The Pros & Cons of Establishing a Palliative Care Program
June 11, 2013

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Introduction

• More & more health care providers are embracing the need for palliative care
• There are many potential models for providing this important service
• We will explore the myriad benefits to having such a program & ways in which you can help others understand the value of palliative care to your health care continuum
Objectives

Upon completion of this webinar, participants will be able to

• Define palliative care & describe the role of a palliative care team within the organization as a whole
• Discuss what it takes to make the case for palliative care services
• Identify how palliative care programs are delivered & financed
• Recognize when palliative care programs should be integrated with home health & other providers

What is Palliative Care?

Coordinated, interdisciplinary care of patients with serious illness with a special focus on pain & symptom management & exploring patient choice & goals of care
Current State of Palliative Care in U.S.

• Rapidly growing field in many, if not most hospitals in the United States
• Relatively new specialty, having only been officially recognized as a specialty in 2006
• JCAHO has just recently created advanced certification in Palliative Care in the past year

What Palliative Care is Not

• Not the same as hospice, though much more in common than different
• Leads to confusion of services if both are offered at the same institution
• All hospice is palliative care but not all palliative care is hospice
What are the Differences?

• Hospice is for patients with a limited prognosis & focuses on the care of those in the final stages of disease & for many hospice programs, patients must choose between continuing their current treatments or enrolling with hospice
• Palliative care can be accessed at any time, regardless of prognosis & regardless of treatments being received
• Example of how varied my days can be

Nuts & Bolts

• Structure of the palliative team
• Infrastructure Issues
• Choices of level of service
Structure of Palliative Care Team

- Physician
- Advanced practice providers
- Social worker
- Chaplains

Infrastructure

- Administrative support
- Where these departments sit within a hospital
- How are these programs run?
Level of Service

- Consultative versus taking over care of patients
- Five days per week versus 24/7
- Sites of service

A Little More on Sites of Service

- Hospital based
- Facility based
- Home based/house calls
- Outpatient clinic
Hospital Based

- Most common
- Easiest to make work financially (little overhead, staff very productive)
- What happens when patients leave the hospital?

Facility Based

- Long-term care, assisted living, independent living
- Tremendous need
- Concentrated patient base
- Can be confusing who is doing what with respect to nursing home staff/providers
Home Based/House Calls

- For those where it is a burden to get to the physicians
- Patients/families love it
- Tremendous community benefit
- Inefficient/lots of travel time

Outpatient Clinic

- Nice wraparound to an inpatient consultative service
- Patients can be referred there upon discharge for ongoing palliative care
- Much more overhead versus inpatient service & less productive than an inpatient consultative service
- Will likely need to support this financially
How are Palliative Services Accessed?

- Depends on institution
- Wide variety of potential mechanisms
- Will depend on culture of institution & maturity/longevity of palliative care program

Access Framework Examples

1. Consultative model where all consults begin with a physician's order
2. Consultative model where anyone can call for a palliative consult
3. Automatic referral to the palliative care team based upon patient criteria
Why Start Such a Program?

- "It's the right thing to do for our patients"
- "Everyone else is doing it"
- The patient case
- The quality case
- The business case

The Patient Case

- Patients love it
- Expert pain & symptom management
- Help patients/families with extremely difficult medical decision making
The Quality Case

- Pain management improvement
- Helps with more robust discharge planning as advance care planning can be more fully incorporated into the post-hospital plan
- Reduction of avoidable 30-day readmissions
- Patient satisfaction scores

Making the Business Case

- So, how do you sell this idea to the folks who make financial decisions at your institution?
- Money is getting tighter, reimbursement is uncertain
- How will you get buy-in from administration to launch a new program in an era of health care reform?
### Step 1

- Do your homework
- Talk with other programs or link up with a national resource to give you the tools to help tell your story
- Come up with the likely financial impact & work on a presentation that will speak to those who will be making the decisions

### Financial Impact of Palliative Care

- Revenue generation from services provided
- Will not likely be able to cover expenses through revenue generation alone
- Cost avoidance
- Can be significantly more than revenue in terms of fiscal impact
- Depending on the study, can expect to save approximately $2,000 per patient seen*

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Downloaded from [www.archinternmed.com](http://www.archinternmed.com) at Mt Sinai School Of Medicine, on September 9, 2008
Step 2

• Make sure everyone buys in to cost avoidance measures & metrics you use to measure impact
• Get commitment the model chosen will be supported by those who are monitoring metrics
• No sense in coming up with data that not everyone believes

Other Things to Keep in Mind

• You will need to identify & secure partnerships within your organization to help you capture the fiscal impact & potential
• You cannot do this alone
• Seek out partners from the "get go" not only to get buy in, but also to identify internal resources as you move forward
Cost Avoidance as Any Other Line Item

- Budget for expected cost avoidance
- Come up with your best estimate of cost savings per patient, marry that with expected volume outcomes & come up with monthly & annual expected cost avoidance
- Incorporate this into your profit & loss statement & your business plan

Don't Forget About Other Fiscal Benefits

- Referrals to hospice
- Making other providers in the continuum more productive
- Avoidance of 30-day readmits
Financial Aspects of Palliative Care

- Generally, a Palliative Care program doesn’t generate sufficient revenue on a stand-alone basis to produce a positive margin
- Revenue can be subsidized with
  - philanthropic dollars
  - subsidies from a related hospital or health system
  - non-related hospital in which palliative care services are rendered
- Financial benefits of a Palliative Care program come from savings on the cost side

Palliative Care Operating Statement

- Revenue – from professional services (physicians & advanced practice professionals)
- Costs – salary & benefits, rent, travel, billing & collecting, administrative support, other overhead costs
- Cost savings – reduced length of stay more effective/efficient care plans (pharmacy savings, supply savings, procedure savings, etc.)
Cost Savings Financial Model

- Developed/endorsed by CAPC (Center to Advance Palliative Care)
- Information by patient by day
- Gross charges
- Total cost (direct & indirect)
- Palliative Care consultation date

Financial Model – Assumptions

- Eliminate the initial two days of care
- Eliminate the care if either
  - Pre – PC less than 2 days &/or
  - Post – PC LOS is less than one day
- Consultation date (day zero) is not included
- Consistent cost-to-charge ratio, or
- Compute a cost by day
Example

- Medicare patient
- Admit date: 7/26
- Discharge date: 8/4
- LOS: 9 days
- PC consult day: 7/30
- Pre-consult days: 2 (eliminate first 2 days of stay)
- Post-consult days: 5
- Pre-consult cost/day: $1,221
- Post-consult cost/day: $589
- Cost/day savings: $632
- Total cost savings: $3,160

Financial Benefits to Spectrum

- For the first nine months of our current fiscal year, Spectrum estimate they have reduced cost for palliative care patients by a total of $2.4 million
  - 458 encounters
  - $796/day cost savings
  - 3000 post-consult days
- Net operating margin of Palliative Care program before cost savings is a negative $265,000. Equates to net cost savings of approximately $2.1 million through nine months
### Additional Benefits

- Additional benefit of Palliative Care program is to increase referrals into your hospice program
- Can budget for cost savings by hospital department

### Planning/Staffing

- Demand will likely not be your biggest challenge, but rather workforce issues
- The provision of Palliative Care has different productivity expectations than other specialties
- Tends to be very time intensive with much coordination of care
Time-Motion Study

• You need to map out how long you think a visit should take (both intake visits & follow-ups)
• Figure out how many average total visits each new consult will receive
• Come up with the total time you expect each patient will take from intake to discharge
• Use this time amount to calculate how many staff you will need for a given consult volume

Example

• You determine that it takes approximately two hours (120 minutes) to do an initial patient visit after receiving a consult
• Each follow-up visit takes about 40 minutes
• You determine you do about four follow-up visits for every new patient you consult on
Example

So, for each new consult, you would expect the total time spent caring for them to be

- 120 Minutes (initial visit)
- 160 Minutes (four follow-ups)
- 280 total minutes per patient referred

Example

- Multiply total number of expected referrals times the time per patient to give you the total expected clinical hours you will need to cover per week/month/year
- Use this time amount to determine the number of FTEs you will need
Essential Partnerships

• Who are the stakeholders that you need to partner with to ensure the initial & sustained success of your program?
• Who are your customers?
• Who needs to be at the table as you establish your program & on an ongoing basis as your program continues to evolve?

Internal Partners

• Patients/families
• Physicians
• Institution’s hospice program
• Case managers
• Hospital administration
• Nursing leadership
• Quality department/process improvement
• Frontline staff
External Health Care Partners

- Hospice programs
- Home health agencies
- Community health care agencies
- e.g., Alzheimer's Association
- Insurance companies
- Health care facilities
- Outpatient physicians
- Outpatient clinics

Community Partners

- Churches
- Charities
- Social Groups catering to those you will likely serve
What Can Get in the Way?

- Leap of faith needed to believe the cost avoidance numbers
- Confusion with hospice
- Misunderstanding of what we bring to the table/the potential value we bring to patient care & to our partners

Overcoming Barriers

- Educate, educate & then educate again
- One patient at a time
- Lots of communication & looping back with partners within the system
How it is Working Out for Spectrum

• I arrived September 2010
• We have had tremendous growth since, starting about four months after my arrival

Growth Graph

Number of Patient Encounters

- September/2010
- October/2010
- November/2010
- December/2010
- January/2011
- February/2011
- March/2011
- April/2011
- May/2011
- June/2011
- July/2011
- August/2011
- September/2011
- October/2011
- November/2011
- December/2011
- January/2012
- February/2012
- March/2012
- April/2012
Conclusions

- Palliative Care provides myriad benefits to patients, their families & the institutions in which they reside
- Upfront work to help map out value of a palliative care program is essential prior to making the ask to start such a program
- Fiscal benefits extend far beyond simple revenue generation
Conclusions

• Think long & hard about all of your potential partners as you contemplate starting your palliative care program
• There are many potential structures for a palliative care program; assess your local environment & pick the one that works best for you
• Anticipate growth & plan accordingly
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