

NHPCO's New Outreach  
Materials—See Page 15



# NewsLine

August 2007

## Innovative Approaches to Palliative Care

By Larry Beresford



**H**ospice in America has experienced great success as a niche provider of services to patients and families confronting end-of-life challenges. By identifying and responding to needs that weren't being addressed by conventional care, hospice pioneers sparked a revolution in healthcare—a revolution that mainstreamed into an industry that cares for 1.2 million Americans per year.

Predictably, the success of hospice created new challenges. Consumers and other providers wanted the portfolio of services hospices offered—expert pain management, symptom control and psycho-social-spiritual support—but did not want to have to be dying to get it. A variety of approaches to meeting those demands

have emerged in recent years under the rubric of palliative care. Hospice providers are well positioned to leverage their expertise by expanding their reach into new models of palliative care. Some hospices are doing this by creating new service lines while others are crafting partnerships with hospitals, home health agencies and/or long-term care providers.

In recognition of these new developments, NHPCO and the Center to Advance Palliative Care (CAPC) have collaborated on a technical assistance manual that documents examples of palliative care innovation for the hospice provider community, referred to here as the "Palliative Care Project."

continued on page 5

### *Inside:*

#### **Tapping the Power of Performance Measurement**

A commitment to quality demands an increasing amount of data analysis, but you can't measure everything—you need to be strategic in your choices. Management consultant, Melanie Merriman, offers some guidance.

**See page 10.**

Don's Message

3

Free Tools to Help You Measure Performance

12

NHPCO's Educational Needs Assessment

16

People and Places

18

## Palliative Care, continued from cover

This Project builds on a comprehensive survey of 371 hospices, conducted in 2006, which provides clear evidence of the interest in these new models by NHPCO members. In this 2006 survey, 55 percent of respondents said they offered palliative care services to non-hospice patients—up from 26 percent in a similar survey conducted in 2002. Of those respondents not currently offering palliative care, many said they are interested but are deterred by limitations in reimbursement and other funding. In fact, two-thirds said they would provide palliative care if they knew how to bill for it under Medicare Part B physician services reimbursement.

As part of this Project, the manual's editorial team made site visits to 12 palliative care providers in 10 different states (see sidebar on page 7). The sites included the country's largest provider of home care and one of its smallest rural hospices, along with independent hospices, hospital- and health system-based programs, and Veterans Affairs medical centers. The sites provided care in settings ranging from the acute hospital to patients' homes and a variety of long-term care levels.

The manual, which presents data and narratives from the visited sites, along with general recommendations on palliative care program development, is now available for purchase at NHPCO's Marketplace (see page 8 for details). In this article, however, we share some of the highlights from these site visits.

### **Start Small, Build Slowly**

Recognizing a need to offer palliative care services as an extension of its hospice mission, [Coastal Hospice](#), in Salisbury, MD, chose to send several staff to a CAPC-sponsored Palliative Care Leadership Center (PCLC) training held in Lexington, KY in 2005. Accompanying them were representatives from Peninsula Regional Medical Center, with which the hospice has had a "continuity of care" contract for the past 25 years.

Based on what they learned at the PCLC training, the joint palliative care group brought home a rough draft of a business plan, focused on starting small and aiming for realistic, long-term goals. Within a month, both the hospice and its partnering hospital had approved a proposal to begin offering palliative care services at the hospital.

Today, inpatient consultations are provided by a nine-member multidisciplinary team composed of full-time employees from both partners, including the hospice's medical director and the manager of Peninsula's oncology unit. A nurse practitioner employed by the hospice coordinates the palliative care program. The team meets weekly, supported by a joint professional advisory oversight committee, steering committee, and clinical work group representing additional members of the multidisciplinary palliative care team. Coastal Hospice bills Medicare Part B and private insurers for consultations done by physicians, and plans to bill for nurse practitioner services in the future. Organizational subsidies from the two partners and charitable support are keeping the program in business at this time.

**Hospice providers are well positioned to leverage their expertise by expanding their reach into these new models of palliative care.**

continued from previous page

In the first year of operations, 47 percent of patients who received palliative care consultations were referred for hospice care, although that proportion is expected to go down as the program reaches a broader patient population. The team structure allows for longer visits and more than one visit per day to patients. A continuing challenge lies in finding ways to ensure that chronically ill patients going home without a hospice referral continue to receive the support they need to manage outside of the hospital. Future goals include extending palliative care relationships to two other area hospitals and two nursing homes, as well as establishing an outpatient clinic and home care program over the next three years; at the same time, the program wants to make sure it adheres to its plan for slow growth, with each component becoming solidly established before the next is added.

[Home & Hospice Care of Rhode Island \(HHCRI\)](#), in Pawtucket, is a comprehensive end-of-life provider currently offering a variety of palliative care services for various patient populations. These include: (1) a pain consultation service for nursing home residents, staffed by two nurse practitioners who can work and bill independently in Rhode Island as long as they collaborate with another provider such as a physician; (2) palliative home health care for adults living with life-threatening illnesses; (3) palliative care consultations for pediatric patients at Hasbro Children's Hospital; and (4) palliative home care for children, from infants up to age 12.

Challenges of delivering palliative home care and hospice by the same interdisciplinary team include the need for two licenses, provider numbers and separate business units, as well as meeting requirements of home health care's OASIS outcomes reporting and prospective payment system. For HHCRI, this has required close monitoring to ensure that the palliative home care service remains programmatically and financially viable.

Future plans to broaden access for a wider array of patients include expansion of palliative care consultations into assisted living facilities and hospitals. "At HHCRI, our intent is to be flexible,

making the best use of expertise to provide end-of-life care to all patients," says president and CEO Analee Wulfkuhle. "We adapt our programs and services to meet their needs, rather than expect patients and families to fit a rigid 'hospice' model."

From its founding in 1993, [Hospice and Palliative Care of Western Colorado \(HPCWC\)](#), in Grand Junction, has been committed to open access, as defined by what patients need and want. Developing services responsive to those needs beyond the limits of the hospice benefit has involved experimentation and collaboration with other healthcare providers in the agency's extensive and largely rural service area.

HPCWC began this experimentation with a Transitions Patient Care Program. This Program offers weekly phone calls, nurse assessment visits, and a 24-hour hotline in addition to support and education—including access to volunteers, social workers and chaplains—for patients and families not enrolled in hospice. A palliative care consultation service, launched in 2003, is focused on relieving pain and other symptoms, coordinating care between providers, and assisting families in making informed choices about their care. These consultations are provided by doctors and nurses in the home, nursing homes and assisted living facilities.

Currently, the strongest element of HPCWC's extended palliative care service package is done in partnership with the Grand Junction Veterans Affairs Medical Center, with a "virtually integrated" program of consultations conducted by a team of professionals from both the hospice and the VAMC. In 2006, this consultation service made 700 physician visits and 1,200 nurse practitioner visits, mostly to outpatient settings, typically on referral from VA physicians or nurses. The 85-bed VAMC includes The Care Unit, a 35-bed unit where hospice and palliative care are provided to veterans in consultation with the joint palliative care consultation team.

HPCWC has faced challenges such as lack of receptivity to palliative care from the area's acute care hospital, rising patient acuity demands in

the outpatient setting, and difficulty in finding staff qualified in palliative care in its geographically isolated service area. Palliative care services have been underwritten by the hospice with additional support from grants, a contract with the VA, HMO funding for palliative care, private pay, and philanthropy.

### **What Do Chronically Ill Elders Need?**

Hospice of Siouxland, which is based in Sioux City, IA and serves a large rural area in three states, used support from a capital fundraising campaign and grants from Wellmark, the major private insurer in Iowa, to develop a community-based palliative care service that helps chronically ill and elderly patients remain safely in their homes while reducing the need for emergency room visits and rehospitalizations.

Staffed with four nurses and four social workers, this program enrolled 160 clients in 2005, up from 70 in 2002, with an average length of service of 213 days. The program has discovered that its chronically ill clients have a greater need for social, financial and emotional support, help with navigating the complex healthcare system, and assistance with concrete tasks like medication management, rather than more clinical symptom management that is the focus of acute palliative care services. Just making sure that these forgetful, confused, elderly patients take the right pills at the right time, consistently, makes a major contribution toward avoiding rehospitalizations.

To date, Siouxland's palliative care program has chosen not to seek reimbursement as a licensed home health agency or bill for professional services under Medicare Part B. Financial support comes from contracts for the service with one local hospital, the VA, and the Nebraska Department of Health and Human Services, as well as private payment. There are signs of interest from the other hospital in town and from Wellmark for covering home-based palliative care. Finding additional sources of operational funding remains the program's biggest challenge—even though it has clearly demonstrated a need for the service and its value to primary care physicians.

Although future plans include continuing to advocate for palliative home care benefits from insurers and other providers, and developing billable physician consultation services, one possible solution to the dilemma of how to fund palliative care in the home is PACE (the Program for All-Inclusive Care of the Elderly), a national Medicare and Medicaid benefit modeled on San Francisco's legendary On Lok Senior Health Services. Launching a PACE project requires considerable investment in start-up costs for the package of services required to manage the needs of chronically ill patients who are frail enough to qualify for SNF-level care. The agency recently received one of 15 rural PACE development grants from the federal government, and hopes to launch the service in 2008.

A different approach to providing palliative care in the home is offered by [Heartland Home Health Care and Hospice](#), a division of HCR/Manor Care, a major national long-term care company. Heartland, which is the third largest provider of hospice care in the country, integrates home care and hospice divisions in most of its 100-plus local offices in 28 states. Through a process of exploring the needs of chronically ill home care patients, many of whom

## **The Project's 12 Participating Sites**

- Coastal Hospice  
Salisbury, MD
- Heartland Home Health Care and Hospice  
Toledo, OH
- Home and Hospice Care of Rhode Island  
Pawtucket, RI
- Home Nursing Agency Hospice, Altoona, PA
- Hospice and Palliative Care, Charlotte Region  
Charlotte, NC
- Hospice and Palliative Care of Western Colorado  
Grand Junction, CO
- Hospice of Siouxland  
Sioux City, Iowa
- Hospice Savannah  
Savannah, GA
- Mount Carmel Health System, Columbus, OH
- Sakakawea Hospice  
Hazen, North Dakota
- VA/Veterans Integrated Service Network 3,  
Brooklyn, NY
- VNSNY Hospice Care  
New York, NY

continued on next page

continued from previous page

were not reaching hospice in a timely manner, the company created Sincerus Care to bring the palliative care philosophy to all of its home care patients.

This palliative approach to home health care means that most patients receive at least one social work visit, every patient is asked to express goals of care on admission, and those expressed goals shape the emphasis and mix of services provided by the home care team. Pain and suffering—including spiritual distress, quality of life and “fragile” status—are regularly assessed by the home care team while hospice team members are called upon to provide consultation visits, even for patients who are not appropriate for hospice admission.

“Palliative, holistic care is how we provide care for everybody,” says Dan Peel, home care administrator in Heartland’s Pittsburgh, PA office, which has been one of the most successful in implementing the Sincerus model within Heartland. This approach may result in a different mix and array of services than the typical home health agency provides, but it doesn’t necessarily mean more visits or higher costs of care per episode. Heartland’s palliative home care is provided profitably within home health prospective payment system limits and regulatory requirements. The close integration between the home care and hospice teams in Sincerus offices has also been beneficial for both programs.

### **Is Palliative Care Right for Your Hospice?**

Obviously, many programmatic approaches in a variety of care settings are possible, but these are best developed in response to identified unmet needs in each local service area. The palliative care program administrators at [Home and Hospice Care of Rhode Island](#) recommend that any hospice considering palliative care carefully consider the following questions:

- Does it fit your mission and organizational goals?
- Are there regulatory or philosophical barriers?
- How will it be “sold” to the community? Is your message clear?
- Are you ready to be licensed to provide home care and hospice, and be certified and surveyed for both?

- Are you prepared to bill Medicare Part B for professional services provided by a physician and/or nurse practitioner (if that is allowed in your state)?
- How will your staff adapt to this different type of patient?

HHCRI CEO, Analee Wulfschle, emphasizes the need for flexibility in offering programs and services tailored to the needs of the community, much as the hospice plan of care is tailored to the needs of the individual patient. This kind of flexibility can be demanding, but it is essential to success for hospices venturing into the new world of palliative care.

*Larry Beresford is a freelance writer who has authored numerous articles on end-of-life care. He can be reached at [larryberesford@hotmail.com](mailto:larryberesford@hotmail.com).*

*The author extends thanks to the other members of the Project’s editorial team for their assistance: Amber Jones, Judi Lund Person, and Emil Zuberbueeler.*

*The Palliative Care Project’s technical assistance manual, [Navigating Palliative Care: Positioning Hospice for the 21st Century](#), not only profiles 12 successful models, but also includes chapters on getting started, relationship building, developing a business plan, staffing, billing issues, and more. To order it, visit [NHPCO’s Marketplace](#) ([nhpco.org/marketplace](http://nhpco.org/marketplace); item 821136).*

