# In-Home Palliative Care Growing

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pice in that it can be initiated earlier in the course of a serious or end-stage illness, can be utilized with conventional or curative care, can be accessed in conjunction with other health care providers, and does not require a 6-month prognosis for admission, said Dr. Lee, who is medical director of hospice at Metropolitan.

Referrals to the palliative care team come from a variety of sources including physician offices (55%), hospitals and oncology practices (34%), and certified home health aides (9%). As community awareness of the program increased, referrals to the palliative care team jumped from 20 referrals in its first year to more than 500 in 2008—almost as many as the health system's hospice referrals.

As the only community-based palliative care program, Metropolitan has also had to demonstrate its outcomes to HMO providers, who are slowly coming around to working with the program.

The team has only six full-time employees and reimbursement has been challenging, particularly since home-based palliative care is not regulated, Dr. Lee said. When grant funding for the program ran dry, Metropolitan had to step up and provide institutional support.

It's taken about 2 years, but the program is building other lines of revenue, primarily through Medicare and Medicaid, Dr. David Wollner, director of palliative medicine at Metropolitan, said in an interview. It is also seeking philanthropic support from within the organization and externally by applying for grants, and is developing products such as a palliative care consultation model it's selling to a large HMO in New York City, he said.

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"There are many reasons why we're surviving, but the key element is having a core of committed, seasoned professionals who are willing to go the extra mile during the early years," he said. "The other thing is that there is never [just] one element of support."

Dr. Wollner credits the program's success to understanding and respecting their clients' ethnic and cultural diversity. "Each referral is unique," he said. "We serve the old, the young, the rich, the homeless—and part of our success is being sensitive to the diversity of our population."

Brian Mandel, a certified palliative care social worker with the team, said that on the same day he might visit an 89-year-old Orthodox Jew with advanced prostate cancer, a 55-year-old Catholic with colorectal cancer, and a 38-year-old Jehovah's Witness from the Caribbean with amyotrophic lateral sclerosis.

Translators are used and patient literature is translated into various languages, but Mr. Mandel agreed that cultural differences must be understood and respected. For example, Hasidic Jews will not touch the body when someone is actively dying because doing so is thought to possibly hasten death, whereas Asians believe it is bad luck to have a person die in the house, he said.

Patients and families may also lack a full understanding of the diagnosis, proposed interventions, or prognosis. They may be angry or in denial, or may not be ready to discuss end-of-life practical tasks such as choosing a funeral home or burial/cremation services.

Anne Walsh, one of three certified palliative care nurse practitioners on the team, said that patients often get overwhelmed with multiple providers in their home, and there can be a real or perceived duplication in services. Many patients with life-limiting illness receive the services of a 24-hour home health aide through Medicaid, but the registration process can be lengthy.

Ms. Walsh highlighted one of the program's success stories: a 77-year-old man with stage IV lung cancer who was undergoing daily radiation and was referred to the team for pain and symptom management as well as psychosocial support. Despite being on 10 different medications (including 10 Percocets per day), the patient rated his pain at 10 on a 10-point scale. He refused to contact relatives despite being unable to care for himself. "He was very proud of his independence," she said.

The team changed his pain management regimen so that his pain score dropped to 3, and and worked with his insurance plan to get home care. They had him fill out a health care proxy form, and contacted his daughter. Ultimately, he moved to an inpatient hospice unit.

Ms. Walsh noted that a recent systematic literature review of 33 studies showed that although most patients with terminal cancer prefer home palliative care, most die in an institution (Oncol. Nurs. Forum 2009;36:69-77).

None of the speakers disclosed any relevant financial relationships. ■

# Certificate Program for Hospital Palliative Care Faces Delay

BY PATRICE WENDLING

AUSTIN, TEX. — The release of the long-awaited Joint Commission–sponsored palliative care certificate program has been put on hold in order to complete a strategic planning process, Dr. Diane Meier said at the annual meeting of the American Academy of Hospice and Palliative Medicine.

The certificate program was expected in August 2008 after the Joint Commission announced it would release a new certificate for hospital palliative care programs. The commission convened an expert panel to establish quality standards and conducted market research showing strong interest in the program.

But that research was conducted before the economy began to tank, said Charles Mowll, executive vice president for business development, government, and external relations at the Joint Commission.

"Because of the change in the economic environment, we want to proceed carefully," he said in an interview. "Unfortunately, it's sometimes difficult to convert that enthusiasm to spending the resources and energy to pursue and obtain certification. The next steps for us are to refresh that market research and get a more contemporary view of the world and interest in the program. But it's a clear message that we have a significant collective investment in palliative care certification."

The fate of the program should be decided sometime this summer, he said.

In the meantime, the Center to Advance Palliative Care (CAPC) at the Mount Sinai School of Medicine in New York has agreed to advertise the program and raise funds to help offset costs to the Joint Commission to develop it, said Dr. Meier, director of CAPC and professor of geriatrics and internal medicine at Mount Sinai.

**Health care quality assessment organizations are seeing palliative care as a way to control costs.**

DR. MEIER

"Development of a quality assessment program to ensure high standards for the nation's 1,300 hospital palliative care programs is of the highest priority," she said in an interview.

► **Low-hanging fruit.** Cash-strapped states are eyeing the nursing home Medicaid Hospice Benefit as a way to shore up their budgets.

"There are a lot of hospices making a very large profit on stable long-term nursing home patients that are tarring the entire industry," Dr. Meier said. "The problem is that rather than identify and censor the bad actors, they [state and federal policy makers] just want to eliminate the benefit."

In late 2008, Florida proposed eliminating reimbursement for hospice in nursing homes, claiming that it would save the state $343 million. The effort was defeated after a statewide group, Florida Hospices and Palliative Care, hired its own research firm, arguing that the move would actually boost state health care costs by $3.7 million.

President Obama provided some breathing room by imposing a 1-year moratorium on hospice rate cuts through Sept. 30, 2009, as part of the economic stimulus plan. The National Hospice and Palliative Care Organization (NHPCO) is urging members to push for a permanent freeze.

"We're not expecting that this will completely go away," said audience member Judy Lund Person, NHPCO vice president of regulatory and state leadership. "There have been lots of discussions about whether it's double-dipping. … We don't believe that that's true, but it's an area where we have to be extraordinarily careful."

► **Part of the solution.** In other circles, hospice and palliative care are being viewed as part of the solution to the health care crisis. The National Priorities Partnership, convened by the National Quality Forum in 2008, named palliative and end-of-life care as one of six national priorities for transforming the nation's health care system.

Dr. Meier noted that another benchmarking group, HealthGrades, is getting increasing inquiries for help in starting palliative care programs, a sign that health care quality assessment organizations are seeing these programs as a way to get a handle on costs.

► **Coding conundrum.** Although the Centers for Medicare and Medicaid Services began recognizing hospice and palliative care as a new physician specialty as of 2009, a specific specialty code won't be assigned until this fall, said copresenter Lynn Hill Spragens, CEO and president of the consulting firm Spragens & Associates, Durham, N.C. A delay in implementation is not unusual, but in the meantime reimbursement denials continue.

Core causes of denials include a lack of professional preparation to do Part B billing, misinformed or underinformed billing specialists, and an increasing number of providers from different core specialties delivering palliative care services in the same hospital.

Many programs are staffed by specialists with primary credentialing in a specialty such as geriatrics or hospital medicine, who are also board certified in hospice and palliative medicine, Ms. Spragens said. Pending the assignment of the new CMS specialty code, when they receive referrals from physicians in their primary specialty, there is a high potential for bill denial, unless there is very careful documentation by the provider and the billing office.

Until the new specialty code is in place, she advises providers to use the 77 modifier to report a repeat procedure by another physician, include notation about palliative care on the bill, and follow up thoroughly with denials to identify acceptable documentation with payers. After the specialty code is assigned, providers will need to revise their credentialing information, she said.

Dr. Meier and Ms. Spragens reported no conflicts of interest. ■