

The HPM Practitioner

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

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News Notes

Medical Specialty Code:

Effective Oct. 1, the federal Centers for Medicare and Medicaid Services (CMS) will implement a new medical specialty code for hospice and palliative care. Physicians and other practitioners who bill Medicare file a CMS-855i application to self-designate their primary and secondary medical specialties, and HPM will now be available as an option. It does not require board certification or completion of a fellowship, and it does not involve additional payment for palliative care, at least not yet. But this new code offers an opportunity for physicians with an interest in HPM to consider how they wish to represent their practice to Medicare. [Downloadable 855i form.](#)

Commentary on President Obama's Grand Junction

Town Hall: President Obama held a town hall last week in Grand Junction, Colorado. To healthcare reformers, Grand Junction is the land of innovation - a place that provides high-quality healthcare at a fraction of the regular price. According to some experts, Grand Junction chalks up some impressive statistics. Only 12% of Medicare patients required readmission 30 days after a hospital visit, as opposed to

Welcome to the inaugural issue of *The HPM Practitioner*. We have launched this e-newsletter because we believe the physician community of hospice and palliative medicine needs a forum to exchange questions, concerns, information and best practices regarding the business and practice management of HPM.

If you have attended a national conference of the American Academy of Hospice and Palliative Medicine, you know how eagerly participants learn and exchange clinical knowledge. And a variety of resources are available to help satisfy that hunger.

But the business of hospice and palliative medicine - its organization, structure, productivity, compensation, billing and coding, and other essential challenges of practicing as an HPM physician or group - is not as well established.

How do we know this? Well, consider that there are some 4,000 hospices and perhaps 1,500 hospital-based palliative care programs in the United States. But the best available evidence suggests that the majority of physicians who belong to AAHPM, who have earned board certification in HPM, and/or who have positions as medical directors of those hospices and palliative care programs are only part-time.

There are about 2,800 physician members of AAHPM, and a roughly equivalent number of physicians who are board-certified in HPM, either by the now-defunct American Board of Hospice and Palliative Medicine or under the new certification established by the American Board of Medical Specialties. We know that HPM physicians fill a variety of different roles. Some are hospice medical directors, with responsibilities defined by Medicare's conditions of participation. Others are physician members of hospital-based palliative care services, while a few others essentially practice as a lone wolf or a palliative care team of one in inpatient or outpatient settings - or some combination of these roles.

We believe that increasing the hours of physician involvement in hospices and palliative care services and the number of physicians working full-time in HPM is good - for the field, for the quality of patient care and, in some cases, for the career enhancement and job satisfaction of individual physicians.

And therein lies the puzzle that persuaded us to create this newsletter: an emerging and growing field of physicians who are committed to mastering the art and science of palliation - but who in many cases have not yet translated their commitment into full-time work or HPM practice as a career. Is that because of salary disparities for the field, or questions about whether HPM constitutes a viable, long-term full-time career path for physicians?

How do we intend to address this puzzle? First by endeavoring to serve as the

the nationwide rate of 20%. Children on Medicaid in the HMO are four times as likely as other Colorado Medicaid children to receive all immunization treatment - and adults on Medicaid were up to 10 times as likely to get comprehensive diabetes care. How does Grand Junction stack up for its palliative care practices? The Community Palliative Performance Profile, compiled by *DAI Palliative Care Group*, graded Grand Junction as an A-plus (an exemplar community). Why did Grand Junction earn this superlative? For starters, less reliance in the final months of life upon intensive care (less than half of national average) and one of lowest percentages of deaths occurring in a hospital (20.7%). Plus, hospice enrollment is nearly 30% greater than the national average. In a future issue, we'll probe more deeply into what palliative medicine physician practices are like in the Grand Junction area.

Compensation

Among the top three reasons why hospice and palliative medicine (HPM) physicians seek new practice opportunities is the desire for better compensation. What could an HPM physician expect to find in the marketplace? Results from the 2008 Palliative Medicine Compensation survey, compiled by the *DAI Palliative Care Group*, offer some insights. The median compensation for HPM physicians in staff (non-executive) positions is \$148,558. Compensation at the 75th percentile (meaning that this figure is higher than all but the top quarter) is \$167,870. Probing deeper into the survey results, Tim Cousounis states that the competency most valuable in securing higher compensation is a track record of performing palliative care consults for hospital inpatients.

This fall, *DAI Palliative Care Group* will be releasing an updated Compensation Report.

Featured Practice

town crier for the essential business and practice issues of hospice and palliative medicine physicians, with your input on what you want and need to hear. We will illustrate how some of your peers have answered the evergreen professional practice issues by profiling in each issue an HPM physician or group, starting with the interview with Dr. John Mulder in this issue. We will also let you know about relevant news and resources.

In return, we'd like to know what you think. Is HPM a distinct community, with its own unique culture and professional aspirations - even though it is divided between full-timers and part-timers, between hospice and palliative care? Do you view HPM as a viable career choice - and why or why not? What will it take for you or your colleagues to go that next step in the commitment to HPM by becoming full-time at it?

I have been working on HPM physician recruitment, compensation and performance for more than ten years. Editor Larry Beresford has written about all aspects of hospice and palliative care for a variety of trade and professional publications for more than two decades, including co-authoring the "Notes from the Field" column in the *Journal of Palliative Medicine*. Together, we aim to be partners in the field's growth and development - with the hope that business and practice issues could receive the same attention that clinical aspects of palliative medicine already enjoy.

Thank you for your interest,
Tim Cousounis

Balancing Clinical and Administrative Roles:

Interview with HPM Physician John Mulder, MD



"I find that my passion to make sure no one suffers needlessly outweighs my desire to go home from work at 5 pm," John Mulder, MD, says to explain how his commitment to hospice and palliative medicine (HPM) shapes his balancing act of clinical and administrative responsibilities for Faith Hospice and the Spectrum Health hospital system, both based in Grand Rapids, MI.

Dr. Mulder formed a professional corporation in order to contract with his two primary clients, Spectrum and the hospice's parent company, Holland Home. For Spectrum he provides palliative care consultations in two acute care hospitals (with two to three new consults ordered per day) and fills a variety of administrative roles aimed at promoting and advancing palliative care within the system. These include strategic planning, one-on-one meetings with physicians, and attendance at tumor board and cancer interdisciplinary meetings.

For the hospice, he serves as vice president of medical services and sits on its leadership team. Recently, he relinquished to a colleague, Dr. Martha Ording, the responsibility of hospice medical director as spelled out in Medicare's conditions of participation. His current role emphasizes quality initiatives such as protocol development, a new HPM fellowship program, and medical management of the hospice's freestanding, 20-bed inpatient facility. "That's

Opportunity

Showcase both clinical expertise and business savvy to "manage" the relationship between a hospice and academic health center. This opportunity is an employment-based position with one of the leading not-for-profit hospice and palliative care enterprises (more than \$60 million in patient service revenues) serving multiple states along the Atlantic Coast. The service promises to redefine how end-of-life care is provided in one of the premiere academic health centers on the East Coast. This service has generated significant interest among key stakeholders, who are eager to integrate its palliative care protocols into their practices

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

Link Category Title

About DAI Palliative Care Group

Commentary on Palliative Care Success

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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

the daily clinical environment for my hospice physician practice."

Dr. Mulder also carries a beeper 24 hours a day ("I've always done that; I feel very possessive of my patients"), although with the option of arranging for back-up as needed. Time management remains an ongoing challenge, and it can be difficult to precisely parse out which is hospice versus palliative care or administrative versus clinical (and billable) time.

"But I don't stand on protocol. I feel comfortable with how my time is spent, as do the folks to whom I'm accountable," he says. "At the end of the day, I want to make sure that they have gotten their money's worth. And there is the intangible value of my availability as a hospice and palliative physician – that existential presence, that leadership role brings value in and of itself. It's all about establishing relationships and building trust in my role and in what HPM offers."

Dr. Mulder recently took a phone call from a colleague who is well known as a pioneer in the field of HPM, and is considering a job change from an academic to a hospice setting. "She asked about the business aspects: employed versus contracted, how to negotiate salary and benefits, things like that. These are basic issues for those who are immersed in the business, but they can be confusing if you've never had to deal with them."

In Dr. Mulder's previous job as chief medical officer of Alive Hospice in Nashville, TN, the position was structured in a way that allowed him to learn on the job the business and practice management aspects, gaining a clearer sense of what the medical director contributes to hospice and palliative care.

"(CEO) Jan Jones understood and fostered the medical component of hospice, and emphasized my education as medical director and medical leader," he relates. One of the keys was attending national hospice educational meetings.

"It's not only having a seat at the table for the physician's role, but sharing what I know. Which affects how care is given, and the policies that are developed – just being able to exercise what you know as a doctor to be a partner on the team."

How to Find Satisfaction - and Make a Living

Dr. Mulder was instrumental in convening an informal group of about two dozen HPM physicians practicing in Western Michigan. They now meet every other month to talk about both practice and clinical issues, and they are in discussion with a local managed care company about establishing a contracted physician network that could provide expanded hospice services and covered palliative care benefits, including in the outpatient setting.

Several of these physicians work full-time in hospice or palliative care, others are part-time, and a few are board certified in HPM but not currently working in the field. "Two or three others have a deep interest in palliative medicine and want to do it some day," he explains.

At the group's first meeting in January, "I could see doctors huddled in groups of three or four. They couldn't stop talking. There was such a hunger for this exchange," Dr. Mulder reports. "We want to communicate through this dialogue how you can make a living, how you can find satisfaction, meaning and personal growth in HPM – but also that the work requires a personal commitment to scientific, cutting-edge medicine and a willingness to be truly

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.

present with patients and families."

He agrees that it is curious that so many physicians who are motivated to become board-certified in HPM have not gone the next step to full-time positions practicing this specialty.

"A lot of part-time hospice docs, because of their hospice compensation and the hospice's lack of commitment to the medical role, don't believe that this can be a career option. It's hard to extrapolate from their experience to how it could turn into a full-time job. And if they don't believe it can be, they will remain shy in their contract negotiations with the hospice - even though a portion of every per diem the hospice collects is meant to cover the medical director's role."

Unfortunately, hospice physicians too often are underused, overused, misused or abused. "Their responsibilities are defined by people who may have very little understanding what physicians do - or could do. The physician's role and responsibilities in hospice care need to be viewed in different ways. Not that the doctor is more special than other members of the hospice team, but what he or she brings to the table is different," Dr. Mulder says.

"If a hospice wants someone simply to come to meetings and sign documents, that's how it will structure the position. But if you truly want what a physician can contribute to increasing the skill levels of all staff and the quality of the care that is provided, that's a whole different ball game. It requires a different level of commitment by the agency."

Just as palliative care consultations in the hospital more than pay for themselves through decreased length of stay and reduced use of expensive, unbeneficial treatments, the active presence of a substantially full-time physician raises the hospice's exposure in the medical community and can lead to increased referrals and lengths of stay and better decisions about drug therapies and other palliative treatments for hospice patients.

"We're fortunate to have a very strong, high-quality hospice program here in Grand Rapids, respected by physicians and the community at large," Dr. Mulder says. In fact, data from the *DAI Palliative Care Group*, derived from the Dartmouth Atlas of Health, gives the Grand Rapids region an A grade for its end-of-life care. The region has fewer deaths occurring in hospitals or associated with ICU admissions than state or national averages and a higher percentage of decedents (46 percent) enrolled in hospice than national (31 percent) or state (38 percent) averages.

Dr. Mulder was trained in family medicine and practiced obstetrics. He was first asked to serve on the Board of Directors of a local hospice in 1985, and became intrigued by its work. "When they asked me to be the medical director, I began learning what a difference hospice made at the bedside."

Today, he finds HPM a great field to work in. "I am well compensated, and have never been more satisfied. Who knew?"
