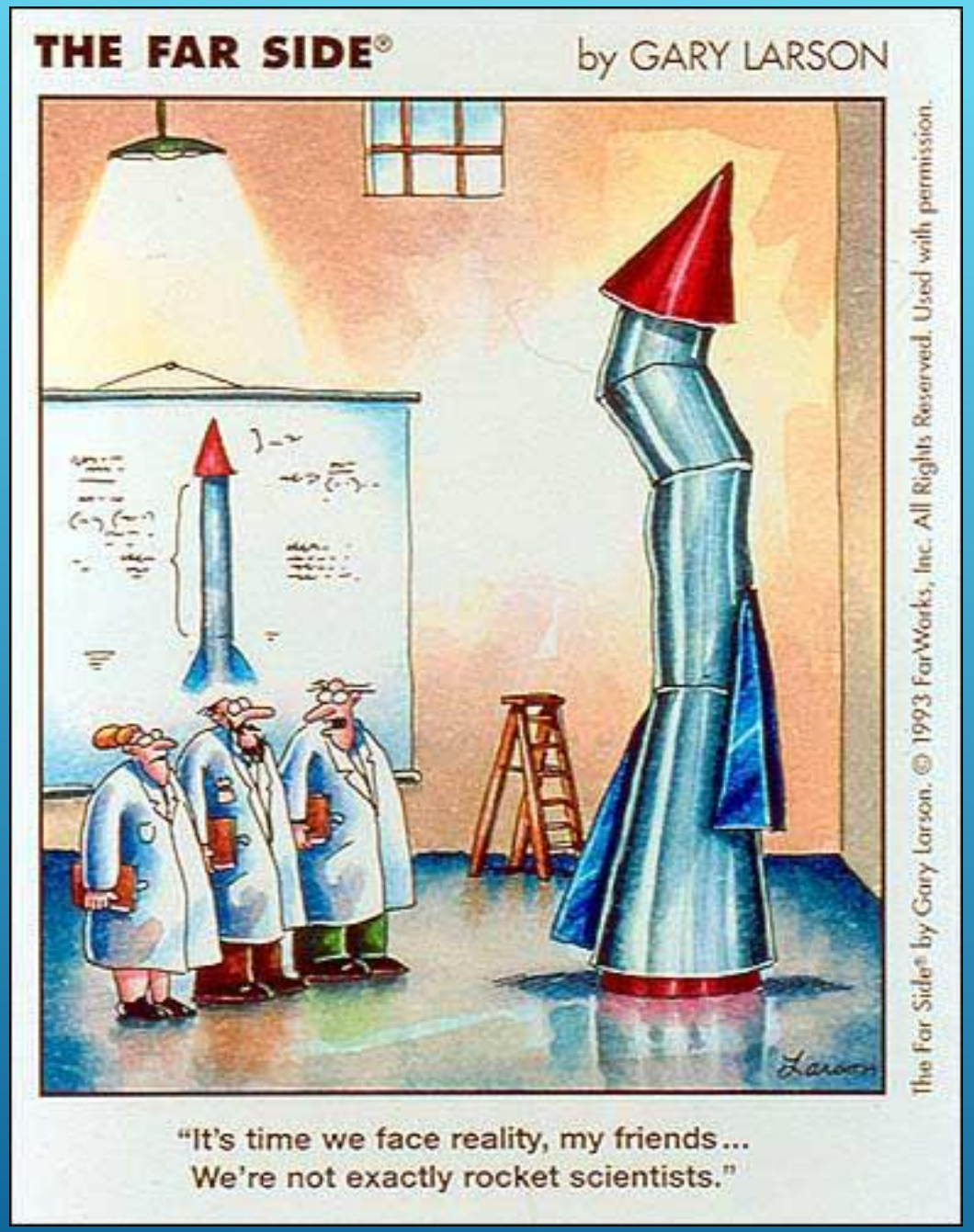
- Over 41K Hospitalsits in all 50 states
- Thousands of Nurse Practitioners and Physician Assistants

Going back down the Rabbit hole



- No surprise, Orthopedics is the top service requesting Co-management, followed by Neurosurgery
- Interesting, about 10% of these initial consults are transferred to a medical service as primary.

Wang et al. [Who Consults Us and Why? An Example of Medicine Consult / Co-mangement Services at Academic Medical Centers]. Journal of Hospital Medicine. 2018; 13(12): 840-843


THE FAR SIDE®
by GARY LARSON
Larson
The Far Side® by Gary Larson. © 1993 FarWorks, Inc. All Rights Reserved. Used with permission.
"It's time we face reality, my friends...
We're not exactly rocket scientists."

What makes us uncomfortable?

- Top patient population makes us uncomfortable?
- 24.9% with behavior health
- 20.9% with substance abuse
- 20.6% with neurology / neurosurgery

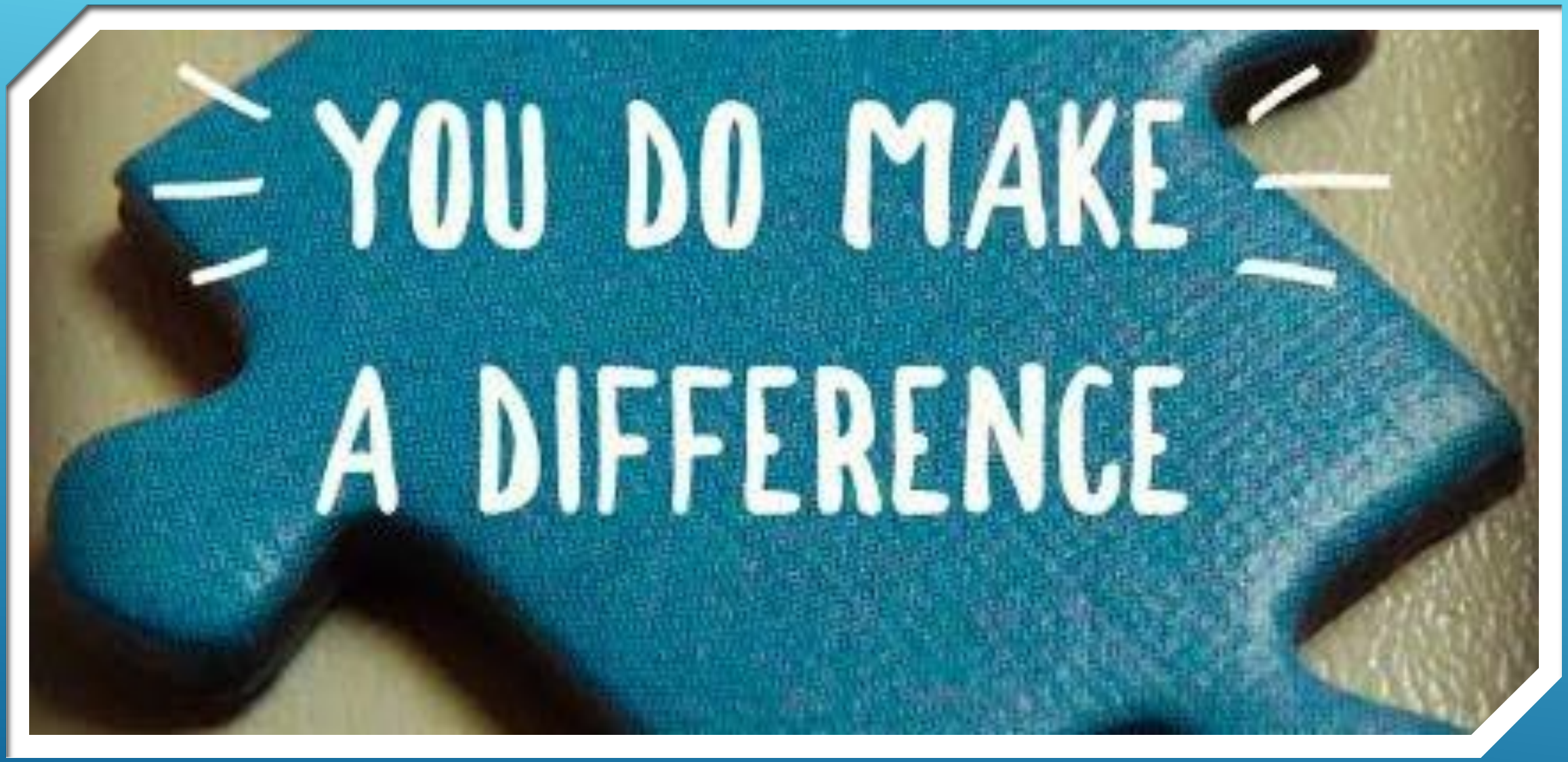
Doyle, Edwards. (2025, April). *What types of Co-management make hospitalists nervous? Todays' Hospitalist*. Todayshospitalist.com/types-specialty-comanagement-hospitalist-feel-nervous/

MY PATEINTS ARE THE SICKEST!

There is some actual truth behind this!

The advancement of surgical techniques has given surgical options to those patients who are older, frail, and multiple Comorbidities.

Dr. Ruhnke with the Journal of Hospital Medicine has noted "despite a national reduction in hospital bed per capita, hospitalist [encounters] have continued to rise."


YOU DO MAKE
A DIFFERENCE

Article published in 2021 in ScienceDirect

Systematic search for studies that reported cost outcomes after implementing surgical co-management service

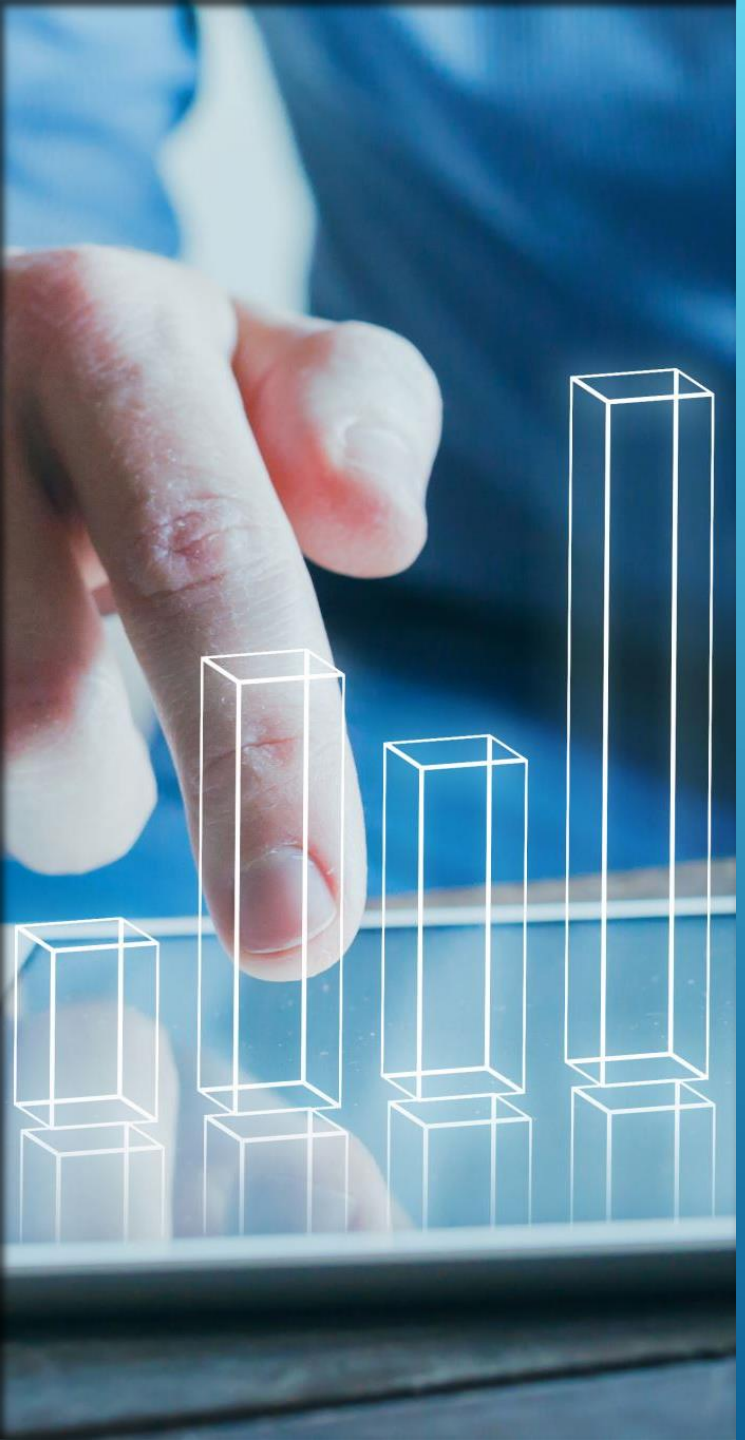
After reviewing over 1400 articles they found 7 artilces meeting criteria detailing 8 different studies

5 studies reported an overall cost savings

- the average age was 68 yr
- average cost savings of $4100

3 studies reported reported an increase in cost

- Average age of these patients was 39
- Average increase of $11,000 per patient



- All studies did show a positive impact on
  - Complication rates
  - Length of stay
  - Mortality rate
  - Patient satisfaction

It's all about the KPIs

Luu et al [*Cost-effectiveness of surgical comanagement: A Systematic Review*]. ScienceDirect. 2021; 19(2): 119-127

Abstract from SHM Converge 2024

- Compared patients managed by the vascular team vs the co-management team
- Both had similar LOS
- Co-management pts were more likely to be discharged home rather to facility (80.2% vs 68.2%)
- Co-management pts were less likely to be readmitted within 30 days (14.5% vs 26%)

Ebers S. (July 2024). Hospitalist Co-Management improves outcomes for vascular surgery patients. Journal of Hospital Medicine. https://shmabstracts.org/abstract/hospitalist-co-management-improves-outcomes-for-vascular-surgery-patients

Journal of Orthopaedic Scinece

- LOS in co-managed group was lower
- "As good as they're going to get
- Co-managed patients were discharged to rehab sooner
- UTIs were lower in the ortho group, but maybe from under reporting
- Blood transfusion more in ortho group
- 30 day readmission lower in Co-managed group

Tsunemitsu et al [Effects of hospitalist co-management for hip fractures]. Journal of Orthopaedic Science. 2022; 29: 278-285

WHAT HAVE WE DONE AT UK?

- Decreased labs
- Same day discharges
- Fragility service

I find knowing how the “sausage is made” makes my job easier.

- Which surgeon uses a tunicate
- Do all patients get steroids
- Anticoagulation guidelines
- Use of Tranexamic Acid

ASA VS DOAC

TRANEXAMIC ACID

A physician who treats himself has a fool for a patient.

~ William Osler

AZ QUOTES

Well, for one……get a damn primary care provider!

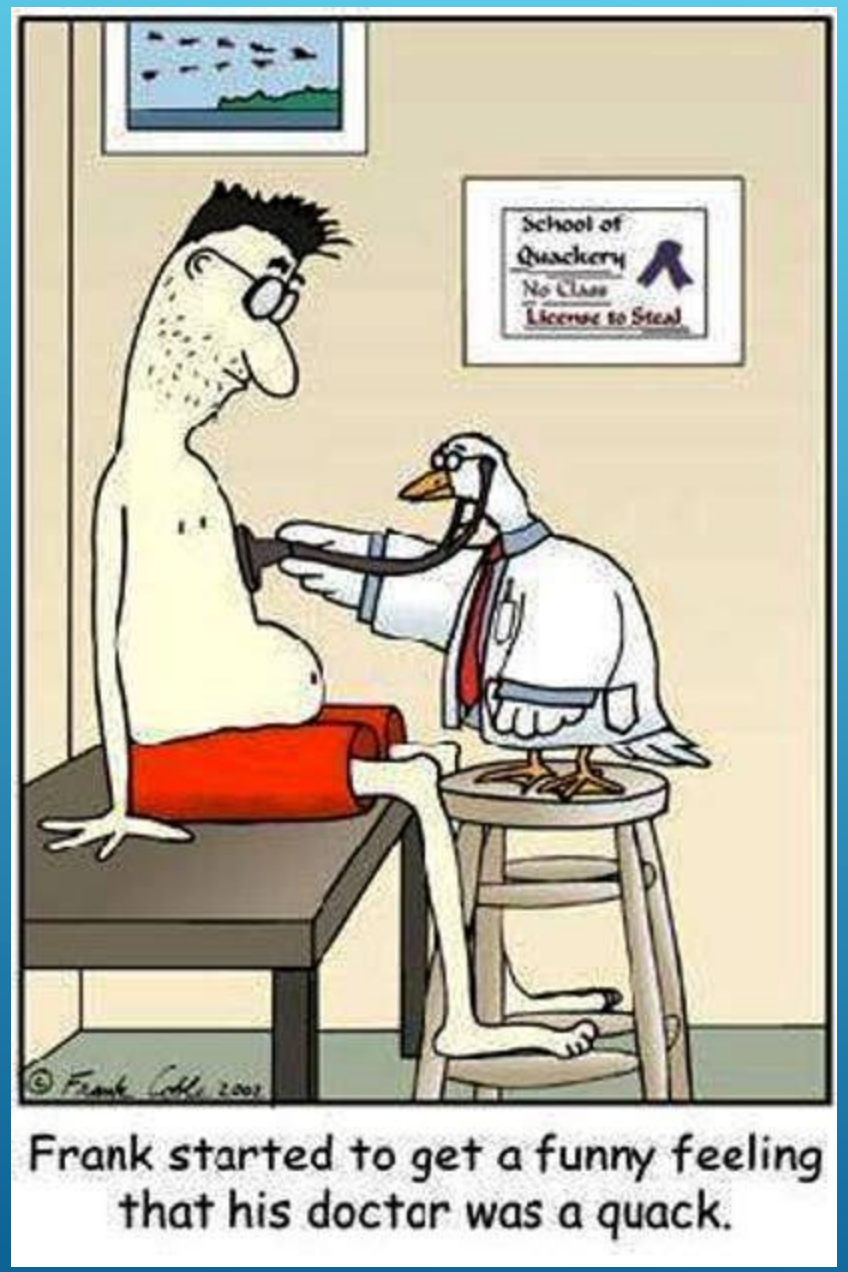
As I tell every student I have…….Treat patients how you want your Mom / Dad to be treated

Bed Shortages have impacts

Protocols are in place for a reason

Always know your patient is watching you, whether you are in the room or not

WHAT DID I LEARN ?



Patient's perceptions matter…… they want to know that everyone is communicating

- Bedside nursing report
- Good Samaritan co-management rounding model
- CO-managenment agreements


FUTURE AHEAD

CJR-X Model and what it means for us

CMS is proposing an episodic-based payment system for ALL acute hospitals, includes all LJRs

The WHY

- Aim is to "encourage" surgeons, care teams, and post-acute care providers to collaborate to improve outcomes …….. When they say its not "financial, its financial!
- CMS found that when the CJR model was rolled out to a limited market, about $112.7 million were saved from 2021 and 2023

Why Does a 90-day Window Matter?

- It broadens responsibility across the entire recovery from 30-day to a 90-day window

- Aims to focus on delayed physical rehab
- Late readmissions
- Post-acute care utilization

This model will place more financial risk on acute care hospitals, especially when patients experience unrelated or expensive medical setbacks

We may need to be more involved with :

- Pre-admission vs Pre-anesthesia
- Primary care Providers

NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS

Physician specialty	Adequacy 2038
Allergy & Immunology	83%
Anesthesiology	83%
Cardiology	85%
Colorectal Surgery	98%
Critical Care & Pulmonology Medicine	112%
Dermatology	95%
Emergency Medicine	116%
Endocrinology	109%
Family Medicine	76%
Gastroenterology	98%
General Internal Medicine	83%
General Surgery	91%
Geriatrics	84%
Hematology & Oncology	96%
Hospital Medicine	78%

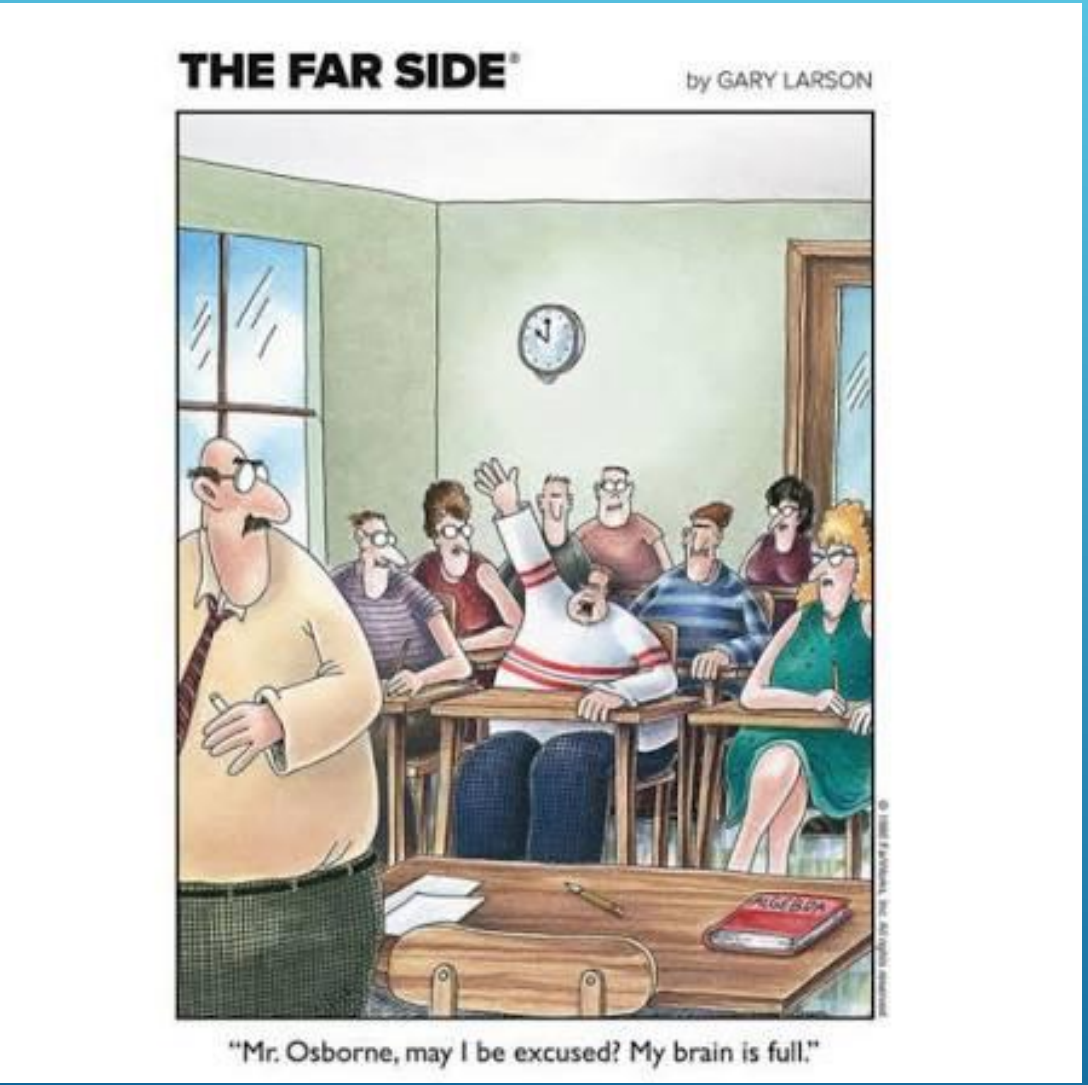
How many are we?

Current Models

- Traditional Care Model / Modified Teams
- Procedural Teams
- Admission / Discharge Teams
- Nocturnal Teams
- Call Centers
- Standalone Models with offsite supervision

WHAT About AI?

QUESTIONS


THE FAR SIDE
by GARY LARSON
"Mr. Osborne, may I be excused? My brain is full."