



Physician Newsletter

January 2009



I am very pleased to introduce the first electronic communication to physicians from Hospice & Palliative Care Charlotte Region (HPCCR). From time to time, I will send out this e-newsletter as I find interesting articles to share with the clinical community and as I receive requests from colleagues for information about our services. I welcome your [feedback](#) and your suggestions as to how we can make this e-newsletter a more valuable resource for you and your staff.

My original intent for the initial e-newsletter was to include several articles designed to help you learn more about HPCCR. However, I felt compelled to share with you the moving experience I had several weeks ago at a healthcare discussion focus group. I hope it will resonate with you as a practicing member of the healthcare community. In addition, I have included important information about two very common questions that I am often asked by physician colleagues: "How do I know when to refer for hospice versus palliative care?" and "How do I get paid for my services once a patient comes under hospice care?".

I hope you enjoy this first physician e-newsletter and I sincerely thank you for the opportunity to work together to improve the lives of your patients and their families.

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Wake Up Call

On December 30, I attended a "Healthcare Community Discussion", hosted by HPCCR, as part of the Obama-Biden Transition Project. Like many other volunteer groups around the country, our task was to outline concerns facing our healthcare system and to suggest how possible policy initiatives could assist the healthcare reform that has been promised by the new administration. There are many pressing issues facing the American healthcare system including uninsured and underinsured citizens, a fragmented delivery system, and health outcomes that are well below other western countries that spend far less. However, at the risk of sounding mushy, the most striking aspect of this gathering was the stories regarding end-of-life care.

I cannot adequately convey the emotion that was expressed that day by the 37 people representing healthcare professionals, clergy, community members, and family members of patients who have died. Person after person told their own version of the same story- namely that they and their loved one learned of hospice too late or not at all; that they did not learn about hospice from their treating physician; that if they were referred it was often with reluctance; that pain and other symptoms were poorly or completely uncontrolled; and that there was little to no regard for the family. To be sure, there were some positive stories of compassionate care but the general mood was one of, "Why are doctors that way?"

I imagine most, if not all of us, would immediately dismiss this type of report as applying to someone else. Having been formerly on the private practice side, and now on the hospice side of things, I would humbly submit that all of us can, and should, do better. Based on recommendations from multiple medical societies including the American Medical Association, American College of Chest Physicians, the American Society of Clinical Oncology, the American College of Cardiology, the Society for Critical Care Medicine, and many others, and factoring in the stories that were shared during the Obama-Biden Healthcare Community Discussion group, I urge all of us to adopt the following practices:

1. Discuss palliative care and hospice as options when advanced and/or incurable illness is diagnosed.
2. Ask patients and families what their goals are beyond curing or controlling the underlying disease.
3. When disease progression occurs, re-visit the issue of hospice care and how it pertains to patient and family goals.
4. Encourage and assist our patients to complete advance care planning documents such as Medical Orders for Scope of Treatment (MOST), Living Wills, and Health Care Powers of Attorney.

Finally, let's not forget the overwhelming fear and frustration that patients and families experience when coping with a life-threatening illness. By adopting the above practices, we will make great strides toward achieving our primary obligation as physicians to relieve suffering for all those in our charge.

"How Do I Know When to Refer for Hospice vs. Palliative Care?"

The Difference Between Hospice Vs. Palliative Care

Patients afflicted with serious and life-threatening illnesses are often not familiar with the concept of palliative care. They are consumed with their fight against the disease; words like "ICU", "chemotherapy", or "surgery" are more commonplace in their vocabulary. But palliation is also an important element of treating patients; the relief that it gives them is immeasurable. Palliative care provides pain and symptom management-particularly in complicated cases where relief is difficult to achieve. It is appropriate for patients continuing to seek cure-oriented treatment for their disease, without regard to life expectancy.

Hospice care, on the other hand, is appropriate for patients who are facing an illness that is no longer responding to aggressive disease-specific treatments; in other words, hospice care is palliative care for the terminally ill. These patients are no longer seeking or receiving curative treatments, and likely have a life expectancy of six months or less. They want to be as comfortable and as pain-free as possible during their last weeks and months. A hospice care team consisting of doctors, nurses, nursing assistants, social workers, chaplains, grief counselors, and volunteers ensure that these comfort-directed goals are achieved.

Please click here to see a detailed table explaining the [differences between hospice and palliative care](#).

When To Refer

Often it is difficult to know when to make a referral for hospice or palliative care or even which one is appropriate for your patient. As a general rule of thumb, patients should be referred to palliative care when they have a serious medical illness with complex symptom management needs. Patients should be referred to hospice once they are entering the terminal phases of their illness. Of course, these are just broad guidelines to help you determine the right course of treatment. We know that each patient has unique needs and characteristics and that the treatment plan may be not straightforward. This is when we can help. Our expert clinical team will help you determine the best plan of care for your patients. Our goal is to minimize suffering for those with serious or terminal illnesses so that they may live life as vigorously as possible.

HPCCR now has four options for referring your patients for our expertise in pain and symptom management and end-of-life care:

1. Call us at 704.375.0100.
2. Fax us at 704.335.3522.
3. Use ProviderLink.
4. Complete an online referral form, located on our website (www.hpccr.org).

"How Do I Get Paid for my Services Once a Patient Comes Under Hospice Care?"

Helping patients is the most rewarding aspect of our duties as physicians. It is the role that we have been trained to perform. Deciding who to bill for which services after the visit is over is a part of the job that is often confusing, time consuming, and daunting. In order to make this process more manageable, HPCCR has documented the process with the proper steps that must be taken according to the CMS Medicare Claims Processing Manual. We have included the sources, services, and modifier codes necessary to process a claim as well as definitions to make billing more comprehensible. Please visit the ["Reimbursement for Services"](#) section on our [website](#) for more detailed information or call 704.375.0100 and ask to speak to a member of our business office.