

SPECTRUM HEALTH



Palliative Care: A Business Analysis of the Pros and Cons of Establishing a Palliative Care Program

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Introduction

- More and more hospitals 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 at your institution and ways in which you can help others understand the value of palliative care to your local institution

Objectives

After attending this session, participants will be able to:

- Define palliative care and describe the role of a palliative care team within the organization as a whole
- Describe three potential financial benefits of having a palliative care program
- Describe 3 potential barriers to the establishment of a palliative care program and strategies to overcome these barriers

So, what is palliative care?

Coordinated, interdisciplinary care of patients with serious illness with a special focus on pain and symptom management and exploring patient choice and goals of care.

Current State of Palliative Care in the 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 and focuses on the care of those in the final stages of disease and 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 and regardless of treatments being received
- Example of how varied my days can be

Nuts and Bolts

- Structure of the palliative team
- Infrastructure Issues
- Choices of level of service

Structure of Palliative Care Team

- Physician
- Advance 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
- 5 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 wrap around to an inpatient consultative service
- Patients can be referred there upon discharge for ongoing palliative care
- Much more overhead versus inpatient service and less productive than an inpatient consultative service
- Will likely need to support this financially

How are palliative care services accessed?

- Depends on the institution
- Wide variety of potential mechanisms
- Will depend on the culture of the institution and the maturity/longevity of the 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 Quality Case
- The Business Case

The Patient Case

- Patients love it
- Expert pain and 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 healthcare reform?

Step 1

- Do your home work
- 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 and 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 \$2,000.00 per patient seen

Step 2

- Make sure that everyone buys in to the cost avoidance measures and metrics you use to measure impact
- Get commitment that 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 and secure partnerships within your organization to help you capture the fiscal impact and 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, multiply that with expected volume outcomes and come up with monthly and annual expected cost avoidance
- Incorporate this into your P and L and your business plan

Don't forget about other possible fiscal benefits

- Referrals to hospice
- Making other providers 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 and advanced practice professionals)
- Costs - salary and benefits; rent; travel; billing and collecting; administrative support; other overhead costs
- Cost savings – reduced length of stay; more effective/efficient care plans (Rx 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 and 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 and/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**

Benefits

- For the first 9 months of our current fiscal year, we estimate we've reduced cost for palliative care patients by a total of \$2.4 million.
 - 458 encounters
 - \$796/day cost savings
 - 3000 post-consult days
- Net OM of Palliative Care program before cost savings is a negative \$265,000. Hence, net cost savings is 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 and follow-up's)
- 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 2 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 4 follow-up visits for every new patient you consult on

Example (cont.)

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

120 Minutes (initial visit)

160 Minutes (4 follow-up's)

280 total minutes per patient referred

Example (concluded)

- Multiply the 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 FTE's you will need

Essential Partnerships

- Who are the stakeholders that you need to partner with to ensure the initial and sustained success of your program?
- Who are your customers?
- Who needs to be at the table as you establish your program and 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 Healthcare Partners

- Hospice Programs
- Home Health Agencies
- Community Healthcare Agencies
 - e.g. Alzheimer's Association
- Insurance Companies
- Healthcare Facilities
- Outpatient Physicians
- Outpatient Clinics

Community Partners

- Churches
- Charities
- Social Groups catering to those you will likely serve

So, 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 and to our partners

Overcoming Barriers

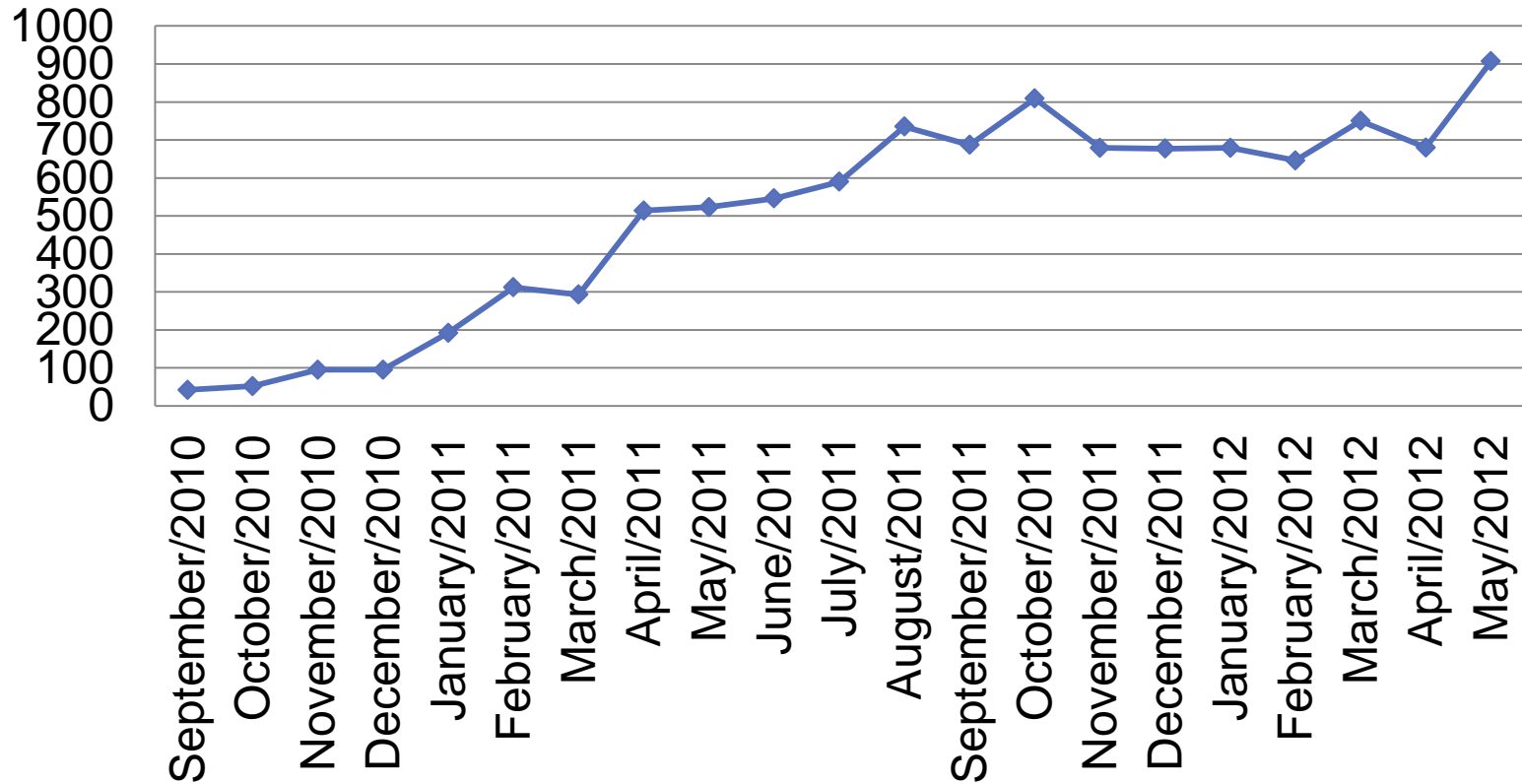
- Educate, Educate, and then educate again
- One patient at a time
- Lots of communication and looping back with partners within the system

How it is working out for us so far

- I arrived September, 2010
- We have had tremendous growth since, starting about 4 months after my arrival

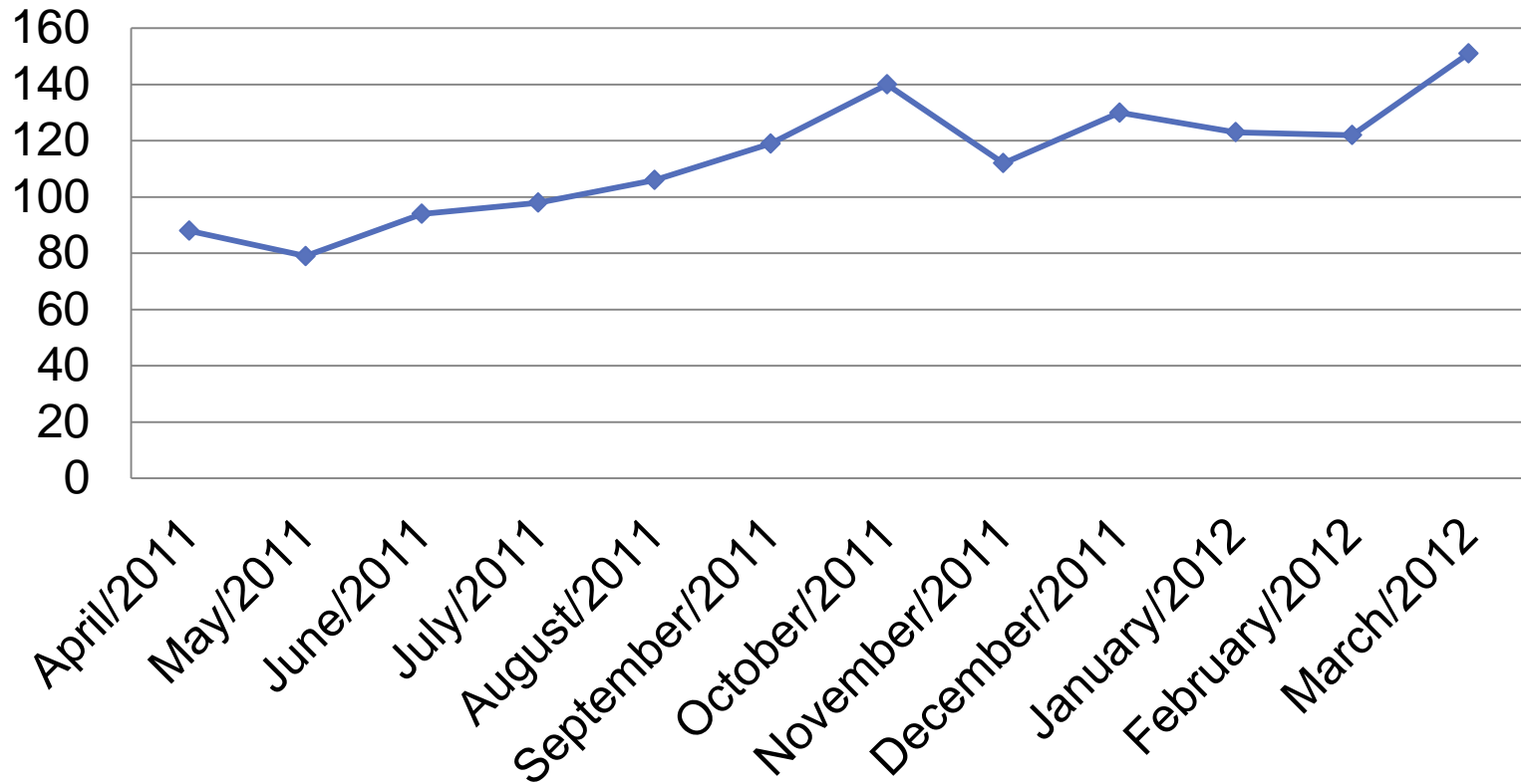
Growth Graph

Number of Patient Encounters



Growth Graph

Number of Patient Consults



Conclusions

- Palliative Care provides myriad benefits to patients, their families, and the institutions in which they reside
- Up front work to help map out the 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 (cont.)

- Think long and 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 and pick the one that works best for you
- Anticipate growth and plan according

Thank you

Questions?

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