After the Operating Room:
POST-OPERATIVE MANAGEMENT FOR PEDIATRIC HOSPITALISTS

Presenters:
Sonaly McClymont, MD
Anjna Melwani, MD
David Rappaport, MD
Rebecca Rosenberg, MD
Sarah Denniston, MD
Moises Auron, MD
Shimona Thakrar, DO
David Pressel, MD

Disclosures

We have no relevant financial relationships with the manufacturers(s) of any commercial products(s) and/or provider of commercial services discussed in this CME activity.

We do not intend to discuss an unapproved/investigative use of a commercial product/device in my presentation.
American Academy of Pediatrics (AAP)  
Section of Hospital Medicine (SOHM)  
Surgical Care Subcommittee (SCSC)

➤ Mission:
• To advocate for high quality care, outcomes, and research for surgical patients cared for by pediatric hospitalists

https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-Hospital-Medicine/Pages/Surgical-Care-Subcommittee.aspx#sthash.D1jdo6HN.dpuf

July 29, 2016

Learning Objectives

• Review epidemiology and care models for pediatric hospitalist involvement in post-operative care.

• Define surgical comanagement.

• Review the available and missing evidence behind common pediatric post-operative clinical management practices.

• Formulate post-operative management plans for healthy and medically complex patients.

• Review skills/approaches to identify and mitigate potential post-operative sequelae based on the patient and the procedure.

July 29, 2016
Agenda

- Review post-operative care models and surgical comanagement 10 min
- Interactive Evidence Review 20 min
- Small group cases 40 min
- Discussion and Wrap-Up 5 min

Overview of Post-operative Care Models and Surgical Comanagement
Pediatric Hospitalists providing post-operative care

- 74% of pediatric hospitalist provide inpatient care to surgical patients (2012 SHM Survey)

- Surgical pediatric patients
  - Healthy, low-risk patients
    - High prevalence, low-complexity procedures
    - More common to occur at community hospitals
  - Medically complex patients
    - Some common low-risk procedures
    - Often high-risk procedures
    - More likely to occur in tertiary care center
    - More likely surgeon with pediatric specific training


---

Models of Shared Care

<table>
<thead>
<tr>
<th>Primary Service</th>
<th>Consulting Service</th>
<th>Automatic Consultation</th>
<th>Who Writes Orders?</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>Pediatrics</td>
<td>No</td>
<td>Surgery</td>
<td>Similar to “traditional” consultation</td>
</tr>
<tr>
<td>Surgery</td>
<td>Pediatrics</td>
<td>Yes</td>
<td>Usually Surgery</td>
<td>Pre-arranged consultation, consultant may sign off</td>
</tr>
<tr>
<td>Pediatrics</td>
<td>Surgery</td>
<td>Yes</td>
<td>Usually Pediatrics</td>
<td>Pre-arranged consultation, consultant may sign off</td>
</tr>
<tr>
<td>Combined</td>
<td>N/A</td>
<td>N/A</td>
<td>Each service writes their own</td>
<td>Comanagement, no sign-off from either service permitted</td>
</tr>
</tbody>
</table>

**One must be used as the primary attending service for legal/systems reasons**

What is Surgical Comanagement?

- Comanagement: “Shared responsibility, authority, and accountability for the care of a hospitalized patient across clinical specialties.”

- In the case of comanaged surgical patients
  - Surgeon manages the surgery-related treatments
  - Hospitalist manages the medical conditions
  - Shared decision making over some aspects

Local determination of comanagement

- Comanagement Agreements
  1. Who is the primary service?
  2. Who is the consulting/comanaging service?
  3. Are consults as-needed or automatic?
  4. Who writes orders for the patient?
  5. Which staffing model will be use for patient care?

- Best with comanagement champions from each service
- Requires leadership support, both at division and administration level


**Impact of comanagement**

**Potential Benefits**
- To Patient:
  - Hospitalist available more promptly for serial evals and changes to mgmt plan
  - Fosters family-centered care
  - Hospitalist expertise in pediatric specific-care
  - Hospitalist expertise in coordination of care
- To Care Team/System:
  - Hospitalist more available to RNs/staff, improved communication
  - Decreased resource utilization
  - Decreased LOS

**Potential Risks**
- To Patient:
  - Confusion regarding decision making (Who’s in charge??)
  - Inadequate communication or conflicting messages
  - Fragmented care
- To Care Team/System:
  - Poor communication → Mixed messages to RNs/staff
  - Provider disengagement
  - Increased costs?

---

**Systematic Approach**

- **Patient-Specific Risk Factors**
- **Risk of the Procedure**
- **Risk of Anesthesia**

**Risk to this patient undergoing this surgery**

July 29, 2016
Post-operative Evaluation: Special Considerations

- **History**
  - Type of surgery and indication
  - Summary of Intra-operative course and Anticipated Complications
  - Medications and fluids given, Estimated Blood Loss, Intake/Output
  - Medication Reconciliation

- **Physical Exam**
  - Mental Status
  - Fluid Status
  - Pain scores
  - Respiratory Status
  - Cardiac Status
  - Surgical Site Evaluation

- **Labs/Studies**
  - Post-Op H/H (major surgeries)
  - Others as needed

- **Safety/harm risks**
  - Need for VTE prophylaxis
  - Monitoring of lines (CVL, foley, etc)
  - Fall Risk

---

Post-operative Plan: Special Considerations

- Transitioning from IV medications to enteral
- Advancing diet
- Fluid management
- Pulmonary plans
- Bowel regimens
- Wound care
- Safety/harm prevention
  - VTE ppx, Foley care/removal, CVL monitoring, Fall risk, etc.
- Therapies
- Disposition planning
  - Case management (equipment/supplies)
  - Follow up appointments
  - Transportation

July 29, 2016
Benefits of Clinical Pathways/Ordersets

➢ General Benefits
  • Reduce variability
  • Improve quality of care, safety, efficiency
  • Promote evidence-based care

➢ Specific benefits in Surgical Comanagement
  ▪ Unified expectations for entire care team
  ▪ Examples of post-operative clinical standardizations:
    o Post-op labs
    o Post-op consults (PT/OT, Nutrition, etc.)
    o Foley removal, Antibiotic prophylaxis, etc.
    o Advancing diet
    o Positioning restrictions
    o Safety/harm prevention

Interactive Evidence Review
Small Group Cases

- Two Small Group Stations (18 min each)
  - One surgical patient management scenario per station
  - 1-2 facilitators per station
  - Scenario and discussion led by facilitator
  - Handout with key points at each station
- Facilitators to Rotate Between Stations (2 minutes)
- Rules of Engagement
  - “Rule of Vegas”
    - Confidential
    - We are all learners
    - We are not experts but facilitators
Conclusions

• What did you learn in this workshop that will change your current practice?

• Are there any tools provided here today that you will use to teach other colleagues or trainees?

• What additional tools or strategies are you still looking for?
Questions?

References

Contact Info

- Sonaly McClymont, MD - smcclymo@childrensnational.org
- Anjna Melwani, MD - amelwani@childrensnational.org
- Sarah Denniston, MD - sarah.denniston@christushealth.org
- David Rappaport, MD - David.Rappaport@nemours.org
- Rebecca Rosenberg, MD - Rebecca.Rosenberg@nyumc.org
- Moises Auron, MD - AURONM@ccf.org
- Shimona Thakrar, DO - Shimona.thakrar@yahoo.com
- David Pressel, MD – david.pressel@nemours.org

July 29, 2016

American Academy of Pediatrics (AAP)
Section of Hospital Medicine (SOHM)
Surgical Care Subcommittee (SCSC)

➢ Mission:
  • To advocate for high quality care, outcomes, and research for surgical patients cared for by pediatric hospitalists

  • [https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-Hospital-Medicine/Pages/Surgical-Care-Subcommittee.aspx#sthash.D1jdo6HN.dpuf](https://www.aap.org/en-us/about-the-aap/Committees-Councils-Sections/Section-on-Hospital-Medicine/Pages/Surgical-Care-Subcommittee.aspx#sthash.D1jdo6HN.dpuf)

➢ Co-Chairs:
  • Becca Rosenberg, David Rappaport, Joshua Abzug (representing surgical perspectives)

July 29, 2016