Team Serves Diverse Population

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in 12%, and a neurologic disorder in 6%.

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

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

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

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

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

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

Dr. Wollner credits the program's success to understanding and respecting the ethnic and cultural diversity of their clients.

"Each referral is unique," he said. "We serve the old, the young, the rich, the homeless—and part of our success is being sensitive to the diversity of our population."

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

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

As community awareness of the program increased, referrals—coming largely from physician offices, hospitals, and oncology practices—jumped from 20 in the first year to more than 500 in 2008.

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

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

Ms. Walsh highlighted one of the program's success stories: a 77-year-old Italian American man with stage IV lung cancer who was undergoing daily radiation and was referred to the team for pain and symptom management as well as psychosocial support.

Despite being on 10 different medications (including 10 Percocets per day), the patient rated his pain at 10 on a 10-point scale. He reported having had no bowel movement for a week, and refused to contact relatives despite being unable to care for himself.

"He was very proud of his independence," she said.

The team changed his pain management regimen so that his pain score dropped to 3, and resolved his constipation. They negotiated a lower price for home-delivered meals and worked with his insurance plan to get home care. They encouraged him to fill out a health care proxy form, and contacted his daughter. Ultimately, he moved to an inpatient hospice unit.

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

None of the speakers disclosed any relevant financial relationships. ■

Patient-Centered Medical Home Experiment Shows Promise

BY JOYCE FRIEDEN

WASHINGTON — Results from trials of a patient-centered medical home suggest that such arrangements result in cost savings and reduced hospital readmissions, according to Dr. Barbara Walters, senior medical director of southern New Hampshire community group practices at the Dartmouth-Hitchcock health care system.

Dr. Walters' organization is involved in a medical home trial sponsored by the Centers for Medicare and Medicaid Services that includes 10 multispecialty groups operating in a fee-for-service environment. Under the trial protocol, the practices are responsible for the entire cost of care for their Medicare patient population; they receive per-patient monthly fees for care management.

Dartmouth-Hitchcock got a $6.8-million bonus in 2008 because of the money the groups saved Medicare, and the 3-year project has been extended an additional 2 years. "On 35,000 Medicare patients, we saved $10 million for the Medicare trust fund," she said at the sixth annual World Health Care Congress.

Key to the clinical intervention was the transformation of the registered nurses' role. "Our nurses used to be 'triagers' and traffic cops. We didn't take their licensure and their scope of their ability to practice into account," said Dr. Walters. "Now they are health coaches, patient advocates, and referral coordinators."

Training staff in proper coding also helped. "We needed to train all of our doctors," she said, because, like it or not, severity adjustment and the total cost of care is assessed by the diagnoses that go on the claims form.

Dartmouth-Hitchcock also developed a registry that "allows you to look at [an] individual patient and get a snapshot of all the key indicators that help their health," said Dr. Walters, adding that "you can look at the entire population of patients . . . so that you can take care of the health of the population of [for example] the diabetics or congestive heart failure [patients] that you serve."

Protocols were developed for postdischarge phone calls. "The nurse calls the day after you get out of the hospital, checks to make sure patients understand which medications they're supposed to take, which medications they're no longer supposed to take, and gets them into their primary care doctor, their medical home," Dr. Walters said.

'On 35,000 Medicare patients, we saved $10 million for the Medicare trust fund' over 3 years.

DR. WALTERS

As a result of these changes, every single practice in the pilot had lower risk-adjusted costs of care and admission rates and better quality measures than a comparison group, she said.

In addition, while hospital readmission rates are typically upwards of 20%, "we talked to the Cleveland Clinic; they got theirs down to 14%. In one of our communities where we're the only provider, we got it down to 9%," Dr. Walters said.

The results have spurred a partnership between Dartmouth-Hitchcock and CIGNA to develop a pilot medical home project.

Under that project, the practice hopes to improve on the Medicare model and get primary care physicians to reap more financial benefit from any money saved. Dartmouth-Hitchcock wants to include ongoing payments for care management, "which is the biggest [implementation] issue across every group that we talked to," said Dr. Walters. "There's lots and lots of nonvisit care that you can apply" if the payment system allows for it.

That's easier to do in a system like Kaiser Permanente, where one entity owns the whole delivery system, she continued, "but those of us who practice in a fee-for-service world, where we only get reimbursed for individual-based care when patients come in, we need some slack in the system for us to be able to build the infrastructure so we can do e-visits, nurses can develop care plans, and nurses can call patients before a visit and have the lab work done when they show up" to visit the doctor. The CIGNA program only began in April, so no results are available yet, she said.

Health care organizations increasingly are looking at patient-centered medical homes, according to Edwina Rogers, executive director of the Patient-Centered Primary Care Collaborative in Washington, D.C., whose 475 members include large employers, primary care physician associations, health insurers, trade associations, academic centers, and health care quality improvement associations.

Ms. Rogers cited research from Johns Hopkins University, Baltimore, showing that adults who have a primary care physician coordinating their care had 33% lower costs of care and were 19% less likely to die.

The 3-year-old collaborative is currently involved with 22 pilot medical home projects in 16 states. The model used by the collaborative includes a monthly care coordination fee in addition to fee-for-service payments and performance bonuses.

Figuring out which outcomes to analyze and report on "is the hardest part to do," said Ms. Rogers. A group led by the U.S. Department of Health and Human Services is "trying to figure out standard outcome measures that we can all agree on. . . . That's probably one of our biggest problems." ■