

Pediatric Hospital Medicine 2016 Workshop Presentation  
Friday, July 29<sup>th</sup>, 2:30-3:45PM

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

**Presenters:**

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## 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.

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## 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.dpufs>

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## 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.

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## 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

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# Overview of Post-operative Care Models and Surgical Comanagement

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## 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
    - Adult and/or Pediatric surgeons
  - 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

Rappaport DI, et al. Pediatric Hospitalist Comanagement of Surgical Patients; Structural, Quality, and Financial Considerations. J Hosp Med 2014; 9(11):737-742).

## Models of Shared Care

Primary Service	Consulting Service	Automatic Consultation	Who Writes Orders?	Notes
Surgery	Pediatrics	No	Surgery	Similar to “traditional” consultation
Surgery	Pediatrics	Yes	Usually Surgery	Pre-arranged consultation, consultant may sign off
Pediatrics	Surgery	Yes	Usually Pediatrics	Pre-arranged consultation, consultant may sign off
Combined <small>**One must be used as the primary attending service for legal/systems reasons</small>	N/A	N/A	Each service writes their own	Comanagement, no sign-off from either service permitted

Adapted from: Rappaport DI, et al. Pediatric Hospitalist Comanagement of Surgical Patients; Structural, Quality, and Financial Considerations. J Hosp Med 2014; 9(11):737-742).

## 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

Society of Hospital Medicine Co-Management Advisory Panel. A white paper on a guide to hospitalist/orthopedic surgery comanagement. SHM website. Available at: [http://tools.hospitalmedicine.org/Implementation/Co-ManagementWhitePaper-final\\_5-10-10.pdf](http://tools.hospitalmedicine.org/Implementation/Co-ManagementWhitePaper-final_5-10-10.pdf). Accessed on September 25, 2014.

## 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

Rappaport DJ, et al. Pediatric Hospitalist Comanagement of Surgical Patients; Structural, Quality, and Financial Considerations. J Hosp Med 2014; 9(11):737-742.

# 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:

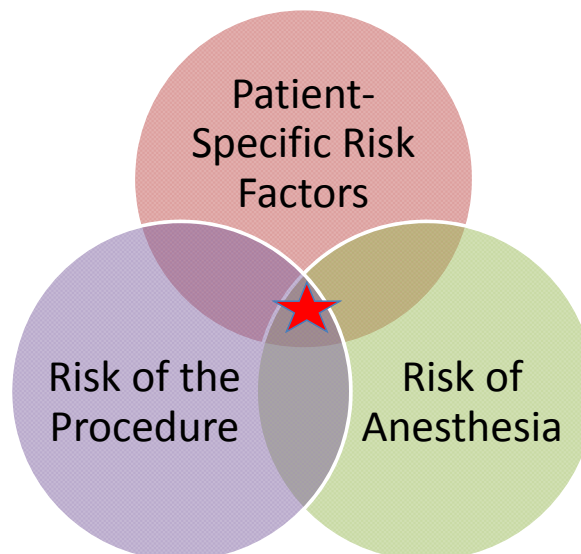
- Confusion regarding decision making (Who's in charge??)
- Inadequate communication or conflicting messages
- Fragmented care

### ❖ To Care Team/System:

- Poor communication → Mixed messages to RNs/staff
- Provider disengagement
- Increased costs?

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# Systematic Approach



**Risk to this patient undergoing this surgery**

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## 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

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## 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

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## 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:
  - Post-op labs
  - Post-op consults (PT/OT, Nutrition, etc.)
  - Foley removal, Antibiotic prophylaxis, etc.
  - Advancing diet
  - Positioning restrictions
  - Safety/harm prevention

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# Interactive Evidence Review

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# Small Group Cases

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## 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

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# Conclusions

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## 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?

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# Questions?

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## References

- 2012 State of Hospital Medicine Report, Society of Hospital Medicine. Further information available at: <http://www.hospitalmedicine.org/survey>.
- Buchert A, Butler G. Clinical Pathways: Driving High-Reliability and High-Value Care. *Pediatr Clin N Am* 2016 Apr;63(2):317-28.
- Burd RS, Mellender SJ, Tobias JD. Neonatal and Childhood Perioperative Considerations. *Surg Clin N Am* 2006; 86:227-247.
- Rappaport DI, et al. Pediatric Hospitalist Comanagement of Surgical Patients: Structural, Quality, and Financial Considerations. *J Hosp Med* 2014; 9(11):737-742).
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### ➤ Co-Chairs:

- Becca Rosenberg, David Rappaport, Joshua Abzug (representing surgical perspectives)

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