Memorandum of Understanding for the Orthopedic/Internal Medicine Hospitalist Co-management Service

Definition of the Co-management service: The Orthopedic/Internal Medicine Hospitalist Co-management Service is a service designed to allow both of these services to assist in a coordinated way in the management of patients undergoing orthopedic surgery who also have significant medical comorbidities.

Statement of purpose: This service intends to involve the Internal Medicine Hospitalist Service early in the care of orthopedic patients with significant medical comorbidities. Specifically, Internal Medicine consultation will be provided to these patients in the preoperative time period, and the Hospitalists will be available to assist with perioperative management of medical comorbidities if appropriate. The main objectives of such a service are to: a. Improve the quality of preoperative optimization and perioperative management of medical problems that fall outside of the area of expertise of the orthopedic surgeon, and b. Improve patient and provider (nurses, surgeons) satisfaction with perioperative care.

Suggested patient inclusion: The Orthopedic faculty ultimately decides which patients have medical comorbidities that might warrant Internal Medicine consultation and/or co-management. A list of comorbidities that might warrant consideration of Internal Medicine involvement include:

- age >75
- diabetes, treated with oral medications or insulin (not diet controlled)
- congestive heart failure
- coronary artery disease
- cerebrovascular disease (e.g. h/o TIA or stroke)
- chronic renal insufficiency (e.g. SCr > or = 2) or dialysis patients
- chronic obstructive pulmonary disease
- immunosuppressed patients (on chronic steroids or other immunosuppressive meds, or those with AIDS or other immunocompromising illness)
- morbid obesity with BMI > 35 or known obstructive sleep apnea
- poorly controlled hypertension (BP not currently well controlled, or BP requiring > 2 meds for control)
- anticoagulant treatment
- dementia

Role of the Orthopedic Service:

- The Orthopedic Service will be the primary care team for the patient during the hospitalization and will be responsible for:
  - coordinating care for the patient, including obtaining appropriate subspecialty consults in cases when expertise is required beyond that of the Orthopedic or Internal Medicine co-managing services.
  - writing admission and post op orders.
• responding to urgent or emergent issues arising during the hospitalization, including fielding all “calls” from nursing staff and performing all bedside evaluations for acute medical problems (The Hospitalist Service availability is discussed below).

• The Orthopedic Service will write orders for DVT prophylaxis.

• The Orthopedic Service will dictate the discharge summary.

• The Orthopedic Service will manage all issues related to the orthopedic surgery, including perioperative management of the wound, pain, IV fluids, and surgical complications.

Role of the Internal Medicine Hospitalist Service:

• The Hospitalist Service will not serve as the primary care team during the hospitalization and its primary role will be the provision of advice regarding the management of medical problems. They will write orders when indicated in the management of problems in their area of expertise such as electrolyte replacement, diabetes management, complex anticoagulation issues, or other specific medical problems.

• The Hospitalist Service lacks the man-power to field “calls” from the nursing staff or to be the first physician to evaluate the patient in the event of an acute problem or change of status. In these cases it will be expected that the “1st call” will be fielded by the orthopedic resident or midlevel practitioner, who will personally evaluate the patient. The Hospitalist attending will be available by pager to the orthopedic physicians or midlevels during the day (8:00 a.m to 4:00 p.m.) to answer questions or re-evaluate patients if needed. During off hours (4:00 p.m. to 8:00 a.m.), the Hospitalist Service will be covered by a different hospitalist who will only be able to respond to urgent questions, and will only be able to evaluate patients with urgent concerns.

• The Hospitalist Service will accept “calls” from the nursing staff for specific questions regarding orders that they have written.

• The Hospitalist Service may make recommendations for DVT prophylaxis or subspecialty consultation, but generally will not write orders/requisitions for these.

• The Hospitalist Service will see all co-management patients on a daily basis during the week, and on an “as needed” basis on the weekend. The Hospitalist Service attending will determine which of the co-management patients should be seen by the covering hospitalist over the weekend. A hospitalist will be available by pager 24/7, even on the weekend, for assistance with urgent issues.

Overlap of the Orthopedic and Hospitalist Service roles: Inevitably there will be circumstances where either of the co-managing services could manage a specific
problem, or where it is unclear which service would be best equipped to manage a specific problem. These situations can be best managed by following two basic principles: a. Do what is best for the patient in a timely fashion and do not assume that a problem is being handled by the other service, and b. Communicate frequently and directly with the other service. Patient discharge from the hospital will be initiated once both services agree that the patient is medically stable and discharge is appropriate.

Communication between the two services: Communication is critical to the success of any co-management situation, and good communication will be maintained between the two services by having one person designated to round with both services. This will usually be a midlevel practitioner who will understand the management plan from the perspective of both of the two services. In addition, it will be a requirement that there be open lines of communication between the attendings on each of the services, and there will be an expectation that either of these physicians will contact the other in a timely fashion if requested.

Patient communication: It is expected that the patient will be told why he is being referred to the Hospitalist Service for preoperative consultation by the referring orthopedist. It is also expected that the hospitalist will introduce himself to the patient in the postoperative setting, and briefly explain his role in the patient’s care.

Follow-up care: As a rule, the Orthopedic Service will be responsible for arranging patient follow-up after discharge. The Hospitalist Service does not have a mechanism for the follow-up of outpatients after discharge.

Financial considerations: There is no financial arrangement between the Orthopedic and Hospitalist Services. The orthopedists will bill per their usual standards for surgical care, and the hospitalists will bill as consultants. The hospitalists will be evaluating and managing medical problems that are outside of the expertise of the orthopedic surgeons. There will be no “fee-splitting” or transfer of money between the services.