HOW TO DEVELOP A CO-MANAGEMENT DASHBOARD

Background: Co-Management

Co-management of surgical patients is a multidisciplinary service designed to improve the quality, efficiency and safety of inpatient surgical care compared to traditional medical consultation. Each member of the team functions at a level commensurate with his or her experience.

Co-management of surgical patients implies that the consultant is more available and has greater ownership of surgical or specialty patients. Hospitalists may use the skills that they have acquired in taking care of medical patients to improve the care of surgical patients. Well-structured co-management models with adequate staffing may promote better care through the identification of new, undiagnosed problems that may adversely impact on the patient's postoperative recovery, initiation of preventative measures and therapies to optimize chronic conditions that may decompensate during the stress of surgery, anticipation of complications, and the promotion of seamless transitions of care to the post-hospital setting.

Although co-management may promote professional satisfaction through collaboration with other specialists, steps need to be taken to ensure that hospitalists have the skills to handle problems that may be outside of their internal medicine, family practice or pediatric training and that there are clear rules of engagement of all parties. Ideally, hospitalists should define co-management and establish rules such as responsibilities of each team member and levels of communication to patients, families and receiving physicians.

The Need for Measurement

Just as with any quality improvement initiative, the intervention of a new co-management service requires tracking of key outcome measures.

Although co-management is widely performed by hospitalists, especially in the community, best practice has not yet been defined nor do we know which patients will benefit the most from co-management by hospitalists. There are increasingly competitive markets and pressures from outside agencies such as the Joint Commission on the Accreditation of Healthcare Organization (JCAHO) and the Agency for Healthcare Research and Quality (AHRQ) that will require hospitals to report on performance. Increasingly hospitals in a region will be compared to each other and uniform standards implemented through public review. In this environment, hospitalists will need to demonstrate improved outcomes relative to their peers who perform traditional consultation. The performance of hospitalist services is already being measured, and these services will be increasingly expected to actively set quality parameters, lead teamwork opportunities, and to improve performance.
The concept of a “Balanced Scorecard” is emerging as a strategic framework for action. By identifying the parameters for measurement, any hospitalist service can develop a hospitalist scorecard to clarify the vision and strategy of the service by gaining consensus regarding what will be measured and reported. The scorecard requires setting targets, aligning strategic initiatives, allocating resources and establishing milestones. Once these goals have been set, a process of communication and education of the members of the service must take place about the goals and linking rewards to performance measures. The Balanced Scorecard articulates the shared vision, at a glance supplies strategic feedback, and facilitates strategy review and learning. Ultimately, compensation can be linked to strategy.

*How to get Started*

Utilizing available data from hospital sources is the first step in generating a report card for a hospitalist co-management service. Hospitals have readily accessible **financial data** such as average acuity, net operating margin per inpatient discharge, budget variance and net operating margin per service as well as efficiency data.

In addition, **quality measures** such as readmission rates, mortality, and intensive unit transfers are monitored. Hospitalists may approach the chairman of the Department of Medicine and hospital administrators for guidance, the head of Health Information Systems (or medical records) for demographics, and the Quality Improvement (QI) director for QI data, including JACHO performance measures. These leaders should be able to provide specific information relating to:

- Who to approach to find out what data is already being collected
- Who might help examine the data to ensure that the data is accurate and allows for meaningful statistical comparisons, for example:
  - Are physician lists accurate in different comparison groups?
  - What are the response rates relating to patient satisfaction data?
  - How many cases/patients are involved in the calculations (mortality and other endpoints)?
  - How is length of stay calculated, are “outliers” and inter-departmental transfers included, and how are individual physicians identified?
- Who might advise the service about what should be measured (i.e., easily and accurately)?

Even if the data presented is imperfect, it is a critical first of many steps to proactively identify and measure quality indicators of performance and sets up expectations for improvement.

Once hospitalists determine what parameters are already being measured, the hospitalist service needs to proactively define quality measures that can be tracked over time and choose quality measures that reflect a prioritization of the goals of the co-management
Service. A consensus will need to be reached on how important the measure is to the specific patient population served by the hospitalist program. A hospitalist service may need to prioritize efficiency, for example, if there are issues relating to average length of stay (ALOS) compared to budgeted ALOS or to the ALOS provided by other physicians on the general medical consultation service.

Hospitalist services may wish to obtain information not available through computerized hospital systems to supplement assessment of quality. Although time consuming, chart review of selected conditions for documentation of patient safety measures such as hospital acquired complications such as wound infection, pneumonia, and UTI, VTE prophylaxis, smoking cessation counseling, advice for pneumonia patients, evaluation on admission and periodically after for risk and prevention of pressure ulcers, documentation of information such as left ventricular function in congestive heart failure, and patient/family education may be already done for the entire department of surgery.

Quality officers should be able to track data according to specific groups for the purposes of comparison. Periodic survey of primary care physicians and rehabilitation hospitals for feedback on quality and safety measures may be helpful, starting with many questions which can subsequently be narrowed to the three to five key questions that the service wishes to track over time and the busy primary care physician has time to answer. However, survey response rates from primary care physicians and/or patients and families will determine usefulness as a quality measurement tool. Ancillary support such as automatic computer generated survey instruments by email following patient discharge or administrative support to mail and collect survey instruments will be required to have a meaningful response rate.

Summary

With careful planning and consensus building, hospitalist report cards should improve quality, reduce variability of service, provide hospitalists with benchmarks and incentives to improve the six different quality domains, and enable hospital administrators to appreciate at a glance the value of a hospitalist comanagement service compared to traditional consultation care.