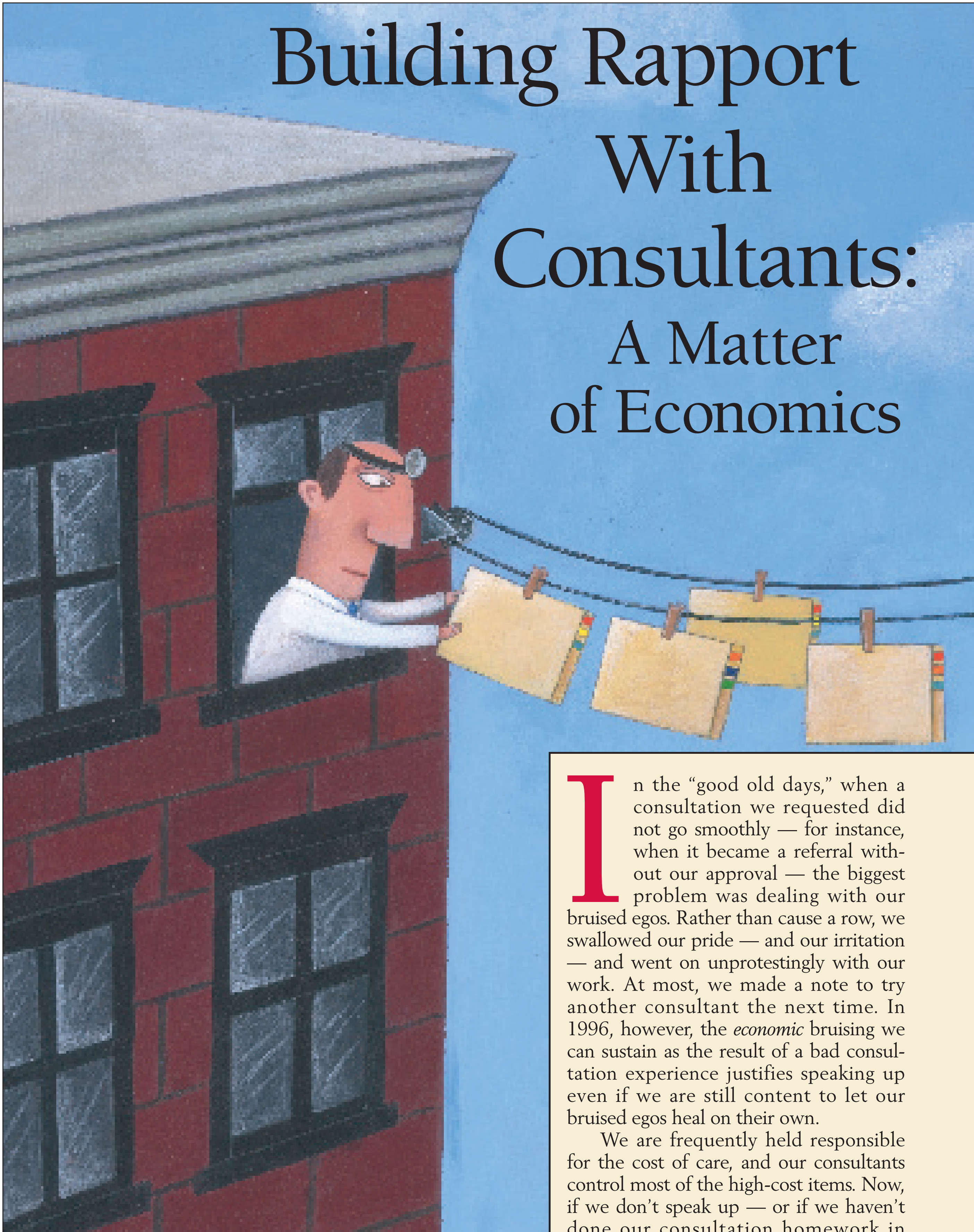
Building Rapport With Consultants:

A Matter of Economics



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In the "good old days," when a consultation we requested did not go smoothly — for instance, when it became a referral without our approval — the biggest problem was dealing with our bruised egos. Rather than cause a row, we swallowed our pride — and our irritation — and went on unprotestingly with our work. At most, we made a note to try another consultant the next time. In 1996, however, the *economic* bruising we can sustain as the result of a bad consultation experience justifies speaking up even if we are still content to let our bruised egos heal on their own.

We are frequently held responsible for the cost of care, and our consultants control most of the high-cost items. Now, if we don't speak up — or if we haven't done our consultation homework in

Nowadays, if communication breaks down between family physicians and their consultants, there is more at stake than egos.

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advance — one bad consultant can damage our financial profiles and our credibility as cost-effective practitioners. We must work well with consultants. They need us, and we need them. The patients need us both. As responsible primary care physicians *in* or *out* of managed care, we have an obligation to manage consultations and referrals efficiently.

Knowing when to involve consultants

In the past, we were able to go along with patient requests: Whenever they wanted to see a specialist, we could send them. In tightly managed care, that option is not always available. It used to be that we could resolve a little diagnostic or therapeutic uncertainty with a consult. Now we are being asked to live with more uncertainty. Insurers warn against wasting premium dollars by requesting a consultation when the therapeutic options are limited or the outcome is certain.

While greater caution may be in order, the primary indications for consultations remain unchanged:

- Diagnostic uncertainty you can't resolve — when it matters.
- Poor or unexpected response to your best shot at treatment.
- Condition beyond your expertise or comfort level.
- Questioning, seriously concerned patient, family or ancillary caregiver.
- Anticipated bad outcome — death of the elderly or chronically ill not included.
- Unexplained anger in anyone.
- That sick feeling in the pit of your stomach as a case unfolds.

Referral (total transfer of care)

CME COVERED IN *FPM* QUIZ

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Use the primary indications for consultation to decide when to seek assistance.

Involve the patient and patient's family in the selection of the consultant.

Be as specific as possible about what you expect the consultant to do.

Give the consultant all pertinent information before the patient's first visit, and keep channels of communication open after the consult.

should be considered if your involvement hinders optimal care. Critically ill patients may need an attending physician who is at the bedside more than your availability permits.

Keeping the lines of communication open

A major factor in the success of a consultation is how and when you make your request. (See "Keys to effective consultations.") It should be *timely*. Consultants do not like to get involved late in a case when their earlier involvement might have improved the outcome or when they are forced to act in haste.

Whenever possible, the choice of consultants should be discussed with the patient and the patient's family. It's awkward to involve a consultant only to later discover that for some reason the patient or family did not want that person involved.

Don't predict what the consultant will do. While you may impress your patient if your observations are accurate, trying to second-guess what a consultant will say or do can also cause very awkward moments. And should you disagree with your consultant, the patient will think that one of you doesn't know what he or she is talking about.

If you expect your consultant to be efficient and avoid duplication, be very clear about what you want done. What type of tests do you want run? What should be done if surgery is needed? Do you want other consultants contacted? Either be specific or do not complain if the results aren't what you expected. Some consultants can read your mind, but most cannot. Consider developing a preprinted consultation/referral request form to facilitate this communication (see "Strategies for Managing Referrals ... Without Losing Your Patients," *FPM*, January 1994, page 109). You can save yourself and your consultants lots of anguish by being specific.

Either be specific or do not complain if the results aren't what you expected.

You also need to put together all your office notes, lab and X-ray data and hospital summaries and see that the consultant has this information before the patient arrives. While a phone call is a good strategy for complicated or touchy situations, the consultant may not remember the details of your conversation when he or she finally sees the patient. If possible, include this information in a cover letter.

Once you have received the consultant's report, the exchange of information should not end. If the consultant makes recommendations, you are responsible for implementing them in a timely fashion. Do not hesitate to ask your consultant to educate you on technical issues you do not understand. This can be a fertile source of continuing education and can help you understand their logic.

A good consultant will call you about things that need to be expedited. If you or your patient elects to decline a proposal, the consultant is entitled to know why, and your rationale needs to be documented in the chart for the protection of every provider involved.

It is also important to let consultants know when they do a good job and when

Keys to effective consultations

Here are five steps to take to make sure both you and your patient are happy with the outcome of a consultation:

- Request the consult in a timely fashion.
- Involve the patient and the family in the selection of consultants.
- Do not predict what the consultant will do or say.
- Be specific about what you expect of the consult.
- See that the consultant has all the relevant clinical data before the patient arrives.

Consultation feedback survey

Dear Dr. ______________________:

Thank you for your consultation assistance with those patients whose care I manage. I would appreciate your feedback on several issues:

Is the timing of my consultation requests generally appropriate? Y ___ N ___
Comments:

____

____

Do you know what I expect when my patients arrive? Y ___ N ___
Comments:

____

____

Do I provide adequate background information? Y ___ N ___
Comments:

____

____

Do I manage insurance company precertification well? Y ___ N ___
Comments:

____

____

What can my staff or I do to enhance our working relationship with you and your staff?
Comments:

____

____

Thank you for your help. Please return this questionnaire to me as soon as possible, and if you think we should discuss any of the issues you raise, please don't hesitate to call me.

Very truly yours,

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► Let your consultant know how his or her recommendations were handled and what the results were.

► Seek input from the consultant about how effectively you coordinated the consultation.

► Give serious thought to terminating your relationship with any insurance plan that inappropriately restricts you or your consultants.

► Carefully consider the options available for billing for time spent in arranging and coordinating consultations.

their recommendations work out well. Normally they only hear back from you or from the patient when clinical results are poor. They deserve some positive feedback and will be less reluctant to completely turn patients back over to you when they know you will keep them informed. If you drop your surgeon a note when a patient with breast cancer is cured 10 years later, he or she will be both surprised and pleased. And it goes without saying that you should let your consultant know when his or her suggestions go poorly. That process is our medical school heritage and an important part of your consultant's continuing education.

If a consultant consistently does not heed your wishes, you should stop using that individual.

Since you are the coordinator of the consultation team, it would also be appropriate to ask your consultants how you are doing in this role. This can be difficult. Consultants won't want to offend you and lose referrals, but you should know how they feel. One option is to develop a routine questionnaire to generate constructive suggestions. (See the "Consultation feedback survey" on page 39.) It should open the door for better communications.

Remember, we have moved beyond dealing with bruised egos to protecting our financial status.

Dealing with more practical matters

If a managed care plan or other insurance product will not permit you to use your medical judgment concerning when or whether to consult, and if the consultants the plan provides are not satisfactory, you should terminate your relationship with that plan. This is not just a matter of medical liability. Your participation in a plan reflects your professional ethics. Your patients trust you to make good decisions. Your choice of insurance plans is one of those decisions. No plan should inappropriately restrict you or your consultants. Likewise, if a consultant consistently does not heed your wishes and is not trainable, you should stop using that individual. Remember, we have moved beyond dealing with bruised egos to protecting our financial status.

Doing a thorough job of arranging consultations is time-consuming for you and your staff. You should bill for your time, whenever possible. Case management fees make sense but are usually not available. Two or three dollars per member per month in a tightly managed system that depends on you for care management would not be out of line for the time required. A few capitated plans include a care management fee in the capitation payment to primary care physicians; this results in a cap rate that is well above mere equivalence with fee-for-service revenue. When operating under fee for service, if there is no other financial allowance for case management, you may find isolated instances to use the Care Plan Oversight codes (99375-99376) or the "special reports" code (99080). Although it is neither logical or appropriate, time spent in arranging most consultations is assumed to be bundled into office visit codes. Billing for phone calls could help, but it is irritating to patients, hard on staff and may not be worth the effort. Third-party payers and HCFA have been slow to recognize the resources needed to do a good job of arranging consultations and the value of this service. And we have foolishly done it for free.

Society expects its family physicians to develop smooth, controlled, cost-effective relationships with consultants. We must do everything we can to achieve this goal. Effective communication is the key. Optimal consultations will occur when we give the process the attention it deserves. FPM