

The HPM Practitioner

Business/Practice News and Views for Physicians in
Hospice and Palliative Medicine

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Greetings,

HPM Practitioner was launched last fall with the single goal of supporting the development of the specialty of Hospice and Palliative Medicine (HPM) as a medical practice -- and a career.

We have pursued that goal primarily by illustrating successful, real-world HPM practices, showing how physicians who decided to make HPM a full-time career have organized their practices and work days to address fundamental issues such as billing and revenue, administrative versus clinical time, and the other nuts-and-bolts challenges of having a medical practice in this field.

We think that is the most valuable and unique service we can offer to a field that all too often, despite its commitment to relieving the suffering of advanced illness in all its manifestations, doesn't quite believe this can be a medical career.

We know there are as many ways to organize a practice as there are HPM physicians, but we hope to provide examples that may inspire or inform other HPM physicians. Therefore, we have decided to offer not one but two portraits in this issue of practicing HPM physicians and how they made it work for them.

Tim Cousounis

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Dr. Michael Nisco: Knowing What You Are Worth

Interview with HPM
Physician

Michael Nisco, MD,
by Larry Beresford

Can physicians credentialed in HPM create busy, thriving, financially viable, full-time medical practices specializing in hospice and palliative care? Dr. Michael J. Nisco of Fresno, CA, president of the independent medical corporation California Palliative Care, Inc., answers with a



Dr. Janet Bull: One Quality Consultation at a Time

Interview with HPM
Physician

Janet Bull,
MD, by
Larry Beresford

Dr. Janet Bull, Chief Medical Officer of Four Seasons in Hendersonville, NC, a fellow of the American Academy of Hospice and



resounding yes -- although the pace of his HPM practice might make your head spin.

Dr. Nisco's medical corporation employs eight other physicians in part-time capacities and contracts with St. Agnes Medical Center for medical direction of its palliative care service; with St. Agnes Hospice for medical director services; with the University of California-San Francisco (UCSF) Fresno campus for consulting and to direct its developing palliative care fellowship program; and with Hinds Hospice inpatient facility for consulting and clinical services. But that's just the beginning, since he has been asked to participate in two other programs.

Dr. Nisco himself works seven days a week. But between contractual stipends to the corporation and billing revenues, "I make well above what I ever could have made as an employed physician or in family practice, and the people who work for me are paid competitively."

He advises other credentialed HPM physicians not to sell themselves short. "Whether you realize it or not, chances are the hospitals and hospices that you work with know how much they can benefit from having an experienced HPM physician on staff. Hospice and palliative physicians are in big demand, and at this point most hospitals are aware that they need palliative care for reasons of quality, satisfaction and throughput," he says. Establishing a new palliative care program requires a lot of time just walking around talking to people, so HPM physicians should not be shy about asking for a stipend and the support needed to run a successful service.

Although his practice in Fresno has grown rapidly, "in no way did I try to build an empire. My only goal was to help hospitals and hospices address palliative care needs and do the best I could for patients. I was never driven by who would pay me the most, and most of my relationships in fact began with me volunteering my time to discuss opportunities with institutional committees interested in building HPM programs. I think if your intentions are principally to support providers as they struggle to improve the quality of care for their patients, people will recognize that and they'll want you on their side."

Finding His People

Trained in family practice, Dr. Nisco felt a pull to end-of-life care, based on both family experiences and an end-of-life care research project in medical school that took him to China. In his first family practice group position, he became the default, go-to end-of-life care provider. "But I did it after work and on weekends, and it wasn't highly valued in my

Palliative Medicine (AAHPM) and board-certified in HPM, entered this field from the unusual vantage point of obstetrics. She was drawn to the work after watching her office manager die at a young age in a major teaching hospital without the benefit of good end-of-life care.

After moving to Asheville, NC, and taking a three-year sabbatical to be with her children, she started as a volunteer hospice physician and became hooked. She was Four Seasons' first part-time paid physician in 2000 and, starting in 2003, its first full-time staff physician. The organization experienced tremendous growth in hospice census -- 250 percent in two years -- after launching a highly successful palliative care program. Now she's back working long hours, which she estimates at 60 to 70 hours per week.

Hendersonville is a retirement community of about 100,000 people, 20 miles from Asheville in the hills of Western North Carolina. Four Seasons serves a current census of 250 hospice patients and, in conjunction with its palliative care program, cares for 74 percent of all patients who die in Henderson County. The palliative care consultation service, launched in 2003 and offered seven days a week in two local hospitals, nursing homes, assisted living facilities and patients' homes, has a current daily census of 400 patients. About half of the hospice's patient referrals are generated from palliative care.

According to data analysis from the DAI Palliative Care Group, the Asheville region, which includes Henderson County, outperforms national averages and some better known palliative care communities on Dartmouth Atlas-derived measures of end-of-life care.

Today, Four Seasons employs four nurse practitioners, four physician assistants and two physicians dedicated to palliative care, under the direction of Dr. John Morris, a pulmonologist and critical care physician. The team is rounded out by a full-time social worker, part-time chaplain, full-time scheduler and other administrative support. The hospice program has 5.5 FTEs of physicians. That roughly breaks down as 1.5 FTEs covering Four Seasons' 19-bed freestanding inpatient facility; 1.5 FTEs seeing patients in nursing homes; and 1.5 FTEs visiting patients at home -- plus Dr. Bull herself.

"We are very heavy in physician staffing, and think that is a good real positive," with the physicians mainly out making billable visits to hospice patients and serving as attendings or consultants on about 80 percent of patients enrolled in hospice care, she explains. "They actually paid for themselves last year."

In 2005, Four Seasons started a research department, which offers clinical trials to patients for a variety of symptom management issues. It collaborates with

group," Dr. Nisco says.

Eventually he landed a fellowship in HPM at Harvard Medical School. "That was a life-changing experience, doing my fellowship with Andy Billings and Susan Block. I had gone into family practice to get involved with patients and families in meaningful ways. But it wasn't satisfying, because of the time pressures. Now, in palliative care, I was able to really connect with patients and families, to be invited into their lives during such an intimate time."

After the fellowship was over, Dr. Nisco's wife Yen chose Fresno, in California's Central Valley, as a place to settle, given the highly rated Clovis School District and the slower pace and not-too-urban lifestyle. He began sending emails to local hospital and hospice administrators. "They agreed to meet with me, but it quickly became apparent that none of them had any idea what to do with a physician who wanted to practice HPM full time." One hospital offered him a 0.2 FTE stipend to run a palliative care service. But with minimal other support or resources, it was not enough to overcome the huge barriers to implementation, such as the attitudes of oncologists and primary care physicians.

A year out of his fellowship, Dr. Nisco was approached by the newly hired medical director and director of oncology services at St. Agnes Medical Center in Fresno, both of whom had worked at other hospitals with palliative care programs. St. Agnes also belonged to a larger Catholic health system that was pushing palliative care implementation. "I no longer had to prove to them the value of palliative care, they already got it. They offered me a half-time stipend, two nurses, an office and administrative support."

Based on the challenges at the other hospital, Dr. Nisco made a strong commitment to treat every referring physician as a customer, getting to know them personally and respecting boundaries. "I tried my hardest to let them view me as supporting them and their relationships with their patients." His medical corporation provided the structure for his working relationship with the various groups.

"Within two months, I was overwhelmed by my success. There were so many inpatient referrals that I literally couldn't do it all myself." So out of necessity, the service was reorganized, with most of the initial contacts coming from the palliative care nurses, who talk with him several times each day about who needs to be seen by the doctor.

A year later, St. Agnes' hospice program, with an average census of 100 patients, asked him to be its medical director. The inpatient team continued to grow, evolving into a true interdisciplinary team.

academic institutions like Duke Medical Center and M.D. Anderson, as well as pharmaceutical companies. Participating in clinical trials offers patients access to treatments not currently available, and the generated revenue supports palliative care services, Dr. Bull says.

In collaboration with Dr. Amy Abernethy at Duke, Four Seasons launched a multi-site palliative care benchmarking initiative called the Palliative Care Database Project. Its purpose is to support quality assessment and improvement by providing critical data collection and data management infrastructure, identifying patterns of access, utilization, symptoms and advance care planning. "For example, our data show that chronic obstructive pulmonary disease patients are less likely to complete advance directives, suffer a high symptom burden and require multiple hospitalizations."

In 2009 Four Seasons established the Center for Excellence, which provides on-site training, consultation and mentorship for other end-of-life care programs and professionals. This service experienced a spike in demand after the American Hospital Association gave Four Seasons its Circle of Life Award in 2009. A disease management program targets hospice patients with conditions such as cardiac or pulmonary disease for special interventions and focused pharmaceutical management.

"My role as Chief Medical Officer is overseeing the hospice side of operations, and also the research component," Dr. Bull explains. "Dr. Morris oversees the palliative care division. We complement each other and both of us sit on the senior leadership team, giving the agency two strong, visionary physician leaders." Dr. Bull makes clinical visits to research study participants, provides overflow coverage at the hospice house, makes assessment visits when more information is needed for terminal certifications, and does scheduled on-call shifts. As hospice medical director, she oversees day to day clinical operations, supervises the other physicians, and leads special projects like the Center for Excellence and the state Palliative Care Database.

She frequently travels to research meetings and serves on AAHPM's research committee and Palmetto's Hospice-Intermediary Advisory Committee. She makes educational presentations on evidence-based prognostication, hospice eligibility, appeal of claims denials and physician billing, with a preconference presentation on billing and coding scheduled for the AAHPM annual meeting in Boston on March 3.

Integrating Palliative Care with Hospice

Dr. Bull says it was not a difficult decision for Four Seasons to commit to palliative care. "It was an emerging field, and it made so much sense for our

Suddenly there was a list of doctors who wanted to be part of the service, from fields such as emergency medicine, internal medicine and family practice. Next step is to open a 30-bed palliative care unit, slated for later this year, and Dr. Nisco is right in the middle of its development.

"I had become frustrated with patients having to die on telemetry units, cared for by telemetry nurses who themselves were stressed and frustrated due to a lack of specialized training in end-of-life care and discomfort with caring for dying patients." This new unit will admit hospice patients in need of general inpatient-level care, but mostly it will focus on "any patient in the hospital who has palliative care needs unique to the skill set of palliative care nurses, in a nice private room. That's better for the nurses, better for the patients, and better for the hospital."

Incredibly Busy, but not Always

Dr. Nisco acknowledges that he is incredibly busy. "But I've never been happier. I wake up every day and love what I'm doing. I love working with hospice and palliative care people. I'm helping so many different hospices and hospitals develop programs. I'm giving lectures and doing all sorts of education. I'm sitting down with administrators every day to develop new care systems. I have a broad reach, and I'm still able to get daily face-to-face encounters with patients." The only downside is the hours, which he estimates at more than 80 per week. "And when I'm not on an airplane, I'm reachable by cell phone 24 hours a day."

Roughly 30 percent of that time is purely administrative, 30 percent is education and teaching, 25 percent is palliative care consultations in the hospital, and the rest of Dr. Nisco's work week is spent filling the hospice medical director role, although without a lot of patient visits. "After two years, the nurses finally got the idea of what a physician at the table can bring to hospice, but they're still not entirely used to physicians making home visits. We're making progress, though, and I'm in the process of interviewing a doctor specifically to make regular home visits to hospice patients." He also spends time developing policies and procedures, such as ICU, pain or ethics protocols, and an inpatient DNR order set, used in three local hospitals, which is fully aligned with California's POLST (physician orders for life-sustaining treatment).

In the middle of this cyclone of activity, Dr. Nisco noticed a lack when he met with hospital administrators, who sometimes seemed to be talking over his head with terms like return on investment. So he has been pursuing an MBA with a health care emphasis from UC-Irvine, four days a month, and

patients. We could incorporate this holistic model of care earlier in the disease trajectory and use it to take better care of our patients. We didn't anticipate quite such rapid growth, but it goes to show that once people have a good framework for making personal treatment decisions, they often choose comfort care," she says.

In the program's early stages, the Center to Advance Palliative Care was a useful source of technical assistance and tools. "It's mind-boggling how much there is to learn about this field -- even basic things like billing and coding. We had a tremendous amount of help early on. We had a community that supported moving in this direction, and we've been fortunate to enjoy ongoing support from the Duke Endowment," she explains.

"We are also very cognizant that you're never going to make money providing palliative care. You can be smart, efficient and effective in how you deliver the care -- but you must be fiscally responsible, making sure to keep your losses at a minimum. We establish visit expectations for professional staff, and we provide a support system so that the providers, who work virtually based out of their homes, don't spend their time calling patients to arrange appointments or doing administrative tasks. We follow the National Consensus Project guidelines and, basically, teach the importance of one quality consultation at a time."

Essential to the palliative care program's success was being clear on what kinds of patients it would see -- or not see. "We learned early on that we can't be all things to all people. We didn't want to be a chronic pain service or post-acute, post-surgical consultants. We wanted to stay focused on serious, advanced illness, generally for patients with three years or less to live. At Four Seasons, we are all about delivering quality care and looking at measurable outcomes. We take our patient and family satisfaction surveys very seriously."

The program emphasizes continuity of care across care settings. "From the get-go, we saw patients where they were, and we followed them from one setting to the next," she says. Integrating the hospice and palliative care departments was also a priority. "Many organizations bump up against the problem of palliative care being viewed as a step-child to hospice. Here we value the great things palliative care brings, and how it complements hospice," Dr. Bull says.

"We consider ourselves one big team, whether palliative care or hospice, with a lot of interface between the two. Patients can flow both ways between these programs. We used an explicit strategy of building the connections between the two. Some employees serve both programs, and we share resources and administrative tasks, integrating them whenever we can," she reports. "Often at staff meetings we'll have presentations by palliative care leadership or providers,

will earn the degree in June of this year. "We often joke as physicians about administrators as being from the 'dark side,' but this education has made a huge difference in my ability to understand and be flexible and align myself with the hospitals' goals," he says.

Does he see keeping up this pace indefinitely? "I hope not. My goal is to look back in 10 years and see a wonderful, thriving palliative care community in Fresno, with a qualified physician group offering end-of-life care to patients throughout the area by contract to multiple agencies, via a group of full-time providers, including mid-level practitioners." In the meantime, he says, "If any hospice and palliative care physicians want to work in Fresno, give me a call. We need you!"

Featured Practice Opportunity

Enrich your palliative medicine portfolio of competencies with a full-time practice opportunity that "blends" direct patient care in a variety of settings with management and teaching responsibilities. In this role, you will join a group of three experienced, highly respected, and certified HPM physicians serving a hospice and hospital palliative consult service located in a highly desirable suburb of a major Midwestern city. You'll join just in time to assume a leading role in the management of an inpatient hospice unit, slated for opening in the summer of 2010.

You will have at your fingertips an exceptional professional development environment and an opportunity to develop a thriving practice in all aspects of hospice and palliative medicine. And senior management has made a concerted effort to design this practice opportunity with reasonable, well-articulated workloads which strive for a sought-after work-life balance.

In this practice, you'll showcase your clinical expertise as well as consultative and collaborative practice style, and you'll have the opportunity to promote and maintain a culture of clinical excellence with a strong interdisciplinary team by applying your knowledge of the best practices of palliative medicine.

This is a high-impact, high-profile role where success will lead to potential leadership opportunities and a thriving clinical practice.

explaining their work to hospice staff. We focus on education, both internally and externally, explaining the differences between hospice and palliative care, and how they complement each other. We inform patients that hospice offers many more services than palliative care."

How the agency managed rapid growth has also been important. "I think you need to have strong leadership. That's an essential ingredient of our success. We brought on CEO Chris Comeaux about the same time as launching the palliative care initiative," she says. "Chris has been an essential ingredient to our success by bringing in a thoughtful leadership structure. Yes, there have been growing pains. When you grow that quickly, you outgrow systems and processes. So it's important at times to stop and catch up."

Work Hard, Play Hard

"It's really true that birth and death have many similarities," Dr. Bull observes. "As a physician at the bedside, you're caring for a patient at a very intimate time of life. It's very rewarding and very much a privilege. So it wasn't such a big stretch for me to move from obstetrics to hospice. Of course, I had to learn palliative medicine. But I had good mentors. I read often, went to conferences, and was never afraid to ask questions," she says.

"I work hard, and really enjoy the variety that each day offers. I love my job and working for an organization that is so focused on its mission and values. Luckily, I don't require much sleep. I get up early and can get a lot done. Essentially, I can work from anywhere, as long as I have my laptop. The flexibility allows me to attend my kids' athletic and school events, something that was hard to do as an obstetrician. My motto is: work hard and play hard." That includes world travel, road bicycling, snowboarding, camping and yoga, as well as enjoying Hendersonville's beautiful mountain setting.

Billing Corner: Meeting the Split/Shared Visit Requirements

By Chris Acevedo

Growth of hospital-based palliative care services has been accompanied by the increased use of non-physician practitioners (NPP). Accordingly, substantiating split (or shared) visits requires a good understanding of documentation requirements for billing these Medicare Part B visits.

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

Visit with Tim Cousounis at the AAHPM Assembly Job Fair (Thursday, March 4th, 5-7 p.m.) to learn about other career advancement opportunities for HPM physicians. Information will also be available about HPM Physician Performance Profiles. Find out more about one of the newer tools used to manage expectations and performance while reducing role confusion.

Compensation and the Evolving Role of the HPM Practitioner

As the roles of HPM physicians expand beyond the traditional ones of Hospice Medical Director or Hospital Palliative Consultant, the contractual arrangements (based upon hourly pay) common to these roles are yielding to more complex compensation arrangements. Today, as more HPM practitioners take on full-time roles, we see employment relationships becoming the norm, accompanied by income guarantees and practice subsidies. What does the future hold for compensation models, as more HPM physicians take on full-time roles that include a significant component of direct patient care, in the form of home visits, hospital encounters, and inpatient hospice visits?

We're seeing more compensation plans utilizing metric-based incentives and tiered models, as a means to raise the physician's earnings potential and align physician and organizational objectives. Regardless of the type of organization and the incentive chosen, certain tactics are key to successful compensation plan design.

Learn more at the AAHPM Annual Assembly, where on Friday, March 5th, at 3:15 p.m., Drs. Edward Martin and Charles Wellman, along with Tim Cousounis, will present a one-hour educational session on Physician Compensation Models. Included in the presentation will be case studies of hospices which have moved to incentive compensation models.

[Click here](#) for more information about the *DAI Palliative Care Group 2009 HPM Physician Compensation Report*.

First, please note that split/shared visits **do not** apply in an outpatient setting, nor do they typically apply to hospice physician services.

Medicare defines a split/shared visit as, "... a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision making key components of an E/M service." [1] Thus, to be covered by Medicare (or any payer that follows Medicare guidelines for split/shared visits), the documentation must substantiate that **both** the physician and NPP **personally** performed a substantial portion of the face-to-face Evaluation and Management service. The documentation should be clear to a reviewer exactly who provided which portion of the service. A statement by the physician attesting to the clinical merits of the NPP's findings will not suffice.

Medicare Part B contractors, like WPS, have clearly stated the following, "When the supporting documentation does not demonstrate that the physician performed a substantive portion of the E/M visit face-to-face with the same patient on the same date of service as the portion of service performed by the NPP, a service billed under the physician's Provider Transaction Access Number (PTAN) will be denied." [2]

The following examples, provided by WPS, illustrate just what type of physician documentation is not adequate to substantiate a split/shared visit to be billed as a physician visit:

- "I have personally seen and examined the patient independently, reviewed the PA's Hx, exam and MDM and agree with the assessment and plan as written" signed by the physician
- "Seen and examined and agree with above (or agree with plan)" signed by the physician
- "As above" signed by the physician
- Documentation by the NPP stating "The patient was seen and examined by myself and Dr. X., who agrees with the plan" with a co-sign of the note by Dr. X

Incorporating the use of NPPs into your palliative service practice can be an effective way to "extend" your time, but extra caution needs to be taken to ensure compliance with rules and regulations of Medicare and other payers.

[1] CMS IOM Publication 100-04, Chapter 12, Section 30.6.13 (H)

[2] WPS Provider Communication 11-17-2009

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Chris Acevedo is a partner with Acevedo Consulting Incorporated, a firm providing on-site education and consultative services on reimbursement and coding-related concerns for the HPM Practitioner billing for hospice and palliative care services. He can be reached by phone at (561)278-9328 or by e-mail at: cacevedo@acevedoconsulting.com

Note for AAHPM Annual Assembly attendees: Chris Acevedo will be one of the presenters of a Preconference Workshop on Wednesday, March 3rd, at 1p.m., addressing hospice and palliative care billing and coding.

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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 how a partnership would benefit you.

What do you think of our publication? How can we best serve the needs of the HPM community? What would you like to know about the business and practice issues facing HPM doctors today? What do you know that your HPM colleagues need to learn?

[Click here](#) to send us your comments.