

The HPM Practitioner

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Hospice and Palliative Medicine

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News Notes

Palliative Care Growth and Challenges: America needs an alternate strategy for mid-career physicians who want to shift into hospice and palliative medicine but are not able to take a year off to complete a fellowship, said Russell Portenoy, MD, chair of pain medicine and palliative care at Beth Israel Medical Center in New York during an Oct. 27 audio conference on challenges and opportunities in HPM, sponsored by the American Academy of Hospice and Palliative Medicine. Starting in 2013, completing a year-long fellowship will be the only recognized path to medical board certification for the HPM subspecialty, but current fellowship programs can generate perhaps a hundred new graduates a year for a workforce demand in the thousands.

One key to operationalizing the various formal definitions of palliative care to the bedside, Dr. Portenoy said, is to view HPM as a therapeutic model that defines best practice for the routine care of all patients with serious or life-threatening illnesses (i.e., generalist-level care) and

Welcome to the second issue of *The HPM Practitioner*. We launched this e-newsletter in August because we believed the physician community of hospice and palliative medicine needed a forum to exchange questions, concerns, information and best practices regarding the business and practice management of HPM. Response to our inaugural issue suggests that there indeed is an avid audience for this kind of information. But with the rapid pace of changes in the HPM subspecialty -- and in larger currents of health care reform -- this kind of information is more important than ever to physicians interested in turning hospice and palliative medicine into a career.

Once again, we profile a successful HPM physician practice in terms of its workload, scheduling, compensation and other fundamental practice management concerns, this time an interview with Dr. Amy Mohler of Hospice and Palliative Care of Western Colorado in Grand Junction. But we also include current information about HPM's place in health care reform and a few highlights from a recent American Academy of Hospice and Palliative Medicine teleconference. We introduce a new feature, Billing Corner, with concrete tips and perspectives on billing for HPM professional services by Chris Acevedo, a billing consultant experienced in palliative care. As always, please let us know what you think, whether we are addressing the real concerns of your HPM practice, and what else we ought to be covering.

Tim Cousounis

Balancing Clinical and Administrative Roles:

Interview with HPM Physician Amy Mohler, MD



Grand Junction, CO, was recently lauded in the news media and at a town-hall meeting with President Obama as "a health community that works" -- for controlling health care costs while maintaining high quality. Data from the Dartmouth Atlas and from the DAI Palliative Care Group show it to be an exemplary palliative care community as well, based on metrics such as lower rates of in-hospital deaths, fewer hospital readmissions, less reliance on ICU care and higher hospice enrollments. (For more information on DAI's palliative care community metrics, see www.DAIpalliativecaregroup.com.)

"We can't take all of the credit," quips Dr. Amy Mohler, a board-certified hospice and palliative physician and the Chief Medical Officer of Hospice and Palliative Care of Western Colorado (HPCWC). The local medical culture

access to specialist-level care for those patients who need more intensive, interdisciplinary support. Beyond the workforce shortfalls in all palliative care disciplines, other challenges include a business model that depends on demonstrating cost reductions; limited continuity of care in transitions beyond the hospital; and inadequate linkages between hospital programs and hospices, nursing homes and home care. The hospice industry faces reimbursement uncertainties because the government wants to control hospice costs and Congress is expected to make changes in the Medicare benefit. An "open access" model of hospice care cannot grow unless the current reimbursement system changes, Dr. Portenoy said.

Legislative News: HPM leaders traveled to Capitol Hill in late October to urge lawmakers to consider the needs of people with serious illnesses in their deliberations on national health care reform. AAHPM President Gail Austin Cooney, MD, and other HPM leaders went there "to ensure that the needs of the most vulnerable patients are represented in the process." AAHPM's agenda for health care reform includes support for the National Pain Care Policy Act, the Life-Sustaining Preferences Act, and Sen. Ron Wyden (D-OR)'s proposal for Medicare hospice concurrent care demonstration projects to test the simultaneous provision of hospice care and curative treatment. (See [AAHPM Press Release](#) for more information.)

Meanwhile, hospice advocates were working to try to minimize the impact of proposed "productivity factor adjustments" that would reduce the annual inflationary increases in Medicare hospice benefit rates. Other hospice provisions in Congressional reform proposals include concurrent care for children under Medicaid, recognition of physician assistants as attending physicians for hospice patients, and a mandate for public Medicare hospice quality reporting by

emphasizes the role of primary care physicians. Grand Junction's non-profit hospitals and health plan came together 16 years ago to establish HPCWC as hospice provider for the entire community.

"Those entities have been in Grand Junction for decades, and our medical culture has grown from the ground up. But for the past 16 years, HPCWC has been an integral part of that system," Dr. Mohler says. "I see great collaborative relationships here, and our local physicians are very open to our palliative expertise and to getting calls from us whenever we see opportunities to improve our patients' symptoms and quality of life."

The hospice's census has grown to 250 in a metropolitan area of less than 140,000 people. HPCWC also offers in-hospital and community-based palliative care consultations, community bereavement services, grief programs for children and teens, and a cadre of 1,200 volunteers. It operates three satellite hospice teams an hour or more from Grand Junction.

"Grand Junction is like the poster child for primary care, and this is fertile ground to be passionate about your work," says HPCWC CEO Christy Whitney. "Even before our hospice existed, there was a very active non-profit HMO, Rocky Mountain Health Plans, that closely monitored hospital days. But I believe we have helped considerably to lower hospital days at the end of life, which means lower end-of-life costs. Having excellent hospice physicians who are available for teaching other physicians has also helped us make inroads."

Scheduling, Compensation and Call

Dr. Mohler and two physician colleagues work full-time for HPCWC, dividing up medical responsibilities for 12 hospice interdisciplinary teams based in home settings, nursing homes and assisted living facilities. Four days a week, Dr. Mohler sees patients at the hospice's freestanding 13-bed inpatient unit, which opened last October. The other doctors put in four-day work weeks heavily tilted toward direct patient visits, which are scheduled and geographically bunched by an administrative assistant. They generally make four or five home care or six to eight facility-based visits per day, and the local geography does not impose long driving times. "We try to get all of our new hospice patients seen early in their admission, especially since we see 30 percent of them for seven days or less," Dr. Mohler says.

Each physician spends about an hour a week on interdisciplinary team meetings, with each team coming together every other week for a tightly structured reporting format to get through 20 to 25 patients within 30 minutes. "We used to be quite fantastic about allowing the IDT to run for hours, which wasn't helpful to anybody," Dr. Mohler says. Regular contacts between IDT meetings include "mini-team" updates and frequent phone calls.

This year HPCWC implemented a productivity model for compensating its staff physicians, based on their billable visits, with a base salary to cover essential administrative activities. "I think everyone is happier with it, in terms of their workload. If they want to make more money, they know they can work harder and make more visits. If they like their balance of quality of life versus workload, that's okay too. The expectations are clearer and there's a feeling of shared responsibility," Dr. Mohler says.

Between them, the three doctors also divide up evening on-call coverage, "physician-of-the-day" responsibilities, including first response for palliative care consultations, and three-day weekend call, including daily patient visits at the inpatient care center. The three-day weekend shift is designed to give

2014. (See NHPCO update and other commentary for more information.)

Psychiatry and Palliative

Care: The Palliative Care Psychiatry Program of San Diego Hospice was recently honored with the 2009 Gold Award of the American Psychiatric Association. Directed by psychiatrist Scott Irwin, MD, PhD, this is the only full-time psychiatry service focused on the mental health needs of hospice and palliative care patients and their loved ones, and on addressing the under-recognition and under-treatment of psychiatric symptoms at the end of life. The program emphasizes rapid interventions to find and reduce symptoms of psychological distress among hospice patients, research into better assessment and treatment of mental health concerns, rotations for University of California-San Diego psychiatry residents, and training for palliative care fellows from around the world. For more information, contact Dr. Irwin at sirwin@sdhospice.org.

Dementia in the Literature:

A study of nursing home patients with advanced dementia, published in the Oct. 15 *New England Journal of Medicine*, found that while comfort was the identified goal of care for these patients, at least 40 percent received burdensome interventions such as hospitalizations, emergency room visits or feeding tubes. Researchers led by Susan Mitchell of Harvard Medical School found that residents whose proxy decision makers had an understanding of their poor prognosis and expected clinical complications were far less likely to receive these burdensome interventions. A study by McCarty and Volicer, published Oct. 17 in the online *American Journal of Alzheimer's Disease and Other Dementias*, found that hospice care is still underused for individuals dying with advanced dementias. They determined that hospices offering bridge or transition programs had on average four

the doctor on call more time to acclimatize to the needs of those patients.

That may seem like a lot of call responsibilities, especially with the spectacular scenery of Western Colorado so close at hand. But it really isn't as bad as it sounds, Dr. Mohler says. "We find the schedule is still reasonable, because of the emphasis on primary care physicians in this community, their investment in what happens to their patients, and our commitment to supporting that relationship. That translates, when we are on call, into serving more as specialists consulting on their patients, so that our responsibilities aren't such a huge deal," she explains.

"Our staff knows that when something is going on with a patient, their first line of help is the primary care physician. They still may call me to spend a few minutes running through the scenario and what might be most helpful for the patient, before they call the physician. I tell the nurses they need to know what they want to ask for from the doctor in a given clinical situation before they place that call."

Still, the hospice is finding that three physicians are not enough to cover everything that needs to be done, especially since a nurse practitioner who made most of the in-hospital palliative care consultation visits moved away earlier this year. "When you are the doc of the day, you're in the hot seat. You may get the consultation call that comes in at ten minutes before five. But we're not doing a huge volume of inpatient palliative care consultations right now. We also have a community-based nurse and social worker palliative care team that uses more of a case management model, with a current census of 58," she says.

HPCWC hospice teams in the three satellite offices draw upon local community physicians in part-time or volunteer roles to staff their hospice teams. The three full-time hospice doctors in Grand Junction are HPM-certified, but the four part-time satellite physicians, who have full-time clinic practices in internal medicine or family practice, are not. The satellite team physicians don't make many home visits. "If there are complex patients who need to be seen, we try to make special arrangements for seeing them out of this office," Dr. Mohler says. The agency also has a medical suite available at its inpatient unit to see patients who may be in central Grand Junction for other medical services.

Dr. Mohler would like to have more time for visiting the satellite sites and working hands-on with their physicians and teams, rather than doing that by phone and email. Current plans are to recruit a fourth full-time physician for HPCWC while perhaps involving other Grand Junction physicians in on-call coverage and encouraging the satellite office physicians to enhance their palliative care skills through occasional shifts at the inpatient unit.

A Representative of Hospice

Although Dr. Mohler's job is largely clinical, covering the inpatient unit Monday through Thursday, Friday is spent in the hospice office on administrative functions. These include supervising the other physicians, participating in quality improvement activities and on the hospice's senior leadership team, teaching in a local family practice residency program, staff teaching, educating the local physician community and the public about hospice care, and "quite a lot of social networking as a representative of hospice."

"We have made a big investment in physician services. At our best we cover

times greater dementia caseloads than those without such programs. Providers identified the biggest barriers to hospice use for dementia patients as prognosis, education and finance.

Featured Practice Opportunity

Showcase both your clinical expertise and business savvy as you implement clinical and service growth strategies for a hospital-based palliative consult service in Florida. The service is well established (almost eight years old), and has helped redefine how late-life care is provided in the 458-bed flagship hospital of this regional health system. While this service is well-established and some strategy is in place and activities have been underway for some time, you'll put your personal stamp on these programs as you expand development efforts and provide palliative services to patients in acute and long-term care settings throughout the health system. The palliative care service has been instrumental in the hospital's citation by the DAI Hospital Palliative Performance Profiles as an Exemplar Hospital for its late-life care practices and outcomes. The opportunity is an employment-based position with the hospital-affiliated physician group, and will be viewed as the palliative medicine expert within the community.

To learn more about this opportunity (confidentially, of course), just send an email to tcousounis@digital-action.com

The *DAI Palliative Care Group* is a national consultancy partnering with hospices and palliative care practices to build their medical staffs. Recruiting, medical staff development planning, physician performance management and opportunity assessments for palliative medicine practices are our competencies.

We invite a discussion of

only 50 percent of medical costs from billing revenues," Whitney says. "But we decided to make that commitment, and having Amy, with her geriatric background, has been fabulous for our patients. My feeling is that hospice and palliative medicine is a specialty. Having our physicians available by phone supports our nurses, who sometimes have a hard time reaching the attending physician when they're out in the field. It brought a higher standard of care to our patients, and it gives us the opportunity to truly practice evidence-based medicine."

Dr. Mohler has been with HPCWC for seven years and its Chief Medical Officer, a position created to oversee the medical care provided by the other hospice physicians, for the past 18 months. An Arizona native, she trained as an internist and did a geriatrics fellowship at Good Samaritan Hospital in Phoenix. "I always knew that I would do geriatrics and, specifically, long-term care. But I became interested in end-of-life care during my residency," she says. "I spent so much time in the hospital and ICU and attended so many deaths there that I just felt there had to be a better way."

Your Service is Growing: When to Add an HPM Physician

Most hospice and palliative medicine (HPM) programs and practices are finding increased demand for their physician services. These growing pains, obviously, can put a strain on current staff and the practice's infrastructure. A physician practice that is stretched beyond capacity because of an unfilled position cannot carry the patient and on-call load of a larger group for an extended period of time. The overtaxed and overwhelmed physicians are prime candidates to leave the practice, seeking opportunities where they can find better control over their workload. In other words, unfilled positions beget unfilled positions. That is why turnover is often referred to as the "silent killer" of a practice.

One of the most challenging tasks for a HPM medical director or practice manager is determining how many physicians are needed to staff the program. Since most HPM practices do not generate revenue greater than their compensation, knowing when to add a full-time physician is not an easy decision to make. But it is important to consider the costs and lost revenue associated with an unfilled position as well as the salary it takes to fill it.

Take a hospital inpatient palliative care consult service, for example. A 2008 study by the National Palliative Care Research Center found that savings from palliative care consults for hospital inpatients ranged from \$1,500 to \$5,000 per admission. A palliative medicine physician who performs 40 such consults per month will produce savings of at least \$60,000 per month for the hospital. Or take a hospice program with a palliative care consultation service and a physician making home visits to palliative care patients. One-third of those patients can be expected to transition to the hospice benefit, generating, on average, \$1,500 in hospice revenue per patient. An HPM physician visiting 30 patients per month on the palliative service will produce \$15,000 in patient service revenue for the associated hospice.

While these guidelines are handy in building a case, alone they do not make a clear case for when a physician should be added. Nor will the conceptual approach, projecting the work for a time period (e.g., 5,000 home visits/year) and dividing that projection by the amount of work performed by one FTE HPM physician (e.g., 920 home visits/year). Careful consideration of several other factors will also enhance the decision-making process: use of non-

how a partnership would benefit you.

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Commentary on Palliative Care Success

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physician providers, such as nurse practitioners; variation in workload (need to staff higher than the average to address spikes in service demand); expectations around nonclinical commitments that may include administration, teaching and research; and the need for off-hours coverage, vacations and the like.

The right timing in adding a physician to a HPM practice will likely accelerate success. Mistiming will stymie program (and practice) growth. The next issue of *The HPM Practitioner* will look more closely into effective ways to attract the right candidates to your practice.

Compensation

Compensation for full-time HPM physicians continues to lag behind other primary care subspecialties, according to preliminary findings of the 2009 DAI Palliative Medicine Compensation Report. While median compensation for HPM physicians increased by 8.5% over the previous year, compensation still lags that of family practitioners by 9%, and internists and hospitalists by nearly 15%.

While overall numbers do not yet suggest a groundswell movement, more employers/practices are shifting away from straight salary to a combination of income guarantee and productivity incentives. To learn more about models of compensation, plan to attend the AAHPM Annual Assembly workshop presented by Ed Martin and Chuck Wellman, March 3-6, 2010 in Boston, MA.

Meanwhile, look in your email inbox next month for more information on how you may purchase the 2009 HPM Physician Compensation Report. Among the uses of the report previous purchasers have found:

- easily benchmarking current physician salaries against those within a peer group;
- a source of compensation information to bolster program case statements to senior management;
- rapidly implementing a physician recruitment strategy using compensation as a competitive edge.

Billing Corner: Substantiating Your Visits

(Editor's Note: The following article by Chris Acevedo addresses some of the basic issues in billing for HPM consultation services concurrent with primary physician services. Billing remains a fundamental challenge for most hospice and palliative physician practices, essential to growth and long-term viability even though unlikely to cover the full costs of providing the service. We offer this billing information to help contextualize that challenge and share some of the techniques of successfully maximizing billing reimbursement for HPM physicians.)

As your palliative care program continues to expand, ensuring that physician and non-physician practitioner (NPP) services are not viewed by payers as duplicative will be imperative to your program's success. The Medicare Policy Manual clearly warns Medicare contractors to "assure that the services of one physician do not duplicate those provided by another." Thorough, concise documentation is your best ally in substantiating that the services you are rendering are medically necessary and non-duplicative. It also helps to

coordinate the care with your attending physicians and other specialists, so that they have a clear understanding of your role. With many practitioners still uninformed about the benefits and roles that palliative care providers play, such communication is paramount.

Medicare specifically addresses concurrent care and states that "reasonable and necessary services of each physician rendering concurrent care could be covered where each is required to play an active role in the patient's treatment, for example, because of the existence of more than one medical condition requiring diverse specialized medical services."

CMS has instructed its contractors to apply the following criteria in determining the worthiness of concurrent care: (1) does the patient's condition "warrant the services of more than one physician on an attending (rather than consultative) basis"? and (2) are the services provided by each physician/NPP "reasonable and necessary"? It is imperative that your documentation supports your services as a necessary, concurrent but not duplicative component of the patient's care. Although the patient's overall condition and the underlying necessity for your services must be considered, the recent recognition by Medicare of hospice and palliative care as a medical subspecialty could determine whether or not the payer will question the reasonableness of your services.

Once you have established the necessity for your services in general, then the focus turns to substantiating the necessity for each visit. Again, this is an area that takes coordination and communication between physicians. Typically what we see are palliative providers addressing symptoms and attending physicians addressing underlying or chronic conditions. In a hospital setting this can work well, but for patients seen in a nursing facility or at home, you must be sure to paint a clear picture of the services you are providing.

Think of Medicare as any other health insurance payer. Certain items and services are covered, and others are not. And those that are must meet the coverage criteria and at minimum be "reasonable and necessary."

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