Collaborative Practice

By
Judith S. Parnes
LCSW, CMC
Executive
Director

Recently, Mr. L, an 82-year-old man, was hospitalized in a local hospital after having a serious fall in his home. Unfortunately, he then developed numerous other very serious medical complications, resulting in a transfer to the ICU.

The family, who was also elderly, struggled for days in order to be able to speak with *their* "doctor" or actually to be able to identify exactly who that doctor was.

The primary care physician in the community, an internist, was part of a group of physicians that rotated their hospital visits. The orthopedist was part of a group of physicians that rotated their hospital visits; a nephrologist was part of a smaller group of physicians that rotated their hospital visits; a pulmonologist was part of a larger group of physicians that rotated their hospital visits, and the gastroenterologist was part of a group of physicians that rotated their hospital visits daily.

The family was distraught over the situation. Mrs. L got the attention of someone on the staff, possibly the social worker, quite admirably printed out pictures of several doctors that were treating the gentleman. Mrs. L then proceeded to carry the computer pages in her pocketbook and try to match the professional in the white coat with the picture. She would have needed more than 30 pages of photographs to be able to really have this system work. This is a true story.

The treatment team was ultimately successful in stabilizing this patient. The patient could be discharged from the hospital to a lesser care setting. However, what was missing? Who was the captain of the ship? Who was responsible for communicating what was occurring to a very caring and scared family? Everyone was so busy saving the life of this man, that no one had time, or took the time, to keep the loved ones in the loop.

Maybe the "team" didn't know who was to be the leader? Every day, Mrs. L would try to speak with whomever she saw, and she did get a little bit of information that way. Unfortunately, not always the same information.

A Care or Case Manager could have helped. One of the key functions that care managers can bring to the health care arena is the ability to improve care coordination by collaborating with all member of the treatment team. This needs to be more than discharge planning. By ensuring effective and efficient collaboration, care managers are able to provide the assistance necessary to reduce frustration, duplication, fragmentation and confusion among patients, families and providers.

In our increasingly challenging cost containment Medicare world, with shorter hospital stays, multiple medical disciplines being called in for consultation and more community options for short term sub-acute care, the need for someone to help navigate and negotiate the medical maze becomes that much more significant.

The day of Marcus Welby, MD no longer exists. Recognizing the need for someone to coordinate and facilitate communication is one sure way to improve the quality of care for hospitalized patients.

Judith S. Parnes, L.C.S.W., C.M.C., Gerontologist and Elder Care Consultant is Executive Director of Elder Life Management, Inc., Ocean, NJ. ELM provides quality elder care planning and management services to older adults and their families. Please visit www.elderlifemanagement.org .or call (732) 493-8080 for more information.