



Hospital - Hospice Partnerships in Palliative Care

Creating a Continuum of Service



A Joint Project of the
National Hospice and
Palliative Care Organization
and the Center to Advance
Palliative Care



Center to Advance
Palliative Care
in Hospitals and
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Executive Summary

Despite public-opinion research showing that most Americans would prefer to be cared for at home if they were terminally ill, the majority of patients who confront life-limiting illnesses can expect to receive at least some of their care in acute hospitals, and as many as half will die in the hospital. In recent years, medical research and the news media have sparked a sustained national dialogue on the contrast between what people say they want and what they are likely to experience at the end of their lives.

In response to reported shortcomings in medical care at the end of life and growing recognition of the unmet needs of patients who confront serious, life-threatening and terminal illnesses and their families, palliative care has been growing in importance in recent years. Palliative care focuses on quality of life, control of pain and symptoms and attention to the psychosocial and spiritual experiences of adapting to advanced illness. Hospice care is a specialized and intensive form of palliative care for patients with advanced, life-threatening illnesses and for their families, emphasizing quality of life, life-closure issues and the relief of suffering.

This document is a report on new approaches to palliative care emerging from partnerships between hospitals and hospice programs. Since a significant proportion of care for patients with serious and life-threatening illnesses is provided in hospitals, it makes sense to focus on the hospital setting as an opportunity for making improvements. And since hospice is the only large-scale national provider of care specifically designed for patients nearing the end of their lives, it also makes sense to involve hospice programs in the development of hospital-based palliative care, drawing upon their skills and experience to extend patient-and family-centered, supportive palliative care to more hospitalized patients earlier in their illnesses.

Bringing hospitals and hospice programs together, with their respective resources and abilities, to partner in the pursuit of improved end-of-life care can be a win/win/win proposition – for patients with serious illnesses and their families, for hospitals and for hospice programs. For patients and families, access to coordinated, high-quality palliative care can help them regain a sense of personal autonomy and control over their care and treatment choices. If a hospital is already considering a palliative care initiative, establishing a dialogue with its local hospice program is a logical place to start. The hospital can also enhance its ability to meet the needs of seriously ill patients by building upon hospice’s ability to achieve high customer satisfaction. For hospice programs, collaborating with hospitals is an opportunity to learn more about the realities of end-of-life care in the hospital setting, to participate in program development and to integrate hospice care into a broader continuum of palliative care services. But collaborative initiatives also face significant challenges in areas such as financing, regulation and institutional culture – which are explored in depth in this report.

The project was conceived as a technical assistance monograph by the Center to Advance Palliative Care (CAPC) at the Mount Sinai School of Medicine in New York City, in collaboration with the National Hospice and Palliative Care Organization (NHPCO) of Alexandria, VA. Its primary target audiences are the senior management and clinical leadership of hospitals and of hospice organizations, with the goal of encouraging them to come together and explore collaboration in their own communities. It is hoped that such partnerships will promote the development of a coordinated continuum of palliative care, wider access to such care, and improved quality of care for patients confronting serious and life-threatening illnesses and for their families. Other groups and individuals in the movement to improve

care at the end of life – including educators, professionals in health and human services, activists and consumer advocates – may also discover opportunities to contribute to such collaborations.

In developing this report, a number of sites were visited where hospitals and hospice programs are actively partnering in new and exciting ways to address identified needs for end-of-life care. The sites were chosen to represent a broad range of organizational models and relationships, different regions, urban and rural settings, greater and lesser degrees of competition and a range of different ownership models for the partnering agencies.

Currently, there is no third-party reimbursement (other than for hospice care) specific to the provision of palliative care, although palliative services often are billed in other reimbursement categories. In addition, there is no regulatory structure or standard-setting body for palliative care. The absence of targeted reimbursement and regulation is reflected in the improvisational, ad-hoc nature of the partnerships and demonstration projects profiled in this report. Those projects utilize existing reimbursement streams for hospice, home care, hospital and physician services while supplementing inadequate reimbursement with other diverse funding sources.

At the sites, hospital-hospice partnership generally is proceeding on two parallel tracks. The first overall direction lies in enhancing utilization of the Medicare Hospice Benefit for appropriate patients by promoting closer relationships between the hospice program and the hospital, offering professional education about hospice care, developing specialized hospice inpatient units, encouraging the direct admission of appropriate hospitalized patients onto the Medicare Hospice Benefit and other efforts aimed at reducing barriers to hospice access. The second track is developing new non-hospice-benefit palliative care services, which are less clearly defined, not explicitly reimbursed and more likely to be experimental, ad-hoc and funded from alternate sources. However, it should be acknowledged that at the

sites themselves there is significant overlap between these tracks.



FORMS OF COLLABORATION

An effort was made in conceptualizing and executing this project to identify “models” of hospital-hospice partnerships, in the sense of schematic descriptions of defining properties for broad categories of programs. However, the field is too new and diverse for such definition, although the research suggests some ways to begin to categorize the palliative care partnerships that are now emerging. Perhaps the most important characteristic in describing hospital-hospice collaborations is the organizational form of the hospice partner and its relationship to the hospital. Those forms include:

- An independent hospice entity that enters into a contractual relationship with one or more hospitals in its community.
- A hospice program that is organizationally based within a hospital or health system.
- Another, less formal connection in which the hospice agency provides advice, training or other kinds of support for the hospital’s palliative care development.

The three basic forms of hospital-hospice relationships uncovered in the research could be further modified by other variables:

- Does the hospice program or the hospital take the lead in advancing palliative care development, or is it a 50/50 partnership?
- Is the local healthcare environment relatively competitive or non-competitive?
- Is the partnering relationship exclusive or non-exclusive?
- What is the hospital partner’s organizational model?
- Is the partnership focused primarily on enhancing utilization of the Medicare Hospice Benefit, on developing new kinds of palliative care services, or on both?

The types of collaborative palliative care programs and services being developed by hospital and hospice partners include the following:

- Contract related to the Medicare Hospice Benefit – most often defining protocols for the hospital to refer patients in need of hospice care to the hospice program and/or for the hospice program to refer its patients in need of inpatient care to the hospital.
- Hospice liaison nurse position based at the hospital. Hospice team based at the hospital to facilitate hospice admissions and care management for the hospice’s patients who are in the hospital.
- Hospice inpatient unit.
- Acute palliative care unit (which may include hospice beds).
- Smaller-scale comfort suite with one or more environmentally enhanced beds preferentially available for dying patients.
- Inpatient palliative care consultation service that goes anywhere in the hospital to share palliative care expertise.
- Outpatient clinic-based, home-based and/or nursing-home palliative care consultation.
- Separately incorporated palliative care medical practice or physician corporation.
- Palliative home care.
- Other palliative care-related services, which include professional education, bioethics committees, palliative care coordinating committees, life-transition counseling and case management, grief support and counseling, managed care projects and programs targeting specialized patient populations.



ISSUES IN HOSPITAL-HOSPICE COLLABORATION

Two underlying issues shaping palliative care partnerships were highlighted in the site-visit research:

A) FINANCIAL CONCERNS: The lack of a specific reimbursement mechanism for palliative care remains one of the biggest challenges in its development, with no easy or obvious answers except in the realm of changes to national health policy. With the exception of hospice care, there is no reimbursement explicitly for palliative care

services, although such services often are billed through hospital, home health care or physician rate structures. Hospice benefits, whether from Medicare, Medicaid or private payers, are an important source of coverage for the end-of-life care needs of many terminally ill patients and their families. However, there are structural, legal and psychological barriers that preclude full utilization of hospice care per se and stand in the way of providing such care to all patients who could benefit from it.

The collaborations described in this report are attempting to enhance access to hospice care for appropriate patients while simultaneously drawing upon other reimbursement sources for other forms of palliative care. At the same time, most of the sites have needed to supplement third-party reimbursement with a patchwork of alternative funding sources including foundation grants, research projects, physician fellowships, charitable contributions and institutional subsidies. None of the visited sites operating a palliative care consultation team report that it is able to break even on billing income alone, although each is working to improve its billing performance.

Recently published studies provide evidence to support the assertion that greater use of hospice and palliative care can generate significant indirect cost savings for a hospital resulting from more appropriate treatment decisions, avoidance of futile treatments and earlier discharges. However, more documentation is needed at the visited sites to translate such purported savings into actual dollars.

B) LEGAL CONCERNS: Since the Medicare Hospice Benefit and hospice inpatient contracts are obvious starting points for expanded hospital-hospice partnerships, it is important for hospital management to have a working understanding of the regulatory requirements for hospice care, particularly in an era of heightened national attention to healthcare fraud and abuse. Hospital partners need to understand, for example, that under the Medicare Hospice Benefit, hospice providers operate within a self-contained regulatory and reimbursement system based on a unique payment mechanism that is distinct from conventional medical coverage.

Legal considerations (discussed in Chapters 2 to 4) include the Medicare Hospice Benefit’s eligibility requirement for patients to

have a terminal illness and a prognosis of six months or less to live – if the illness runs its expected course. Other key issues are coverage and benefit periods, the all-inclusive per diem payment mechanism and levels of service, the hospice program’s professional management responsibility for its patients who enter the hospital, issues in hospital-hospice contracting and the role of hospice liaison nurses based in the hospital. An entire chapter (4) is devoted to the important antikickback issue, which can exert a chilling effect on potential collaborations, as well as relevant safe harbor provisions.



EXAMPLES OF PARTNERSHIPS

1) LEXINGTON, KY

The community-based Hospice of the Bluegrass (HOB) is Lexington’s sole hospice provider and the largest hospice in the state. HOB collaborates effectively with all three acute-care hospitals in the city. They are the University of Kentucky Chandler Medical Center, the teaching hospital for UK’s medical school; St. Joseph Hospital, which belongs to the national Catholic Health Initiatives system of Denver, CO; and Central Baptist Hospital, one of six hospitals in the Kentucky Baptist Hospital System. Partnering has followed a somewhat different path at each hospital, but each relationship includes some combination of liaison nursing, interdisciplinary palliative care consultation and/or a hospice inpatient unit.

HOB has also developed an outpatient clinic-based palliative care consultation service, using staff from its inpatient programs. Although requests for consults have been growing recently, initial demand was slow. Physicians in the community need to be informed of the contributions palliative care can make earlier in the course of a patient’s illness.

2) EVANSTON/SKOKIE, IL

In the competitive Chicago healthcare market, Palliative CareCenter & Hospice of the North Shore (PCC) in Evanston has pursued a broad, coordinated continuum of largely home-based palliative care services in which hospice care is the “jewel in the crown.” Other components of the continuum include a joint

venture with a private-duty home-care service; a pediatric hospice and palliative care program in collaboration with Children’s Memorial Hospital; a physician-led, largely home-based, palliative care consultation team and telephone-based case management.

Rush North Shore Medical Center in nearby Skokie is part of the Rush System for Health, affiliated with the largest community hospital in the state, which also operates its own health-system-based hospice program. Rush North Shore opted to collaborate with community-based PCC on a 15-bed hospice inpatient unit, which is leased, staffed and operated by PCC in a licensed psychiatric facility on the hospital’s campus. The hospice inpatient unit, opened in 1999, is a key ingredient in the collaboration between the two partners, promoting cultural change within the hospital and paving the way for future joint ventures.

3) GREENSBORO, NC

Hospice and Palliative Care of Greensboro (HPCG) is a community-based hospice organization that has a close fiduciary relationship with the Moses Cone Health System, which operates three acute hospitals in Greensboro. In 1984, Moses Cone made a significant financial investment in HPCG’s future. The hospital also operates a 10-bed acute hospice and palliative care unit primarily for the benefit of HPCG patients who need hospice inpatient care.

HPCG manages a 12-bed, HIV-priority, freestanding hospice residential facility, a children’s program and a community counseling and education center. HPCG is also pursuing a multi-faceted, grant-funded Project to Improve Care at the End of Life, which has major emphases on research and education, on expanding its consultative presence within Moses Cone hospitals and on facilitating the admission of hospitalized terminally ill patients onto the Medicare Hospice Benefit without having them physically leave the hospital. A system-wide palliative care consulting service is now under development.

4) NEW YORK, NY

In 1997, Beth Israel Medical Center (BIMC) in New York City established the country’s first hospital-based Department of Pain Medicine and Palliative Care, with significant emphases on research, education and the development of a coordinated continuum of services. The department also includes innovative

quality improvement initiatives, a family education component and an educational web page targeting professionals and the public (www.StopPain.org).

Jacob Perlow Hospice at BIMC, established in 1988, opted to integrate as fully as possible within the new palliative care department in order to extend its influence on the culture of end-of-life care throughout the medical center. One major step in that integration was to expand the hospice inpatient unit at BIMC from 8 to 14 beds combining hospice, palliative care and pain-medicine patients in a single setting. The mixing of different kinds of patients was a difficult transition but also an opportunity for longstanding hospice staff to extend their professional skills.

5) SACRAMENTO, CA

The University of California-Davis Health System (UCDHS), affiliated with UCD's medical center and the Davis campus medical school, includes a home health agency and a certified hospice program. Several veterans of hospice work, who also have teaching responsibilities at UCD, have formed a palliative care research and planning group, which meets weekly. The hospice medical director, who is also chair of Internal Medicine at UCDHS, provides leadership for this group and is a key champion for hospice and palliative care within the health system.

The umbrella for the planning group's activities is the West Coast Center for Palliative Education and Research, established at UCD in 1994 with a training grant from the National Cancer Institute. The planning group tries to identify other grant-funded opportunities to pilot palliative care projects for defined populations as part of a long-range strategy of introducing palliative care throughout the health system. One such initiative is called Simultaneous Care, offering hospice-like, home- and clinic-based support for patients enrolled in Phase I and II cancer investigational clinical trials. UCDHS hospice program supports the research initiatives by providing a setting for skill development and educational placements.

6) SAN FRANCISCO, CA

In a metropolitan area where large health systems dominate, Hospice by the Bay (HBB) operates as an independent, communi-

ty-based hospice program by collaborating with an array of other community organizations. The UC-San Francisco medical center, on the campus of UCSF medical school, has never established its own hospice program but instead refers patients to hospices in the community, including HBB.

UCSF has two current palliative care initiatives: (A) the Comfort Care Suite, comprised of two beds on an acute medicine unit preferentially set aside for imminently dying patients; and (B) the Comprehensive Care Team, a grant-funded "controlled trial of care at the beginning of the end-of-life," based in a general medicine outpatient clinic setting and offering hospice-like interdisciplinary support for patients newly diagnosed with cancer, chronic obstructive pulmonary disease or congestive heart failure. Both of those initiatives have worked closely but informally with HBB, which has contributed its end-of-life expertise and training and is a referral target for the two projects' patients who need hospice care.

7) LEBANON, NH

Dartmouth-Hitchcock Medical Center, a Dartmouth Medical School-affiliated teaching hospital with a history of regional health initiatives, has established a medical-center-based palliative care program. The program grew out of two previous grant-funded, regional palliative care projects, which supported the development of a critical mass of resources and expertise. The palliative care team, formally launched in January 2001, includes five physicians from diverse specialties who rotate through two-week, full-time assignments on the service.

Home health-agency-based Hospice VNH in nearby White River Junction, VT, has worked collaboratively with the palliative care program at Dartmouth in various ways, including support for the two palliative care grant applications. In turn, the palliative care service is now reaching out to Hospice VNH and other community health agencies within its service area to offer collaborative educational and networking opportunities.

8) BURLINGTON AND BARRE, VT

While Dartmouth has deliberately pursued a comprehensive, regionally oriented palliative care service (see site 7 above), some other healthcare organizations in New Hampshire and Vermont

have launched their own, more modest, palliative care initiatives. Two examples include Fletcher Allen Health Care (FAHC) in Burlington, VT, and Central Vermont Medical Center (CVMC) in Barre, VT. Both hospital palliative care consulting services were built on close personal and working relationships with their respective local hospice programs, Hospice of the Champlain Valley and Central Vermont Home Health & Hospice.

Overlapping staff relationships and responsibilities have been key to the physician- and nurse-led palliative care service at FAHC. At CVMC, the team hopes to broadly disseminate palliative care expertise and involvement to nursing staff within the small-town hospital. Both programs first explored prospects for designated palliative care beds but found consulting services to be more feasible starting points.

9) HOLLYWOOD, FL

Privately held VITAS Healthcare Corp., based in Miami, FL, with operations in seven states, is the country's largest provider of hospice care. It also staffs and operates 16 hospice inpatient units, ranging from 12 to 22 beds each, within hospitals in its major service areas, by leasing space either from the hospital or under management services agreements. VITAS as a company is tightly focused on its core business, which is providing care under the Medicare Hospice Benefit. It views palliative care development as synonymous with hospice care and with greater utilization of the hospice benefit.

Memorial Regional Hospital in Hollywood, FL, part of the four-hospital Memorial system in Southern Florida, was host to one of the VITAS leased units. The unit, with 13 private and semi-private beds, opened in 1997 at a time when the hospital had shrinking occupancy rates and unused space. However, in March 2001, when occupancy rates again rose, the hospital opted to reclaim the beds.



THEMES FROM THE SITE VISITS

Based on initial snapshots from the front lines of hospital-hospice partnerships, some common themes and characteristics of such collaborations can be offered. They include:

1) PARTNERSHIPS: Successful partnerships are built on positive, productive relationships between the hospice program and the hospital. There is no substitute for the mutual respect, trust and history of successful problem-solving that is most easily developed over time. Every partnering relationship is different, but courage, commitment, flexibility and willingness to take risks are essential characteristics of success. The partners need to understand each other's objectives and find areas where their goals are in alignment, building on mutual recognition of their respective skills and experience.

In the collaborations described in this monograph, the hospital tends to be the larger partner, with more resources and greater leverage within the healthcare system. Hospice programs need to recognize that imbalance, which in many instances means that they will have to initiate the conversations, generate the ideas and play a more vocal role in the partnership.

2) WHAT MAKES HOSPICE CARE UNIQUE: Hospice care is a specialized approach specifically targeting the physical, psychological, emotional, social, practical and spiritual needs of patients with life-threatening illnesses and their families, provided by an interdisciplinary team on which the represented disciplines contribute to planning, problem-solving and compassionate patient care. Hospice care emphasizes quality of life and life-closure issues, empowerment of the patient and family and their essential role in decision-making, and it allows their needs and goals to determine the plan of care. The role of hospice programs in the collaborations is derived from this specialized philosophy of care, the providers' broad experience in providing care during the last phases of illness and their commitment to enhancing the experience of patients and families by sharing what they have learned.

Although hospital staff has some awareness of hospice as a model of care and as a covered benefit, that awareness may rest on misconceptions. Palliative care is likely to be an even less familiar approach. As a result, advocates are challenged to teach hospital staff how palliative care can benefit patients, families, providers and the hospital itself.

3) **CHAMPIONS:** Champions of palliative care and of collaboration are key to making the partnerships work. At each visited site, committed, well-placed advocates were essential to the project's success. Their experience also suggests that having more than one champion is important because a program's development could be jeopardized if a single key advocate changes jobs or leaves the institution.

In some cases, the advocates were the most knowledgeable palliative care experts within their institutions. In others, a spark of interest among professionals who were novices to the field was fanned through planning committees and education. Often the champions had a personal end-of-life experience that drove their interest in palliative care. In other cases, an embryonic palliative care initiative was boosted by a high-profile illness or death among hospital staff or a prominent member of the community. Many of the collaborations benefited from close personal relationships, friendships and collegial connections between the partners.

4) **CLINICAL LEADERSHIP:** The importance of medical leadership in palliative care was repeatedly emphasized at the collaborating sites. Medical advisory committees, medical directors and other physician champions often provide a bridge between the palliative care advocates and the program's acceptance within the institution. Palliative care programs have found it helpful to employ high-visibility physicians who have working experience and positive reputations in the hospital.

For hospice programs, palliative care is an opportunity to expand their medical director's profile in the local community through a more "hands-on" role in areas such as patient consultations, education and research. For a hospice program seeking a more prominent role in palliative care, it is critical to have a medical director who is well known, clinically competent, respected, visible, active in training and accessible for consultations.

5) **HOSPICE INPATIENT UNITS:** Many hospitals and hospice programs are already engaged in palliative care collaborations. The most common form of partnership, and a logical starting place for enhancing the relationship, is the provision of hospice general inpatient care within the hospital for patients enrolled on the

Medicare Hospice Benefit. Although hospice care in America is predominantly delivered in patients' own homes, a small proportion of a hospice provider's caseload at any given time (approximately 3 percent nationwide) will be receiving general inpatient care for brief periods of intensive care management. The most common partnering arrangement for providing such care is by contract between a certified hospice program and a hospital. In such cases, the hospital becomes a subcontractor to the hospice program, which purchases inpatient services from the hospital.

Such arrangements are most often provided on a "scatter-bed" basis, which means that hospice patients who are admitted to the hospital are placed in available beds in different parts of the facility, rather than grouped together in a designated unit. Other hospice programs have developed freestanding hospice inpatient facilities, often built to order. At a number of the sites presented in this report, the development of a specialized hospice inpatient unit within the hospital has become an important focus for their collaborative relationship and a springboard for further programmatic development. Avenues for such partnerships include the following:

- The hospital establishes and operates a specialized inpatient unit for the patients of a certified hospice program. The hospice program pays the hospital a per diem rate for each hospitalized hospice patient and retains care management responsibility for its patients.
- The hospice program leases unused beds from the hospital; refurbishes, staffs and operates an inpatient hospice unit in those beds; and pays the hospital for rent and ancillaries.
- The hospice program staffs and operates a specialized inpatient unit for the hospital under a management services agreement.
- A number of beds are preferentially designated for hospice and/or palliative care within a larger hospital unit.
- Several hospice programs in a locality collaboratively establish a shared inpatient unit within a centrally located hospital.

Another method for increasing access to the Medicare Hospice Benefit is the direct admission of hospitalized patients onto the benefit without requiring them to leave the facility. This onsite hospital discharge and simultaneous hospice admission, which is explicitly authorized in Medicare regulations, is not new to the

field. But it is an important adjunct to palliative care initiatives at several sites.

6) **LIAISON NURSES:** A number of sites demonstrated an expanding presence for a hospice liaison nurse based in the hospital and filling a pivotal role as facilitator of assessments, admissions, discharges, transfers and communication. There are important legal and regulatory considerations for the liaison nurse position, discussed in Chapter 3, but this role can effectively embody and represent hospice care within the hospital.

The liaison nurse provides accurate and detailed information on hospice care and eligibility, as well as about constraints on eligibility. This individual can plan for delivery of hospital beds and other equipment, supplies and pharmaceuticals to the home from hospice-approved vendors; can teach caregiving techniques to family members; and can assist physicians with the difficult "conversation," in which the patient and family are informed that curative treatments are not achieving the desired outcome. The liaison nurse, who typically operates with considerable autonomy in the hospital, can represent multiple hospice programs within a hospital's service area, so long as the contract for the position is structured to appropriately allocate associated costs.

7) **SPECIALIZED PROGRAMMING:** A number of visited sites are exploring palliative care services targeting specific populations, with the potential to open up exciting new collaborative opportunities with specialist staff, programs and units at the hospital. Examples under discussion or development include pediatric palliative care, HIV/AIDS, congestive heart failure, chronic-obstructive pulmonary disease, Alzheimer's and other dementias, geriatric care generally, programs targeting nursing homes or assisted living facilities and collaborations with pain programs or ethics teams.

One often overlooked opportunity for palliative care is in the hospital intensive care unit (ICU). For ICU patients receiving futile treatment, the hospice/palliative care team can counsel family members, convene family conferences or ethics consults, respond to requests for second opinions on medical treatments and

decisions and help launch dialogues that may lead to modified care plans. Palliative care teams can be especially helpful in the humane withdrawal of ventilator support.

8) **RESEARCH AND EDUCATION:** Research on palliative care, its clinical effectiveness, its contributions to overall quality of life and its cost implications is a priority for many of the collaborations, some of which were established with research grant support. Most of the sites also are committed explicitly to the development and validation of quantifiable outcome measures that could be used to document the clinical achievements and cost-effectiveness of palliative care programs.

Education is another important component of palliative care programs. Educational outreach includes participation in internships, residency training and fellowships; palliative care seminars for hospital staff; local dissemination of the national EPEC (Education for Physicians on End-of-Life Care) and ELNEC (End-of-Life Nursing Education Consortium) curricula; and sponsorship of professional conferences on end-of-life care.

9) **CONTINUA OF PALLIATIVE CARE:** The visited sites generally were careful to avoid suggesting that the main point or purpose of their collaborations was to increase referrals and/or lengths of stay in hospice care. There was a general perception that patients and families may benefit from palliative care long before they are eligible for – or willing to consider – a referral for hospice care. Positioning hospice in partnerships within a broader continuum of palliative care services that can respond to patients' needs from the point of diagnosis is seen as beneficial for patients and families but also for hospice programs. By focusing on broad palliative care needs, rather than on a narrow agenda of earlier referrals for hospice care, palliative care collaborators also believe they will be more likely to effect timely referrals for hospice care by encouraging earlier conversations about end-of-life treatment preferences and by familiarizing patients, families and health professionals with hospice care and what it offers. Thus, they might be more open to a hospice referral when that becomes appropriate.





Hospital-Hospice Partnerships

Despite public-opinion research showing that most Americans would prefer to be cared for at home if they were terminally ill, the majority of patients who confront life-limiting illnesses can expect to receive at least some of their care in acute hospitals, and as many as half will die in the hospital. In recent years, medical research and the news media have sparked a sustained national dialogue on the contrast between what people say they want and what they are likely to experience at the end of their lives. Insights from the landmark SUPPORT study¹ and the report of the Institute of Medicine's Committee on Care at the End of Life² have helped to advance the conversation among health professionals and the public.

One solution proposed for the shortcomings identified in the research is palliative care, which aims to relieve suffering and improve the quality of living and dying through the comprehensive management of the physical, psychological, social, spiritual and existential needs experienced by patients confronting serious, life-threatening and terminal illnesses and by their families.³ Palliative care can be part of the treatment of any person who has a serious medical condition, at any time in the course of an illness for which a patient-centered approach, expert pain and symptom control, family involvement and compassionate care are needed, but it has particular relevance in promoting quality of life when the patient's underlying condition is expected to be fatal. Palliative care, which is most effectively delivered by an interdisciplinary team, may complement and enhance

disease-modifying therapy, or it may become the total focus of the patient's care.

Although palliative care is not a new concept, there has been a recent explosion of interest in it by hospitals and other health facilities. The Last Acts Task Force on Palliative Care has developed useful "Precepts of Palliative Care."⁴ However, there is little consensus on what set of services is encompassed in the term. Nor are there enforceable care standards or explicit reimbursement streams for palliative care – with the notable exception of hospice care.

Hospice care is a specialized and intensive form of palliative care that emphasizes quality of life and life-closure issues, managing disease processes so as to minimize suffering, and helping patients and their families adjust to the changes brought on by advanced illnesses. It promotes comfort and support for patients and their families while ameliorating the manifestations of a life-threatening illness and thereby facilitating opportunities for living with as much peace, dignity and personal control as possible, even as the end of life draws near. The hospice concept was introduced to this country from England in the 1970s and codified in part through the 1982 enactment of the Medicare Hospice Benefit (see Chapter 2 for a description of its provisions).

From those origins, the hospice movement in the United States has grown steadily to more than 3,000 hospice providers, which together served approximately 700,000 terminally ill patients in 1999.⁵ As articulated by the

Alexandria, VA-based National Hospice and Palliative Care Organization (NHPCO) Standards and Accreditation Committee, the ultimate goal of hospice care is to facilitate the realization of three outcomes for terminally ill patients and their families: (1) self-determined life closure, (2) safe and comfortable dying and (3) effective grieving.⁶ NHPCO and other groups are now working to refine scientifically valid outcomes measures that could be used to quantify hospice providers' success in achieving those end-result outcomes. Standards of care for hospice providers have been promulgated by NHPCO, through Medicare's conditions of participation and by the three national organizations that accredit home health agencies, hospices and other healthcare providers: the Joint Commission on Accreditation of Healthcare Facilities (JCAHO), the Community Health Accreditation Project and the Accreditation Commission for Home Care.



A STUDY OF ACTUAL COLLABORATIONS

This report was designed to shed light on some approaches to palliative care development now emerging in the United States, primarily for patients in hospitals. Those new approaches are built on partnerships between the hospitals and hospice programs, tapping the expertise of both partners, emphasizing an interdisciplinary approach to care and extending patient- and family-centered, supportive palliative care to seriously ill hospitalized patients earlier in their illnesses.

The report was conceived as a technical assistance monograph by the Center to Advance Palliative Care (CAPC) at the Mount Sinai School of Medicine in New York City, in collaboration with NHPCO. CAPC was established by The Robert Wood Johnson Foundation as a national program office in order to promote wider access to high-quality

palliative care for patients in hospitals and other healthcare settings nationwide, building upon the example of the hospice movement.⁷ NHPCO is a non-profit, national member organization for hospice and palliative care programs and professionals, committed to improving end-of-life care and expanding access to hospice and palliative care services.

Primary audiences for this report are senior management and clinical leadership of hospitals and hospice programs located in communities across the country. It aims to encourage exploration and implementation of collaborations tailored to local needs. Other groups and individuals active in the movement to improve care at the end of life – including educators, health professionals, activists and consumer advocates – may also discover opportunities to contribute to such collaborations. Desired outcomes include the development of broad continua of palliative care, wider access to palliative care services, improved quality of overall care and enhanced quality of life for patients confronting serious and life-threatening illnesses and for their families.

Hospital managers today may not be well versed in the day-to-day issues, opportunities, challenges and financing mechanisms of end-of-life care, even within their own institutions. Palliative care may not appear to be among the largest or most urgent priorities for their attention. For hospice managers, by contrast, end-of-life care is the primary focus of their jobs. However, prospects for expanding relationships with hospitals and for developing new palliative care programs may seem uncertain and even threatening.

Some would argue that hospitals and hospice programs have different patient care missions and that when the two meet, a cultural clash ensues. Admittedly, hospitals have a focus on

¹ Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments. See: SUPPORT Principal Investigators, "A controlled trial to improve care for seriously ill hospitalized patients." JAMA 1995, 274: 1591-1598.

² Field, M.J., and Cassel, C.K., Eds., *Approaching Death: Improving Care at the End of Life*. Washington: National Academy Press, 1997.

³ See: Ferris, F.D., Balfour, H.M., Farley, J., et al., 2001 Proposed Norms of Practice for Hospice Palliative Care. Ottawa, Ont.: Canadian Palliative Care Association, 2001.

⁴ Last Acts Task Force on Palliative Care, "Precepts of Palliative Care" December 1997 (www.lastacts.org)

⁵ National Hospice and Palliative Care Organization, Alexandria, VA, "Facts and Figures on Hospice Care in America," August 2000.

⁶ National Hospice and Palliative Care Organization Standards and Accreditation Committee, "A Pathway for Patients and Families Facing Terminal Illness."

⁷ Center to Advance Palliative Care website (www.capcmssm.org).



acute care and on disease treatment, as opposed to the strictly palliative and comfort-focused orientation of hospice programs. Such differences in institutional mission are likely to be reinforced in the attitudes of staff and in the overall organizational culture. Recent evidence suggests, however, that those differences in focus are changing in light of greater recognition by hospital leaders of the importance of improving symptom management, communication and supportive services for seriously and terminally ill inpatients and their families.

New pain management standards issued by JCAHO in January 2001 have also helped to raise awareness of the need for palliative care in the hospital setting. In addition, there is growing recognition among hospital and hospice leaders that patients and families are in need of (indeed demanding) a more effective continuum of care from their local delivery system, and that community health-care providers have a responsibility to assure that such a continuum is available. In order to foster that emerging perspective, leaders of hospitals and hospice programs need to be better educated as to the benefits each organization can derive from collaboration. In this report, many such benefits are identified and discussed.

The message of the report, in brief, is that hospital-hospice collaborations can be a win/win/win proposition – for patients with serious illnesses and their families, for hospitals and for hospice programs. For patients, expanded access to coordinated, high-quality palliative care can help return to them personal autonomy and control over their care and treatment choices and bring a degree of humanity and sensitivity to illness-related emotional, psychological and spiritual issues that otherwise might get lost in the imperatives of medical treatment. If a hospital is already considering a palliative care initiative, establishing a dialogue with one or more local hospice programs is a logical place to start. Hospitals can also enhance their ability to meet the needs of seriously ill patients by building upon hospice programs' success in achieving high quality of care and customer satisfaction. For hospice programs, collaborating with hospitals can create new opportunities to extend the influence of the hospice philosophy of care into the acute care setting while they learn more about the realities of providing palliative care in the hospital and integrate hospice

care into a broader continuum of palliative care services. (See sidebar box on p.7 for more on the mutual benefits of collaboration.)

In developing this report, a number of sites were visited where hospitals and hospice programs are partnering in new and exciting ways to address identified needs for end-of-life care in their communities. The sites were chosen to represent a broad range of responses, organizational models and relationships reflecting different regions, urban and rural settings, greater and lesser degrees of competition and different organizational structures of the partnering agencies.

It is important to emphasize that the sites visited for this report were not chosen as “models” or exemplars of palliative care but rather as illustrations of diverse current approaches to collaboration. Instead of trying to showcase the “best” examples of collaboration, the project focused on describing a manageable number of representative partnerships that were willing to share their experiences through this document. Sites were visited in person in November and December of 2000, usually for one full day of interviews with hospice and hospital administrators, medical directors, program coordinators, board members and other collaborative participants.

It is too soon in the evolution of hospital-hospice collaborations to identify the best or most characteristic models of collaboration. Many of the projects described are new, experimental and tentative – responding to identified local needs for palliative care but proceeding with caution, based on clinical, financial, organizational and regulatory uncertainties. Some of the innovations discussed in this report are still under development; others are being implemented in stages. None of them has solved all of the dilemmas of integrating palliative care into the mainstream hospital setting, but all are generating insights and data that will contribute to the search for answers.

The sites also struggle with continuity of palliative care as seriously ill patients move from hospital to long-term care facility or home and back. Although the initial focus of the research was on care provided in the hospital setting, the visited sites were also aware of

the importance of promoting and enhancing continuity of palliative care beyond the hospital setting.

With the exception of hospice care, there is no current third-party reimbursement explicitly directed at the provision of palliative care – although such services may be covered through other reimbursement categories – and no regulatory structure or standard-setting body for palliative care. Such absence of targeted reimbursement and regulation is reflected in the improvisational, ad-hoc nature of the collaborations and demonstrations profiled in this report. The sites are trying to take advantage of existing reimbursement streams – for hospice, home care, hospital care, physician services, etc. – while supplementing them with grants, fellowships, research projects, community donations, start-up funds, institutional subsidies and other funding sources.

As a result, the financing of palliative care remains a significant challenge. Recent published research suggests that palliative care programs can generate indirect, compensatory cost savings for their host institution, the result of offering patients with life-threatening illnesses more appropriate services and potentially facilitating earlier hospital discharges. But at the visited sites, translating those indirect savings into actual dollars to support palliative care development continues to be a challenge.

In most cases, the hospital and hospice partners were more interested in describing how they respond to unmet needs in their communities than in what their partnerships should be called. At some of the sites the hospital is the lead agency, developing internal palliative care services and drawing upon an external hospice program for certain consultative or supportive services. In other settings the hospice program is driving the innovation by introducing new initiatives into the hospital. All of the sites chosen for this study present examples of growing collaborations between the hospital and the hospice program, demonstrating some effort to build upon the expertise of the hospice in furthering the development of palliative care in the hospital.

It seems clear, based on the research, that the ad-hoc nature of the partnerships in palliative care portrayed in this document accurately

reflects the current state of hospital-hospice collaboration. It is hoped that the initiatives described here will inspire other hospitals and hospice programs to explore their own partnerships. Many providers are already engaged in contractual relationships, but there may be significant opportunities, as illustrated in this report, to build on existing relationships in order to expand access to palliative care services.



PALLIATIVE CARE

It is difficult to discuss the emergence of palliative care in the U.S. healthcare system without acknowledging the role played by hospice programs. Hospital managers can look to partnerships with hospice programs as a logical starting point and springboard for their palliative care explorations. Hospice care and hospital-based palliative care are both parts of a broader spectrum or continuum of palliative care. Each has its own unique opportunities, challenges and funding streams that would tend to make collaborations between them logical and fruitful. Hospice care, which operates under a distinct regulatory and financing structure (see Chapter 2), currently is the only large-scale national provider of specialized services explicitly targeting patients nearing the end of life. In 1999, one out of every four Americans who died from any cause received the support of a hospice program, while an even higher proportion of those who had a diagnosable incurable illness such as cancer were enrolled in hospice care. Preliminary NHPCO data for 2000 suggest that the utilization of hospice care is continuing to grow.

Hospice care as currently defined, regulated and organized thus meets the needs of a proportion of patients who have serious or life-threatening illnesses and could benefit from palliative support. Other opportunities also exist to identify and serve that population and the hospital is one of them. Although hospice programs vary in their capacity to provide a broader range of palliative care services, including physician, laboratory and intravenous services, many are now attempting to provide a more comprehensive continuum of palliative care services. At the same time, planning or experiment-

FORMS OF PALLIATIVE CARE COLLABORATION

In trying to categorize collaborations between hospitals and hospices at the visited sites, perhaps the most important characteristic is the form of the hospice partner and its relationship to the hospital:

1. An independent hospice entity that enters into a contractual relationship with one or more hospitals in its community (see Chapters 5, 6, 7 and 13 for examples).
2. A hospice program that is corporately based within a hospital or hospital-centered health system (Chapters 8, 9 and 12).
3. Another, less formal connection in which the hospice agency serves as advisor, trainer, participant in quality improvement or catalyst for change in palliative care development within the hospital (Chapters 10 and 11).

Those three basic forms of hospital-hospice collaborations can be further modified by other variables:

1. Does the hospice program or the hospital take the lead in advancing palliative care development – or is it a true, 50/50 partnership, with a jointly staffed palliative care team and each party making a significant commitment of time, staff and resources?
2. Is the local environment for hospitals or for hospice care relatively competitive or non-competitive?
3. Is the partnering relationship exclusive or non-exclusive for either the hospital or the hospice program?
4. What is the hospital partner's organizational model?
5. Is the partnership focused primarily on enhanced utilization of the Medicare Hospice Benefit, on developing new kinds of palliative care services, or on both?

The varieties of palliative care programs and services being developed by the hospital and hospice partners include the following:

1. Contract related to the Medicare Hospice Benefit – most often defining protocols for the hospital to refer appropriate patients in need of hospice care to the hospice program and/or for the hospice program to refer its patients in need of general inpatient care to the hospital.
2. Hospice liaison nurse position based at the hospital.
3. Hospice team based at the hospital to facilitate the direct hospice admissions of hospitalized patients and coordinate care management for the hospice program's patients who are receiving general inpatient care in the hospital.
4. Hospice inpatient unit.
5. Acute palliative care unit (which may include hospice beds).
6. Smaller-scale comfort suite with one or more environmentally enhanced beds preferentially available for dying patients.
7. Inpatient palliative care consultation service that goes anywhere in the hospital to share palliative care expertise.
8. Outpatient clinic-based, home-based and/or nursing-home-based palliative care consultation.
9. Separately incorporated palliative care medical practice or physician corporation.
10. Palliative home care, which may be offered in conjunction with hospice, clinical trial, outpatient clinic or private duty nursing services.
11. Other palliative-care-related services, such as:
 - a. Professional education through fellowships, residency rotations or inpatient rounding.
 - b. Broadly representative institutional palliative care planning or coordinating committees.
 - c. Bioethics committees or consultation.
 - d. Life transition counseling, case management or disease management services – generally unreimbursed but occasionally private pay or covered by private insurance.
 - e. Grief support, counseling and support groups.
 - f. Specialized palliative care programs targeting, for example, children, people with HIV/AIDS, or Alzheimer's /dementia patients.
 - g. Capitated or other managed care demonstration projects.

ing with new approaches to palliative care is underway in many communities and health facilities. Simultaneously, interest is growing to define national standards and reimbursement mechanisms for palliative care. Hospice programs can enhance such efforts by sharing their extensive skills and experience in providing palliative care to terminally ill patients.

In the national dialogue about improving care at the end of life, access to hospice services has been raised as a public policy concern. The discussion acknowledges the value of hospice care for patients who need palliative care, while recognizing that there are significant barriers to its full utilization. One illustration of this important theme is the short length of time that many patients spend enrolled in hospice care. Current median length of stay in hospice care is just 23 days.⁸ Often patients are referred for hospice care mere days or even hours before their deaths.

A committee appointed by NHPCO, charged with examining the assumptions on which the Medicare Hospice Benefit rests, concluded that the benefit as written into law is more flexible than many have assumed, with a significant underutilized capacity for responding to patients' needs.⁹ Hospice providers themselves sometimes inhibit maximal utilization of the benefit for a variety of reasons, some related to regulatory pressures and others reflecting a lack of creativity, flexibility or concerns about limitations in financing. NHPCO's committee recommended that hospice programs review their policies and procedures to determine how they might maximize the existing benefit structure to serve better more patients with life-threatening illnesses.

Hospice as a concept or philosophy of care predates the 1982 enactment of the Medicare Hospice Benefit, and many hospice programs have a broader tradition of service than what is defined in the benefit. Although the Medicare program has encouraged the growth of hospice care nationwide and helped to define minimum requirements for providers to qualify for reimbursement, the hospice concept has more to offer than the Medicare benefit describes. Hospice demonstration projects are now underway test-

ing how to care for patients who have an extended life expectancy or are receiving experimental or disease-modifying treatments. Policy proposals are exploring whether it might be possible for hospice programs to receive reimbursement for providing palliative care consultations to recently diagnosed patients and how to define alternative eligibility criteria that could be substituted for the six-month prognosis requirement.

Some hospice programs provide a broader range of services by utilizing more liberal internal eligibility criteria, flexible state hospice licensing provisions, home health agency licensure, no-fee volunteer support programs, counseling centers and other approaches. Many hospice programs have extended their services to incorporate new palliative treatments, eliminated access barriers by admitting patients who live alone or lack a family caregiver or stable home setting and cared for more patients with diagnoses other than cancer, including children with life-threatening illnesses.

Other hospice agencies have pursued a somewhat different path to the same goal of expanded access by labeling their broader service offerings as "palliative care." Some have changed their services and their names to include palliative care components through discrete programs or separately incorporated subsidiaries, integrating those initiatives with traditional hospice care. Such changes are mirrored by national and state organizations representing hospices and hospice professionals, which have added palliative care to their names, for example, the National Hospice and Palliative Care Organization, American Academy of Hospice and Palliative Medicine, American Board of Hospice and Palliative Medicine and Hospice and Palliative Nurses Association. Hospices today are engaged in creating and providing broadly based palliative care, directly or indirectly, formally or informally, with or without reimbursement, separately or in collaboration with other providers. This document offers glimpses of how some of them are contributing to the expansion of palliative care in the hospital setting.

At the sites visited for this report, hospital-hospice collaboration generally is proceeding on two tracks. The first overall direction

⁸ NHPCO, 2000 Hospice Census.

⁹ NHPCO, Committee on the Medicare Hospice Benefit and End-of-Life Care, Final Report to the Board of Directors, 1998.

lies in enhancing utilization of the Medicare Hospice Benefit for appropriate patients by promoting closer relationships between the hospice program and the affiliated hospital, offering professional education about end-of-life care, developing specialized hospice inpatient units, encouraging the direct admission of hospitalized patients onto the hospice benefit and other efforts aimed at reducing access barriers. The second track is to develop new, non-hospice-benefit palliative care services, which are less clearly defined, not explicitly reimbursed and more likely to be experimental, ad-hoc and funded from alternate sources.

However, it should also be acknowledged that the distinction

between the two overall approaches identified in the research might be less important to the sites themselves. At the visited sites, there is considerable give-and-take, overlap and effort to blur the boundaries between the two approaches to expanding palliative care access, all out of a commitment to seamless continuity of care for patients and families – except in one key regard. Under current regulations, a Medicare beneficiary with a life-threatening illness either is a Medicare Hospice Benefit patient – or is not. If so, the patient enters a self-contained regulatory and reimbursement system for hospice care (see Chapter 2), which has a unique payment structure and boundaries distinct from conventional medical coverage.

BENEFITS OF COLLABORATION FOR HOSPITAL AND HOSPICE PARTNERS

FOR THE HOSPITAL:

- Improve the quality of care for hospitalized seriously and terminally ill patients and their families.
- Learn more about the nature and value of hospice services, including psychosocial, spiritual and bereavement components and the functioning of the hospice interdisciplinary team.
- Launch palliative care and end-of-life services in collaboration with an experienced partner.
- Improve continuity of care with post-hospital settings.
- Utilize training opportunities for staff.
- Affiliate with hospice's positive community image and philanthropic success.
- Draw upon a new avenue of reimbursement (the Medicare Hospice Benefit) for terminally ill hospitalized patients.
- Improve resource utilization for seriously ill patients and reduce the costs of their care, according to recent research.

FOR THE HOSPICE:

- Access more patients who will benefit from hospice care earlier in the course of a terminal illness.
- Learn more about the challenges and practice of end-of-life care in the acute care setting.
- Gain access to the organizational resources of the hospital.
- Learn more about inpatient palliative care treatments.
- Establish new or improved organizational linkages to larger health systems.
- Participate in palliative care expansion by applying knowledge and expertise to a setting where many patients with life-threatening illnesses receive their care.
- Integrate hospice services within a broader continuum of palliative care.
- Achieve more appropriate and timely referrals through participation in the broader continuum.

Clinical benefits of a hospital-based palliative care program:

- Reduction in symptom burden.
- Care concordant with patient-family preferences.
- Patient-family-professional consensus on the goals of medical care.
- Improved patient and family satisfaction.
- Reduced costs via shorter length of stays and more appropriate treatment ordering.



The Medicare Hospice Benefit: An Overview

By Hogan & Hartson, L.L.P., Washington, DC

In exploring the opportunities and challenges for collaborating on palliative care in the hospital setting, it is important to understand the Medicare Hospice Benefit, including its specific statutory and regulatory requirements and the effect its structure may have on the provision of palliative care services, including the setting for services.

A hospice benefit was first added to the Medicare program in 1982. Although the benefit has been changed a number of times since then, its basic structure has remained the same and is in keeping with the goals that led to its creation. Hospice was, and is, viewed as a philosophy of care as well as a complete package of services that stresses palliative, as opposed to curative or disease-modifying care, and that takes into consideration all aspects of the patient and his or her family's lives, rather than simply focusing on the medical condition. Hospice care is primarily provided in patients' homes or in alternate residential settings such as nursing homes, and the Medicare benefit was structured to support the patient's ability to remain at home until his or her death. The benefit also covers inpatient care under specified circumstances.



ELIGIBILITY

Patients may be referred for hospice care by their physician or another healthcare provider, or they may independently request hospice care. In order to be eligible for the Medicare Hospice Benefit, a Medicare beneficiary must be certified by the hospice medical director and by the beneficiary's attending physician (if there is one) as being "terminally ill,"

which is defined as having a medical prognosis that the patient's life expectancy is six months or less if the illness runs its expected course.¹⁰

Upon electing the hospice benefit, beneficiaries sign an election statement with the particular hospice agency they have chosen, acknowledging that they fully understand the palliative, rather than curative, nature of hospice care. In this statement, they agree to waive their entitlement to Medicare payment for any Medicare services related to the treatment of their terminal condition, or that are equivalent to hospice care, except for the services of an attending physician or those provided (or arranged) by the hospice provider they have elected.¹¹ In other words, once Medicare beneficiaries elect the hospice benefit, they agree that all care related to their terminal illness will be the responsibility of the hospice agency they have chosen, and only that hospice may bill Medicare for such care. Therefore, once a beneficiary has elected hospice care, all Medicare payments related to the terminal illness (except for the services of an attending physician) flow only to, or through, the hospice agency. Hospitals and other facilities that provide services to hospice patients are paid by the hospice rather than by the Medicare program, under the terms of agreements between the hospice and those facilities. However, any services that are not related to the patient's terminal illness (for example, treatment of diabetes in a patient dying of cancer) continue to be covered and paid for under the regular Medicare program.

Patients may revoke their election of hospice care at any time, at which point they are again eligible for full Medicare

¹⁰ Social Security Act (SSA) section 1814(a)(7); 42 CFR § 418.22.

¹¹ SSA section 1812(d); 42 CFR § 418.24.

services under the regular Medicare program.¹² If patients later decide that they want to return to hospice care, they can re-elect the benefit at any time, provided they meet the eligibility criteria.

In some respects, hospice was the first Medicare “managed care” benefit. The hospice provider is responsible for providing or arranging for all necessary services under the hospice plan of care, and also for arranging for any services it does not provide directly, such as inpatient care in an acute care hospital. The hospice program also remains responsible for the professional management of all of those services.¹³ In addition, as discussed in more detail below, hospices receive a set payment for each day a patient is enrolled in the hospice benefit. This payment is intended to cover all services related to the patient’s terminal illness, other than physician services, which continue to be paid under the Medicare physician fee schedule.



BENEFIT PERIODS AND CERTIFICATION

Once a Medicare beneficiary has elected the hospice benefit and has been certified as being “terminally ill,” the beneficiary is re-evaluated at regular intervals to determine that he or she continues to meet the eligibility criteria, and a recertification statement must be completed at that time.¹⁴ The Medicare Hospice Benefit currently consists of two benefit periods of 90 days each, followed by an unlimited number of 60-day periods.¹⁵ There is no actual limit on the amount of time a beneficiary is eligible to receive hospice benefits, since the course of a particular illness and a person’s life expectancy often are variable and difficult to predict. However, information regarding the patient’s condition and the clinical basis of the eligibility for recertification should be documented in the medical record.

Recent federal legislation, the Benefits Protection and

Improvement Act of 2000, amended the Medicare statute by clarifying that the certification of terminal illness of an individual who elects hospice care “shall be based on the physician’s or medical director’s clinical judgment regarding the normal course of the individual’s illness.”¹⁶ This clarification was effective for certifications made on or after December 21, 2000. The federal Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration) also recently issued a program memorandum regarding this change in the law, further emphasizing that medical prognostication of life expectancy is not an exact science.¹⁷



LEVELS OF SERVICE AND PAYMENT

As discussed above, the Medicare Hospice Benefit is intended to provide comprehensive coverage of palliative care for terminally ill patients. In seeking Medicare coverage for a hospice benefit, advocates of the hospice approach fought for a statutory requirement that hospice services must be provided and overseen by a group of professionals from different disciplines, and that it not just be a “medical” benefit. As a result, the Medicare statute requires that the scope of hospice care be determined and overseen by an *interdisciplinary group* (IDG) of hospice personnel.¹⁸ This group must include a physician, a registered nurse, a social worker and a pastoral or other counselor. The IDG establishes for each patient and family a plan of care, which is regularly reviewed and updated. The IDG is also responsible for providing or supervising the care and services specified in that plan of care.¹⁹

The Medicare Hospice Benefit covers a wide array of services and requires that certain *core services* be provided directly by hospice employees.²⁰ Although the hospice program may use contracted staff to provide those services during periods of peak patient load, it still must maintain professional, financial and administrative responsibility for the services. The core services include nursing services, medical social services and counseling services.

Other specifically covered services may be provided by the hospice program directly or by contracting with others. They include physical, occupational and speech-language therapy, home health aide and homemaker services, short-term inpatient care and medical supplies and appliances including durable medical equipment, drugs and biologicals.²¹ In addition to other types of counseling services, hospice programs are required to make efforts to arrange for visits of clergy and other members of religious organizations for patients and their family members who request them and to provide bereavement services to families after the patient’s death.²² Hospice programs also must recruit and train volunteers to provide administrative and/or patient care services, must document the level of such services, including the number of hours of volunteer services and the cost savings attributable to volunteers, and must provide a minimum amount of volunteer services.²³ The cost of ambulance services may be covered if they are part of the patient’s plan of care. The specific services provided to a particular patient by a hospice program also may vary depending on who is available to provide them as needed (e.g., whether the service is provided by a family caregiver or a volunteer assigned by the hospice).

As noted above, Medicare pays for hospice care on the basis of a set rate for each day of a beneficiary’s election of hospice. There are four different levels of payment that may be made, depending on the type of care being provided on a given day.²⁴

The vast majority (approximately 93 percent nationwide) of hospice care days are paid at the *routine home care* rate. This rate covers care provided to patients who are at home and who are not receiving “continuous care.”²⁵ It is important to note that nursing facility residents also may elect to receive hospice care. For such patients, the nursing facility is considered their “home” for purposes of the hospice benefit. For care and services furnished on or after October 1, 2001, the routine home care rate is \$110.42. (All rates are subject to a geographic cost-of-living adjustment, so the actual rate paid to

a particular hospice program may be slightly more or less than this amount.) For each day a patient remains enrolled in the hospice benefit, payment is made at the routine home care rate unless services are provided under one of the other three levels of care.

The second category of care for which hospices may be paid is for a *continuous home care* day, in which the patient is at home but is receiving hospice care consisting primarily of nursing care on a continuous basis.²⁶ This level of care is provided only during brief periods of crisis, as necessary to maintain the patient at home. The payment for a continuous home care day as of October 1, 2001 is \$644.45. If the care is provided for more than eight hours but less than 24 hours in a given day, then the daily rate is divided into an hourly rate (\$26.85 per hour) and paid accordingly. If the care is provided for fewer than eight hours, reimbursement is paid at the routine home care rate.

The third category of hospice payment is for an *inpatient respite care* day.²⁷ This care must be provided in an approved inpatient facility (e.g., a hospital or nursing facility) when necessary to provide respite to the family members or other persons caring for the hospice patient. Inpatient respite care may be provided as needed, but each period of respite care is limited to five consecutive days. The payment for an inpatient respite care day as of October 1, 2001, is \$114.22.

The Medicare Hospice Benefit also pays for *general inpatient care* when needed for specialized pain management or management of acute or chronic symptoms that cannot feasibly be treated in other settings.²⁸ In addition, the *Medicare Hospice Manual* states that such care “may be needed by a patient whose home support has broken down if this breakdown makes it no longer feasible to furnish needed care in the home setting,” or when a patient elects the hospice benefit at the end of a covered hospital stay but continues to need pain control or symptom management while he or she prepares to receive hospice care in the home.²⁹ Other examples of appropriate

¹² SSA section 1812(d)(2); 42 CFR § 418.28.

¹³ 42 CFR § 418.56.

¹⁴ SSA section 1814(a)(7).

¹⁵ SSA section 1812(d).

¹⁶ Subtitle C, Section 322, Benefits Protection and Improvement Act, P.L. 106-554.

¹⁷ Transmittal AB-01-09, dated January 24, 2001.

¹⁸ SSA section 1861(dd).

¹⁹ Id.

²⁰ 42 CFR § 418.80.

²¹ 42 CFR 418 Subpart E.

²² 42 CFR § 418.88.

²³ 42 CFR § 418.70.

²⁴ 42 CFR § 418.302.

²⁵ 42 CFR § 418.304.

²⁶ Id.

²⁷ Id.

²⁸ Id.

²⁹ Medicare Hospice Manual § 230.1(E).



Legal Issues in the Hospital-Hospice Relationship

By Hogan & Hartson, L.L.P., Washington, DC

inpatient care include patients in need of medication adjustment, observation or other stabilizing treatment or a patient whose family is unwilling to permit needed care to be furnished in the home.³⁰ For care and services provided starting October 1, 2001, the general inpatient care rate is \$491.19.

The Medicare benefit includes a provision referred to as the *inpatient care limitation*, which specifies that the total number of inpatient days used by Medicare patients of a certified hospice program in the aggregate may not exceed 20 percent of the total number of hospice days billed by that hospice in a given year.³¹ In addition to the inpatient care limitation, hospice programs are subject to an overall limit on Medicare reimbursement known as the *hospice cap*. The cap amount is adjusted annually, and each hospice program's total allowed payment is calculated by multiplying the cap amount by the number of Medicare beneficiaries who have elected to receive hospice care from the hospice during that particular "cap year."³² (For fiscal year 2000, the aggregate per patient hospice cap is \$16,650.85.) In practice, these two limitations rarely become issues for hospices.



MEDICAID HOSPICE SERVICES

In addition to Medicare coverage, most state Medicaid programs also cover hospice care for patients who are certified as terminally ill.³³ If a Medicaid program opts to include hospice coverage, the care must be provided by a Medicare-certified hospice, and the scope of hospice services available must include all of the services provided under the Medicare Hospice Benefit. The optional Medicaid benefit may include additional services.³⁴ Medicaid payment for hospice care must be no lower than the rates provided under Medicare and must be calculated using the same

methodology.³⁵ States may, however, establish their own procedures for how patients elect the hospice benefit, and they may have different benefit periods from those required under Medicare.³⁶



INPATIENT HOSPICE CARE

As discussed in Chapter 2, the Medicare Hospice Benefit pays for general inpatient care when that is necessary for specialized pain management or acute or chronic symptom management, as well as for inpatient respite care.

Hospice programs are responsible for making arrangements for their patients to receive those types of inpatient care when necessary. Such arrangements may be structured in a variety of ways. For example, a hospice program might contract with a hospital or skilled nursing facility or freestanding hospice facility for the provision of short-term inpatient services for its patients. Another option is for the hospice program to lease space from a hospital or other institution on an autonomous basis. Beds may be located within a designated unit, scattered throughout the institution or located within a more limited area of a hospital, such as an oncology unit. Under such an arrangement, the hospice program may pay rent to the hospital and directly provide certain services such as staffing while purchasing other services (e.g., laundry or food services) from the hospital. Another approach is the creation of a freestanding hospice inpatient unit, where the hospice directly employs and manages the staff and provides all inpatient services. (See sidebar on p.15 for the varieties of hospital-hospice collaborations in establishing hospice inpatient units in the hospital setting.)



PAYMENT FOR HOSPICE SERVICES PROVIDED IN A HOSPITAL

Regardless of the nature of the arrangement between a hospice program and a hospital, Medicare reimbursement for hospice services must flow through the hospice rather than

the hospital. The hospice program bills Medicare and pays the hospital according to the terms of their contractual agreement. Typically, the hospice program pays the hospital a fixed percentage of the hospice payment amount established by the federal Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration). The hospital may only seek Medicare reimbursement and bill a hospice patient for Medicare deductibles and co-insurance for Medicare-covered services that are not related to the patient's terminal illness.

Just as all Medicare payment for hospice services must flow through the hospice program, the program maintains certain responsibilities for its patient's care at all times, including when the patient is in the hospital. Even when the hospice patient is in the hospital, the hospice program must retain professional management responsibility for the services provided, and the hospital services must be provided in accordance with the patient's hospice plan of care or as authorized by the hospice program.



THE HOSPITAL-HOSPICE AGREEMENT

In order to ensure continuity of care for patients and to specify the roles and responsibilities of the parties, the arrangement between a hospice program and a hospital for the provision of inpatient care must be set forth in a legally binding written agreement. At a minimum, hospice regulations require that the agreement include at least the following:

1. Identification of the services to be provided.
2. A stipulation that services will be provided only with the express authorization of the hospice program.

³⁰ Id.
³¹ SSA. section 1861(dd)(2)(A)(iii); 32 S.S.A. section 1814(i)(2).
³² SSA. section 1814(i)(2).

³⁴ SSA. section 1905(o)(1)(A).
³⁵ SSA. section 1902(a)(13)(D).
³⁶ SSA. section 1905(o)(2).

³³ Currently 43 states and the District of Columbia's Medicaid programs cover hospice care. National Hospice and Palliative Care Organization, Alexandria, VA, "Facts and Figures on Hospice Care in America."

3. The manner in which the contracted services will be coordinated, supervised and evaluated by the hospice.
4. The delineation of the roles the hospice and hospital will each play in the admission process, the patient/family assessment and interdisciplinary team care conferences.
5. The requirements for documenting that services are furnished in accordance with the agreement.
6. The qualifications of the personnel providing the inpatient services.³⁷

As stated above, the hospice program retains both professional management and financial responsibility for its patients who are in an inpatient setting. The hospice also is responsible for appropriate hospice care training of hospital staff who provide inpatient services to its patients. The regulations also require that the hospice program furnish the inpatient provider with a copy of the patient's hospice plan of care and specify the inpatient services to be provided. In addition, the patient's medical record should reflect all inpatient services and events. The hospital must also provide the hospice program with a copy of the discharge summary and, if requested, a copy of the medical record. Finally, the hospital must agree to abide by the patient care protocols established by the hospice program.

When a hospice program admits a patient to a hospital, both the hospice and the hospital must still meet their respective Medicare conditions of participation. The procedures set forth in the hospital-hospice agreement should reflect agreement by the hospital to provide services in accordance with the patient's hospice plan of care and by the hospice program to be cognizant of any applicable hospital regulatory requirements in its care planning. For example, the Medicare conditions of participation require that a hospital conduct and document a physical examination of a patient no more than seven days before or 48 hours after a patient's admission to the hospital, but this requirement could be met by having the examination performed by a hospice physician within the specified period of time.

³⁷ 42 C.F.R. §418.56(b)

There are a number of other issues that also should be addressed in the hospital-hospice agreement. For example, there needs to be an arrangement to grant temporary or full *medical staff privileges* to a properly licensed physician who serves as a hospice patient's physician as well as to physicians employed directly by the hospice program to render medical care to its patients in accordance with the hospice plan of care. Most hospice patients retain their personal physician upon entering the hospice program, and those physicians participate in patient assessment, care planning and direct medical care. Frequently, the physicians already possess or are able to obtain admitting privileges and continue to provide care to their patients in the inpatient setting. With other hospice programs, the patient receiving inpatient care temporarily may come under the care of the hospice medical director or other hospice physician, either of whom would continue to work closely with the patient's attending physician. The hospital-hospice agreement should anticipate such possibilities and facilitate the goal of continuity of care by having an efficient process for ensuring that qualified physicians serving hospice patients are able to obtain some level of hospital privileges.

The hospital-hospice agreement should set forth the *responsibilities of each entity*, including, to the extent possible, the liability of each for any negligent acts that occur while a hospice patient is cared for in the hospital. While determining who is liable for a particular event necessarily will be fact-dependent, under the requirements of the Medicare Hospice Benefit the hospice maintains professional responsibility for the hospice services provided and beneficiaries remain patients of the hospice program regardless of the setting in which those services are provided. If negligence arose because the hospice program was not appropriately supervising the services or due to something omitted from a patient's plan of care, then the hospice may bear greater responsibility for the negligence. However, if the hospital fails to permit the hospice program to maintain professional responsibility for the patient or if a hospital employee was involved in a negligent act, then the hospital may bear greater responsibility. The hospital-hospice agreement should clearly set forth the responsibilities of each party and should include a discussion of liability and indemnification.

The hospital-hospice agreement should address policies and procedures for protecting the *privacy of medical records*, as required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and related regulations. This might include provisions regarding the exchange of protected health information, the staff that may need access to such information for purposes of providing patient care and a process for facilitating the patient consent required by each entity prior to using or disclosing protected health information. Staff of both entities will need to be trained in the privacy procedures to be followed while a hospice patient is in the hospital.

The hospital-hospice agreement should also reflect the need for *coordination among hospice and hospital staff*. For example, the hospice interdisciplinary group continues to direct and manage the care of hospice patients receiving inpatient care. The care coordinator will continue to oversee the patient's care and assure continuity through the admission, stay and discharge process. Hospice social service staff continue to provide counseling and supportive services to the patient and family members, as well as assisting in details related to issues such as discharge planning. Volunteers, counselors and spiritual service providers may also continue to be involved. The hospice care coordinator, as well as other hospice staff, will need to work closely with the hospital staff, particularly the unit's nursing staff. To facilitate such coordination, both hospice and hospital staff should understand the hospital-hospice arrangement, including communication and coordination procedures, policies and procedures related to the delivery of hospice inpatient services, the services the hospice and the hospital will each provide to hospice patients, the involvement of the interdisciplinary team and the relationship of the inpatient component of the hospice program to the home care component.

Under the Medicare conditions of participation, hospitals are required to provide discharge planning for all patients and evaluation of the need for post-hospital services, including hospice

³⁸ SSA section 1861(ee)(2).

³⁹ Determining the "fair market value" of a given item or service may depend on a number of factors, but the parties to a transaction should be able to show, through independent assessments or some other proof, that the payment between the parties for a particular good or service is consistent with what would be paid in an arm's-length transaction between unrelated parties for similar goods or services in that area.

services, if appropriate.³⁸ If a hospice program uses a *liaison nurse* to manage and facilitate the transfer of a hospital patient from acute care to the hospice benefit, the role of the nurse needs to be set forth in an agreement. A liaison nurse typically coordinates a patient's transfer and ensures continuity of care. The nurse may perform those duties in various settings, including the hospital and the location where hospice services are provided, such as the patient's home. Liaison services may be provided once the patient has decided to receive hospice services, the patient's physician has determined that the patient is eligible for hospice care and the patient has chosen a particular hospice program.

Liaison activities should not duplicate or take the place of the discharge planning services that a hospital is required to provide for its patients under Medicare's hospital conditions of participation. A hospital may, however, pay the hospice program *fair market value*³⁹ to perform its required discharge services. The hospital-hospice agreement should detail any discharge services the hospice is providing on behalf of the hospital and the specific costs of such services. If multiple hospice programs or a hospital and hospice share in the costs of a liaison nurse position, the services should be set forth in an agreement. The liaison nurse should not be soliciting patients for a particular hospice, and the amount of payment from each entity supporting the liaison nurse should be unrelated to any referrals to or from that entity. Agreements regarding liaison nurses, particularly if their salary is funded by both hospices and hospitals, should be reviewed by legal counsel to avoid potential problems under federal and/or state antikickback and related laws, which are discussed in greater detail in Chapter 4.

As mentioned above, the hospice program is responsible for *training the inpatient staff* providing care to hospice patients. The amount of training necessary will depend in part on the amount of past experience the staff has with hospice services as well as the nature of the arrangement between the hospice program and the hospital. For example, where hospice inpatient services are

COLLABORATIVE HOSPICE INPATIENT UNITS

Avenues for hospitals and hospices to collaborate on the development of hospice inpatient units located in the hospital include the following:

1. The hospital can establish and operate a specialized inpatient unit for the benefit of one or more certified hospice programs, which refer their patients who need inpatient care. The hospice provider pays the hospital a per diem rate for each of its patients receiving inpatient care and retains care management responsibility for those patients.
2. A hospice program can lease vacant beds from the hospital and then refurbish, staff and operate a hospice inpatient unit in those beds, paying the hospital a space rental fee and purchasing certain ancillary services.
3. The hospice can staff and operate the inpatient unit on the hospital's behalf under a management services agreement.
4. A smaller number of beds may be designated for hospice and/or palliative care patients within a larger unit, such as an oncology ward, using training and other efforts to develop specialized expertise among the unit's staff.
5. Several hospice programs can cooperate in establishing a shared inpatient unit in a centrally located facility, achieving a critical mass of patients and supporting resources that none could have achieved on its own.

provided within a particular unit in the hospital, training may be more extensive and focused because the inpatient staff on that unit are likely to provide hospice care on a regular basis. Where the services are provided throughout the hospital in a scatter-bed arrangement, the hospice program will have to depend more on a general orientation through various hospital departments and then conduct more detailed orientation on a case-by-case basis as patients are admitted to various floors. Particularly in the latter type of arrangement, it may be helpful for the hospice program to provide written materials that concisely delineate basic hospice policies and procedures.

The inpatient care provided to a hospice patient, like hospice home care, focuses on the combined physiological, emotional, sociological and spiritual needs of the patient and his or her family. The inpatient setting should, to the extent possible, provide a home-like environment for the hospice patient and the hospital-hospice agreement should reflect how that is to be achieved. The agreement should also address other issues pertaining to the continuance of a hospice environment for patients receiving inpatient care. For example, the visiting privileges available to relatives and friends of hospice patients should be unlimited. There should be adequate space, such as a lounge, for private visiting among hospice patients and their visitors as well as adequate accommodations for family members to remain with the patient throughout the day and night.



The Antikickback Law and Hospital-Hospice Relationship

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BACKGROUND

Since hospitals are sources of referral for hospice programs, and vice-versa, the financial relationships that these entities enter into with each other can pose risks under healthcare fraud-and-abuse laws. In the last few years, state and federal governments have significantly increased the resources available to investigate healthcare fraud and abuse across all types of providers. Hospices and hospitals have not been exempted from this heightened level of review, and there is no reason to believe that the tide of governmental fraud-and-abuse investigations has crested. Increasingly, private individuals (including disgruntled employees) are also becoming active in the prosecution of alleged healthcare fraud through the filing of *qui tam* lawsuits (brought on the government's behalf by individuals who potentially could share in the settlement or penalties imposed) under the federal False Claims Act.

With respect to hospital-hospice arrangements, applicable laws, including the state and federal laws prohibiting kickbacks, should be well understood in order to avoid costly lawsuits and potential liability. The federal antikickback law is discussed below in general terms – what the law prohibits, how arrangements can be structured to assure protection from liability under the law and how the law has been applied to hospital-hospice arrangements.

It is important to understand, however, that many states have similar laws that may apply regardless of whether Medicare, Medicaid or other federal funds are at issue. Although such laws will not be addressed specifically here, they are conceptually similar to the federal law. It is also important to understand that whether or not a particular arrangement may run afoul of the antikickback laws will depend on a very fact-specific analysis. Because each situa-

tion must be analyzed independently and because applicable state laws may differ from federal laws, hospitals and hospice programs entering into collaborations should seek guidance from legal counsel knowledgeable about both federal and state antikickback and related laws.



FEDERAL PROHIBITION AGAINST KICKBACKS

The federal antikickback statute contains both civil and criminal penalties. It proscribes, among other things, offering or paying any remuneration to induce someone to refer patients to or for, or to purchase, lease or order (or arrange for or recommend the purchase, lease or order of) any facility, item or service for which payment may be made by a Federal Health Care Program. The term "Federal Health Care Program" includes Medicare, Medicaid and virtually all federally funded healthcare programs except the Federal Employee Health Benefits program. The statute also prohibits soliciting or receiving any remuneration in exchange for engaging in any of those activities. The prohibition applies whether the remuneration is provided directly or indirectly, or "in cash or in kind." Examples of the kind of behavior the government is trying to prevent would be a hospice program offering goods for free or below market value to a nursing facility or other provider to induce that provider to refer patients to the hospice, or a hospice program providing staff at its expense to a nursing home to perform services that otherwise would be performed by the nursing home's staff.

Penalties for violations of the antikickback statute are severe, consisting not only of substantial criminal fines and imprisonment (five years in prison, \$500,000 fine), and the imposition of civil monetary penalties (\$50,000 per kick-

back), but also exclusion from participation in the Medicare and Medicaid programs. The exclusion remedy may be imposed in an administrative proceeding, even in the absence of any criminal proceeding or investigation.

Although the antikickback statute does not outlaw all financial transactions or relationships that providers of healthcare items or services may have with each other, interpretations of the law have been very broad. The antikickback statute has been held applicable to a wide variety of financial relationships that are quite different from an obvious kickback on a patient referral or a bribe to recommend the purchase of specific products or services. Federal courts and administrative bodies considering the statute in the context of actual enforcement cases have established several important interpretive principles:

- The statute is violated if even *one purpose* (as opposed to a primary or sole purpose) of a payment is in exchange for or to induce the referral of patients or the ordering, purchasing or recommending of items or services.
- Although some financial benefits may be too remote or *de minimis* to affect referral practices, the threshold appears to be relatively low, and a payment or other benefit may violate the statute when the amount is sufficient to influence the physician's (or other provider's) reason or judgment.
- Giving a potential referral source the opportunity to earn a fee that exceeds the reasonable value of any services provided (or return on investment made) will constitute evidence that the payment is unlawful; however, a reasonable fee will not in itself serve as a defense if the intent underlying the arrangement is to exchange payment for referrals.
- Intent may be inferred from the circumstances of the case, and there need be no proof of an agreement to make referrals, or to order, purchase or recommend medical items or services for illegal intent and a violation to be found.
- The mere potential for increased costs to Medicare or Medicaid may be enough to violate the law, and no actual payout by Medicare or Medicaid is necessary as long as the challenged remuneration is for an item or service that could be paid for by Medicare or Medicaid.

- The fact that a particular arrangement is common in the healthcare industry is not a defense to an antikickback violation.



EXCEPTIONS AND SAFE HARBORS

The antikickback statute itself contains several limited exceptions to the prohibition on remuneration. Moreover, the Department of Health and Human Services may issue regulations defining certain practices that would not be deemed to violate the antikickback statute. The federal Office of Inspector General (OIG) published an initial set of final regulations, creating a relatively small number of "safe harbors" from the reach of the antikickback statute, in July 1991 and has promulgated others since then.

While those who structure their business arrangements to satisfy all the criteria of a safe harbor are protected from liability under the antikickback statute, failure to qualify for a safe harbor does not necessarily mean that there has been a violation of the antikickback statute. However, the OIG has stated that arrangements that are of the same generic kind as those for which a safe harbor is available may be subject to scrutiny if they fail to satisfy all the criteria for the appropriate safe harbor.

Where a practice does not qualify for a safe harbor, the OIG will examine the practice to determine whether it involves any remuneration and, if so, whether the practice appears to involve the types of abuses that the antikickback statute was designed to combat. In determining whether to prosecute, the OIG will look at a variety of factors, including:

- The potential for increased charges or reported costs for items or services paid for by Medicare or Medicaid.
- Possible encouragement of over-utilization.
- The potential for adverse effect on competition by freezing competing suppliers out of the marketplace.
- The intent of the parties.

No single factor determines whether a case will be pursued, and the OIG and the Department of Justice (which is responsible for criminal enforcement of the antikickback statute) have considerable discretion in selecting cases to prosecute.



PERSONAL SERVICES AND MANAGEMENT CONTRACTS SAFE HARBOR

The most relevant safe harbor to hospital-hospice arrangements is the "personal services and management contracts" safe harbor. An arrangement would be protected from antikickback law liability if *all* of the following criteria were satisfied:

- There is a signed written agreement for a term of not less than one year that specifies the services to be performed.
- The aggregate compensation paid is set in advance, consistent with fair market value in arms-length transactions, and is not to be determined in a manner that takes into account the volume or value of any referrals or business otherwise generated between the parties.
- If services are to be performed on a part-time basis, the agreement specifies exactly the schedule of intervals, their precise length and the exact charge for each.
- The services do not involve counseling or promotion of any arrangement or other activity that violates state or federal law.



APPLICATION TO HOSPITAL-HOSPICE RELATIONSHIPS

The OIG has issued a number of "Special Fraud Alerts" setting forth its views regarding the application of the statute to certain types of arrangements. While there have been no alerts specific to hospital-hospice partnerships, some of the principles in an alert addressing fraud and abuse in hospice arrangements with nursing homes also appear relevant to hospice arrangements with hospitals. According to that fraud alert, a hospice program that offers remuneration in return for securing an exclusive or semi-exclusive arrangement with a nursing home to provide hospice services to its patients could run afoul of the antikickback law.

The same could be true if a hospice program offered remuneration to a hospital to ensure that hospital patients needing hospice serv-

ices are referred to that hospice program. Indeed, in its Compliance Guidance for Hospices, the OIG indicated that a hospice that provides nursing or administrative services that are the responsibility of the hospital could be in violation of the antikickback law because those services are a form of "remuneration." Accordingly, when a member of the staff of a hospice program performs hospital discharge planning duties at no cost to the hospital, there is a potential violation of the antikickback law.

In addition, there are a variety of issues to avoid in establishing a financial relationship between a hospital and a hospice program that refer patients to each other. Any payment in such an arrangement should not be tied to patient census or referrals. For example, an agreement with a hospital to accept hospice patients for inpatient care with the hospice program paying a set percentage of the Medicare rate for the first 20 patients and a lower percentage for the next 20 patients may be viewed as an unlawful inducement to the hospice program to refer its patients to that hospital. In addition, when one entity pays the other entity for services provided, the payment should be at a fair-market-value level. Thus, if a hospice program provides an employed nurse to a hospital to provide certain services for which the hospital is being compensated, the hospital's payment to the hospice program for that nurse's services should be at fair market value.⁴⁰ If the payment is in excess of fair market value, it could be viewed as an incentive from the hospital to refer hospice patients to that hospital.

The current climate regarding healthcare fraud and abuse and providers' concerns about potential violations of the antikickback statute have had a chilling effect on the utilization of hospice care, as clearly seen in the reduction in average length of enrollment in hospice care. The experience of hospital and hospice collaborations portrayed in this monograph suggests a need for the government to develop and expand the safe harbor for personal services and management contracts to assure that such partnerships are not unnecessarily restricted from providing appropriate types and levels of services to hospitalized patients in need of palliative and hospice care.

⁴⁰ See Footnote 39, Chapter 2, p.14.



Three Hospitals and a Hospice

Lexington, KY

MODEL/SUMMARY: Community-based Hospice of the Bluegrass has pursued the collaborative development of palliative care services with all three hospitals in Lexington, KY. Each collaboration is following a somewhat different path, reflecting the unique culture of each hospital but including some combination of liaison nursing, inpatient unit and/or palliative care consultation. Each hospital has also committed money to that development.



COLLABORATORS/SETTING

Lexington, KY, population 240,000, has three acute care hospitals:

- The University of Kentucky Chandler Medical Center, with 473 beds, is the teaching hospital for the UK medical school.
- St. Joseph Hospital, with 600 beds, belongs to the national Catholic Health Initiatives health system, which is headquartered in Denver, CO, and has made a national commitment to improving end-of-life care.
- Central Baptist Hospital, with 371 beds, is one of six hospitals in the Kentucky Baptist Hospital System.

Independent, nonprofit, community-based Hospice of the Bluegrass (HOB) has carefully tended collaborative relationships with all three hospitals, building on the dynamics of each relationship to create a continuum of hospice and palliative care services. HOB, founded in 1978, has grown to be the largest hospice provider in Kentucky and one of the largest in the country through indispensable service, brand identification as the only hospice in its home base of Lexington and mergers with smaller hospices in other parts of the state.

Currently, the agency has an average daily census of nearly 600 hospice patients, two-thirds of them served by its Lexington central program and the rest from separately certified offices in Eastern and Northern Kentucky. The state's certificate of need law for hospice care, which has tended to dampen competitive pressures, and HOB's high average length of stay of 81 days (median: 33 days), have also contributed to its financial stability and ability to innovate. HOB offers other specialized services including a federally funded children's hospice demonstration project, a management services company to assist other hospices, a volunteer-based cancer support network for newly diagnosed patients and extensive community bereavement services.



WHAT IS THE PROGRAM/EXPERIENCE OF COLLABORATION?

A) *University of Kentucky Chandler Medical Center (UKCMC):* HOB's first collaborative relationship, with UKCMC, was launched in 1995 with a foundation grant to cover the salary of a hospice liaison nurse who would provide continuity of care between the medical center and 15 community hospices in its 80-county service area. HOB employed the liaison nurse and organized the Bluegrass Hospice Council to represent the 15 hospice programs working with the hospital. The liaison nurse's role has included formal and informal education within the medical center, case management and discharge planning, information and referral, evaluation of hospice referrals, counseling and advocacy on end-of-life issues with patients and families and facilitation of communication and continuity of care among the medical center, physicians, hospices, patients and families.

Over the past six years, the liaison nurse has worked with an

average of 378 patients per year, one-third of whom were never referred for hospice care. After the initial grant ended, UKCMC agreed to hire the liaison nurse on staff and cover approximately 80 percent of the position's salary – related to discharge planning and palliative care functions. The 15 hospice programs together pay the remainder, which covers essential hospice tasks such as care plan transfers. The liaison nurse is now entrenched in the medical center, filling a role much like that of a palliative care nurse, but without direct clinical involvement.

Financial analysis by the hospital at one time suggested that the liaison nursing service had saved approximately \$250,000 – when compared with patients who had similar ICD-9 codes but did not receive the service – through better coordination of care leading to earlier discharges. However, despite the drafting of several business plans, UKCMC has not yet established a more formal palliative care program. Because of turnover of key personnel, divergent projections of costs and revenues and the administrative complexities of the university and medical center setting, palliative care program development has moved forward at a very deliberate pace. The recent hiring of a new director for UK's Markey Cancer Center has renewed interest in palliative care and may accelerate its development.

B) *St. Joseph Hospital:* Discussions starting in 1993 between HOB and St. Joseph Hospital led to an agreement in 1996 for the hospice to lease space in a former medical-surgical wing at St. Joseph and open a hospice inpatient unit called the Hospice Care Center. Originally 12 beds, expanded to 17 beds in 2000, the unit is modeled on the dedicated hospice inpatient units of VITAS Healthcare Corp. (See Chapter 13.) HOB pays a monthly rental fee, purchases services such as pharmacy, respiratory therapy, laundry, dietary and housekeeping from the hospital and directly employs and manages the unit's staff. The hospice also paid for renovation, furnishings and start-up costs for the unit, totaling \$50,000.

Hammering out a contractual agreement for the leased unit took two years, but the detailed negotiations made it possible to resolve many potential problems in advance. The Hospice Care Center is the only inpatient hospice unit in Lexington, and it is utilized for referrals from the other hospitals and from hospice programs in neighboring communities. Thirty percent of referrals to the unit come from within St. Joseph Hospital, with 10 percent from other hospitals, 5 percent from other hospices and most of the rest from HOB for its home-based patients who need inpatient care. Length of stay on the unit, which is reserved for hospice patients with short-term acute medical needs, is 6 days; occupancy rate is 77 percent. The rooms, former semi-private hospital rooms turned into private hospice rooms, are all comfortably spacious with pullout sofas for families to stay overnight.

In its four-year history, the Hospice Care Center has begun to demonstrate an impact on medical culture within a system that already was explicitly committed to collaborating and to improving care at the end of life. For example, some of the hospice unit's treatment protocols, such as its bowel regime, are being adopted around the hospital. As the unit's influence began to spread, conversations between the two partners turned to establishing a consulting service within the hospital. In 1997, the two organizations participated together in the first national Breakthrough Series Collaborative on Improving End-of-Life Care, sponsored by the Institute for Healthcare Improvement and emphasizing techniques for implementing rapid-cycle quality improvements.

A joint palliative care consulting service at St. Joseph began on a limited basis as a pilot project in January 1999 with expenses shared between the hospital and HOB. They split the salary of the advanced practice nurse coordinator, while HOB provides a social worker and medical leadership from its full-time medical director and the hospital assigns a chaplain to the team. The nurse coordinator is responsible for educating staff in the hospital about how to use the



service and also works on an outpatient consulting service (see below). Referred patients have life-limiting illnesses and unresolved symptom management needs but may still be receiving curative treatments. A palliative care checklist developed by the consulting service is used by hospital staff to help assess when a referral is warranted.

Attending physicians requesting a formal consult are contacted by the nurse coordinator, who discusses what the patient needs, makes an assessment and notifies the rest of the team – which becomes involved as needed. The palliative care service does not take over primary medical responsibility from the attending. The consulting physician provides follow-up communication to the attending in the form of phone calls, letters and copies of clinical notes. Patients on the inpatient service are seen daily, and the team also interfaces with nursing staff on the units. In its first 20 months, the service received an average of seven referrals per month, primarily from the departments of surgery, internal medicine and oncology and from hospitalists.

C) *Outpatient Palliative Care*: In an effort to advance the concept of palliative care and reach a broader population not yet appropriate for hospice care, HOB established an outpatient palliative care service as a separately incorporated nonprofit medical practice in January 1999. The practice is certified for Medicare Part B provider billing and meets licensing and tax requirements. Called Palliative Care Center of the Bluegrass, the program operates an outpatient clinic two afternoons a week out of a rented office suite adjacent to St. Joseph Hospital.

The practice includes HOB's medical director, the advanced practice palliative care nurse at St. Joseph, a licensed clinical social worker and a part-time practice administrator. The outpatient clinic office provides a physical presence for the program on the St. Joseph Hospital campus and a base of operations for the hospital palliative care consulting service as well as a billing office. According to its mission statement, Palliative Care Center of the Bluegrass serves patients who have incurable diseases with limited life expectancies, either to complement conventional treatment or to serve as the patient's primary care provider. Most common rea-

sons for referral were for pain consultation and symptom management of acute and chronic illness. Recently, the service received referrals from a local managed care plan for in-home physician consultation visits. However, initial demand was modest for the service, which is not yet widely known or well understood.

D) *Central Baptist Hospital*: Central Baptist Hospital, with 371 beds, is the smallest of Lexington's three hospitals. Yet it has the highest occupancy rate and is the largest source of referrals to HOB. Due in part to its high occupancy rate, the hospital has not established an inpatient palliative care unit but instead has opted to pursue a service that could consult with patients throughout the hospital while encouraging all Central Baptist staff to participate in meeting the palliative care needs of their patients. In August 2000, Central Baptist and HOB launched the palliative care consulting service, similar to the one at St. Joseph but developed more deliberately over a 12-month planning process, starting with a multidisciplinary planning committee that broadly represented hospital staff.

The program's origins lie in the 1997 appointment of a hospice liaison nurse from HOB at Central Baptist, filling a role similar to the one at UKCMC, along with a growing recognition of the number of patients who were referred for assessment but never reached a hospice program – despite a need for palliative support. Central Baptist physicians began informally requesting palliative care consultations well before the service's formal unveiling.

The concept got another boost in November 1999 from the Oncology Service Pathway at Central Baptist, which articulated a goal of forming a palliative care service at the hospital during the coming year. Its recommendation led to the formation of a Palliative Care Committee, chaired by the liaison nurse from HOB to plan the development. A Palliative Care Physician Advisory Committee comprised of 24 influential physicians on the hospital's medical staff began meeting in March 2000. Also that month, a retrospective review of charts for 100 readmitted hospital patients helped to identify potential patient populations in need of palliative care, their unmet needs and opportunities for improving their care.

Although HOB's liaison nurse helped to guide the development of palliative care at Central Baptist, the hospital's Palliative Care Committee assumed responsibility for a collaborative process of defining palliative care, determining the model and designing screening tools, practice guidelines and marketing materials.

The palliative care consulting service at Central Baptist, which launched an educational and marketing rollout throughout the hospital late in 2000, is staffed on a shared basis, like the team at St. Joseph. The hospital provides the team's part-time social worker and chaplain, along with half of the nurse coordinator's full-time salary, while HOB picks up the other half and all of the medical director's time. Team members carry pagers, and referrals are starting to pick up for the new program. A dedicated hospice or palliative care unit at Central Baptist is not part of current plans but may be in the hospital's future.



LEADERSHIP AND CHAMPIONS

Staff from all of the palliative care programs and services sponsored by HOB meet monthly to compare notes and coordinate efforts. HOB's full-time medical director, who provides leadership for all of the services, previously had been chief of staff at St. Joseph and completed a one-year palliative care fellowship at the Cleveland Clinic Foundation in Ohio. Palliative care team members have played other roles such as serving on ethics committees in the hospitals and their parent health systems. HOB's director of the Hospice Care Center at St. Joseph had worked as a social worker at the hospital.

At UKCMC, the new director of the cancer center is an advocate for palliative care and is promoting its development. The success of the palliative care physician advisory committee at Central Baptist, with the active involvement of 24 physician leaders at the hospital, has inspired HOB to try to develop a similar advisory body to support the already-established palliative care service at St. Joseph.



EDUCATION AND RESEARCH

HOB's medical director is an adjunct professor at UK medical school and provides monthly sessions for third-year medical students. A hospice and palliative care rotation is now being planned for third-year medical students. The medical director has also provided EPEC (Education for Physicians on End-of-Life Care) trainings at grand rounds and medical staff meetings at the hospitals. In addition to training nursing and social-work students, HOB also provides one-month placements for UK pharmacy doctoral students. HOB's formal continuous quality improvement efforts include the Palliative Care Center. Among other measures, the hospice regularly tracks patient data using the Palliative Performance Scale and the Missoula-VITAS Quality of Life Index.



FINANCIAL ISSUES

The overall financial impact of specific palliative care services within HOB's annual budget of \$27 million is difficult to quantify. The agency is committed to providing an interdisciplinary approach to palliative care, which mandates a full team with physician, nurse, social worker and chaplain members – and to collecting payment where it can – although not all members of the team qualify for reimbursement. The new services are popular with the agency's Board of Directors and, much like HOB's community bereavement outreach, reflect its mission of serving the community and putting patients and families and their care goals first. A higher profile for palliative care is also an opportunity to introduce end-of-life care issues and options to physicians and the community and to raise awareness and appreciation for hospice and palliative care services overall. HOB believes that raising community awareness in this area may have the effect of encouraging patients to be enrolled sooner in hospice care, although that is also hard to quantify.

The Palliative Care Center of the Bluegrass outpatient clinic has budgeted expenses of \$155,000 for 2001, with anticipated revenues

of \$60,000 and a net deficit of \$95,000. In terms of generating revenue, the PCC program billed for 355 outpatient physician visits and 329 inpatient physician visits in 2000. Those numbers are below initial budgeted projections for billable visits but represent a significant and growing source of income for the service. More recent data indicate that billed visits increased significantly in the first half of 2001 and are running above projections. Continuing to improve the service's bottom line depends on increasing the agency's skill in this new category of billing and utilizing more of the medical director's time for billable visits, especially for inpatient consults, with the nurse coordinators providing more of the ongoing coordination of care. However, the organization believes it will be hard to make palliative care consultation self-supporting on Part B physician billing income alone.

The impact of palliative care on the hospitals' bottom lines has also been difficult to quantify, although it is believed that the availability of palliative care might encourage earlier discharges and help to steer terminally ill patients away from futile treatments.



CHALLENGES OF IMPLEMENTATION

- Lack of awareness about palliative care and the need to teach physicians that it is not necessarily limited to the end of life but can have value in promoting quality of life even for patients still pursuing curative or disease-modifying treatments.
- Gaps in reimbursement for the services of some members of the interdisciplinary consulting team.
- Potential continuity-of-care issues with only one specially trained physician available for palliative care.



KEYS TO SUCCESS

- HOB's commitment to the interdisciplinary model of hospice and palliative care and to putting the expressed desires of patients and families first in defining interventions.
- HOB's longevity, reputation and high visibility in the community.

- A commitment to the mission by all of the collaborating partners.
- The presence of the hospice inpatient unit at St. Joseph, which has provided a visible focus for palliative care development and an opportunity for hospital staff to observe its value.
- The HOB medical director's prior experience working at an outpatient palliative care clinic.
- St. Joseph's assigned staff liaison to the hospice unit, an essential communications link between the partners.



LESSONS LEARNED

- Physicians and discharge planners who have one successful experience with palliative care are likely to use it again, while some who might be uncomfortable referring a patient for hospice care may be more open to requesting a palliative care consult.
- One innovation naturally leads to others, particularly in a community where medical staff at each hospital is aware of what goes on at the others.
- The greater the profile for palliative care within the hospital, the more influence it can have on the hospital's culture.
- Palliative care program development can be a difficult and time-intensive process, with the need to subsidize start-up and development costs until the program becomes better known.
- The outpatient palliative care service received more referrals from the community for patients who were not previously involved in palliative care than for recently discharged patients served by the inpatient palliative care service. That suggests a need for further education and buy-in from physicians at the hospital and underscores the fact that many seriously ill patients in need of palliative care may already be in the community with the primary care physician's office as their primary point of contact with the system.
- Cancer has been the primary diagnosis for palliative care referrals, although more come from surgeons than from oncologists.

HOSPICE OF THE BLUEGRASS SERVICE STATISTICS			
	1998	1999	2000
Total hospice admissions	1,906	2,181	2,428
Lexington office hospice admissions	781	815	897
Hospice Care Center admissions	214	212	236
Average daily census, hospice			566
Average length of stay, hospice			81 days
Median length of stay, hospice			33 days

- Palliative care patients often have a great need for support. Their need for emotional support may be even greater at the point of diagnosis of a life-threatening illness than later, when the patient transitions into hospice care.
- Pairing a hospice inpatient unit with a palliative care consulting service offers the potential for greater continuity of end-of-life care.
- It may be difficult for a solo physician or physician-led palliative care consulting service to break even on consultant billing alone.
- For HOB, the investment in palliative care development is a way to position the organization in the palliative care continuum and to help ensure that it will have a continuing place in the evolution of end-of-life care in its community.

NEXT STEPS

- Potential next steps for HOB and its hospital partners include:
- Expansion of the palliative care consultation service to patients' homes and employment of an additional physician to expand its capacity.
 - A cardiopulmonary palliative care team, targeting patients who may not be well served by existing hospice and home care services.
 - An additional hospice or palliative care unit.
 - Greater use of care-planning checklists and standing orders for palliative care consultation.
 - Expanded emphasis on education about palliative care for physicians and for the community.
 - A renewed interest in palliative care development at UKCMC, potentially leading to a formal program by the end of 2001.



A Palliative Care Continuum

Evanston/Skokie, IL

MODEL/SUMMARY: In Evanston, a close northern suburb of Chicago, IL, Palliative CareCenter & Hospice of the North Shore has assembled a hospice-based continuum of palliative care services that includes hospice care, home health care, private-duty caregivers, case management and palliative care consultation. A cornerstone of its continuum is a hospice inpatient unit operated by the agency in leased space on the campus of Rush North Shore Medical Center in neighboring Skokie. Collaboration between independent, community-based Palliative CareCenter and the hospital, part of Rush System for Health, centers on the successful inpatient unit but holds the potential for a variety of future partnerships.



COLLABORATORS/SETTING

In the highly competitive metropolitan Chicago healthcare market, there are more than 30 competing hospice providers, and a wave of hospital mergers has created six major hospital systems. One of those is Rush System for Health, based at Rush-Presbyterian-St. Luke's Medical Center, the largest private hospital in Illinois. Rush System for Health has a number of health divisions and hospital partners, including since 1987 Rush North Shore Medical Center (RNSMC) in Skokie. The Rush System has its own hospice program, Rush Hospice Partners, assembled through mergers by its hospitals. But despite its corporate affiliation with the huge tertiary medical center, 268-bed RNSMC operates in many ways like a community hospital. The hospital enjoys a collaborative relationship with independent Palliative CareCenter & Hospice of the North Shore (PCC), located nearby in Evanston.

PCC was founded in 1978 as a volunteer hospice and grant-

ed Medicare certification in 1989. In 1990, it was serving an average daily census of five patients, but it has since grown into a multi-faceted organization that serves an estimated 2,000 patients per year from its various programs, plus another 1,500 families receiving bereavement support. PCC has an annual budget of \$11 million; its hospice program carries an average daily census of 165 patients.

In 1995, the community-based, non-profit organization changed its name from Hospice of the North Shore to Palliative CareCenter of the North Shore – and, more recently, to Palliative CareCenter & Hospice of the North Shore. The changes were made with deliberate intent to establish a broader continuum of palliative care services from the point of diagnosis for patients and families confronting serious, life-challenging or life-threatening illnesses. Within that continuum, the licensed, certified hospice division has a key role as the provider of intensive, end-stage care. Currently, in addition to its hospice and associated bereavement program, PCC offers the following components:

- A licensed, JCAHO-accredited home health agency, which has been somewhat constrained recently by implementation of Medicare's home health prospective payment system.
- A joint venture, through a for-profit subsidiary, with a private-duty home care service called Respite Care, Inc., providing home caregiving staff on a private-pay basis.
- A comprehensive pediatric hospice and palliative care program in collaboration with Children's Memorial Hospital, which includes a contract for inpatient beds at the hospital.
- A kid's bereavement camp and other specialized pediatric services.

- A community outreach program staffed by a registered nurse providing no-cost, phone-based care management services to clients who otherwise might fall through the cracks of reimbursed healthcare services.
- A physician-led palliative care consultation team that operates in hospitals, nursing homes and an outpatient clinic – but primarily in patients' homes – at the request of attending physicians, billing Medicare and other payers for its consults.
- A 15-bed hospice inpatient unit, operated in leased space on the campus of RNSMC.

PCC has contracts with 12 area hospitals, primarily to obtain acute care beds on a scatter-bed basis for its hospice patients in need of general inpatient care. Usually, those referrals follow the hospital affiliation of the patient's attending physician. PCC also contracts with 70 long-term care facilities to provide hospice care to terminally ill residents of those facilities. The hospice has a full-time medical director and nine part-time assistant medical directors. PCC's continuum of services is tied together by an agency philosophy of directing patients who are confronting life-threatening or life-limiting illnesses to the most appropriate setting for their care and then billing for the reimbursement that is available to pay for the care.



WHAT IS THE PROGRAM?

A) HOSPICE INPATIENT UNIT: In July of 1999, RNSMC and PCC opened a collaborative, 15-bed hospice inpatient unit on RNSMC's hospital campus. The origins of this partnership lay in a previous collaboration between PCC and Evanston Hospital, part of the Evanston Northwestern HealthCare system. Starting in 1995, PCC had leased space from Evanston Hospital to operate a 12-bed hospice unit in the hospital. In 1999, Evanston Hospital opted to reclaim its beds for acute care expansion plans, so PCC had to quickly relocate its inpatient unit. The original unit contract

with Evanston Hospital had been painstakingly negotiated over a two-year period. Based on that experience, PCC was able to work out all of the details of reestablishing a unit at RNSMC within eight weeks.

As at Evanston Hospital, RNSMC's acute care beds are mostly full. However, RNSMC had unoccupied space to offer in an adjacent building that was also home to medical offices and a psychiatric treatment facility. PCC and RNSMC shared the expense of refurbishing and converting the floor to a homelike atmosphere. Evanston Hospital and the community also made significant charitable contributions.

The 15-bed hospice unit, currently operating within licensed psychiatric beds, is intended for terminally ill, hospice-appropriate patients. Occupancy on the unit is running more than 80 percent, with frequent waiting lists. The unit admits RNSMC patients who are transferred directly from the hospital at the time they enroll in hospice, patients enrolled on PCC's hospice program who need inpatient care and patients from other local hospices and hospitals, subject to the approval of PCC's hospice medical director. Average length of stay on the hospice unit is nine days, and half of admitted patients die there. The unit, which has numerous homelike amenities, includes clinic space for palliative care consults and is also used for community bereavement and patient support groups.

B) PALLIATIVE CARE CONTINUUM: Staff of PCC emphasizes that by adopting a palliative care philosophy they are not using the term as a substitute or euphemism for hospice care. Palliative care is defined as interdisciplinary care that aims to relieve suffering and improve quality of life at any age, at any stage and in any setting from the point of diagnosis of a life-threatening illness through the end of life and bereavement. While hospice care has a crucial place in the care continuum as the most intensive form of palliative care, palliative support may be needed by patients much earlier in the progression of a life-threatening illness.



Other services are designed to plug specific holes in care delivery, with the aim of meeting more of the needs experienced by patients confronting life-threatening illnesses. Each component operates and receives reimbursement within its own regulatory structure. Within those limits, PCC has attempted to provide a care continuum that is broad enough to meet the palliative care needs of most seriously ill patients.

Palliative care, under PCC's reorganized structure, is the umbrella concept for its service continuum. Access to consultations by the core interdisciplinary palliative care team is the glue that holds the discrete services together – with the team re-evaluating patients' needs and helping to direct them to the most appropriate setting and service to meet their needs. The various programs operate as separate divisions, but with a shared admission department and close inter-departmental communication to achieve a more seamless, integrated continuum of care.



EXPERIENCE OF COLLABORATION

When PCC approached RNSMC administrators in 1999 to explore its urgent need for new inpatient space, the timing was fortuitous, since the hospital had unoccupied licensed psychiatric hospital beds and was considering whether to return the bed licenses to the state. The hospital's president met with his senior management team to determine if there was a consensus for collaborating with PCC on a leased hospice unit. Having reached a consensus, the institution committed itself to working out details of the transition as quickly as possible. RNSMC contributed more than \$300,000 in financial and in-kind support toward opening the hospice unit. With hospital space at a premium and other departments having space needs of their own, making 10,000 square feet available to PCC demonstrated a genuine commitment to the collaboration by RNSMC. Another sign of that institutional commitment is the respective partners' ability to resolve problems quickly when they arise.

Previously, the hospital had established a task force to explore palliative care development on its own, and members of that task

force visited other hospice and palliative care units. Ultimately, RNSMC concluded that it would be easier, less costly and more "professional" to work with an established hospice/palliative care partner, rather than trying to create the expertise from within. Already, according to the hospital's chair of internal medicine, there are signs that physicians within the hospital are observing and learning from the palliative medicine practiced by PCC on its hospice inpatient unit, for example, in terms of drugs and dosages used for managing symptoms.

The hospital also reports that in the year following the simultaneous openings of the hospice unit and a skilled nursing unit on its campus, overall length of stay for all hospitalized patients went down one-half day. In a context of limited acute care beds, having the hospice unit nearby provides an outlet for transferring terminally ill patients who may be dying imminently but are not candidates for discharge. PCC also collaborates with the hospital's pain center.

Despite the stresses of having to move its inpatient unit on short notice, PCC has maintained good relations with Evanston Hospital. Referrals to PCC's hospice unit at RNSMC come from Evanston Hospital's physicians and its hospice program, from Rush Hospice Partners for its patients who live in the North Shore area and from nine other area hospitals.



LEADERSHIP AND CHAMPIONS

PCC has had the same chief executive since 1990 and the same medical director since 1989. The medical director, who at one time was chief resident in internal medicine at Evanston Hospital and is a nationally prominent leader in hospice and palliative medicine, has played a key leadership role in the hospital collaboration.

RNSMC's current president and its chair of medicine both have been instrumental in advancing the partnership. In opening the hospice unit with such a short turnaround, PCC also enjoyed the support of the hospital's facility director and other senior staff, the chair of the hospital's Board of Directors, the construction crew and leaders in the community, including the Mayor of Skokie.



EDUCATION AND RESEARCH

Plans are being finalized for rotating Rush internal medicine residents through a clinical experience on the hospice unit at RNSMC, and discussions are underway with several area hospitals about establishing a palliative care residency. PCC is also a participating site in the MediCaring Demonstration Project sponsored by RAND Center to Improve Care of the Dying, and plans to launch a palliative care fellowship in July 2001 with significant financial support from RNSMC.



FINANCIAL ISSUES

For RNSMC, the hospice unit generates rent "at the going rate" for a mixed-use facility. PCC also pays the hospital for meals, floor stock and supplies, equipment repair, telephone usage, pharmacy, laboratory, rehabilitation, respiratory, laundry, housekeeping and other ancillary services. The greatest cost of operating the unit is for staff salaries. In the first nine months of 2000, 63 percent of PCC's total cost of operating the leased inpatient unit went to employee salaries, benefits and other staffing expenses.

Converting the space to a homelike 15-bed unit cost a total of \$843,000, although that figure reflects the deteriorated condition of the long-unoccupied physical plant, the need to finish the work on a very short timeline, unit operating costs during the transition and a desire to create a state-of-the art facility. RNSMC contributed \$334,000 in build-out costs.

PCC's palliative care consultation service, which utilizes its medical director, an assistant medical director, a nurse manager and a licensed social worker (with plans to add a nurse practitioner), was established in 1999 with \$85,000 in donated start-up costs. Currently, the service is not breaking even, although PCC believes that it is a valuable addition to the palliative care continuum, an important entry point for access to other services and an opportunity for the agency to fulfill its mission of service to the community.

Budget projections for the service for 2001 anticipate \$131,724 in consultation revenues and total expenses of \$180,211, for a net loss of \$48,467. The agency believes that the deficit for the consultation service can be reduced and eventually reach a break-even point. Keys to achieving that goal include the acquisition of more billing experience, the addition of a nurse practitioner who can bill for consultations, the provision of additional administrative support, exploration of previously untapped opportunities for reimbursement from managed care organizations and tightening the gap between services provided and consults billed.

As for the other components of PCC's palliative care continuum, the private duty service is showing a profit and has grown to more than \$2 million in annual gross revenues. The care management program, which is not reimbursed, currently costs \$45,000 per year. The hospice program currently represents nearly two-thirds of PCC's total operating budget, not counting the for-profit subsidiary, and projects a budgeted surplus on operations for 2001. Home health care, operating under the new Medicare prospective payment system, projects a deficit on operating expenses for 2001.



CHALLENGES OF IMPLEMENTATION

- PCC's Medicare hospice reimbursement rates were cut in 2000 by a net amount of 2.5 percent – even counting an annual cost-of-living increase – through the annual adjustment of the regional wage component of Medicare's rates.
- PCC was challenged to move its established, well-functioning hospice inpatient unit on very short notice, while the high cost of local real estate and high occupancy rates at area hospitals limited the available options.
- The complexities of different reimbursement systems for patients with palliative care needs have fully challenged PCC's management capacity. The financial implications for the overall organization from various pilot programs within its continuum have been difficult to project.
- The organization has consolidated a large number of organizational changes and new programs in recent years, accompanied

by the need for internal staff education and cross training.



KEYS TO SUCCESS

- A shared vision of palliative care by PCC's senior management and medical leadership.
- PCC's independence, reputation and high profile in the community.
- A high degree of mutual respect between RNSMC and PCC.

- A close working relationship with the Illinois Department of Health and the department's commitment to the success of the inpatient unit at RNSMC.
- The hospice unit's location on the hospital's campus but outside of the main hospital building, allowing it to draw upon hospital resources such as the surgery and emergency departments while simultaneously creating an identity as a community resource.
- PCC's active role on advocacy on the local, state and national levels, including extensive dialogue with regulators and fiscal intermediaries.

PCC SERVICE STATISTICS 2000

Hospice patients	1,189
Inpatient unit admissions	466
Average length of stay, hospice care	49 days (median: 11 days)
Average length of stay, hospice unit	9 days
Home health care patients	424
- Visits	7,363
Bereavement clients	1,473
- Adults	1,200
- Families with children	273
Pediatric clients	21
Community pediatric consults	15
Average daily census:	
- Hospice	165 (200 in 2001)
- Home health care	70
- Community outreach	250 (active cases)
- Bereavement	700 (ongoing)
- HomeCare assistants	60 (per month)
- Palliative care consults	50 (per month)
- Care Center for Kids	30 (per year)
Palliative care consultation visits in 2000	480
- Nurse	160
- Physician	240
- Social worker	73



LESSONS LEARNED

- Hospital culture can be influenced by a strong daily presence for hospice and palliative care through interacting with nurses and other staff, daily rounding and informal consultations.
- Hospice inpatient units can be almost as service-intensive as intensive care units when measured in terms of the frequency of medication adjustments and other changes in the plan of care.
- If the hospice program is going to invest in renovating and establishing an inpatient unit within a leased hospital setting, it should obtain contractual assurances that the lease will not be arbitrarily withdrawn.
- If acute care beds are at a premium, it may be advisable to consider beds that are licensed at a different level of care. For PCC, having its inpatient beds licensed as psychiatric hospital beds has presented no significant downsides.
- When first introduced, palliative care services may not be as well understood or appropriately utilized as hospice care, which is a more familiar concept for health professionals.
- Hospice care and palliative home care are distinct, differently regulated programs, optimally operating independently from, rather than subordinately to, one another. (For example, at PCC, both divisions report independently to the agency's vice president of clinical services.)
- Reimbursement is available for a range of palliative care services in a variety of settings, but the provider of a palliative care continuum is challenged to efficiently tap those sources.
- Some terminally ill patients may never be able to accept the hospice concept, but if a functioning continuum of palliative care is in place, patients can still be directed to an appropriate level of care for their needs.



NEXT STEPS

- PCC is busy planning a number of potential next steps in solidifying and advancing its continuum of palliative care services – some in collaboration with RNSMC – including the following:
- Participation with RNSMC in the MediCaring pilot study for patients with chronic-obstructive pulmonary disease and congestive heart failure.
 - Implementing a palliative medicine fellowship, exploring a palliative care residency program with area hospitals and participating in hospice rotations at RNSMC for internal medicine residents.
 - Establishing PCC's palliative care team as a core service in a planned new cancer center on the RNSMC campus.
 - Growth for the palliative care consultation service (building on a significant increase in physician visits during the first two months of 2001), with further outreach targeting cardiovascular, orthopedic and dementia patients.
 - Establishing a non-Medicare, home-care-licensed division to provide private-pay professional services in the home without the constraints of Medicare's home healthcare regulations.
 - Exploring the ramifications of developing an incorporated physician practice model.
 - Further extending community outreach, care management and palliative care clinic consultations to assisted living facilities and continuing-care retirement communities.
 - Expanding PCC's infrastructure (office space, information technology, website, corporate endowment, etc.), perhaps through a capital campaign.
 - Participation in exploration of a collaborative, multi-specialty geriatric outpatient clinic on RNSMC's campus.
 - RNSMC might further explore the creation of a hospital palliative care unit separate from the hospice unit.



A Hybrid Joint Venture

Greensboro, NC

MODEL/SUMMARY: Community-based Hospice and Palliative Care of Greensboro in Greensboro, NC, enjoys a partnering relationship with local community hospital Moses Cone Memorial Hospital and the hospital's parent Moses Cone Health System, the only hospital system in Greensboro. Their hybrid joint venture arrangement offers the agency many of the benefits of affiliation with the larger system while preserving its independence and community base. In addition to their close relationship on governance issues, the two partners also collaborate on a hospice inpatient unit located in Moses Cone Hospital. More recently, the hospice agency has launched a multifaceted, grant-funded palliative care project, which ultimately aims to introduce palliative care consultation throughout the health system's hospitals and long-term care facilities.



COLLABORATORS/SETTING

Greensboro is a city of 185,000 people in a county of 300,000 in north-central North Carolina. The Moses Cone Health System (MCHS) was created in 1997 through the merger of Moses Cone Memorial Hospital (547 beds) and Wesley Long Community Hospital (309 beds), both in Greensboro. The combined system also includes the Women's Hospital of Greensboro (115 beds), as well as a behavioral health facility, long-term care facilities and a regional cancer center. Approximately 1,000 patients die each year in the system's hospitals, which currently operate at close to capacity.

The system has no acute care competitors located in Greensboro, although it does compete with academic medical centers in nearby cities. MCHS is still finalizing the consolidation of services from its 1997 merger and is also

pursuing a construction project to expand and relocate its regional cancer center from Moses Cone Hospital to Wesley Long Hospital.

Hospice and Palliative Care of Greensboro (HPCG) initiated patient services in 1982 as Hospice at Greensboro. The agency changed its name in 2000 to reflect its vision and commitment to expanding access for end-of-life care. In addition to its Medicare-certified, home-based hospice services, the agency operates three specialty programs:

1. Beacon Place, opened in 1996, as a freestanding, HIV-priority hospice facility with half of its 12 beds set aside for inpatient-level care and the other half for longer-term residential hospice care.
2. Kids Path, a program of hospice, home care and grief support for children coping with illness or loss and Kids Path Center, a child-focused counseling space.
3. Counseling and Education Center, which offers community-focused grief support for the families of hospice patients and for others who have experienced loss, including support groups, counseling, a lending library, a correspondence program, a workplace program and community education and outreach.

In 1984, Hospice at Greensboro and Moses Cone Hospital entered into a joint venture under which the hospital made a one-time equity investment in the hospice agency equal to the nonprofit hospice's assets at the time. The purpose for the hospital's investment was as a community donation to strengthen the quality of hospice care in Greensboro. Under a revision in HPCG's bylaws, the hospital became the "institutional member" of the nonprofit hospice corporation, which also has individual members from the community, and its existing Board of Directors was replaced

by a new board of 12 members, half selected by the hospital and half representing the community. If HPCG were to disincorporate, the hospital's half-share investment would revert to MCHS.

The joint venture thus created a hospice organization that remains independently incorporated but with a significant fiduciary role for the hospital (now the health system) in its governance. MCHS representatives on the hospice board have included senior administrators, physician leaders and hospital trustees, while inter-relationships between the two organizations on a variety of other levels have also flourished. HPCG enjoys advantages from the partnership such as access to the hospitals' group purchasing, employee benefits and other resources, while retaining its independence for community fund-raising and program development – an arrangement it characterizes as the best of both worlds.



WHAT IS THE PROGRAM?

A) HOSPICE INPATIENT UNIT: A major focus for collaboration between HPCG and MCHS has been an inpatient hospice and palliative care unit, opened in 1987 by Moses Cone Hospital at the hospice's request. Initially six beds and now 10, the hospice unit is managed and staffed by the hospital. It admits hospice patients (from HPCG and other nearby hospice programs) in need of general inpatient care, as well as other hospitalized patients who are not enrolled in hospice care but have palliative, end-of-life needs. Until recently, the beds were licensed as acute (4) and hospice inpatient (6), but the hospital changed the designation of all 10 to general acute, in order to increase the unit's flexibility in caring for both hospice and palliative care patients.

In the past, HPCG assigned a liaison nurse to the hospice unit while hospice team members regularly visited the unit to direct the care of their hospitalized patients. A new palliative care initiative, described below, proposes to increase HPCG's clinical involvement in day-to-day

operations of the hospice unit through the creation of a core interdisciplinary team stationed at the hospital.

B) PROJECT TO IMPROVE CARE AT THE END OF LIFE: In 1998, HPCG launched a new palliative care initiative with three-year funding of \$485,000 from the Duke Endowment and the Moses Cone Wesley Long Community Health Foundation. The purpose of the Project to Improve Care at the End of Life was to study access to end-of-life care and develop new ways of caring for dying patients, with an emphasis on hospice and palliative care development in partnering MCHS hospitals. The project aims to take greater advantage of the Medicare Hospice Benefit for hospitalized patients while simultaneously reaching beyond the benefit's coverage limits for patients who might not be eligible for hospice care but experience the need for palliative, end-of-life care. There are four major components:

1. *Research:* using consumer focus groups and in-depth after-death interviews developed by the Missoula Demonstration Project to assess quality and satisfaction for end-of-life care in Greensboro and establish a baseline for future studies.
2. *Professional Education:* including a "dinner and dialogue" presentation on end-of-life care for opinion leaders in the health system; local presentations of the EPEC (Education for Physicians on End-of-Life Care) training; a specially designed course for local health professionals on communicating with dying patients; and a professional conference in May 2001.
3. *Public Engagement:* using a hospice speaker's bureau and building on outreach opportunities created by the 2000 PBS series, "On Our Own Terms: Moyers on Dying."
4. *Program Development:* including:
 - a) A palliative home care service in collaboration with Advanced Home Care, a regional home health agency. The home health agency uses an OASIS-based screening tool to objectively identify patients with advanced disease who need expert palliative care to address symptom management, psychosocial and life-transi-



tion issues. Palliative care is provided by staff from HPCG on a subcontracting basis under the home health agency's license and certification.

- b) A fee-for-service consultation and case management service called Transitions & Life Choices (TLC), offered to the public and designed to support people who are confronting life-limiting illnesses in making important life-transition decisions.
- c) A hospital rapid response team.
- d) A palliative care consultation service.

The project's director is a physician who is also trained as a social worker. Formerly on the internal medicine teaching faculty at Moses Cone Hospital, she concurrently serves as HPCG's associate medical director and as medical director for its Beacon Place residence. Originally, HPCG's role in the initiative was conceived more as change agent and catalyst for the hospitals to expand their involvement in palliative care. However, competing issues for the hospitals, such as the need to consolidate their merger, created a vacuum for HPCG to assume a larger direct role in inpatient palliative program development.

A major focus for the project is establishing a core palliative care team based within MCHS hospitals, composed of a nurse coordinator, a social worker and a part-time nurse practitioner from HPCG's staff along with volunteer and bereavement support from

HPCG, chaplaincy services from MCHS and medical leadership from the project's director. HPCG's palliative care team will increase its presence on the hospice inpatient unit at Moses Cone Hospital for pain and symptom management, psychosocial-spiritual care and staff support – with the project physician becoming more accessible to inpatient staff as the unit's medical advisor. A planned palliative care consultation service will also be piloted on the hospice unit.

C) HOSPITAL-BASED INTERDISCIPLINARY TEAM (PHASE I OF HOSPITAL EXPANSION): According to HPCG data, approximately 200 patients a year are referred for its hospice services but never admitted because they die soon thereafter without leaving the hospital. A key component of HPCG's palliative care initiative is an interdisciplinary team based at the hospital that can quickly respond to referrals and directly enroll terminally ill patients onto the Medicare Hospice Benefit while they are still in the hospital – either in the hospice unit or, if that is full, in the beds they currently occupy.

In order to implement this venture in 2001, HPCG and MCHS renegotiated their contract governing inpatient care for hospice patients. Implementation required streamlining admissions, discharges and other paper processes, developing a communication strategy within the hospital and expanding the role of HPCG's core hospital team in managing the care of newly admitted hospice patients while they are in the hospital, whether they are transferred to the hospice unit or remain in their current beds. The team was launched in 2001.

The intentional policy decision by HPCG to increase access to hospice care by direct admission of terminally ill hospitalized patients to hospice beds is expected to reduce average length of stay in the hospice program, because it will increase the number of patients who are admitted very close to death. It will also increase the percentage of HPCG's overall days of care that are provided in the inpatient setting, although that is not expected to jeopardize the hospice's compliance with the Medicare rule that inpatient hospice care can comprise only 20 percent of a hospice's total days of care. Currently, only six percent of HPCG's total days of hospice

care are inpatient, giving it considerable leeway to expand in the inpatient arena. (Hospice patients receiving a general inpatient level of care must present a documented need for inpatient care in order to qualify for coverage at that level.)

D) PALLIATIVE CARE CONSULTATION SERVICE (PHASE II OF HOSPITAL EXPANSION): The final component of the Project to Improve Care at the End of Life, an interdisciplinary palliative care consultation service, is still in the conceptual stages and will be rolled out on a limited basis in the fall of 2001. The consulting service will be piloted on the hospice inpatient unit, making its expertise available to nurses on the unit while the team develops procedures, methodologies and standing orders for use in the rest of the hospital system. Referrals will be accepted from attending physicians, and the palliative care team will not assume primary care responsibilities but will bill for its professional consultation services.

For HPCG to implement an interdisciplinary palliative care consultation service throughout the hospitals and nursing homes of the MCHS system, it will need grant funding for the first year of operation, until the number of billed consults is adequate to make the program self-sufficient. Budget projections have not yet been set. Eventually, HPCG hopes to incorporate palliative care into the responsibilities of the pain nurse specialists currently assigned to each unit of MCHS hospitals. That way, its consultation service could be coordinated with their activities.



EXPERIENCE OF COLLABORATION

MCHC administrators emphasize that their partnership with HPCG reflects an overall system culture that is open to partnering and collaborating with specialty providers. The system also partners with a regional home health agency, among others.

Because of hospital administrators' involvement on HPCG's Board of Directors, they are often able to identify opportunities for further collaboration and openings for sharing HPCG's end-of-life care messages. When the system's regional cancer center moves

from Moses Cone Hospital to its new home at Wesley Long Hospital, the hospice inpatient unit will also move to new, upgraded facilities. HPCG's palliative care team will also have a designated place as a core service in the outpatient cancer center.



LEADERSHIP AND CHAMPIONS

As noted above, key administrative, physician and volunteer leaders from Moses Cone Hospital and Health System have served on HPCG's Board of Directors – including its current executive vice president, who was president of the hospice board from 1997 to 1999. Board members have served at different times on behalf of both partners.

Day-to-day direction of the hospice unit at Moses Cone Hospital is provided by the nurse manager of the oncology and hospice units. Several different managers have filled this role in the past 14 years, with the tenor of the relationship varying depending on the manager's personal commitment to the hospice unit.

The director of HPCG's Project to Improve Care at the End of Life was on the teaching faculty of the internal medicine residency program at MCHS prior to assuming her current position and also chairs the hospital's Ethics Committee.



EDUCATION AND RESEARCH

The director of HPCG's Project to Improve Care at the End of Life has developed a four-module professional training course, "Communicating with Terminally Ill Patients and Their Families: An Interactive Learning Experience for Healthcare Professionals," which has been offered to staff at MCHS.

The hospice's principal current research activity is its after-death survey project, in collaboration with the Missoula Demonstration Project, which developed the tool. The research will provide HPCG with baseline data for future palliative care development.

HPCG HOSPICE SERVICE STATISTICS 2000

- Patients served: 792
- Average daily patient census, hospice program: 138 (Census reached 150 in December)
- Average daily census, children's program: 25
- Average daily patient census, Beacon Place: 11
- Average length of stay in hospice care: 67 days (median: 34 days)
- Annual budget: \$6.325 million
- Annual community support: \$787,000

HOSPICE INPATIENT UNIT AT MOSES CONE HOSPITAL 2000

Beds: 10
 Admissions per month (average): 37
 Deaths per month: 23
 Other discharges: 14
 Admissions of HPCG patients: 19.5
 Average length of stay on the unit: 7.25 days
 Total patient days (monthly): 262
 Percent of total days by HPCG hospice benefit patients: 54%
 By other area hospice programs' patients: 6%
 Occupancy rate: 86%



FINANCIAL ISSUES

With implementation of its hospital-based interdisciplinary team and the need to assign core staff to manage the program, facilitate direct hospice admissions of hospital patients and step into a more hands-on role in managing the care of hospice patients in the hospital, HPCG realized that it needed to retain a portion of its Medicare per diem inpatient reimbursement to cover such costs. Previously, HPCG had passed through 100 percent of its per diem inpatient reimbursement from Medicare, which still was far less than the hospital's daily charges. HPCG calculated the resources it would need to implement the new hospital-based team and proposed to the hospital – which concurred – that it retain 10 percent of its Medicare inpatient reimbursement (roughly \$44 per patient per day) starting in 2001, while passing through the remaining 90 percent of the Medicare daily rate to the hospital for each day of general inpatient care. Assuming an average daily census of six hospice patients in the hospital, the reserved reimbursement is expected to cover much of the estimated annual cost of \$180,000 for HPCG to establish and staff its new core hospital team.

MCHS administrators say they believe the increased role for hospice and palliative care within their hospitals under the Project to Improve Care at the End of Life will decrease the length of acute hospital stays and offer expanded opportunities to move patients to more appropriate settings and levels of care. However, the system has not done the financial analysis to quantify those assumptions and is not planning to do so, because other financial issues are viewed as more pressing.

HPCG has not yet calculated the costs of implementing an interdisciplinary palliative care consultation service in the three hospitals and two nursing homes of MCHS. It believes that the program could be self-sustaining on billing for Part B consulting services in as few as 12 to 18 months, depending on the actual volume of referrals generated and the respective roles played by the consulting team's physician and nurses. Part of the key to financial self-sufficiency for such a service is to focus the physician's time on making billable visits while using the nurses for follow-up.



CHALLENGES OF IMPLEMENTATION

- Lack of alignment between the financial incentives of the hospital and hospice may lead to differences of opinion. For example, when HPCG proposed its freestanding residential/inpatient facility, Beacon Place, hospital leaders expressed concerns that this new service could compete with their collaborative hospice inpatient unit, although they eventually agreed to support its development.
- The hospital merger focused most of the health system's attention on redefining and consolidating services among its facilities. Other challenges such as the nursing shortage have also diverted the system's attention from its relationship with HPCG and from end-of-life issues generally.
- The hospital and medical culture has a focus on cure. Despite a longstanding relationship with HPCG, inroads into that dominant culture for palliative care philosophy have been slow in coming. Teaching hospital staff to see the value of a palliative care consultation for any seriously ill patient experiencing

- symptom-management or life-transition issues will be a long-term project.
- Mixing hospice and non-hospice patients on the hospice unit at Moses Cone has created misunderstandings with patients and families and conflicts over treatment philosophy.
- HPCG's staff needs an intimate understanding of the hospital's culture. When staff members come into the hospital facility to implement palliative care programming, they may encounter subtle but significant resistance and political minefields.



KEYS TO SUCCESS

- Longevity of the partnership between HPCG and the hospital, and the strength of their relationship, with the hospital's close involvement and investment in the hospice agency's governance but not ownership of it.
- The hospital system's fiscal health and endowment.
- Shared mission, values and orientation to patient care.
- HPCG's strength, independence and favorable reputation in the community, which have enabled it to focus on its mission, successfully raise community donations, advocate on behalf of dying patients and develop new programs.
- Lack of healthcare competition in Greensboro – with only one major hospital system, one hospice provider, one major oncology medical group, etc. – which has made collaboration easier.
- Hard work by both partners in enhancing communication.
- Active physician leadership and involvement in the hospice program, along with a history of collegial relationships with the local medical community.



LESSONS LEARNED

- Being acquired and owned by a hospital partner doesn't necessarily open more doors for a hospice program seeking to innovate in palliative care development. Sometimes an independent hospice can more forcefully advocate for end-of-life issues than one that has been taken over by its hospital partner.

- If HPCG managed the hospice inpatient unit, it could assert more direct control over clinical care on the unit, potentially with fewer communication breakdowns or conflicts in care philosophy. But in Greensboro, because of the historical relationships between the two partners, they have opted to retain the existing collaborative approach.
- HPCG uncovered numerous patients in the hospital who could benefit from hospice care but could only receive it if the hospice program was able to admit and care for them while they were still in the hospital setting.
- As the Project to Improve Care at the End of Life has been implemented, HPCG's hospice patient census has continued to grow.



NEXT STEPS

- A major focus for HPCG in 2001 will be to develop and launch its new palliative care consultation service, which initially will be offered on a few hospital units but eventually system-wide in MCHS hospitals, long-term care facilities and patients' homes.
- The Project to Improve Care at the End of Life has identified additional opportunities for palliative care in the ICU and in the care of patients with congestive heart failure and dementia.
- HPCG plans to streamline its corporate structure and bylaws so that it can be more responsive to future opportunities in palliative care.



Palliative Care on a Larger Scale

New York, NY

MODEL/SUMMARY: In 1997 Beth Israel Medical Center, a major teaching hospital in New York City, launched the country's first full department of pain medicine and palliative care within a tertiary medical center. The department was established with an institutional commitment to become a national model and center for education, research and the provision of a coordinated continuum of palliative care for patients needing symptom relief at any point in the disease trajectory. Beth Israel's pre-existing, hospital-based hospice program has been integrated into this new department. Although the integration required sometimes painful changes by the hospice and its staff, it also opened opportunities to place hospice care within a larger continuum of palliative care and, potentially, to have more influence on the culture of the acute care setting.



COLLABORATORS/SETTING

Beth Israel Medical Center (BIMC) is a 1,368-bed, full-service, tertiary teaching hospital with a main campus on Manhattan's Lower East Side and several other divisions, including Phillips Ambulatory Care Center (home to a comprehensive outpatient cancer center) and two other acute care hospitals in New York City. Reflecting the consolidation of health systems in New York City, BIMC in turn belongs to Continuum Health Partners, an alliance with several other major medical centers in the metropolitan area.

BIMC's Jacob Perlow Hospice, housed on the medical center's main campus, was founded in 1988. The hospice program has a reputation for quality and extensive philanthropic support from the community. The Medicare-certified program, which serves four New York boroughs, has an

average daily census of 110 to 120 patients. Specialty services targeting Alzheimer's patients and the deaf are offered. Jacob Perlow Hospice previously operated a dedicated eight-bed inpatient hospice unit within the hospital, but in 1998 the unit was expanded to 14 beds while its focus was broadened to include palliative care and pain medicine as well as hospice patients.

That expansion followed the creation at BIMC of the country's first Department of Pain Medicine and Palliative Care in September 1997. The department is an ambitious, multifaceted, grant-funded initiative attempting to integrate pain medicine and palliative care into the heart of a major urban medical center. The department is on an equal footing with other medical departments in the hospital and provides national leadership in palliative care.

The origins of the new department lie in the United Hospital Fund's Palliative Care Initiative, which in the mid-1990s awarded grants for planning new palliative care program development to a number of New York City hospitals. The UHF grant enabled BIMC to hire the former co-chair of the Pain and Palliative Care Service at Memorial Sloan-Kettering Cancer Center, also in New York City, to develop and lead the new Department of Pain Medicine and Palliative Care. Initiated with several other major start-up grants, today the department has an annual budget of more than \$10 million and eight attending physicians among a staff of 120. It has four divisions:

1. **THE PAIN DIVISION**, which emphasizes drug and non-drug therapies, rehabilitation, interventional treatments and complementary approaches to treating chronic pain, headaches and pain due to nerve injury.
2. **THE ACUTE PAIN DIVISION**, which offers a consultation

- service for the management of acute, post-operative pain.
3. **THE INSTITUTE FOR EDUCATION AND RESEARCH**, which conducts clinical trials and carries out educational programs for health professionals and the public.
4. **THE PALLIATIVE CARE DIVISION**, which participates in a number of programs:
 - Jacob Perlow Hospice, with a large in-home component.
 - The 14-bed, acute hospice, pain medicine and palliative care unit.
 - An interdisciplinary inpatient consulting team (composed of physicians, advanced practice nurses, a social worker, psychologist, chaplain and others) for assessment and management of patients with palliative care needs in coordination with their primary physicians.
 - An ambulatory pain medicine and palliative care practice in the Phillips Ambulatory Care Center.
 - A drop-in clinic where hospice or palliative care patients receive same-day consultations with department physicians on urgent symptom-management problems.

At the heart of the Palliative Care Division's operation is its weekly staff meeting. The department's attending physicians, fellows, other professional team members, representatives from the inpatient unit, the hospice intake coordinator and others review cases from throughout the division, coordinate services, evaluate patients' changing needs and direct them to the most appropriate level of care, including – when timely – hospice. The team emphasizes continuity of care and relationships with team members as patients move across settings and levels of care.



WHAT IS THE PROGRAM/EXPERIENCE OF COLLABORATION?

Jacob Perlow Hospice, as a program within the Department of Pain Medicine and Palliative Care, has pursued a path of integration with other services in the department. One of

the primary interfaces between the hospice program and the larger department is the pain medicine and palliative care unit on BIMC's main campus. The 14-bed unit serves the inpatient needs of the department, although the largest share of its caseload are Jacob Perlow hospice patients who need general inpatient care. The unit is the setting where hospice, palliative care and pain medicine professionals at BIMC can meet regularly and learn from each other.

When the new department began, its education division planned a five-session educational program on palliative care for staff of the hospice program. In addition to introducing concepts and techniques of palliative care for non-hospice patients, the sessions also provided an opportunity for veteran hospice professionals and new palliative care staff to get to know each other. Other examples of the integration of the hospice program within the palliative care division:

- Physicians and other team members remain involved directly or on a consulting basis when palliative care patients transfer to the hospice benefit.
- Hospice and non-hospice quality improvement activities are jointly reviewed and reported within the department.
- Information from the department is shared in a combined departmental newsletter.

One of the best illustrations of the growing collaboration is the Palliative Care for Advanced Disease (PCAD) pathway, developed as a quality improvement initiative by the department's director of nursing with funding from the New York State Department of Health Quality Measurement. Identifying 12 basic elements of good end-of-life care (drawn from the medical literature on hospice care, palliative care and geriatrics), the pathway was introduced simultaneously in the hospice, oncology and geriatric units of the hospital. However, it has been utilized to its greatest extent by hospice staff.

Although the issues raised by the pathway may have been

routinely addressed in hospice care previously, hospice staff have embraced the document as an opportunity to improve their practice and demonstrate consistent compliance with recognized markers of quality end-of-life care. The project has also generated other spin-offs in the hospital, such as a memorial service for deceased patients on the oncology unit and an interest in developing bereavement support services throughout the hospital – both of which can draw upon the expertise of Jacob Perlow Hospice.



LEADERSHIP/CHAMPIONS

Jacob Perlow Hospice has long enjoyed the support of senior administrators at BIMC, including a former CEO who volunteered to make omelets for Sunday brunch on the hospice unit, reflecting its emotional appeal for donors and the community. However, such support did not always translate into momentum for reshaping the medical culture within the hospital – until the new department came along and offered the hospice program a wedge into the system.

The hospital's current chief medical officer chaired the hospice's corporate advisory committee until turning that responsibility over to the chair of the Department of Pain Medicine and Palliative Medicine. The department chair sits at the table with other senior

JACOB PERLOW HOSPICE SERVICE STATISTICS

Annual budget, 2001 (including 8 inpatient beds): \$9.2 million

Average daily census: 110-120 patients

Average length of stay, hospice: 54 days (median 24)

Patient demographics: white 54%; non-white 46%

Living alone: 46%

Aged 65 years and above: 68%

Diagnosis: cancer 74%; non-cancer 26%

administrators and department heads within the medical center, and thus is able to advocate for hospice and palliative care within the system. He also serves as Jacob Perlow Hospice's medical director.



EDUCATION AND RESEARCH

The Department of Pain Medicine and Palliative Care at BIMC has a strong commitment to research and education, reflected in its Institute for Education and Research. In addition to the palliative care training for hospice staff and the PCAD initiative described above, other education and research initiatives have included:

- A six-session course containing a core curriculum in pain medicine and palliative care, which was offered to BIMC medical staff for the first time shortly after the department opened.
- A parallel course on palliative care for other health professionals in the hospital.
- Provision of education for the public and health professionals on the Internet at www.StopPain.org, with resources such as a downloadable pain audio library, online conferences and highlights from past conferences put on by the department.
- A family caregiver program, including publication of a caregiver manual and a caregiver resource directory.
- A palliative care manual for professionals.
- Specialized programs addressing issues such as illness-related fatigue and sexual health and rehabilitation.
- "Chairman's Rounds," sharing the department chair's expertise in palliative medicine.
- Clinical trials on analgesics, treatments for symptoms other than pain and quality of life, among other topics.
- Hosting local, national and international symposia and conferences on topics such as geriatric palliative care, pain and chemical dependency and research in palliative care.
- In addition to full-year fellowships in medicine, nursing and social work and one-month electives for residents, the department offers observership/preceptorship opportunities, which brought 207 physicians to BIMC in 1999.



FINANCIAL ISSUES

The department at BIMC has enjoyed extraordinary grant funding and other support for its ambitious model programs and projects. Many of its physicians are involved in funded research or are recipients of other "soft" money, including clinical trials, fellowships and drug company sponsorships. A majority of the department's budget is contained in the hospice program, which benefits from a predictable reimbursement source. Among the department's physicians, pain medicine generates a larger share of physician revenues. Until recently, BIMC had trouble estimating actual reimbursement income for the department as a whole or accurately allocating income and expenses, but finance staff in the department and a new contract billing service have been working to give the department a more comprehensive accounting picture.

BIMC's administration has shown a willingness to support the department for its collateral benefits, such as increased visibility and positive publicity for the medical center, increased philanthropy and community support and the attraction of new patients who might then utilize other hospital services. Eventually, however, like any hospital department, it will need to find ways to better match costs with billing revenues.



CHALLENGES OF IMPLEMENTATION

- Merging the cultures of hospice, palliative care and pain management on the inpatient unit has been a difficult transition for nurses from the formerly autonomous hospice program.
- Hospice staff are learning new skills and techniques in palliative medicine as well as maintaining certification in cardiopulmonary resuscitation and the use of "crash carts" on the inpatient unit.
- Meeting the end-of-life needs of New York's culturally diverse population, including patients who live alone or in marginal home situations, or have other special needs, is an ongoing challenge.

- Barriers imposed by hospice regulations and reimbursement, by traditional hospice attitudes toward which treatments appropriately belong in palliative care and by negative attitudes toward hospice from some in the medical center have sometimes inhibited the appropriate utilization of hospice care.
- Sometimes palliative care professionals may overemphasize the barriers and structural problems of hospice coverage while failing to recognize the potential advantages offered by the Medicare Hospice Benefit.
- Palliative care billing faces significant hurdles, but the department eventually will need to become more self-sustaining on billing income.



KEYS TO SUCCESS

- Respect by hospice and palliative care professionals for each other's unique knowledge and expertise.
- Flexibility and a willingness to experiment.
- A commitment by professionals in the department to put the patient's well-being first.
- Commitment to a truly interdisciplinary approach to care.
- Support for the new department from the hospital's administration.
- Unique skills and knowledge base of departmental leadership.
- Commitment by the hospice program's leadership to a sometimes painful process of integration.



LESSONS LEARNED

- Palliative care training and the demands of providing care on a mixed inpatient unit have expanded the skill sets of hospice and palliative care nurses.
- Both hospice and palliative care partners have much to learn from each other. Hospice professionals can learn about new interventional treatments of palliative care and relevant research. Their palliative care partners can learn about interdisciplinary teamwork, family and caregiver needs, bereavement

follow-up and an inclusive approach to the needs of patients and families.

- Ultimately, the measure of the new department's impact on the medical culture at BIMC will be seen in increased referrals overall for palliative care – although department staff believes it may take years to achieve.
- A major medical center can provide a setting for a hospice program to interface more directly with conventional medical care, encourage end-of-life dialogue and more appropriate referrals and begin to influence the overall medical culture of the institution.



NEXT STEPS

- Further work on outcomes measurement and quality improvement in palliative care.
- Expanding existing Web-based education and information sharing at www.StopPain.org.
- Increased focus on the needs of family caregivers and developing a caregiver screening tool for earlier identification of those at risk.
- Expanding home-based presence and continuity of care in partnership with existing home healthcare providers.
- Expanded emphasis by Jacob Perlow Hospice on reaching underserved populations, including minority groups and patients with non-cancer diagnoses.



A Research and Planning Group for Palliative Care

Sacramento, CA

MODEL/SUMMARY: A research and planning group within the health system and teaching hospital affiliated with the University of California-Davis Medical School has been experimenting with grant-funded projects targeting narrowly defined populations in order to advance palliative care concepts within the system. The health system's long-established hospice program has provided both a setting for clinical skill development in palliative care and an historical base for end-of-life experience, but often is not directly involved in the palliative care research initiatives.



COLLABORATORS/SETTING

The campus of the University of California-Davis Medical Center, located in nearby Sacramento, contains a 528-bed teaching hospital, Shriners' Hospital, an outpatient cancer center, other clinics and outpatient services and research facilities, all part of the integrated UC-Davis Health System (UCDHS), which is closely coordinated with the university's medical school.

The UCDHS hospice program, administratively part of the system's home health agency, has been an integral component of this care continuum. Home health and hospice report to the health system's associate director of hospitals and clinics. The UCDHS hospice program was launched in 1982 and has grown to a current average daily census of 60 to 70 patients within the competitive greater Sacramento hospice market. Average length of stay in the hospice program is 50 days (median: 29 days).

The program is one of only a handful of university teaching hospital-based hospices nationwide. Historically, it has been more open than some hospices to providing its patients

with treatments that might be considered "aggressive." It was also Sacramento's primary provider of hospice care for people with AIDS. The hospice interfaces with other departments in the medical center and provides an arena for education and research and a setting for clinical placements, rotations and observations.

Palliative care development at UCDHS is largely the work of an informal group of educators, clinicians and researchers, many of them experienced in hospice, oncology and/or AIDS care. This group has come together to pursue grant-funded opportunities for palliative care initiatives that draw upon their historical relationships with the hospice program. The hospice program, while providing a core clinical structure for palliative care, is not always directly involved in the grant-funded projects, which tend to focus on discrete underserved populations.

The planning group's intent has been to use those narrowly focused initiatives to introduce palliative care into the institution and create strategic opportunities for integrating palliative concepts into the medical center's overall care delivery system. UCD has not established a system-wide palliative care program or service, although the palliative care planning group is able to exert its influence within the institution in various ways. Nor has the medical center established a designated hospice or palliative care inpatient unit, although that possibility has been discussed and likely will be revisited in the future.



WHAT IS THE PROGRAM?

Palliative care projects at UC-Davis have taken place primarily under the umbrella of the West Coast Center for



Palliative Education and Research (WCCPER). The center was created at UCD in 1994 with a grant from the National Cancer Institute (NCI) to develop palliative education models targeting rural health practitioners. The NCI grant was awarded jointly to UCDHS's cancer center and the hospice program, and WCCPER's educational efforts have continued beyond the completion of the grant.

The center offers brief, intensive palliative care trainings at UCDHS, lasting three days to four weeks, for health professionals and students. Presented four times in 2000, the trainings incorporate didactic and experiential learning, including clinical placements in the hospice program. Other modules of WCCPER's educational programming include a model training program for palliative care in correctional facilities and intensive off-site trainings for rural medical providers, emphasizing skill building and held several times a year.

A second key grant was awarded to WCCPER by The Robert Wood Johnson Foundation's Promoting Excellence in End-of-Life Care program in 1998. Focused on extending palliative care access to underserved populations, the project has three main components:

1. Palliative care training for healthcare providers in three rural communities in Northern California, supported by UCDHS's telemedicine program.
2. A corrections-based project in the Central California Women's Facility in Chowchilla, building on the UCD hospice program's previous outreach and support for a volunteer hospice program at the California Medical Facility Prison in Vacaville, CA.
3. Simultaneous Care, which brings supportive, home-based palliative care to patients who are enrolled in Phase I or Phase II investigational cancer clinical trials.

The third of these projects is the most relevant to hospital-hospice partnerships. It offers hospice-like support to a patient population that is known to resist hospice referrals, based on its pursuit of experimental treatments. Simultaneous Care is delivered in the home by a nurse and a social worker, who help manage the side

effects of the experimental treatments, follow the patient on clinic visits and reinforce information provided by clinic staff. It offers comprehensive symptom management while encouraging advance care planning with the motto "Hope for the best, plan for the worst." A comparative control group, also enrolled in cancer clinical trials, receives usual care but not Simultaneous Care.

The hospice program does not participate directly in Simultaneous Care, although the two staffs have close working relationships. Some participants eventually may opt for hospice care, with the Simultaneous Care team helping to facilitate the transition. But the project is not "pre-hospice" and does not promote hospice referrals. It is exploring perceived incompatibilities among experimental protocols, palliative care and hospice care. It is testing the hypothesis that the provision of Simultaneous Care will result in fewer emergency room visits or unplanned hospitalizations, improved functional status and quality of life for the patient and a greater likelihood of completing the clinical trial. Although it is too soon to say whether the data will bear out the researchers' hypotheses, positive preliminary results have encouraged the palliative care group to consider seeking additional partnering sites and funding for a multi-site national research collaborative.

Through implementation of projects such as Simultaneous Care and a series of National Institute of Aging-funded behavioral research grants, an administrative core of instructors, clinicians and researchers has joined forces under the WCCPER umbrella to promote further palliative care development at UCDHS. The group meets weekly, as well as at an annual retreat, for planning, coordination and exploration of new research opportunities. It also networks nationally with other academic cancer centers that have palliative care initiatives.



LEADERSHIP/CHAMPIONS

The medical director of UCDHS's hospice is also chair of the Department of Internal Medicine for the health system, a position that also has reporting relationships to the hospital and the medical

school. The significant teaching responsibilities inherent in the chair's position have enabled him to exert influence on behalf of hospice and palliative care and to serve as the most visible bridge between conventional medicine and hospice and palliative care, as well as advocating for institutional support of Simultaneous Care and other research initiatives.

Another member of the palliative care research team, currently an assistant professor in the Department of Internal Medicine at UCDHS, previously was a social worker for the hospice program. Other members of the team include the administrative director of WCCPER, a sociologist, an ethicist, the hospital's associate director of nursing, who played a lead role in implementing "Pain as a Fifth Vital Sign" within the facility, and researchers from the Center for Health Services Research in Primary Care at UCD. Many of the group's members have prior hospice experience and most carry teaching responsibilities. Two members were recently designated as National Social Work Leaders by the Project on Death in America.

Support from the clinical trials program at UCDCMC and its medical director were also crucial to implementing Simultaneous Care.

SIMULTANEOUS CARE AT UCDCMC

- Patients on Phase I or Phase II solid tumor clinical trials.
- Medical care continues to be directed by their oncologist, while patients make clinic and infusion visits.
- Simultaneous Care team includes a nurse and social worker, who make home visits, and a medical director.
- Services include comprehensive symptom management, psychosocial assessment and intervention and the concurrent introduction of advance treatment planning and palliative care issues.
- Coordination of care is accomplished in a weekly meeting attended by the nurse, social worker and medical director, plus the clinical trials nurse specialist and clinical research associates for all studies that currently have patients enrolled in or under consideration for Simultaneous Care.
- Forty-two enrolled patients have received Simultaneous Care to date, while 19 out-of-area patients have been enrolled as a non-randomized comparison group.
- Both groups fill out questionnaires every 30 days from baseline through six months, using the Functional Assessment of Cancer Therapy-General (FACT-G) and Missoula-VITAS Quality of Life Index instruments.
- Referrals come from UCDHS Cancer Center physicians, nurses, social workers, professional staff, clinical research associates and the clinical trials nurse specialist.



FINANCIAL ISSUES

The palliative care projects pursued by the planning group at UCDHS tend to be grant-supported. The grant for Simultaneous Care covers the cost of research but not of clinical services. Some home nursing and social work visits are reimbursable under home health care, while the rest of the program's clinical costs are covered by charitable donations in support of cancer research and by institutional funds.



CHALLENGES OF IMPLEMENTATION

- Regulatory and reimbursement limitations on hospice and home health providers.
- The initial resistance of some Simultaneous Care enrollees to considering and planning for end-of-life contingencies.
- Identifying quantitative end points for evaluating and improving the quality of end-of-life care.



KEYS TO SUCCESS

- Support of a key leader, the chair of internal medicine within the hospital's structure, who is also the hospice medical director.
- Demonstrating the efficacy and clinical success of palliative care interventions.
- The presence of the hospice program as a core clinical structure of palliative care expertise.



LESSONS LEARNED

- Hospice advocates who are also active in other areas – such as oncology, HIV care or research – tend to get more respect and have wider influence within the medical center than those who only work in hospice settings. Those with hospice experience can help plant the seeds for change within the institution.
- Clinical eligibility criteria for hospice care and for Phase I and II cancer investigational therapies are strikingly similar – challenging conventional thinking about the historical separation of these two approaches.
- The eventual dissemination of palliative care within the institution may depend in part on changes in reimbursement to specifically cover palliative care.



NEXT STEPS

- Continued pursuit of evidence-based medicine and of new education and research opportunities in palliative care.
- Collaboration with the National Cancer Policy Board and with other palliative care initiatives based in academic cancer centers.
- Exploring models for extending palliative care to chronic diseases.



Two Demonstration Projects and a Community Hospice

San Francisco, CA

MODEL/SUMMARY: In the medical center on the campus of the University of California-San Francisco School of Medicine, two recent demonstration projects are introducing palliative care in the inpatient and outpatient settings. The two projects have close but informal working relationships with Hospice by the Bay, an independent hospice program in the community, but are not planning to formalize their relationships through contracts or a direct clinical role for the hospice.



COLLABORATORS/SETTING

At the University of California-San Francisco (UCSF), 420-bed Moffitt-Long Hospital is an acute care facility at the heart of a huge health sciences education and research complex. UCSF works closely with the city's public hospital and Veterans Affairs Medical Center, while the hospital also belongs to a health system partnership with another San Francisco hospital. Rather than establish its own hospice program, UCSF refers patients in need of hospice care to hospices in the community.

Historically, San Francisco has pioneered the development of community-based residential hospice facilities, spurred by the creation of the "San Francisco Model" of community-based HIV/AIDS services in the 1980s. The city currently is served by four Medicare-certified hospice programs, one based in a large HMO, two affiliated with regional health systems and one independent, community-based, nonprofit: Hospice by the Bay (HBB). HBB has an average daily census of 55 hospice patients and a history of innovative, collaborative relationships with other community-based, end-of-life programs and services in the city.

End-of-life or palliative care development at UCSF centers on two current initiatives, a two-bed inpatient *Comfort Care Suite* for dying patients on the medical floor of Moffitt-Long Hospital and a clinical trial to assess an outpatient clinic-based supportive care service called the *Comprehensive Care Team*. The latter service is intended for patients at "the beginning of the end of life" – in other words, from the point of diagnosis of a life-threatening illness.

For both projects, HBB's executive director and staff have been actively involved in planning and implementation, but largely in informal, advisory roles, not direct service delivery. For example, HBB staff provided an eight-hour training course on end-of-life care issues for the medical floor nurses who would staff the Comfort Care Suite, with another round of training planned for 2001. On the Comprehensive Care Team's successful grant application, HBB was listed as a collaborating organization, with its executive director identified as the "consulting hospice expert."

The Comfort Care Suite's medical director and Comprehensive Care Team's principal investigator both assert that their projects have effective working relationships with HBB, although they are not formalized in contract. Making a referral is as easy as calling HBB, whose phone number they have memorized. The hospice program was instrumental in getting the Comfort Care Suite off the ground and is still involved informally, although less so as the program becomes better established. The Comprehensive Care Team refers patients in need of hospice care to HBB, because of their historical relationship. But hospice care is not a major focus of the project, which aims to apply hospice-like support in a non-hospice setting to a patient population at the beginning of the disease trajectory.

The comparatively small, community-based hospice program, which has survived in an environment of large, integrated health systems, does not possess a great deal of leverage within the UCSF medical center and its acute care environment. HBB provides general inpatient hospice care for its own patients in other settings, primarily skilled nursing facilities, and also collaborates with San Francisco's residential hospice facilities. Its consultation and support for UCSF's palliative care projects has not yet led to a larger role within the institution, although the palliative care leaders at the hospital describe the relationship as a fruitful one.



WHAT IS THE PROGRAM?

A) COMFORT CARE SUITE: The Comfort Care Suite, with up to two beds dedicated to end-of-life care, opened in March 1999 after nine months of planning by a broadly interdisciplinary committee that included representatives from HBB. With the endorsement of the hospital administration, two rooms with sweeping views of the city were remodeled using funds from the administration and from the hospital system's auxiliary organization.

The two beds are part of a 30-bed medical unit in the hospital and care is provided by unit staff, which has received palliative care training. A consulting team, composed of a hospitalist, internists, a geriatrician, nurses, social workers, pharmacists and chaplains, offers additional expertise in palliative care, as needed. Care provided in the two comfort care rooms emphasizes patient comfort, symptom management, attention to psychosocial and spiritual concerns, support for family members and help in clarifying goals of care, typically at the very end of life. Bereavement follow-up is also offered to family survivors in the form of condolence cards, phone calls and an annual group memorial service.

The two beds are not dedicated exclusively to comfort care, but are preferentially available and managed so as to maximize access for dying patients within the mostly full medical center. Referrals have come from every service in the hospital except obstetrics and pediatrics (a separate pediatric Comfort Care Suite is under

development) as well as from outpatient clinics and the emergency room. The beds are acute care beds, and length of stay has been very short, averaging just over two-and-a-half days.

The program was not widely marketed in the hospital in its start-up phase, but word of mouth has generated enough referrals to keep the beds occupied by comfort care patients about half of the time. One-fifth of all patients who died in the hospital since the Comfort Care Suite opened died in one of the two beds. The Comfort Care team serves a consultant role, while patients continue to be followed by their primary medical service. The team's physicians have also begun to provide palliative care consultation in other parts of the hospital, upon request, and to bill third-party payers for the service.

B) COMPREHENSIVE CARE TEAM: The Comprehensive Care Team project, funded by The Robert Wood Johnson Foundation's Promoting Excellence in End-of-Life Care initiative, is designed as a controlled trial testing the provision of comprehensive outpatient care and family caregiver support for seriously ill patients of UCSF's outpatient General Medicine Practice who are at the intersection of curative and comfort care. Recognizing that the transition can be difficult for patients and families, the project aims to offer patients who are newly diagnosed or living with cancer, chronic obstructive pulmonary disease or congestive heart failure some of the same kinds of support that hospice care provides – support that newly diagnosed patients say they want and often do not receive.

Members of the Comprehensive Care Team, which meets weekly, include social workers, pharmacists, chaplains, nurses, physicians and volunteers as well as a medical ethicist, psychologist and clinical artist. The project's principal investigator is an internist, while day-to-day coordination is provided by a social worker. Face-to-face contact with patients primarily occurs in the general medicine outpatient clinic, although team members will make home visits if needed.

The project also includes a monthly support group and support from volunteer patient advocates, as well as an attorney, a

UCSF MOFFITT-LONG HOSPITAL COMFORT CARE SUITE

- What: Two beds on the Medicine floor preferentially set aside for end-of-life care
- Opened March 1999
- Number of patients admitted in first 18 months: 170
- Average length of stay on the unit: 2.61 days
- Percentage of patients admitted to the unit who died there: 77% (12% discharged to SNF; 8% discharged to hospice care)
- Median age of patients: 71 years
- Primary diagnosis: cancer 41%; cardiac 19%; neurologic 18%; pulmonary 6%; other 16%
- Attending service: Medicine 55%; Neurology 13%; Cardiology 10%; other 22%
- Number of different physicians who have referred patients to the Comfort Care Suite: 57
- Source of transfers: All hospital ICUs 33%; emergency department 17%; clinic/home 4%; all other hospital units 46%
- Advance directives: 19% yes
- DNR/DNI: 98% yes

community advisory board and collaboration with a number of other community agencies, including UCSF's Center for Collaborative Innovation in Primary Care and its Art Recovery Program, the Kairos Counseling Center and the San Francisco Zen Hospice. Researchers are testing the intervention's effects on patients' quality of life, symptoms, psychosocial/spiritual well-being, advanced care planning and healthcare utilization, compared with a control group that receives usual medical care.



LEADERSHIP/CHAMPIONS

UCSF is home to a number of nationally recognized leaders in end-of-life care who have lent their support and expertise to the two palliative care initiatives. Leadership for the Comfort Care Suite comes from a hospitalist who is also a Project on Death in America faculty scholar and a national leader in promoting the role of hospitalists in palliative care.



FINANCIAL ISSUES

There is no separate budget for the Comfort Care Suite's consulting team, which primarily provides services on a "volunteer" basis (i.e., on top of its members' other full-time responsibilities within the institution). The team began to successfully bill for palliative care consults within the hospital starting in July 2000, but it faces a Catch-22. More billing volume is needed for the consulting service to be able to start paying salaries, but more committed, paid staff time is needed in order to generate the volume of billable consults to pay the salaries.

Funding from The Robert Wood Johnson Foundation's Promoting Excellence in End-of-Life Care program covers the Comprehensive Care Team's research costs but not clinical services. The project tries to take advantage of patients' usual reimbursement channels, including home health care, and is now evaluating whether billing for physician consulting services would be cost-effective.

The medical center may be willing to continue supporting these two palliative care initiatives, based on the value of the care, the needs of the patient population, the potential benefit of initiating dialogues with patients and families about futile treatments and their relatively small current fiscal demands. However, the programs to date have not yet developed the cost or outcomes data that would justify expanded support from the institution.



CHALLENGES OF IMPLEMENTATION

- Very short lengths of stay in the Comfort Care Suite often preclude other outcomes such as the patient going home with hospice care.
- Lack of space in the usually full hospital has discouraged establishment of a hospice or palliative care unit.
- Inadequate reimbursement specifically for palliative care has constrained the ability to provide palliative care more widely within the institution.
- For the Comprehensive Care Team, a major challenge has been persuading primary care physicians, who are not accustomed to interfacing with such outpatient-based research, to refer their patients.



LESSONS LEARNED

- The Comfort Care Suite has received referrals from 57 different physicians, suggesting that its influence is widely felt within the medical center.
- The Comprehensive Care Team has uncovered significant unmet needs for supportive care among newly diagnosed patients, but without assurance that services to meet those needs could be financially sustainable once the grant-funded demonstration project ends.



NEXT STEPS

- A pediatric Comfort Care Suite in the hospital.
- Comfort care beds on other hospital floors.
- Expanding the inpatient palliative care consultation service.
- Continued collaboration with an ad hoc committee of health professionals interested in palliative care at UCSF, San Francisco General Hospital and the San Francisco Veterans Affairs Medical Center. The committee meets regularly to coordinate teaching, research and clinical care.
- Enhancing bereavement services for the Comfort Care Suite.

- Exploring opportunities for working more closely with HBB.
- Although UCSF has not seriously considered an inpatient palliative care unit, the presence of the two demonstration projects may spark new interest in the idea.
- UCSF and the California Coalition for Compassionate Care – a statewide coalition of 35 healthcare groups formed to improve end-of-life care in the state and funded by The Robert Wood Johnson Foundation’s Community-State Partnerships in End-of-Life Care – recently received a grant to launch the California Hospital Initiative in Palliative Care Services. This new initiative will work with interdisciplinary teams at 40 diverse hospitals from across the state in palliative care development and will identify tools and resources that would be most valuable in such development.

UCSF COMPREHENSIVE CARE TEAM

- What: “A controlled trial of care at the beginning of the end of life”
- Funded for three years by The Robert Wood Johnson Foundation
- Inclusion criteria:
 - Diagnoses: cancer, CHF and COPD (culled from UCSF computerized medical record system)
 - Severity confirmed with objective markers and by primary care clinician
- Exclusion criteria:
 - Currently enrolled in hospice
 - Dementia
 - Delirium
 - Psychosis
 - Age under 18 years
 - Speaker of language other than English, Spanish, Russian, Cantonese, or Mandarin
- Services include:
 - Physical symptom management
 - Psychological, social, spiritual support
 - Support for end-of-life tasks and legal issues
 - Continuity of care
 - Caregiver support
 - Advocacy from volunteer advocates



A Regional Palliative Care Initiative

Lebanon, NH

SUMMARY/MODEL: In recent years, Dartmouth-Hitchcock Medical Center, a teaching hospital in Lebanon, NH, has pursued grant-funded end-of-life care projects that are regional in scope, collaborating with Hospice VNH, a bi-state, home-health-agency-based hospice program headquartered in nearby White River Junction, VT. In January 2001, Dartmouth launched an academic, inpatient and outpatient palliative care consultation service, building on its previous initiatives and having the potential to become an end-of-life care resource for the region.



COLLABORATORS/SETTING

Dartmouth-Hitchcock Medical Center (DHMC) in Lebanon, NH (population 32,000) is a health system composed of Mary Hitchcock Memorial Hospital (429 beds; New Hampshire’s only teaching hospital), the Norris Cotton Cancer Center, Dartmouth Medical School, the Veterans Administration Medical Center in White River Junction, VT, and Dartmouth-Hitchcock Clinic, which operates 30 outpatient sites in the two states. DHMC also participates in a 10-member regional health system called the Dartmouth-Hitchcock Alliance and has a history of supporting regional healthcare initiatives.

The college is home to the Dartmouth Atlas of Health Care, a celebrated national compendium of health data, and was also a research center for SUPPORT (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment), a major national study of care at the end of life. DHMC recently opened the Center for Psycho-oncology Research to conduct research and offer counseling to cancer patients. A 1996 project initiated at DHMC, in collaboration with New Hampshire hospices, used focus

groups around the state to study public attitudes toward the end of life.

Hospice VNH, a program of Visiting Nurse Alliance of Vermont and New Hampshire, a regional home health agency with nine offices, provides Medicare-certified hospice care across significant portions of southeastern Vermont and southern New Hampshire. The hospice program has two geographic teams, each with a part-time medical director, and a combined daily census of more than 50 patients, half of them enrolled on hospice benefits. The other half is served by palliative home care, which offers terminally ill patients pain and symptom management, volunteer support and care oversight from the hospice team and its patient care coordinators. Palliative home care is reimbursed under the Visiting Nurse Alliance’s home health agency license. Hospice VNH offers the community extensive bereavement, patient and caregiver support groups, some of them held on the campus of DHMC, and its hospice volunteers have been called upon to contribute their services in other end-of-life care settings.

The director of Hospice VNH, who has 25 years of experience in the hospice field, played a key role in facilitating DHMC’s successful application for two large grants to fund regional, collaborative palliative care projects based at DHMC’s Norris Cotton Cancer Center:

- I. THE REGIONAL PALLIATIVE CARE INITIATIVE funded in 1997 with \$1.8 million by the local Byrne Foundation for the purpose of creating an institutional infrastructure for sustained, integrated, coordinated palliative care for all patients served by the cancer center in the two-state area.



2. PROJECT ENABLE (EDUCATE, NURTURE, ADVISE, BEFORE LIFE ENDS), funded in 1998 with a three-year, \$450,000 grant from The Robert Wood Johnson Foundation's Promoting Excellence in End-of-Life Care (with matching funds from DHMC).

The overall aim of Project ENABLE was to empower patients and families to take control over their own medical care from the point of a cancer diagnosis. In collaboration with local hospice programs (including Hospice VNH), the project piloted an intervention in three New Hampshire communities to connect cancer patients with a local palliative care coordinator at the time of diagnosis. It also encouraged meaningful dialogue between patients and their primary physicians and recommended that patients attend a series of four educational seminars called "Charting Your Own Course: A Whole Person Approach to Living with Cancer." The curriculum-based seminars were designed to support patients and families living with serious illnesses and to help them navigate the complexities of the healthcare system.

At each of the three sites, a designated palliative care team was formed, including the coordinating advanced practice nurse, a pain management specialist, an oncologist, a psychiatrist or psychologist, a social worker/case manager, a pastoral caregiver and a hospice/home care liaison. The project had a long-term goal of building an academic-community partnership for advancing palliative care in the region. As of early 2001, Project ENABLE had completed the accrual of patients for its grant-funded research study but was continuing to collect data and support those already enrolled in the program. Future offerings of the patient education seminar series were being considered.

Meanwhile, a number of other groups in the two states have been promoting grassroots improvements in end-of-life care and increased access to hospice and palliative care beyond the nexus of Dartmouth's regional initiatives. Two such programs are described in Chapter 12. A partial list of statewide efforts, many of them built around email communication networks, includes:

- The New Hampshire Hospice Organization (with 23 provider

members) and the Hospice and Palliative Care Council of Vermont (with 15 members). Most of those programs are affiliated with VNA home health agencies.

- The New Hampshire Cancer Pain Initiative.
- The New Hampshire Partnership for End-of-Life Care, a statewide alliance of consumer and health-related groups supported by The Robert Wood Johnson Foundation's Community-State Partnerships in End-of-Life Care initiative and based at the New Hampshire Hospital Association. This group is promoting the use of advance directives on the model of a successful initiative in La Crosse, WI.
- The Vermont Ethics Network/Vermont Medical Society Project to Promote Good End-of-Life Care, also known as Vermont ExCEL, a physician-led initiative to improve access to excellent end-of-life care throughout the state. Its efforts include promoting the use of standardized end-of-life care protocols by hospitals and encouraging physician networking on end-of-life issues.
- An informal network of physicians interested in hospice and palliative care has also been formed in New Hampshire.



WHAT IS THE PROGRAM/EXPERIENCE OF COLLABORATION?

The two end-of-life grants awarded to DHMC contributed to a critical mass of palliative care expertise, creating momentum for a comprehensive palliative care program at the medical center. Project ENABLE provided the spark for that development, as well as funding for two advanced practice nurses at DHMC to devote themselves full-time to palliative care skill-building, program development and networking with other community resources. The Byrne Foundation grant provided start-up funding for the palliative care service.

Establishment of a comprehensive palliative care consulting service at DHMC has been a slow and deliberate process, further extended through an unsuccessful, year-long search for a nationally prominent palliative care physician to move to New Hampshire and head up the service. Eventually, the center decided

to hire from within, tapping the head of DHMC's pain service to lead the program and combining palliative care administratively with the pain service. Planning for the palliative care service has also included staff retreats for vision and program building.

The service was piloted on a limited basis in 2000 and formally launched in January 2001, with an immediate and growing demand for consultations. Final institutional approval, to designate the program as a permanent cost center within the system, is still pending but expected soon. The program started in the cancer center but is expanding throughout the medical center, to outpatient settings and into physician education.

The team includes the two advanced practice nurses from Project ENABLE (with plans to hire a third nurse) and five physicians from diverse specialties (anesthesiology, internal medicine, psychiatry, pulmonary medicine, critical care) working closely with area hospices and their medical directors. Weekly palliative care case conferences at Dartmouth include representatives from Hospice VNH (the hospice's director, clinical director and the two patient care coordinators in rotation) and a chaplain, social worker and psychiatric nurse from the hospital. Each physician member of the team rotates in turn through a two-week, full-time block of coverage on the palliative care service, conducting daily rounds in the cancer center and providing on-call availability during the two-week stint. This approach to physician coverage borrows from the model of critical care medicine at DHMC.

The palliative care service's connections with Hospice VNH and other area hospice programs include participation in their interdisciplinary team meetings. Team physicians and nurses also attend a variety of other meetings and activities at other hospice programs, hospitals and home care agencies in the region while seeking ways to enhance and formalize those relationships. Late in 2000, the clinical director of Hospice VNH began a half-time job at DHMC, filling the role of hospice liaison within the medical center and helping to connect the palliative care team and the center with community physicians, hospice programs and home health agencies.

The palliative care service at Dartmouth, with its major grant support, its extensive physician involvement and the medical center's history of regional outreach activities, has the potential to become an important regional resource to other providers in the two states. The service has worked to foster discussion on shared goals and encouraged a collaborative regional perspective on palliative care. Meanwhile, palliative care advocates at other facilities in the region have gone ahead with their own, somewhat more modest versions of palliative care (see also Chapter 12), feeling that they may be able to accomplish more, and more quickly, with limited resources. They have expressed concerns that Dartmouth, with its extensive resources, might try to tell them how palliative care ought to be done in the region. The palliative care program at DHMC is working to dispel such concerns through its emphasis on mutual respect and learning.



LEADERSHIP/CHAMPIONS

Through the implementation of DHMC's grant-funded palliative care projects, the administrators of the medical center and the cancer center have lent public support to the goals of palliative care development. The director of the cancer center, in particular, was a significant booster, while the center's associate director has also been active in advocating and planning for the program. The hospice coordinator at Hospice VNH has been a key advocate for collaborative program development in palliative care based at Dartmouth, while medical directors at hospices in the region have also been active in networking.



EDUCATION/RESEARCH

Monthly palliative care educational seminars are offered to collaborating agencies by Dartmouth's palliative care service. A number of physicians at DHMC met informally as a study group prior to taking the national board certification examination for the American Board of Hospice and Palliative Medicine. The Regional

Palliative Care Initiative launched under the Byrne grant continues to exist under the coordination of the new palliative care service.



FINANCIAL ISSUES

The palliative care consultation service at DHMC has been formally in operation for only a short time. Start-up and initial operating costs are being covered out of the original \$1.8 million grant from the Byrne Foundation, which will enable the program to establish itself within the hospital before having to meet billing targets. The current service includes a total of 1.7 FTEs from the five physician members of the team, plus 1.6 FTEs (expanding to 2.6) for the advanced practice nurses.

Preliminary budget projections suggest an annual cost of \$700,000 for the full program, including administrative support. Based on experience during its first quarter of operation, the service projects potential billing revenues of nearly \$200,000 in 2001. It is thus unlikely that the program will meet expenses from consultant billing alone, so alternative sources of support are needed. Additional funding from the Byrne Foundation is now under discussion.



CHALLENGES OF IMPLEMENTATION

- Effects of the nursing shortage and turnover in clinical staff, particularly at Hospice VNH, which slowed collaborative development.
- Lack of time and staff resources to devote to palliative program development at DHMC.
- An historical lack of continuity of care between the medical center and outpatient settings.
- The very deliberate approach to new program development at DHMC and the slow work of building support for the palliative care concept within the hospital, which necessitated a protracted implementation timetable.



KEYS TO SUCCESS

- The slow pace of program development at DHMC also made it possible to plan more carefully, while major grant funding from a long-time hospice supporter provided the resources for such development.
- DHMC is known for a tradition of multidisciplinary and regionally oriented programs.
- Members of the palliative care consulting service are committed to team building and collaborative problem solving.
- Hospice VNH is committed to working with DHMC and to supporting and collaborating in program development at the medical center.
- The presence of different medical specialties on the palliative care team extends its skill set and holistic approach to palliative care, as well as offering the potential for diverse research projects.



LESSONS LEARNED

- Finding physician leaders within DHMC who understood the need for palliative care and then supporting them in learning the practice of palliative medicine was a more successful approach than trying to bring in an outside expert to head the program.
- Committed nurse leaders have played key roles in getting palliative care established at the medical center.
- Hospice VNH's involvement in palliative care development at DHMC has led to smoother transitions between the hospital and home setting for its patients, while hospice admissions and lengths of stay also increased significantly from 1999 to 2000 (see sidebar box above).
- The palliative care service can play a role in helping to address broader bioethical issues for the institution as a whole and for the community.
- Hospice programs in the two states have emphasized the development of palliative home care services for patients not

HOSPICE VNH SERVICE STATISTICS

	1999	2000	2001/1st Quarter
Total patients served	223	268	107
Hospice benefit	98	151	60
Palliative home care	125	117	47
Average daily census	36	45.6	53.3
Hospice benefit		22	26
Palliative home care		23.6	27.3
Average length of stay (hospice)	60	46	61
Admissions (January-March)	18	34	32

enrolled on the Medicare Hospice Benefit. Such services take different forms, building on the hospice program's affiliation with the local home health agency.

- Developing a designated palliative or hospice care unit at DHMC or a residential hospice facility has been discussed, but is not part of current plans.



NEXT STEPS

- Expanding the reach of the palliative care service and targeting specific populations such as geriatric psychiatry patients and patients with illnesses other than cancer, including Alzheimer's, cardiac, stroke, pulmonary disease and multiple sclerosis.
- Increasing the focus on psychosocial and spiritual aspects of palliative care.
- Expanding consultations into long-term care.
- Expanding partnerships with community hospice programs and reaching out regionally to improve continuity of care.
- Informing the public about palliative care and end-of-life issues.
- One of the medical directors for Hospice VNH plans to do a six-month palliative medicine internship at Northwestern Medical Center in Illinois during 2001 and may then join the palliative care team at DHMC.



Palliative Care Development in Two Hospitals

Burlington/Barre, VT

SUMMARY/MODEL: In the Vermont communities of Burlington and Barre, hospital palliative care services have developed in close cooperation with the local hospice programs. Close personal relationships, more than formal or contractual connections, and a flexible response to unique local environments have been key to these collaborations.



COLLABORATORS/SETTINGS/WHAT ARE THE PROGRAMS?

BURLINGTON: In Burlington (population 50,000 in a metro area of 150,000) in northwestern Vermont, Fletcher Allen Health Care (FAHC), a 620-bed teaching hospital allied with the University of Vermont's medical school, serves a large area that includes northeastern New York State. FAHC has offered an inpatient palliative care consulting service since 1998, primarily provided by a full-time advanced practice nurse who formerly was program coordinator for Hospice of the Champlain Valley, a program of the Burlington-area VNA. Medical direction is provided part-time (20 percent) by a physician who practices internal medicine at FAHC and also serves as the hospice agency's co-medical director.

Those interlocking personal relationships illustrate the close connections between the palliative care service at FAHC and the local hospice program, which serves an average daily census of 50 to 60 patients, two-thirds of them enrolled on hospice benefits. The rest receive palliative home care from hospice staff under the parent home health agency's license. Palliative home care, which also draws upon hospice volunteers and bereavement services, targets patients with life-threatening illnesses who

do not elect or are not eligible for hospice care. The hospice program also contracts for scattered beds at FAHC for hospice general inpatient care and manages Vermont Respite House, a residential facility for terminally ill patients who need long-term residential care.

The spark for palliative care development at FAHC was the arrival of a new head of oncology who took a personal interest in the issue. Planning was conducted by a multidisciplinary group of hospital staff with the initial aim of establishing a palliative care mini-unit of four beds located within the oncology unit. However, trying to operate this mini-unit with beds preferentially but not exclusively available for palliative or end-of-life care has proven to be a challenge. Often there is competition within the facility for the spacious single rooms (converted from doubles), and it has not been possible with the small number of beds to have a significant impact on the overall physical environment of the oncology unit. Nursing staff turnover has also been a problem.

However, the oncology unit is used increasingly for hospitalized patients who need palliative care. Nurses in other units of the hospital have also been inspired by its example to obtain soft lighting and other portable environmental enhancements that can be quickly installed in rooms where patients are known to be dying.

Eventually, the palliative care planning group at FAHC hopes to revisit the issue of a designated palliative care unit in the context of a new hospital building. In the meantime, its attention has focused on establishing a consulting service that could go anywhere in the hospital. The consulting service began in September 1998 and has been called to almost every unit in the hospital, including pediatrics,

surgery and the emergency room. The service's advanced practice nurse performs most of the assessments and consults, including daily rounds with the hospital's oncology team. The medical director is available as needed but has deliberately adopted an arm's-length approach, attempting to assure other doctors that the service will not "take over" their patients. The medical director does not become directly involved without an order from the attending physician.

The nurse works with social workers on each floor and provides coordination when patients from the Burlington hospice program or other area hospices enter the hospital. Her growing confidence in this role, the hospital's increased familiarity with the service and a few high-profile success stories have so increased demand that hiring an additional half-time nurse is planned.

BARRE: In the smaller community of Barre (population 10,000), the sole hospital provider, Central Vermont Medical Center (CVMC, 120 licensed beds), recently implemented its own palliative care service. Discussions about the development of a palliative care consulting service within the hospital began in response to a complaint about the end-of-life care given at the hospital to the friend of a prominent member of the community.

Close relationships that have developed over the past 15 years between the hospital and the hospice program of Central Vermont Home Health & Hospice (CVHH&H) were integral to palliative care development. The hospice program serves an average daily census of 35 patients, along with another 40 to 60 patients receiving palliative home care. It contracts with the hospital for general inpatient care for hospice benefit patients on a scatter-bed basis. More recently, CVMC contracted with the hospice program to purchase consultation services from its coordinator for pain and symptom management, both within the hospital and in CVMC's affiliated Woodridge nursing home.

In 1999, the hospital formally invited the hospice program to join in collaborative discussions about palliative care development and a core planning committee representing multiple disciplines began to meet. The planning committee conducted staff focus groups, interviews with patients and research on national models of palliative care. As in Burlington, it initially looked at establishing palliative care beds, but visits to other hospitals with palliative care beds suggested that this approach might not work as well at CVMC.

Subcommittees of the palliative care planning committee are now exploring further development in the areas of quality improvement, continuing education and establishing a comfort room for the visiting families of hospitalized patients. The planning committee adapted the Vermont Project ExCEL hospital guidelines for palliative care and instituted educational programs for staff nurses in the hospital – with the aim of disseminating palliative care expertise more broadly to staff that has an interest in this area. Also in the works for the hospital is to hire its first full-time chaplain, sparked in part by the planning committee's deliberations.

The palliative care consulting service at CVMC was formally introduced in July 2000 and received six referrals in its first four months. The core team includes two physicians who practice at the hospital (an oncologist and an internist who is also the hospice's medical director) and two nurses (the staff nurse for the two physicians' practice and the coordinator of CVHH&H's hospice program). The nurses and physicians carry pagers, and other team members are available as needed.

The program has an explicit goal of education and empowerment by disseminating palliative care knowledge to staff throughout the hospital and identifying a cadre of nurses who have a particular interest in learning more about palliative care. As their skills, confidence, familiarity with palliative standing orders and advocacy with attending

physicians grow, they would be used to handle the most routine palliative care cases, calling in the consulting team for more complicated cases.



FINANCIAL ISSUES

BURLINGTON: The cost of operating the palliative care service at FAHC, which is borne by the hospital system, is primarily for the salaries of the full-time nurse practitioner and the 20 percent medical director. Direct reimbursement for medical consults has been limited, with more of the medical director's time devoted to teaching and administrative responsibilities than billable visits. The lack of billing has been a source of contention within the system despite an analysis by the hospital's finance department showing the palliative care service's indirect impact on length of stay and the hospital's bottom line.

Its conclusion: for a significant minority of patients, the involvement of palliative care consultation has contributed to shortening DRG stays in the hospital. Using conservative estimates for saved days, the hospital computed a net reimbursement margin of \$306,555 during the period January 1, 1999 to August 15, 2000, covering a total of 288 patients. "Looking at net reimbursement margin in isolation somewhat understates the apparent benefits of the program... It appears that direct cost reductions would make some commitment of additional resources cost-effective."⁴¹

BARRE: In Barre, costs for the palliative care program and its volume of referrals have been small enough to date that a separate budget for palliative care has not been required. One of the nurses on the service is able to bill as a nurse practitioner, while the other bills the hospital at a contracted hourly consultant's rate for her time on the service. The two physicians bill third-party payers for their consultations and are willing to accept the fees they generate to cover their time. However, this approach would become problematic if the volume of cases were to rise significantly, because of the negative financial impact for the participating physicians.



CHALLENGES OF IMPLEMENTATION

BURLINGTON:

- Lack of recognition historically for the hospice concept from the local physician community.
- Lack of understanding about palliative care and an initial opposition to the concept within the hospital.
- Personnel and environmental constraints on the floor where the palliative care beds are located, as well as competition from other departments for placing patients in those beds.
- Financial issues for the palliative care service – such as its lack of billing revenues – despite financial analysis demonstrating the cost savings it generates.

BARRE:

- Convincing the hospital's finance department that the project was not proposing a new, costly, non-reimbursable service and launching the service without grant funding.
- Clearly differentiating palliative care from end-of-life care, cancer care and hospice care, and raising awareness among physicians and staff of its value for patients who are not at the end of life.
- Difficulty in getting survivors of deceased hospital patients to attend formal, scheduled focus groups to help inform program development with consumer responses.
- Teaching and empowering hospital nursing staff to assume advocacy roles for palliative care.
- Finding appropriate times for in-house educational sessions for hospital nurses.



KEYS TO SUCCESS

BURLINGTON:

- Personal and institutional relationships between palliative care staff and the hospice program.

- Keeping the service "open" – with the attending physician remaining in charge of cases and the consulting physician in an arm's-length advisory capacity.
- Early, visible successes, especially with ICU cases and difficult family dynamics.
- The team's emphasis on teaching by demonstration, a flexible approach toward adapting palliative care concepts to its unique local environment and a commitment to going anywhere in the hospital that it is needed.

BARRE:

- The program's support from administrators at both the hospital and CVHH&H, building on a long history of collaborative relationships.
- The closely knit community, which highly values personal relationships.
- The hospice program's positive reputation in the community and with physicians, without the adversarial relationships that have existed in other communities.
- Studying the experience of other hospital palliative care programs and keeping the approach simple to reflect local circumstances.



LESSONS LEARNED

BURLINGTON:

- Beds that are preferentially assigned but not dedicated to palliative care may not achieve a true palliative focus.
- The hospice's bridge program, called "pre-hospice," was problematic for both patients and physicians, so it evolved into a palliative home care program that does not emphasize issues of life-expectancy or transition to hospice care.
- Informal relationships between the palliative care service and the hospice program have been successful because of overlapping roles and personal histories.
- The palliative care service has also increased the census at Vermont Respite House, because it is able to facilitate hospital discharges for appropriate patients.

BARRE:

- Designated beds didn't make sense for the relatively small, rural hospital.
- Nurses often develop relationships with patients dying in the hospital, which would be disrupted by moving a patient off the floor to a "dying room."
- The definition of palliative care has broadened to include anyone with a serious illness and symptomatic needs.
- Demand has grown from just six referrals in the first four months to an average of four to six referrals per month by the spring of 2001 – although the service's primary emphasis remains on education and empowerment of nursing staff, rather than increasing consultations.
- Of 25 non-emergency deaths in the hospital between October and December of 2000, end-of-life standing orders adapted from Vermont ExCEL were utilized more than 80 percent of the time, and of 20 patients presenting painful symptoms, 90 percent received consistent and regular pain assessments.
- For some health professionals, palliative care challenges their customary professional practice and may spark reflection on personal and professional ethics.

PALLIATIVE CARE IN VERMONT

Fletcher Allen Health Care, Burlington, VT

- 620 licensed beds (average daily census: 374)
- Palliative care consulting service initiated: September 1998
- Number of consults: Fiscal year 1998: 6
Fiscal year 1999: 347
Fiscal year 2000: 411

Central Vermont Medical Center, Barre, VT

- 120 licensed beds (average daily census: 46)
- Also on campus: 153-bed Woodridge skilled nursing facility
- Palliative care service initiated: July 2000
- Number of referrals in first four months: 6
- Number of referrals per month, Spring 2001: 4 to 6

⁴¹ Interoffice memorandum from Michael Nix, Measurement Group Manager, Budget and Analysis Division, Fletcher Allen Health Care, Burlington, VT, September 29, 2000.



NEXT STEPS

BURLINGTON:

- Merging the palliative care service with the hospital's ethics department.
- Developing standardized pain protocols for the hospital and helping the institution meet new JCAHO pain management standards.
- Developing a collaborative practice agreement to formalize the relationship with the hospice program.
- Expanding the focus on outcomes measurement.
- Exploring the possibility of a dedicated palliative care unit with a more controlled, homelike environment.
- A growing role for the palliative care service's medical director and a second nurse for the program.

BARRE:

- Expanded involvement for hospice and palliative care in CVMC's affiliated Woodridge nursing facility.
- Implementing a grant from the state Department of Aging and Disabilities in support of a collaborative project to introduce standardized pain protocols in local nursing homes, including Woodridge.
- Hospice-hospital collaboration on a chronic and acute pain management project at CVMC.
- More education for staff nurses and for the community.
- Developing a family comfort room within the hospital as a quiet space for family visitors.
- Increased focus on quality assessment and improvement.
- Introducing a full-time chaplain position within the hospital, with a major emphasis on palliative care.
- Plotting cost savings and exploring reimbursement issues.



Providing Inpatient Hospice Care on a Leased Unit

Hollywood, FL

MODEL/SUMMARY: VITAS Healthcare Corporation, a national hospice company headquartered in Miami, FL, partners with 16 hospitals in the development of hospice inpatient units. In many of those partnerships, VITAS leases unused space from the hospital, refurbishes, staffs and operates a dedicated hospice inpatient unit and then works to integrate the inpatient program into the hospital's care delivery continuum. An example of that approach, at Memorial Regional Hospital in Hollywood, FL, is profiled in this chapter. In contrast with other hospice organizations profiled in this monograph, VITAS' corporate leadership views palliative care development as synonymous with hospice care and with fuller utilization of the hospice benefit.



COLLABORATORS/SETTING

VITAS Healthcare Corporation is a privately held hospice company, incorporated in 1983 as Hospice Care, Inc. In 1992 the company changed its name to VITAS (derived from the Latin word for life). It has grown since then through acquisitions and start-ups, with a strong corporate focus on hospice care as defined by the Medicare Hospice Benefit. With current hospice operations in seven states and a combined daily census of 6,000 patients, VITAS is the country's largest provider of hospice care. The company has also developed a model network-based, hospice management information system called Vx, which enables its staff to comprehensively track and trend national service delivery data on a real-time basis.

VITAS employs approximately 100 self-managed interdisciplinary care teams, each comprised of nurses, social workers, a chaplain and other professionals – including a part-time physician. Each team manages the care of 45 to

60 patients, mostly in their own homes. In each community where it operates, VITAS contracts with local hospitals to purchase general inpatient care on a scatter-bed basis for its patients. But it also leases or manages dedicated hospice inpatient units in 16 hospitals in five states, providing staffing and operations for the units under contract with the host hospital.

The staff for a VITAS inpatient unit functions essentially as a separate interdisciplinary care team, although in coordination with the home-based teams. Each unit has its own part-time medical director, usually a physician who has staff privileges at the hospital where it is located and conducts daily rounds on the unit. Overall, counting the medical directors of the regional hospice programs and national medical staff, the company employs 80 full-time or part-time physicians.

VITAS-leased inpatient units tend to be located in conjunction with its larger hospice programs, primarily in South Florida and Texas, and typically in partnership with a hospital that has extra space. VITAS pays a square-footage rate for the unit and purchases ancillary services such as housekeeping, maintenance, dietary, laundry and security from the hospital. VITAS also pays to remodel and refurnish the unit to create a more homelike atmosphere, at an average investment of \$150,000 to \$200,000 per unit.

VITAS dedicated units are intended for short-term, intensive care management, with stays averaging just over five days nationally and two-thirds of admitted patients dying on the units. Patients admitted to the units are clinically appropriate for hospice care and enrolled in a hospice benefit, usually at a general inpatient level of service. A small percentage of the patients receives inpatient respite care.

Nationwide, five percent of days of care in VITAS hospices

are inpatient, but in South Florida, which has seven dedicated units, inpatient days run over nine percent of total days of care. The company also emphasizes direct hospice admissions for qualified terminally ill, hospitalized patients. Under this approach, a Medicare patient may be transferred within the same facility from an acute care bed and a DRG-based payment mechanism to a hospice inpatient bed and the hospice per diem payment mechanism.

Memorial Regional Hospital, a tax-exempt hospital in Hollywood, FL, just north of Miami, illustrates the VITAS approach to leased units. The hospital is a 684-bed facility and the largest in southern Broward County. It belongs to a four-hospital system called Memorial Health System. Another hospital in the system, 301-bed Memorial Hospital Pembroke, also contains a VITAS leased inpatient hospice unit.



WHAT IS THE PROGRAM?

VITAS began leasing space from Memorial Regional Hospital for the hospice unit, called Hospice House, in 1997. The 13-bed hospice unit, with private and semi-private units, averaged an occupancy rate of more than 80 percent. VITAS typically works with a consulting interior decorator to achieve a more homelike atmosphere on its units, incorporating quiet and family rooms, pullout sofas for family members to spend the night in the patient's room, furnished kitchens, individualized wallpaper in each room and other amenities to enhance the atmosphere and quality of life on its hospice units.

Memorial Regional Hospital's interest in a partnership with VITAS originated in a desire to creatively utilize unfilled space. VITAS had previously sought a leased unit contract with the hospital, but negotiations did not move forward until local occupancy rates dropped in response to pressures from Medicare and managed care to reduce hospital utilization. At that point, the discussion moved briskly, and the program was launched six months after the start of negotiations. More recently, the hospital's

occupancy rate increased. In March 2001, Memorial Regional Hospital opted to reclaim the leased beds from VITAS for other acute care needs and closed down the dedicated hospice unit. The hospice unit leased by VITAS at Memorial Hospital Pembroke is still in operation.

Memorial Regional had chosen not to create a hospice or palliative care program on its own because, according to its administrator, the orientation and practice of tertiary, acute medical care is so different from what is required in palliative care. Instead, it made more sense for the hospital to out-source the end-of-life piece of the care continuum to an organization like VITAS that could model and teach such care to the system. For Memorial Regional, involvement in end-of-life care was closely entwined with its relationship with VITAS, and the hospice unit served as the focus for palliative care within the hospital's continuum of services – particularly its cancer services.



EXPERIENCE OF COLLABORATION

When the hospice unit was launched in 1997, both parties made an effort to present it as a partnership and to integrate it into the hospital's overall service delivery. Jointly sponsored educational presentations introduced the hospice unit and its uses to physicians and other staff. The hospice team also provided education on managing symptoms for patients not on the unit.

Communication between the hospital and the VITAS team included the routine sharing of information on hospital policies and procedures and the team's representation at meetings of hospital department heads. Hospice unit employees wore hospital name badges, participated in hospital orientation and team-building exercises and even attended company picnics and other employee-recognition events. A quiet room on the hospice unit was utilized by hospital employees in need of a quiet space for reflection, and the hospital's therapeutic clown, "Lotsy Dotsy," also visited patients on the hospice unit. The unit's chaplain provided spiritual support to patients and families in the hospital's

emergency room when needed and hospice staff also provided bereavement support to hospital staff.

The partners agree that Memorial Regional's relationship with VITAS succeeded in making end-of-life care inroads into the hospital's medical culture, with growing awareness by physicians and other staff of the value of hospice care and the important role that palliative care can play in supporting individuals in life's final stages.



PROS AND CONS OF LEASED UNITS

The first question a hospital administrator may ask in considering a leased unit arrangement with a hospice program is whether the hospital has empty space for which it wants to find a use. If not, negotiations over the leased unit will need to find another basis of common interest. For the hospital, a leased hospice unit is not likely to be a significant revenue generator, but it can be an opportunity to collect rent on otherwise unused space as well as an outlet for ancillary hospital services such as dietary, pharmacy and housekeeping. Also key is whether the two partners' financial and strategic goals for the unit are in alignment.

A hospital should consider whether it is committed to creating its own hospice/palliative care expertise – or whether it makes more sense to draw upon the expertise of an external agency to introduce and teach hospice and palliative care. For the administrator of Memorial Regional Hospital, hospice and palliative care represented a different philosophy of care from the routines of a tertiary medical center and its financial, technological, pharmaceutical and other imperatives. Therefore, it made more sense for his facility to bring in outside expertise. Other potential advantages for hospitals from leased unit arrangements such as the one with VITAS include:

- The unit's potential to broaden the referral base and attract new patients and physicians to the host hospital.
- Opportunities to better manage the costs of caring for

- terminally ill patients who have exceeded their DRG payments.
- Support to physicians in managing difficult patients. The doctor can elect to continue following the patient's care on the hospice unit or else turn that responsibility over to the hospice medical director.
- Public relations gains in the community resulting from the partnership with hospice.

For the hospice, a dedicated hospice unit enhances its ability to provide holistic, interdisciplinary, patient- and family-centered care that is consistent with its care in the home setting. Care on VITAS dedicated units for hospice patients who need inpatient care can be effectively coordinated with the already established plan of care. VITAS also believes that having a unit in the hospital can increase hospice utilization, because of the higher profile for the hospice concept. The company is now studying the actual impact on hospice census in communities where it operates leased units. VITAS' experience suggests that leased units can be economically viable with 12 or more beds potentially kept full in an average daily hospice program census of 100 or more patients.



LEADERSHIP CHAMPIONS

The administrator at Memorial Regional Hospital was a key advocate for the dedicated hospice unit and continues to support the concept.



FINANCIAL ISSUES

VITAS pays its contracting hospitals an annual square footage rate for units of 5,000 to 6,000 square feet, plus a daily per-patient fee for all ancillaries. According to a recent article in *Strategic Health Care Marketing* newsletter,⁴² the Memorial system had been covering its costs plus a margin of 5 to 10 percent under its contract with VITAS for the leased beds.

⁴² September 2000, pp. 8-9.

VITAS HEALTHCARE CORPORATION AT A GLANCE

- Corporate headquarters: Miami, FL
- Operates 19 certified hospice programs in the states of California, Florida, Illinois, Ohio, Pennsylvania, Texas and Wisconsin
- Cumulative daily census: 6,000 patients
- 16 leased or managed hospice inpatient units, with the first unit opened in 1984
- Size: 12 to 22 beds (average: 16)
- Located in South Florida (7), Central Florida, Texas (3), Illinois (2), Pennsylvania (2) and Ohio
- Occupancy rate, 2000: 81% (December, 2000: 86%)



CHALLENGES OF IMPLEMENTATION

- The current regulatory environment for hospice care nationally is characterized by frequent challenges and medical chart reviews by Medicare fiscal intermediaries for hospice admission and coverage-level decisions, including the provision of general inpatient care.
- Changing a hospital's culture to recognize and appropriately utilize end-of-life services such as hospice care is a long-term project.



KEYS TO SUCCESS

- The hospice unit manager at Memorial Regional used to work in the hospital's emergency department and thus understands politics within the hospital.
- The hospice was able to provide informal grief support to the hospital's staff when a well-liked hospital employee died suddenly.



LESSONS LEARNED

VITAS as a company is focused on its core business, providing the Medicare Hospice Benefit in private homes, nursing homes and acute care settings. Direct admissions of hospitalized patients onto a hospice inpatient unit such as the one at Memorial Regional offers an important opportunity for providing palliative hospice care to terminally ill patients who cannot leave the acute care setting.

Senior managers at VITAS make it clear that they are not interested in creating palliative care programs outside of a hospice context. Instead, they believe their focus should be on how to encourage more and earlier referrals to hospice care. VITAS made one major foray into palliative care development beyond traditional hospice definitions in the early 1990s through a hybrid home care and hospice initiative for people with AIDS called Program Outreach. At one time, before the revolution in anti-viral treatments for HIV greatly reduced the demand, the state-funded program had a caseload of 250 seriously ill AIDS patients in South Florida. But the company's experience, particularly on its inpatient units, was that mixing traditional hospice care with the high-tech interventions received by Program Outreach patients created confusion for patients, families and staff.

Other lessons from VITAS' experience with leased or managed units:

- It is important to purchase supplies and ancillary services from the partnering hospital to the fullest extent possible. Every department of the hospital that can be involved in supplying the hospice unit will enhance its integration.
- It is important to incorporate the hospital's identity into the daily operations of the unit, for example naming the unit or having unit staff wear hospital identification badges.
- Hire a doctor who is already on the staff of the hospital, if possible, to be the unit's medical director and/or involve the hospital's administrative and medical leadership in selecting the medical director.

- Choose partners with care, since the hospice program's reputation will become linked to the hospital's reputation in the community, and vice versa.
- Only about half of patients admitted to VITAS inpatient units have cancer, which is a lower percentage than for hospice caseloads overall, suggesting that a somewhat different patient population is being served on the units.
- At Memorial Regional, as in several other cases, hospitals have opted to reclaim leased space from VITAS. The company now seeks to include contract provisions to protect its investment, such as payouts for its capital investments in the unit.



NEXT STEPS

- The company aims to open several more leased units in the near future and also is focused on improving access to hospice care, for instance by developing specialized programs for African Americans and for other minority and inner-city populations. Through a subsidiary foundation, VITAS supported the development of the Duke Institute on Care at the End of Life at Duke University in Durham, NC, which has made a priority of studying palliative care for underserved populations.
- The company is also exploring long-term answers to the nurse and aide staffing shortage, for example, by partnering with a local community college for training and offering educational scholarships to its staff.



Concluding Observations

The following conclusions summarize key issues, challenges and opportunities for hospital-hospice collaboration in palliative care development, which have emerged from the site visit research and from analysis of the results by project consultants.

COLLABORATION IS POSSIBLE AND EFFECTIVE: Most importantly, the case studies in this report illustrate how hospitals and hospices in different communities, each with particular advantages and difficulties, have come together to implement creative strategies for improving the care given to hospitalized patients with serious and life-threatening illnesses and their families. The varied collaborative approaches and responses undertaken at the sites reflect their unique settings and circumstances and address identified, unmet local needs.

These experiences clearly demonstrate that collaboration between hospitals and hospice programs is not only possible but in fact is a fertile opportunity for innovation and for improving end-of-life care – despite very real challenges and barriers in such areas as regulation, financing and institutional culture. They also show how the complementary skills and expertise of hospitals and hospice programs can be brought together in new and exciting ways – which may involve dedicated units, consulting teams and a variety of other approaches. Prospective collaborators in other communities may not find it feasible to duplicate the specific measures attempted at the visited sites, but they should derive confidence from the evidence that innovative, collaborative program development is achievable.

REGULATORY AND DEFINITIONAL CHALLENGES CAN BE OVERCOME: While hospice care in the United States is most often described in terms of the unique provisions,

requirements, limitations and funding mechanisms of the Medicare Hospice Benefit (outlined in Chapter 2), hospice providers increasingly are unwilling to be constrained or exclusively defined by Medicare's model of hospice care. In trying to broaden the practice of hospice care beyond Medicare limitations (such as its requirement for a six-month-or-less prognosis), and beyond the historical practice whereby hospice patients were given only comfort-oriented services and not disease-modifying therapies, innovators are drawing upon a concept and tradition of hospice care that predates the 1982 enactment of the Medicare benefit. They are also incorporating new observations about the needs and wishes of patients with life-threatening illnesses in the new millennium.

Hospital administrators may find that some local hospice programs are more open than others to providing, for example, disease-modifying treatments such as chemotherapy and radiation therapy. It is recommended that hospitals explore such boundaries in dialogue with their local hospice providers rather than making assumptions that may no longer be true about what the hospice is willing and able to provide.

At the same time, innovators are trying to develop new forms of palliative care that are beyond even the new and expanded definitions of hospice care, in order to meet more of the palliative care needs of seriously ill patients from the point of diagnosis. Some of those pioneering approaches are profiled in this monograph and, in some of those cases, hospice agencies participated in the development of palliative care services that are not hospice care as defined by the Medicare Hospice Benefit.

Meanwhile, the Medicare Hospice Benefit, despite what

some perceive as its regulatory barriers to access, remains an important funding source for palliative care services in general and for collaborative, hospital-based palliative care initiatives in particular. It is also clear from the visited sites that some of the specific concerns raised about provisions of the Medicare Hospice Benefit – such as its 20 percent inpatient limitation and the lack of a case-mix or outlier adjustment to the per diem payment rates – have not turned out to be serious problems. In other cases, Medicare provisions such as the requirement that the hospice program exercise care-management responsibilities for its enrolled patients, even when they are receiving inpatient care under contract in a hospital facility, may offer a basis for closer collaboration and enhanced communication between the hospice and hospital partners. In general, collaborators have been able to work within the spirit and the letter of the Medicare regulations while attempting to meet the needs of patients with life-threatening illnesses.

However, some of the visited sites expressed concerns that government antifraud efforts and antikickback enforcement may have a chilling effect that could constrain or inhibit the kind of experimentation described in this monograph. They point to a series of investigations conducted in the 1990s by the Office of Inspector General (OIG) in the Department of Health and Human Services, focusing in part on hospices with longer average lengths of stay and on physician certifications of patients' eligibility for hospice coverage. Although critics have cited methodological flaws in the OIG's conclusions, the fact of their release and the attendant publicity created serious misunderstandings for hospice providers and served to discourage access to hospice care.⁴³ Recent legislation and a federal policy memorandum (see Chapter 2, p. 9) have clarified that prognostication is not an exact science. Even so, the OIG investigations have had a lingering chilling effect on referrals for hospice care, at the very least contributing to delays in referrals.

⁴³ Office of Inspector General, U.S. Department of Health and Human Services, *Hospice Patients in Nursing Homes*. Washington, D.C.: Office of Inspector General, U.S. Department of Health and Human Services (September 1997), Document OEI-05-95-00250; and Zeran, J., Stearns, S., and Hanson, L., "Access to palliative care and hospice in nursing homes." *JAMA* 2000, 284: 2,489-2,493.

Palliative care advocates argue for the need to develop and expand safe harbors within antikickback enforcement, in order to assure that hospital-hospice collaborations are not unnecessarily restricted from providing needed types and levels of palliative care services. Sound legal advice is essential for the development of collaborative initiatives.

FINANCING REMAINS A SIGNIFICANT BUT NOT INSURMOUNTABLE CHALLENGE: The financing of palliative care is and will remain one of the biggest challenges for hospital administrators relative to potential collaborations with hospice programs.

Some important perspectives on the financial challenge have emerged from the site visit research. First of all, the absence of designated reimbursement for palliative care is viewed as a drawback, although it has not been an insurmountable barrier for the hospital and hospice partners. In fact, other sites have documented significant cost avoidance and savings associated with hospital-based palliative care programs, primarily through reductions in length of stay. In addition, hospitals may receive a per diem payment under a contractual arrangement with a community hospice partner for providing inpatient beds and services to that hospice's patients who are enrolled on the Medicare Hospice Benefit and in need of inpatient hospice care.

The collaborations described in this report have utilized multiple alternative funding sources, including foundation grants, clinical research initiatives, medical fellowships, charitable contributions from the community and institutional subsidies from one or both of the collaborating partners. No single "magic bullet" approach to financing palliative care has been identified, and multiple funding sources may be necessary to assure an initiative's viability.

Where collaborative palliative care consulting services have been established, they are not yet breaking even on billing

consult income alone, although providers perceive opportunities for improving financial performance through improved billing, more efficient utilization of physicians' time, increased education for referral sources and further exploration of untapped opportunities such as managed care.

Although research from other institutions suggests that the provision of palliative care can generate indirect cost savings for hospitals, the sites visited for this report – with one exception (see Chapter 12, p.57) – have not yet generated the kind of sophisticated cost-comparison data or analysis that might shed light on the net impact of palliative care initiatives on the hospitals' bottom lines. Administrators of hospitals participating in the palliative care collaborations did not appear concerned about the absence of such fiscal analysis and stressed that their institutions' comparatively modest subsidies of palliative care were more than justified on humanitarian grounds – by providing needed and appreciated compassionate care for their seriously ill patients. In fact, healthcare providers emphasize the higher quality of care received by patients and their families as the primary justification for hospital-based palliative care programs.

In the long run, better answers to the financial dilemmas may need to come from the public policy arena and from explicit reimbursement policies for hospital palliative care services. Sources for this monograph expressed a hope and expectation that such answers will be forthcoming within the next few years as experience grows in the provision of collaborative, hospital-based palliative care.

In the meantime, important resources exist to aid physicians, hospital staff and their hospice partners in understanding palliative care financing and billing issues, starting with the Website of the Center to Advance Palliative Care (www.capcmssm.org). The experts recommend consulting available billing guides⁴⁴ to determine what services can be billed and what codes to use, as well as working closely with local Medicare carrier medical directors to clarify billing issues and opportunities. Palliative care physicians and other

practitioners can also work collectively to change Medicare policy at the local and national levels.

CULTURAL CONFLICTS CAN BE RESOLVED: Differences in perspective between professionals working in hospital and hospice settings may result from their diverse training and professional experiences. There can be significant misconceptions about hospice care and hospice regulations among health providers, but such misconceptions can be resolved through dialogue between the partners. Hospital-hospice partnerships can provide a strong presence for hospice care within the hospital, establishing an in-house entity that enhances its visibility and serves as a ready resource for information.

Palliative care, which may be less familiar and less clearly defined than hospice care, is also subject to misconceptions. Potential consumers may incorrectly believe that palliative care is only appropriate when all efforts to prolong life have ceased. Patients and families, as well as physicians and other health professionals, need more information about the role palliative care approaches and services can play early in the course of an illness.

Experience at the collaborative sites indicates that an active hospital-hospice partnership succeeds in raising the profile for palliative care within the hospital and enables the hospital and the hospice program to draw upon each other's respective skills and resources. Regardless of the specific functions included, the hospital culture can be influenced by the daily presence of hospice and palliative care professionals as they coordinate care with other hospital staff, participate in rounds and consult on difficult cases. At all of the visited sites, the specific programmatic measures adopted appeared to achieve an effect well beyond their initial scope or point of intervention. The ventures thus have tended to help advance palliative care precepts throughout the institution.

Other Important Opportunities:

- Inpatient hospice and palliative care units developed through

hospital-hospice partnerships offer one of the most significant opportunities for expanding access to appropriate end-of-life care for hospitalized patients. Such units have been developed in various ways, including dedicated units for Medicare Hospice Benefit patients, combined hospice/palliative care units, smaller-scale comfort suites, scatter-bed arrangements and leased units.

- Partnerships and joint participation in demonstration projects have highlighted opportunities to develop new palliative care services targeting a wide range of patient populations ranging from pediatrics to HIV, dementia and chronic-obstructive pulmonary disease, and to establish linkages with the specialists who care for those patients.
- The collaborations have opened new avenues for physician and nursing leadership in palliative care development, such as physician advisory committees and expanded roles for hospice or palliative care medical directors as educators for medical students, residents and fellows.
- A variety of other programs and services have emerged from the collaborations, including palliative care planning committees,

expanded roles for liaison nurses, joint staffing of palliative consulting services, the use of retrospective chart reviews to identify opportunities to improve care and the adoption of checklists and screening tools to identify patients who need palliative care.

Ultimately, through collaboration, hospice programs have been able to share their expertise in order to meet the needs of non-hospice-eligible patients in the hospital while exerting positive influence on the culture of the larger institution. Through collaboration, hospitals benefit from improved quality of service for their sickest and most vulnerable patients and their families, from the education and improved sophistication of hospital staff about palliative care and from more appropriate stewardship of scarce medical resources. Hospice programs benefit from extending their skill and expertise to a much broader population of needy patients and families, from associated increased and earlier referral rates and from gains in knowledge about the integrated and simultaneous delivery of disease-modifying and palliative treatments. The ultimate beneficiaries are patients facing serious and life-threatening illnesses and their loved ones.



⁴⁴ A recent article reviewing coding and reimbursement mechanisms for physician services in palliative care details relevant procedures, services and evaluation/management and diagnosis codes for physician services contained in the Current Procedural Terminology (CPT) codes published by the American Medical Association. See "Procedure/Diagnosis Coding and Reimbursement Mechanisms for Physician Services in Palliative Care," Education for Physicians on End-of-Life Care Trainer's Guide. A version of the same article can be found in von Gunten, C.F., Ferris, F.D., et al., "Coding and reimbursement mechanisms for physician services in hospice and palliative care." *Journal of Palliative Medicine* 2000, 3: 157-164.



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To obtain more information about palliative care, links to other organizations and a variety of other educational resources, visit the websites of NHPCO and CAPC.

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