A Collaborative Approach to Patient Care: the GCM and the Physician

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GCM Partnered with Physician Practice – A Beginning

Background

In 2007 I met a neurologist through a mutual friend. Dr. L was chief-of-staff for a local hospital located in the Los Angeles area. In addition, he had a successful neurology practice which was established in the early 1980's. I was told Dr. L was considering expanding his practice to include a multidisciplinary team of professionals committed to working with the Alzheimer's population. When I first met Dr. L, he had no idea what a care manager was or how I could benefit his practice. I found him to be skeptical and a bit aloof, but nonetheless interested.

Despite his skepticism, he was willing to take a chance with adding a GCM to his practice, even though it was on a tentative, contractual basis. In the beginning, the multidisciplinary team would meet on weekends, working together to create a business plan by using flow charts and envisioning how we would work together. The union was successful, and after six years, we are still sharing a mutually rewarding partnership.

Introduction

Care managers have unique opportunities to partner with physicians for successful outcomes in patient care. While doctors in the recent past have felt threatened or even territorial regarding a GCM "managing" their patient's care, the tides may be changing. With HMOs dictating patient care, doctors often feel compelled to limit their time with each patient. Consequently, the doctor is hard pressed to review medications, changes in status, and address patient/family concerns. There is often incomplete information and gaps in knowledge, especially if the elder has cognitive impairment, or the family does not regularly attend appointments.

Once a diagnosis is given and a treatment plan is developed, many times patients and family members have concerns and questions regarding care, especially when the patient has Alzheimer's or dementia:

- How do I know if mom or dad can continue to live at home?
- Who do I hire and what are the associated costs?

While this is familiar terrain for the GCM, for the physician it is not so. Here is where the GCM comes in.

Window of opportunity for the GCM

Doctors may be reticent to hire a GCM simply because they have not been educated as to how a GCM would be beneficial to their practice. Examples of the ways a GCM can benefit a medical practice include:

1. Reduction in the amount of after-hour calls regarding care issues that may not be related to medical care per se.
2. Continuity of care from the time the of the physician's visit to the next appointment; this is important especially for complex medical cases.
3. Tracking patient progress between appointments.
4. Communication with the doctor as urgent medical needs arise.
5. Communicating with busy family members as to changing status and treatment plan of patient.
6. On Call—being at the hospital or available for urgent matters when the physician is unavailable.

When the GCM and the doctor are in alignment with achieving these goals, the patient (and family) can feel the sense of a "team" advocacy. Families are often relieved when they know GCMs can be reached when the physician can't, and this collaboration of expertise can make families and patients feel more secure that a team of "experts" is tackling the problem.

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Ethical dilemmas – Who is the client?

Working as a GCM within a medical practice is far different from the freedom you have with your own private practice. From the inception of service, the doctor must deem your service necessary as part of the treatment plan for the patient, before the GCM begins the first home assessment. In addition, the GCM must document their findings into an assessment which is usually a shorter version of the more comprehensive care plan that we create for our clients; it must convey the essential facts and problems of the elder.

The assessment is what the physician will rely upon to open the line of communication between the GCM and the doctor as to the problem areas that need to be resolved. Because the physician will need access to the completed assessment before they see the patient/family at the next appointment, all documentation of identified issues and recommendations must be more compact, excluding details the physician may find extraneous.

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This can force the GCM to prioritize identified issues making a clear delineation of urgent vs. non urgent interventions. (Unlike private practice, the GCM write-up is not considered billable time by Medicare standards.)

Another dilemma for the GCM may arise when it comes to referring resources on the recommendations portion of the care plan. This is a sensitive area for most physicians since they do not want their client base to be taken from another professional, even if they think the patient could benefit from another service. Many doctors have their own referral network if other tests / evaluations need to be done, and so the referrals / recommendations for medical providers need to be more general than specific (i.e. instead of another doctor's name given, what service is suggested).

When services are covered by Medicare, there is often a prioritization of what the doctor thinks the patient should have vs. what the GCM may think is medically necessary. For example, the doctor may have an aversion to recommending physical therapy when physical therapy may use up Medicare dollars that would otherwise be used to see the physician.

Fee Structure

Having both a private practice and an additional source of income through the physician practice has enhanced both my knowledge and expertise. While GCM services are not generally covered by Medicare, under the auspices of the physician practice this is possible. When the doctor orders it, Medicare will cover it (one home visit per year, per patient), as long the GCM is providing the "arm of care" for the doctor. When starting out, it is up to the GCM to negotiate a wage (which would be less than private practice) and convince the doctor to hire on a contract basis providing home assessment / consultation as the need arises.

One of the challenges for a beginning GCM is how to negotiate a wage either as a contractual agreement or to be directly on payroll. The distinct advantage for many doctors may be to start on a contract basis until they get comfortable with how you fit within their practice; however, this is not always advantageous for the GCM unless they have their own liability insurance policy.

While in the future cost containment models of GCM services may be available for families on a regular basis in various settings, there may well be limitations on the scope of services we can provide within the physician practice. However the beauty of starting with the physician does not end there. In my experience, many times families want / need more services, which provide them the freedom to contract with me privately, (since the doctor cannot accept private pay from a Medicare patient). Thus, in many instances, what turned out to be a single home visit through the physician, turned into a long-term case that lasted many years.

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Conclusion

There is little doubt that GCMs are becoming more valuable to busy physicians trying to keep up with the volume while providing quality of care for patients, but education of what a GCM is and does is still lacking. This is where the GCM has to be proactive and let their talents be known. We must help the doctor envision how they can become the solution to the problem, creating a collaborative approach to meeting patient care.

The GCM's decision to partner with a physician must be weighed carefully. There are many opportunities for professional growth, but relying upon this as an only income source may not be realistic. Despite the fact that working within a physician practice may bring forth ethical and financial considerations, the exposure to new patients and ongoing referrals is endless.

While the ethical and financial complexities are not entirely resolvable, new opportunities for GCMs must be paved and realized; this is especially important in light of new healthcare policies opening up new windows of opportunity for GCMs and closing others.

Jennifer E. Voorlas MSG, CMC Jennifer has been in the field of gerontology since 1996, incorporating many disciplines integral to understanding quality of life issues for elders and their families. For many years during her graduate studies she worked at the Alzheimer's Disease Research Center at the University of Southern California where she co-authored the first training manual for teachers based upon a pilot study –Memory Enhancement Seminar for Seniors--for at-risk seniors in the community. She founded Geriatric Care Consultants LLC in 2007 and is primary GCM practitioner for a neurology practice in Southern California.