

# **Physician Partnership Strategies: The Case for Co-Management**

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# Objectives for today's presentation:

- Overview of the need for a different medical management model for complex medical patients receiving care on post-acute units;
- Discussion of how the Co-Management model can improve quality of care, patient safety and functional outcomes;
- Discuss how physicians and hospitals can partner together to achieve the triple aim by using the Co-Management model;
- Discuss continuity of care opportunities to optimize transitions between acute care and post-acute care facilities

# What is the Co-Management Model?

- In this model, **physiatrist** and **internal medicine specialists/hospitalists** work synergistically to manage patients
- Being used in STACHS, IRFs, SNFs, LTACHs, and other post acute settings
- One specialty functions as the **attending physician** while the other is a strategic **consultant**

# Why is Co-Management needed?

- Increasing medical complexity of rehab patients
- Continuity of care issues
- Patient safety issues
- Liability issues
- Efficiency of care issues
- Cost of care issues
- Readmissions
- ACO environment incentives/penalties

# Why is Co-Management needed: **Increasing medical complexity**

- The medical complexity of patients in post-acute facilities has increased tremendously over the past three decades.
- Whereas medical stability was once a requirement for admission to a post-acute unit (such as IRF/SNF, etc.) patients today frequently have multiple co-morbidities that necessitate intensive management of ongoing medical issues

# Why is Co-Management needed: **Continuity of Care Issues**

Continuity of care between the acute care hospital and the post-acute rehabilitation unit (IRF/SNF/LTACH, etc.) can be challenging for many reasons including:

- new medical team- usually doesn't know patient
- lack of specialist availability; and/or
- multiple specialist involvement
- lack of information (EHR or other issues)
- resulting in diffusion of responsibility

# Why is Co-Management needed:

## **Patient Safety Issues & Liability**

- Physicians may be responsible for management of complex medical issues that are outside of their expertise and beyond their scope of training.
- Each year beyond residency, physicians lose critical competencies (unless extensive CME is done in Internal Medicine, Cardiology and other areas)
- This can result in potential patient safety and professional liability implications

# Why is Co-Management needed:

## Efficiency of Care Issues

- Getting caught up with internal medicine issues (urgent medical issues prioritized over functional goals)
- Physiatrists (or other attending physician) is not able to fully focus on the critical goal of optimizing the rehabilitation process
- Issues that can result in iatrogenic complications or adversely impact d/c options, get overlooked (skin prophylaxis, bowel/bladder, catheters/lines, contractures, etc.)
- Patient's rehab program can get short-changed (adversely impacting length of stay and functional outcomes)

# Why is Co-Management needed: **Cost Issues**

- If multiple physician specialties are involved without well defined roles- may have difficulty maintaining control of the case
- multiple physicians are involved in ordering diagnostics and treatments that may have adverse financial impact and/or impact the patient's ability to participate in rehabilitation therapies.
- If unsure, physicians tend to order more diagnostics.

# Why is Co-Management needed: Readmissions

- Lack of proactive management of medical issues = increase in acute medical emergencies
- Lack of experience/expertise = lower threshold to 'pull the trigger for transfer'
- Diffusion of responsibility (less commitment to the patient) = easier to get the patient off the unit

# Why is Co-Management needed: Readmissions

- Lower 'trigger for transfer' results in:
- High readmission rates which results in:
  - COST to facilities (due to penalties)
  - Strain on acute care ED systems
  - Annoying the referral sources
  - Adversely impact patient/family satisfaction
  - Drive up costs for the overall bundle of care (acute + post acute)

# Why is Co-Management needed: **ACO environments**

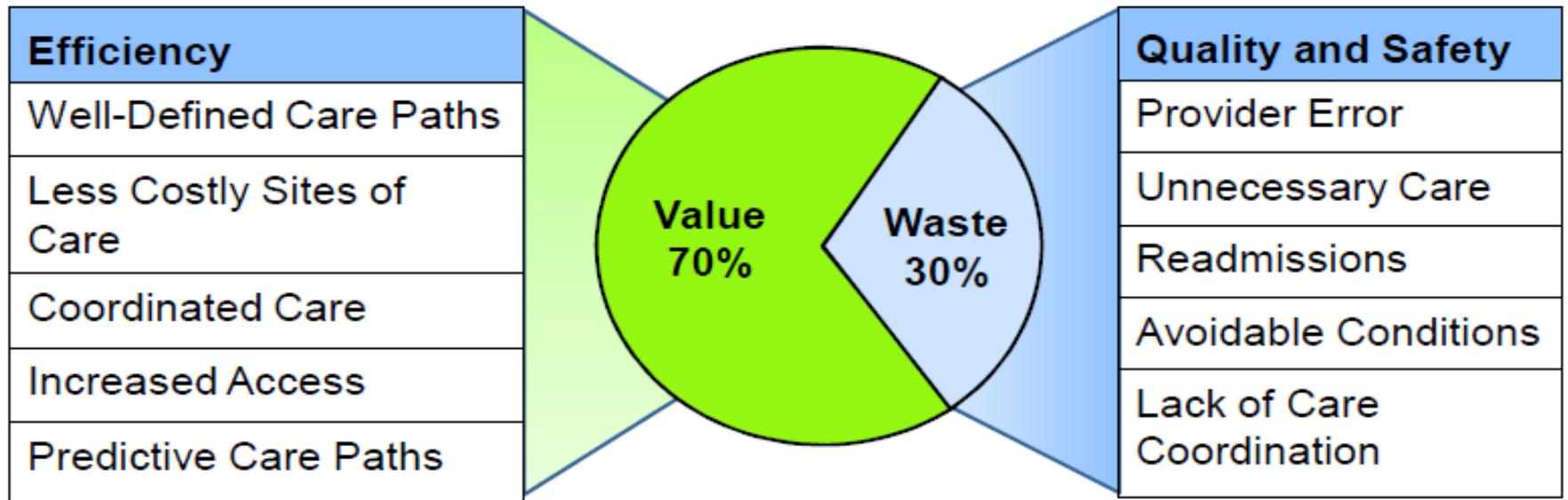
- As USA healthcare reforms, increasing financial implications and accountability for post-acute costs, quality, safety and patient satisfaction.
- Increasingly, post-acute facilities will be incentivized to:
  - limit costs,
  - prevent new medical complications
  - acute care readmissions
  - while concurrently optimizing outcomes, including FIM efficiency and discharges to the community during increasingly shorter hospitalizations

# GOALS of an ACO (Accountable Care Organizations )?

- To provide coordinated care
- To ensure that patients, especially the chronically ill, get the right care at the right time,
- while avoiding unnecessary duplication of services, and
- To prevent medical errors
- To increase **VALUE**

Source: CMS website ([www.CMS.gov](http://www.CMS.gov))

# Delivering VALUE Will Require a Focus on Systems of Care for Populations and Care Coordination Across the Continuum



**“Estimates suggest that as much as \$700 billion a year in health care costs do not improve health outcomes.”**

–Peter Orszag, Former Director of the Congressional Budget Office

# How Does Co-Management Model Work?

## 2 Options

### **MODEL 1:**

**PMR- ADMITTING &  
IM –CONSULTING**

**(usually IRF &  
sub-acute units)**

### **MODEL 2:**

**IM ADMITTING &  
PMR-CONSULTING**

**(Usually  
LTAC/SNF/LTC)**

# Highlands at Brighton - URMC

<https://www.urmedicine.org/locations/highlands-at-brighton/>

- 145 Bed Academic Nursing Home
  - **30 Sub-acute Rehabilitation Beds – Post-acute Care Unit**
  - 20 Ventilator Dependent Beds – Wean Unit
  - 15 Neurobehavioral Beds – Behavior Unit
  - 22 Dementia Beds – Behavior Unit Step-Down
  - 58 Long Term Care Beds – Traditional SNF/LTC
- An affiliate of the University of Rochester
  - A variety of trainees are taught on sites
- Staffed by University of Rochester Physicians

# Highlands at Brighton - URMC

- Located in suburbs just outside city limits
  - 3 miles from 2 primary referring academic hospitals
  - Medical office park setting with many services proximate
- ~210,000 city population
- ~1,000,000 catchment population
- Specialty mission redesign in 2006
  - New Medical Director, New Administrator
- No LTACH in upstate NY
  - essentially bridges for LTACH services
- Accommodates hard to place & medically complex

# Highlands at Brighton - URMC

- Approximate Staffing
  - 1 FTE Primary Care APP (NP)
  - 0.3 FTE IM/Geri Primary Care Physician
  - 0.2 FTE Psychiatrist
  - 1 FTE Nurse Manager - RN
  - 1 FTE Charge Nurse – RN
  - 2 FTE LPN Days
  - 2 FTE LPN Evenings/1 FTE LPN Nights (RN supervisor in building)
  - 4 FTE CNA's Days, 4 FTE CNA's Evenings, 2 FTE CNA's Night
  - 0.5 FTE Recreational Therapist
  - 1.5 FTE MSW
  - PT/OT/SLP/Recreation staffed to need (min 2 PT, 2 OT, 0.5 SLP)

# Highlands at Brighton - URMCM

- Medicine Attending with Physiatry Co-management
  - Most patients
- Physiatry Attending with Medicine Co-management
  - Non-medically complex with
    - Isolated CVA
    - Traumatic Brain Injury
    - Amputation
    - MVA
    - Traumas
- Medicine Attendings take all off hours call
  - Psychiatrist available on-call to Medicine
- Physiatry residents cover about ½ of days

How do you decide which model is best???

- Bandwidth (able to provide 24 hr/365 coverage???)
- Types of patients in facility (primary rehab vs. complex medical)
- Facility culture
- Facility location (free standing vs. integrated unit)
- Market competition
- Referring facility comfort level
- Availability of PMR vs. IM

# Advantages of the Co-Management Model:

## Proactive management of medical issues Results in:

- Fewer medical emergencies
- Few transfers /returns to referring acute care facility
- Better patient/ family satisfaction (see more physicians involved in care on a daily basis)
- Less 'diffusion of responsibility' among consulting subspecialists (cardiology, pulmonary, ID, etc.)
- Improved ability to control costs (control of diagnostics and interfering therapeutics)
- Improved ability of patients to attend/participate in therapies (by intentional co-management that limits 'dropped sessions' )
- Having the initial call regarding acute/urgent medical issues go to the internist allows faster action & resolution.

## Advantages of the Co-Management Model: **Better Coordination of Care**

- Division of labor **allows each physician to stay within their area of expertise/ comfort level**
- Delineation of duties/tasks allows **better efficiency** (functional goals & discharge planning goes on in the midst of medical exacerbations/complications) and eliminates 'diffusion of responsibility inaction'.
- Improved communications to referring and primary care physicians (facilitating **increased trust/satisfaction and increased referrals from physicians**)

## Advantages of the Co-Management Model:

### **Easier physician recruitment**

- Easier physician recruitment of **both** physiatrists and internists to work in post acute settings
  - Neither specialty is forced to work out of their **comfort zone**
  - **Work load** is more manageable.
  - **PMR is freed up** to do acute care hospital consults, assist with referral development & rehab program development (rather than managing medical comorbidities/emergencies that are beyond their area of expertise.)
  - **Internist/hospitalists** are not required to do rehabilitation tasks for which they have little formal training (such as FIMs, Team Conferences, formulating complex rehab goals, etc.), more consistent patient load, have consistent RVUs and less stress.

## Advantages of the Co-Management Model: Improved Medical Education & Research

- **Improved teaching** due to more focus on rehab issues
- **Increased resident satisfaction** (not being a 'rintern')
- **Collaborative research opportunities** for academic programs (for both PMR and Hospitalist residents and faculty)

# Advantages of the Co-Management Model: Marketing Opportunities

- Concurrent Care Model can be used as a marketing tool for:
  - referring physicians
  - facilities patients
  - families
  - payers
- By demonstrating:
  - Higher quality & intensity of physician coverage
  - Increased focus on rehabilitation programming, including complex rehabilitation care
  - Better functional outcomes, FIM efficiency, patient/family satisfaction & readmission rates

## CHALLENGES OF THE CO-MANAGEMENT CARE MODEL:

- **It is critical to recruit hospitalists that referring physicians trust and feel comfortable with.**
- **Staff and Patient/family Education** is critical:
  - Which doctor to call when for various issues (medical issues, rehab issues, patient/family complaints, etc.)
  - Sharing information (lab results, radiology reports, etc.) with appropriate physician.
- **IM Hospitalist Education** is critical:
  - differences between acute & post-acute care
  - how IM orders (diagnostics, treatments) impact rehab

## CHALLENGES OF THE CO-MANAGEMENT CARE MODEL:

- **Physician Education is critical:**
  - PMR & Hospitalist physicians must communicate and develop joint protocols/policies. There must be ongoing dialogue and education, with involvement in PI/Quality initiatives.
  - Both physicians must stay engaged, perform their duties and not allow for ‘diffusion of responsibility’.
  - There should be ongoing metrics to evaluate key performance indicators (such as % H&P done  $\leq$  24 hrs, documentation of co-morbidities, documentation of functional changes/FIMS, % of primary care/ referring physicians who receive copies of discharge orders within 24 hrs of discharge or discharge summaries within 30 days, etc.)

## RISKS OF THE CO-MANAGEMENT CARE MODEL:

- **Concurrent Care Billing & Referrals:**
  - Co-management **MUST be based upon medical necessity** (active medical problems/rehab needs)
  - **MUST use different diagnosis codes:**  
CVA/HTN/DM vs. Hemiplegia/Dysphagia, etc.
- **‘Opening the Door’**
  - **Letting other specialties function as ‘Rehab Doctors’?**
  - **Loss of business?**
  - **Loss of power?**

## Other Considerations: Credentialing criteria

- **Qualifications for ‘Rehab Physician’**
  - Only PMR???
  - Neurology???
  - Orthopedics???
  - Other???
- **Qualifications for ‘Hospitalist’**
  - Only Internal Medicine??
  - Family Medicine???
  - Other subspecialists???
- Credentialing criteria **should match duties.**
- Policy & procedures to support the model.

# Co-Management Opportunities in ACO Environments

## **Transition Teams.**

Same group sees patients at both facilities (via PMR consult services in acute care & IM on both sides)

## **Team Building/Relationship Development.**

Rotation of PMR/IM group members in both acute care/post-acute facilities builds familiarity & understanding)

## **Program development.**

Same protocols used at both facilities.

## **Reducing Paperwork and Administrative Costs through shared Electronic Health Records.**

May require joint privileges at both facilities.

# How can facilities and administrators support this???

**Medical Director roles** are critical to support the administrative duties critical for success-

- To support development of the model
  - defining roles,
  - criteria for triggered consults,
  - protocol development,
  - staff/physician education
- To allow access to patient info/data/quality metrics
  - MEC
  - Joint Quality Councils
- Accountability & adjustments

# This new healthcare environment:

## **If we manage this challenge poorly,**

- It has the potential to decimate post-acute care.

## **If we manage this challenge well, we**

- Have the potential to introduce models/strategies, such as the **Co-Management Model** that can be useful throughout the entire healthcare continuum.
- Have the potential to **focus on function** at the beginning of the episode of care (rather than an afterthought)
- Have the potential to improve outcomes, patient/family satisfaction and value.
- Have the potential to truly help patients be functional and improve the US healthcare economics.

# Thanks for being part of the solution!

## Questions or comments?????

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