



**National Hospice and Palliative Care Organization
Palliative Care Resource Series**

**SHOULD OUR HOSPICE PROVIDE
PALLIATIVE CARE? CONDUCTING
AN ORGANIZATIONAL ASSESSMENT**

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INTRODUCTION

In the late 1990's and early 2000's hospice programs and state and national organizations, including NHPCO, added "and Palliative Care" to their names. Many organizations started palliative care ("PC") programs; some were very successful, others floundered or functioned in fits and starts. The success was dependent on provider capacity, community partners and availability of staff. Other programs considered offering palliative care services, but were unable to make the business case to their governance.

Health Care Reform and its accompanying changes have altered the health care landscape. In many communities hospital systems have acquired physician practices. In other communities, large physician practices have joined with other providers to form care networks. Insurers and hospitals are focused on strategies to keep patients from being re-admitted to inpatient care and/or are joining other entities in new business ventures. All of these changes have resulted in a decreased length of stay for hospices.

This paper will discuss the potential benefits for a hospice organization to create a palliative care program including the addition of a new service line and corresponding revenue and/or referral stream. Program development, needs assessments, program models and financial considerations will also be described.

HOSPICE AS THE PALLIATIVE CARE PROVIDER

A successful palliative care program directed by a hospice depends primarily on three factors: sufficient community need, adequate financial resources and clinical resources at the hospice itself or in collaboration with a partner. Hospices are a natural community resource for the provision of palliative care.

- Hospice team members understand palliative care concepts and interventions and are experienced at discussing patient/family preferences at the end of life.
- Hospice medical staff can comfortably describe the advantages and disadvantages of particular treatments with a wide variety of patient/families.
- Many hospice staff are certified and specifically trained to care for patients who are appropriate for palliative care.
- Hospice staff are experienced at providing care in a variety of settings including the home, the acute care facility, the skilled nursing facility and other sites.
- When offering hospice and palliative care, the hospice may benefit from cross-utilization of the same staff in both programs.

IS PALLIATIVE CARE NEEDED IN MY COMMUNITY?

The first question any organization needs to ask is: Is palliative care needed in my community? If the community doesn't have any kind of palliative care program, the answer may seem obvious. The hospice organization still needs to determine the type of palliative care program it might offer and whether or not the provision of palliative care is feasible for the hospice.

Since hospices first began offering palliative care, many programs have emerged and in some communities there is an overlap in the continuum of care. A hospice organization seeking to initiate or re-energize a defunct or floundering palliative care program may begin with an internal staff discussion about the pros and cons before involving governance. The team involved in discussions should include administrative and clinical leaders, the medical director, and financial staff and representatives from the partner or potential partner. Once assured of the need, the provider can form a planning team/committee.

PROGRAM DEVELOPMENT

Program development considers many issues including developing a list of community programs already providing palliative care; investigating program models, capacity and resources of the hospice provider; examining financial and budget issues and uncovering additional helpful resources.

Develop a comprehensive list of programs providing palliative care in the communities the hospice organization serves.

When hospices began offering palliative care, competitors were few. If palliative care was offered in the community, it was likely that one hospital provided the service in its acute care setting. Today, palliative care is offered by most hospitals; particularly those with over 100 beds. Some hospitals also provide palliative home care. Nursing homes, home health agencies, private physician practices and even insurance companies may also provide services.

In addition, many communities have other services such as PACE programs that may enroll potential patients, transitions programs aimed at reducing hospital readmissions, (often provided by the area's Aging Agency), and private or institutional case management programs that may both limit the potential patient pool, and serve as future referral sources.

Evaluate the available services taking into account their history, competence, community reputation and locations to determine where your program might fill a need.

Is there an obvious gap in services? For example, a program may find that in the multiple county service area, one of three tertiary care hospitals has an inpatient PC program as does a large skilled nursing facility which serves only its residents. The hospice may explore a home care program with the acute care facility that values PC, an inpatient program with one or both of the other hospitals, a program offering PC to the other nursing facilities in the area or a program of any type in the surrounding area. Many hospice organizations serve several hospitals and various communities, thus opportunities may be broader than originally anticipated.

Investigate models, capacity, and resources of your hospice and potential partners.

The financial viability of a PC program is of paramount importance in determining whether and what kind of a PC program to initiate. The team should be brutally realistic about the financial and staff resources needed to operate the new program. New PC programs, and most programs of several years duration, rarely generate a positive bottom line. The program will need adequate financial resources to both fund and experiment with the model chosen for implementation. Every effort should be made to find partner(s) who can assist with the endeavor.

Investigate Program Models

Hospice planning committees, taking community needs into account, may explore the various models of palliative care as well as potential payers. Potential models include: an inpatient acute care model using from one to a full range of palliative practitioners in the hospital setting; an outpatient model that will provide services in nursing facilities; and a patient's home or in a clinic or palliative medicine practice.

Determine Capacity

Hospice planning teams must identify their knowledge deficits. Palliative practitioners need advanced clinical knowledge of aggressive treatment for diseases. The palliative care team also needs to understand the operation, regulations and goals of the settings in which they aspire to practice: home, hospital, nursing facility, long term acute hospital or other entity. Most programs will require some type of 24 hour on call service.

FINANCIAL CONSIDERATIONS

Palliative care programs can greatly decrease the cost of care for the most medically complex patients. However payment for provision of palliative care by an individual hospice organization's palliative care programs is limited. Medicare Part B and insurance payment for reimbursable practitioners such as physicians, nurse practitioners or other billable physician extenders, and in some outpatient settings, licensed social workers, represent the most usual income stream. Institutions such as hospitals, insurers and managed care organizations may augment reimbursement through subsidies or direct payments which reflect the additional costs of palliative care.

Healthcare Systems

Hospices that operate within healthcare systems anchored by hospitals, managed care or other insurers have an easier time funding a PC program as the financial incentives are aligned. In system "credit" for cost savings/cost avoidance to the overall system can fund the program, especially when combined with billing revenue. Successful examples of this model include organizations like Kaiser, a multi- state entity which serves as a healthcare provider and an insurer; Mt. Carmel in Columbus, Ohio; the Sharp system in San Diego; Sutter in the Bay area; and comprehensive systems in which a health system owns the entire continuum of acute care, home care and hospice.

Collaborative Models

Collaborative models can also break even. In these models a health system funds palliative care by contracting to support a large percentage or the entire program, or offers subsidies for visits. In this model the system may collect for the billable service or allow the hospice to do so, perhaps subtracting the billings. In many of the models the healthcare system may provide non billable staff or contract for those staff from the hospice. The collaborative model can be effective for both acute care, home and clinic models. Hospice of the Bluegrass is an example of this type of program.

Fee for Service, Per Diem or Capitated Rate

Some programs have partnered with a large insurance company like Blue Cross that agrees to pay either fee for service, a per diem or capitated rate for home-based palliative care services. Creative programs, such as Hospice of Michigan's @HOME program, have developed contracts which supply not only an adequate number of patients, but also an adequate payment, as well as a system for evaluating the savings generated to the health system, Accountable Care Organization (ACO) or insurer.

Medical homes have also contracted with specific hospice organizations to provide palliative care to their patients, particularly in California where capitated rates are common. Such contracts can provide a stable base for a homecare program. A contract with a dependable partner like an insurer, a union, an Accountable Care Organization, Medical or other entity guarantees both an income and referral stream.

Hospice as the Palliative Care Provider

The most difficult model for a hospice organization to sustain is one in which the hospice operates independently and is dependent on referrals from outside sources. Inpatient programs may have the greatest chance to break even if there are enough consults to support the program. The most difficult to support is a home care program since travel time further erodes the limited patient billing. The planning committee needs to be exceedingly careful in choosing this model.

ANALYZING THE DEMAND AND MAKING THE BUDGET

Once a model is chosen, the hospice organization must put pen to paper to determine the revenue and expense of that model. One of the values of partnership is that the insurer or hospital partner will know more about their patients or beneficiaries, including the value of the cost avoidance when the palliative care program reduces costs, prevents inpatient admissions or leads to earlier and more hospice admissions. Some knowledge of the volume of services is needed to estimate both income and expenses. In most models, space, administrative and some clinical staff can be shared with the hospice.

Additional important to do's for the hospice provider includes the following:

- Hospice providers who chose to provide palliative care will need to obtain a Medicare Part B billing number.
- Billable practitioners also have to be credentialed with other payers including Medicaid and private insurers.
- Payments will vary based on the setting in which the service is rendered (i.e. the inpatient setting versus the patient's home or a facility), the type of service provider (MD, ARNP) and type of visit (initial or follow-up) and the duration of the visit.
- The number and type of each visit will need to be estimated to determine the revenue stream. The hospice may know the cost of staff and can estimate the number of hours for each person working in the program.

Before a hospice organization makes the final decision to provide palliative care, the difference between cost and income must be calculated. Most likely, particularly initially, the bottom line will be negative. Decision makers need to determine if the deficit will be offset by potential service differentiation, partnership or customer development and the potential for additional patients and/or increased length of stay.

OTHER CONSIDERATIONS

Pilot Programs

Pilot programs can be very helpful in determining the potential success of a full-fledged palliative care program. An inpatient program might cover one service or one floor in a facility for a specified period of time. A home-based program could begin with 20 referrals from a hospital or insurer. Pilot programs help staff understand the strengths and weaknesses of their program and may reveal unexpected challenges and opportunities.

State and Federal Regulations

State and federal regulations impact how any program can be organized and implemented. Legal advice from a healthcare attorney should be sought early in the planning process. The hospice organization can benefit from a partner's legal counsel, but should also be represented by its own counsel.

Additional Resources

Some communities have philanthropic resources which can be accessed for startup and support. Since palliative care has been around now for nearly two decades, start-up funding is not as available as it was in the early days and is almost never available from governmental or national philanthropies. However, family, healthcare system and community foundations are definitely worth exploring.

Educational resources are available from NHPCO and other programs. Studying the many resources is a wise investment of staff time and will be helpful in the process. The hospice organization may also consider hiring a consultant to help insure success and help inform decision makers.

CONCLUSION

Education and planning are the keys to making the best decision about providing palliative care. Hospice organizations are ideal palliative care providers and partners, but only if they can provide quality services at a cost that does not negatively affect the hospice.