



NHPCO Palliative Care Playbook for Hospices



NHPCO
National Hospice and Palliative
Care Organization



Kathy Brandt (right) with wife Kimberly Acquaviva (left) and son Greyson Acquaviva.

NHPCO dedicates the Palliative Care Playbook to Kathy Brandt.

The NHPCO Palliative Care Playbook is available in part because of the dedication and excellent work of Kathy Brandt. Kathy was integral to the development of the Playbook serving as an author and editor. Kathy was a writer and editor for the National Consensus Project's Clinical Practice Guidelines for Quality Palliative Care, 4th edition, released in 2018 and NHPCO's Palliative Care Playbook released in 2019. She spent more than 30 years working on behalf of hospice, palliative care, advance care planning, and was helpful to many organizations as the principal and founder of the consulting firm, kb group.

Kathy Brandt was a respected leader in the hospice and palliative care community. She died peacefully at her home in Charlottesville, Virginia on August 4, 2019, from ovarian cancer. When she was diagnosed with a terminal illness, Kathy, along with her wife Kimberly Acquaviva and son Greyson, determined to share her journey via blogs, social media posts, speaking engagements, and photos online. Kathy has left an incredible legacy and NHPCO is grateful for her contributions to advancing the care of seriously ill individuals and their families and raising awareness and strengthening community engagement throughout the country.

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NHPCO Palliative Care Playbook for Hospices

Introduction



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The National Hospice & Palliative Care Organization (NHPCO) added the term “palliative care” to its name almost 20 years ago. Then, as now, NHPCO, is interested in as many people receiving person-centered, interdisciplinary care as possible. Then, as now, the term is defined and delivered in different ways by different people and entities. This playbook is aimed to demystify and clarify the term, and to answer a few crucial questions: what is palliative care, and how do I deliver it in the best way possible? Thank you for your interest, and for the work that you do every day to improve the lives of countless people in your community.

Hospice-based Palliative Care

The National Hospice and Palliative Care Organization (NHPCO) defines palliative care as:

“Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice.”

– **Centers for Medicare & Medicaid Services**, Department of Health and Human Services. Hospice care. Code of Federal Register. 79 FR 50509, August 22, 2014.

The National Consensus Project for Quality Practice Care defines palliative care as follows in the [Clinical Practice Guidelines for Quality Palliative Care](#), 4th ed.:

“Beneficial at any stage of a serious illness, palliative care is an interdisciplinary care delivery system designed to anticipate, prevent, and manage physical, psychological, social, and spiritual suffering to optimize quality of life for patients, their families and caregivers. Palliative care can be delivered in any care setting through the collaboration of many types of care providers. Through early integration into the care plan of seriously ill people, palliative care improves quality of life for both the patient and the family.”

For the purposes of this document, hospice-based palliative care encompasses a service line or subsidiary organization that is developed by a hospice to provide services outside the hospice Medicare or Medicaid benefit. Typically, these services are provided to patients and families prior to their eligibility for the hospice benefit, based on clinical indicators, a decision to continue life-extending care, or other factors.

There are multiple models of hospice-based palliative care services. They are often based on the specific needs of the community that is being served, the identified patient population, the scope of services provided, the care setting, and/or the payer source.

The Palliative Care Playbook for Hospices

NHPCO believes that all hospices should evaluate the feasibility of offering palliative care services in their community for several reasons:

1. By the time patients are referred and admitted to hospice, the majority of them have a very short length of stay, despite significant care needs
2. The move to value-based care has led health systems and payers to develop partnerships with post-acute care providers to provide care to those with a serious illness to manage costs and improve quality
3. The increased competition for patients in the post-acute care space among home-based service providers could lead to fewer or later hospice referrals
4. Hospices need to find diversified funding streams to hedge against cuts to the hospice Medicare/Medicaid reimbursement rates.

This Palliative Care Playbook provides step-by-step instructions developed by hospice experts, to guide hospices in the development and implementation of a palliative care program. It is based on the NHPKO Palliative Care Needs survey, conducted in mid-2018, as well as the expert advice of the NHPKO Palliative Care Council and other experts. The Playbook explores every aspect of program development and includes dozens of templates and resources modified to for easy adaptation by hospices of all sizes and organizational capacities.

While the development process outlined is designed to be followed sequentially, programs at all stages of development and implementation can find suggestions and resources to help improve services and processes.

Hospices are encouraged to use the [My.NHPKO.org](https://www.nhpko.org) palliative care discussion group to ask clarifying questions, share best practices, and upload additional resources to help other hospices.



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Acknowledgements

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Transitions LifeCare

Transitions PalliativeCare

Treasure Coast Hospice

Western Reserve Navigator

NHPKO Palliative Care Advisory Council



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Palliative Care Considerations



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Models

Planning a palliative care program begins with a careful consideration of the existing models of care and ways hospices have implemented these models in various care settings.

There are several models for delivering palliative care:

Consultative

Consultative palliative care is similar to the other types of specialist healthcare. The palliative care team receives referrals, often focused on a specific symptom or issue (i.e. pain and other symptoms, goals of care conversations). Following an assessment, the palliative care specialist provides recommendations to the referring provider.

The consultation is typically delivered by a palliative care specialist practitioner (physician, nurse practitioner, physician assistant). Consultative palliative care is provided in all care settings (home, clinic, long-term care, assisted living facility [ALF], and the hospital).

Practitioner encounters are reimbursed by fee-for-service (FFS) Medicare/Medicaid, and some private insurance providers.

Consultative palliative care services can include, but are not limited to:

- Conducting goal clarification and advance care planning conversations
- Providing symptom management recommendations
- Facilitating a discharge or care transitions process from inpatient to outpatient care

Consultative palliative care specialists or teams typically don't write orders, issue prescriptions, or provide ongoing case management, but instead offer suggestions to the referring provider.

Transitions PalliativeCare is a specialty consultative service serving patients and families in North Carolina. The program is staffed by physicians, nurse practitioners, and medical social workers and care is available in individual homes, assisted living facilities, long-term care facilities, and hospitals. The program is reimbursed via FFS Medicare and Medicaid and health plans.

Co-management

Co-management palliative care is different from consultative palliative care, in that the palliative care specialist works collaboratively with other specialists/providers to develop an integrated care plan that includes ongoing disease-oriented therapies as well as the palliative care interventions and support. The palliative care specialist or team may write orders and prescriptions, and provide ongoing care plan management in collaboration with the patient's other provider(s).

In a co-management model, an interdisciplinary team helps the referring practitioner to manage an integrated care plan that addresses both life-extending and palliative approaches to care. The team can include practitioners (physicians and/or nurse practitioners or physician assistants), social workers, chaplains, and others based upon the needs of the patient and family.

Co-management palliative care is provided in all care settings and practitioner encounters are reimbursed by FFS Medicare/Medicaid. Palliative care teams have also been successful in negotiating a case rate with payers that reimburse for the comprehensive services a palliative care team provides.

Co-management palliative care services can include:

- Conducting goals of care and advance care planning conversations
- Providing ongoing symptom assessments
- Developing and managing the palliative plan of care, in collaboration with referring providers
- Facilitating discharge or care transitions processes
- Writing prescriptions and orders
- Supporting family caregivers

Under the umbrella of Lower Cape Fear Hospice, the Palliative Care program was initiated in 2002. Over the years, the program has grown tremendously to include an inpatient program, home-based community program, and, most recently, the addition of outpatient clinics. The program is consultative and co-management with the patient's provider.

Case Management

When the palliative care team assumes a case management role, they assume primary responsibility for the patient's ongoing care needs, in collaboration with other care providers. The team, which includes practitioners, social workers, chaplains, and other staff, facilitates all aspects of the patient's care related to the serious or life-limiting illness and manage care transitions, as needed. The palliative care team assumes care plan oversight, in close collaboration with the patient and family, coordinating care with other service providers, including physicians, home health care, occupational and physical therapists, and community service providers.

The case management model mirrors many aspects of the hospice model of care, with several important distinctions:

- The palliative care team does not assume financial responsibility for any aspect of the patient's care such as the medications, DME equipment or outpatient therapies
- The patient may continue to receive disease-modifying therapies that are not palliative in nature
- The palliative care team can provide ongoing care and support for months or years
- Palliative care programs can establish visit schedules based solely on patient and family needs

Case management palliative care is provided in all care settings and practitioner encounters are reimbursed by FFS Medicare/Medicaid. Palliative care teams have also been successful in negotiating a case rate with private payers that reimburses for the comprehensive services a palliative care team provides.

Case management palliative care services can include:

- Conducting goals of care and advance care planning conversations
- Providing ongoing symptom assessments for all care needs
- Developing and managing a comprehensive plan of care that addresses all of the patient's care needs
- Facilitating discharge or care transitions processes
- Writing prescriptions and orders
- Supporting family caregivers

Model	Team Role	Reimbursement
Consultative	Provide recommendations to referring provider(s)	<ul style="list-style-type: none"> • FFS Medicare/Medicaid
Co-management	Develop and manage palliative care plan	<ul style="list-style-type: none"> • FFS Medicare/Medicaid • Private payer Contracts
Case Management	Develop and manage care plan addressing all care needs	<ul style="list-style-type: none"> • FFS Medicare/Medicaid • Private Payer Contract

A number of providers offer more than one type of palliative care service, based upon the needs of the referral sources, partner organizations (hospitals, post acute providers, long-term care providers, physician groups), and payers. These "mixed models" can develop a diversified referral base as well as a mix of reimbursement rates, balancing the low FFS Medicare/Medicaid payments with contracts that provide reimbursement for services provided by the entire palliative care team.

Care Settings

Hospices can provide palliative care in all care settings. Below are short descriptions of palliative care offered in the various care settings.

Home

The shift from fee-for-service to value-based care is a driving force behind the need for more home-based care. Seriously ill patients are often discharged from the hospital with intense care needs and very little post-discharge support.

CMS is currently testing the efficacy of home-based primary care and a new demonstration Serious Illness Alternative Payment Model possibly in early 2019. Both home-based primary and palliative care provide essential services that can prevent unnecessary hospital (re)admissions and ER utilization.

Home-based palliative care services are typically delivered via a co-management or care management model, with the team:

- Facilitating goals of care and advance care planning conversations
- Anticipating, preventing, assessing, and managing patient symptoms
- Assessing the needs of family caregivers, providing support and hands-on care education as needed
- Performing a comprehensive medication reconciliation
- Conducting a home risk assessment
- Providing 24/7 access to palliative care experts to address emergent care needs

The intensity and frequency of home-based palliative care encounters depends on the patients' needs. Upon discharge from the hospital or long-term care, patients may need more frequent home visits. Visits may then decrease until there is a symptom exacerbation due to the illness or life-extending treatments (e.g., chemotherapy). In between home visits the team can provide regular telephonic or videoconferencing support to assess how the patient and caregiver are coping, identify physical, emotional, or spiritual distress, discuss new or ongoing challenges, and answer any questions. These regular contacts are a cost effective way for the team to identify new or emergent issues that require a home visit.

Services provided in the home are reimbursed under FFS Medicare or Medicaid as well as through contracts with health plans or other at-risk entities.

Physician Office/Clinic

Some hospices form strong partnerships with physician practices and outpatient clinics to provide earlier access to palliative care. Hospices can co-locate or embed staff in the practice or clinic providing a range of services, based upon the referral from the practitioner.

Palliative care in a clinic is typically consultative in nature. Services provided to patients in a clinic include:

- Discussing patient prognosis
- Facilitating goals of care and advance care planning conversations
- Assessing and recommending pain and symptom management treatment
- Identify community resources that can support the patient/caregiver in the home setting

Services provided in the physician office or clinic are reimbursed under FFS Medicare or Medicaid as well as through contracts with health plans or other at-risk entities. When the palliative care team is embedded in the physician office/clinic, FFS claims to Medicare or Medicaid often are submitted by the physician practice/clinic. In those arrangements the palliative care team is paid by the clinic under a contractual arrangement.

The following image illustrates the type of patients seen in a primary care clinic or physician practice that could benefit from palliative care.



High-Risk Patients (at risk for dying in next 1 to 2 years)

In addition to all interventions for At-Risk Patients:

- ▶ Formalize assessment of functional status, needs for caregivers, and medical equipment
- ▶ Formalize screening for caregiver burnout/distress
- ▶ Refer to specialty palliative care for additional support, if available

At-Risk Patients (with serious illness or illnesses)

In addition to all interventions for All Patients:

- ▶ Formalize routine symptom assessment (pain, non-pain physical symptoms, depression, anxiety)
- ▶ Develop pathways for managing identified symptoms and referring to appropriate specialists when needed
- ▶ Develop routine visits to clarify state of medical conditions, provide information on prognosis (if desired), and anticipate future decisions
- ▶ Develop routine visits to clarify patient/family concerns, goals of care
- ▶ Develop routine visits to discuss end-of-life concerns and wishes

All Patients in the Practice

- ▶ Screen for prior advance directive completion for all adults (or adults over age 50) and provide support and information to encourage completion
- ▶ Identify and document surrogate decisionmaker(s)
- ▶ Conduct discussion of preferences for medical information sharing
- ▶ Ensure electronic health record has the ability to document all of the above

California HealthCare Foundation. *Weaving Palliative Care into Primary Care: A Guide for Community Health Centers*. Accessed on 1/5/19: www.chcf.org/publications/2015/08/weaving-palliative-care

Long-term Care

Residents in long-term care settings benefit from the services that palliative care teams provide. Hospices can expand upon their existing relationships with long-term care facilities providing palliative care consultations to seriously ill residents.

Similar to the services provided in physician offices and clinics, palliative care in long-term care settings is usually either consultative or delivered via a co-management arrangement. Palliative care services provided to long-term care residents can include:

Consultative

- Discussing patient prognosis
- Facilitating goals of care and advance care planning conversations
- Assessing and recommending pain and symptom management treatment

Co-Management

- Facilitating goals of care and advance care planning conversations
- Anticipating, preventing, assessing, and managing patient symptoms
- Assessing the needs of family caregivers providing support and education as needed
- Performing a comprehensive medication reconciliation
- Providing 24/7 access to palliative care experts to address emergent care needs

Services provided in long-term care settings are reimbursed under FFS Medicare or Medicaid as well as through contracts with the long-term care facility or health plans. When the palliative care team is providing co-management of the patient's plan of care, the long-term care provider may submit FFS claims to Medicare or Medicaid and pay the palliative care team under a contractual arrangement.

Resource: Tomorrow's nursing homes must integrate palliative care
www.mcknights.com/blogs/guest-columns/tomorrows-nursing-homes-must-integrate-palliative-care/

Assisted Living Facility

Palliative care in assisted living facilities varies depending on a variety of factors, including state-specific licensure and regulatory requirements for assisted living facilities. The ability of the assisted living facilities to co-manage a palliative care plan will depend upon the level of staffing provided at the facility. As a result, palliative care services provided to assisted

living residents are typically consultative and can include:

- Discussing patient prognosis
- Facilitating goals of care and advance care planning conversations
- Assessing and recommending pain and symptom management treatment

Services provided in assisted living facility settings are reimbursed under FFS Medicare or Medicaid. When an assisted living facility is part of a large senior living community, the palliative care team can contract to provide an embedded practitioner to serve those in independent apartments, an assisted living unit, and the long-term care facility.

Hospital

Palliative care consultations are offered throughout hospitals, from the ER, to the oncology unit, to the ICU. Some hospitals also have dedicated palliative care units, with the palliative care team overseeing or co-managing the patient's plan of care. Typically, patients are referred due to intractable pain and other complex pain and symptom management needs. Palliative care units are staffed by palliative care specialists and provide support 24 hours a day, 7 days a week. The staff assigned to the unit may also provide consultations to patients elsewhere in the facility.

Some hospices contract with hospitals to provide palliative care consultations during an inpatient admission and/or to provide pre- and post-discharge support.

Palliative care services provided in the hospital can include:

Consultative

- Discussing patient prognosis
- Facilitating goals of care and advance care planning conversations
- Assessing and recommending pain and symptom management treatment

Co-Management

- Facilitating goals of care and advance care planning conversations
- Anticipating, preventing, assessing, and managing patient symptoms
- Assessing the needs of family caregivers providing support and education as needed
- Providing 24/7 access to palliative care experts to address emergent care needs
- Identifying and coordinating post-discharge services and supports needed to meet patient and family goals

Reimbursement for hospital palliative care is typically through FFS Medicare or Medicaid. Recognizing the value of hospital-based palliative care, many health systems subsidize the provision of palliative care in order to achieve value-based care goals.

Organizational Structure

Many hospices opt to create a separate entity for each new service line, such as palliative care. Each organization has its own governance structure, strategic priorities, and budget. Sometimes staffing is shared across organizations, allowing for flexibility based upon census and other factors.

To accomplish this, sometimes hospices set up an oversight organization that provides overarching governance for separately incorporated hospice, palliative care, and other entities. Given the complexities of state licensure, corporate practice of medicine, and other regulations, it is imperative for a hospice to check with an attorney prior to starting any new service line, including palliative care.



The results of the palliative care needs assessment also can impact the structure of the palliative care program. For example, the needs assessment results can indicate that a joint venture with a health system or another partner is the most viable approach for hospice palliative care program.



NHPCO Palliative Care Playbook for Hospices

Regulations, Licensure, and Credentialing

This chapter is also available as a Grab & Go Toolkit:
www.nhpc.org/palliativecare



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Introduction

A hospice provider may be familiar with the rules related to offering patients the hospice benefit. However, once a hospice provider decides to offer services outside of the hospice benefit, it is important to be sure that it will be offered in a compliant way. A palliative care offering includes a variety of different types of services and can be defined differently by different states and by health care payers. Consequently, developing a palliative care offering has a variety of business and legal/compliance implications.

Each health care service offered by a provider must be offered in a way that is compliant with both federal and state laws that may relate to the offering. Each health care payer also may have its own additional rules related to the coverage and payment of claims for a particular service. Some rules are about the type of legal entity that is eligible for billing for the covered service. Other rules are about the type of licensure that might be required for the individual service provider to be eligible to perform the covered service. The information below is meant to provide a brief overview of the major legal/compliance issues that you should consider addressing when you are considering expanding to include a palliative care services offering.

It is suggested that hospice providers discuss these various legal/compliance issues with legal counsel before initiating the new palliative care offering. A full disclaimer appears at the bottom of this page.

Corporate Structure

Decision point: What are the factors that I should consider in deciding how to structure a palliative care offering in relation to my existing hospice company?

A palliative care offering can be structured as one of various organizational forms, including through the hospice entity, itself, or through a separate corporate entity (see below for licensing and other factors in this decision). In circumstances where you (and with the recommendation of counsel) have made the strategic decision to establish a separate corporate entity, some common organizational forms to consider using include corporations, limited liability companies ("LLC"), and partnerships. Below is an overview of several key factors to help inform which business structure will be the most appropriate for your palliative care offering.

For additional resources on factors to consider in the business structure planning process, see this guide provided by the Federal Small Business Administration: www.sba.gov/business-guide/launch-your-business/choose-business-structure.

Liability Protection

A corporation limits the liability of its shareholders (the "part-owners" or "stockholders" of the corporation) so that shareholders are generally not held personally responsible for any corporate debts, obligations, and liabilities (unless subject to a "piercing the corporate veil" action). Like its name suggests, a limited liability company also limits the personal liability of its members (those who hold ownership interest in the LLC). Partnerships can be structured in many ways, including in a way that limits liability of its limited partners. However, general partnerships do not provide this protection. In general partnerships, all parties share the legal and financial liability of the partnership equally. An organizational form must be established and structured properly in order to adequately shield its owners from liability. We, therefore, recommend that before you undertake to set up any of these organizational forms that you consult with counsel.

Another consideration to explore with counsel relative to liability protection is how establishing your palliative care offering through a separate legal entity may assist in shielding the assets of your hospice business from potential liability risks that could arise in the provision of palliative care.

Corporate/Ownership Tax Strategy

Corporations must elect, via the Internal Revenue Service ("IRS") [Form 8832](#), to be taxed separately from its owners. Corporations must report their income and expenses and file the U.S. Corporation income Tax Return ([IRS Form 1120](#)). Shareholders must also pay income tax again at their individual rate on any dividends or other disbursements from the

corporation. This means that corporations are subject to “double income taxation.” For IRS purposes, an LLC is treated like a partnership by default so long as it has two or more members. Only an LLC’s members, and not the LLC, itself, are subject to income tax. The IRS does enable LLCs (and other business entities) to affirmatively elect tax treatment like that of a corporation by filing the Form 8832. More information on the tax classification of LLCs can be found on the [IRS website](#). Partnerships also do not pay an income tax. However, partnerships are required to file a U.S. Return of Partnership Income ([IRS Form 1065](#)) and its partners must report their distributive share of partnership income, expenses, and any other items on the [IRS Form 1065, Schedule K-1](#) and their individual income tax returns.

More detailed information on business entity tax requirements and business income can be accessed via the IRS website, notably at tax [“Topic Number 407 – Business Income.”](#)

Corporate Practice of Professional Services

In many states, the corporate practice of a professional service (hereinafter referred to as “Corporate Practice”) prohibits business entities from practicing medicine or other health professions (like nursing, social work, pharmacy) or enlisting individuals to practice a health profession through the business entity. The degree to which Corporate Practice prohibitions restrict a business entity from “practicing” a health profession varies by state. Most states allow professionals to provide these services through some form of “professional” organization, such as a professional corporation or professional limited liability company. The structure and requirements of valid professional organizations also vary by state, but the primary requirement is generally that the owners/shareholders/partners must be licensed to practice that profession.

Refer to the section below for more details on the Corporate Practice of Professional Services.

Licensing Requirements for Any New Entity or for Individuals Providing Care

Licensing requirements for entities and health care providers vary by state. Some state hospice licensure laws limit a hospice organization’s ability to deliver palliative care services to non-hospice patients because these laws lack the flexibility to allow a licensed hospice to provide services to non-hospice patients, or to provide some, but not all, of the interdisciplinary services that hospices are typically required to provide to patients. Conversely, some state licensure laws may define the scope of services requiring hospice licensure so broadly that even palliative care services offered to non-hospice patients must be offered through a licensed hospice. In addition, state laws on home health services and home health agency licensing may be implicated by some models of palliative care.

These limitations may dictate whether your palliative care offering may or may not be offered through a separate entity. In some instances, as described in more detail below, it may be possible to deliver palliative care services to non-hospice patients through a contractual arrangement or through establishing a joint venture.

Access to Financing

Many factors can influence a business entity’s access to financing, including the organizational structure of that entity. Corporations have broad financing capabilities. For example, corporations may be more successful seeking investments through venture capital funds or “angel investors” since these investors will not be taxed individually for these investments (as they would in most LLCs and partnerships). Corporations may also issue public stock. LLCs and partnerships may need to engage in “equity financing,” whereby members/partners invest capital into the LLC/partnership or consider adding new members/partners.

Joint Venture Opportunities

A joint venture (“JV”) is the arrangement between two or more business entities to undertake a specific project or business activity. JVs often create a new business entity, which can have the structure of any of the organizational forms described above but with shared ownership, governance rights and responsibilities. Therefore, the same considerations apply. Some JVs are created on a purely contractual basis and do not involve a new business entity. JVs are described in more detail in the joint venture section below.

Specific Questions About Corporate Practice of Professional Services

What is “the corporate practice” of professional services and how is it regulated?

The Corporate Practice of a professional service prohibits business entities from practicing medicine or other health professions (like nursing, social work, physical or occupational therapy, or pharmacy) or enlisting licensed individuals to practice a health profession through the business entity. The degree to which Corporate Practice prohibitions restrict a business entity from “practicing” a health profession varies by state. Corporate Practice restrictions can be established through state legislation/laws, through the regulations promulgated by the relevant professional board (e.g., Board of Medicine, Board of Nursing), or through case law or administrative actions.

In some states, Corporate Practice prohibitions also encompass what are called “fee splitting” prohibitions. This is discussed in greater detail in the fraud and abuse section below.

Although some changes to state laws and enforcement have occurred since its completion, the American Health Lawyers Association ([AHLA](#)) [Corporate Practice of Medicine Doctrine 50 State Survey Summary](#) provides a good background on, and a starting place for, corporate practice of medicine laws.

How might Corporate Practice regulations impact my palliative care offering?

Corporate Practice laws may determine what type of relationship hospices and palliative care programs can have with health care professionals who are going to render the palliative care services. Some states prohibit the employment of certain licensed professionals by lay entities; other states even go so far as to prohibit lay organizations from contracting with licensed health professionals to provide the particular service to patients of the lay organization. For example, a lay entity operating a palliative care program that employs or contracts with a licensed physician in a state that has a Corporate Practice prohibition against such arrangement may be placing both the physician and business entity at risk. These include: (1) the risk of sanctions against or loss of their respective licenses (if the palliative care entity is licensed); (2) the palliative care entity may face sanctions or penalties from the state medical board for the unlicensed practice of medicine; and (3) in some states the unlicensed practice of medicine can be a criminal offense. In addition, a Corporate Practice prohibition can render the underlying contract or arrangement (e.g., employment contract) unenforceable.

Some states have created exceptions to their Corporate Practice prohibitions. For example, some state laws explicitly allow hospitals or hospices to employ physicians.

What questions should I ask my counsel about the corporate structure of my palliative care offering and the corporate practice of professional services?

Some examples of questions that hospice organizations should ask counsel when structuring a palliative care offering are below:

- What are the types of state restrictions on corporate practice of physician services and are there any exceptions?
- What are the types of state restrictions on corporate practice for other licensed professionals (e.g., physical and occupational therapists, social workers, optometrists, nurses, etc.) that may be involved in the provision of palliative care?
- Does the state impose any restrictions on the practice of professional services by foreign corporate entities?
- Does the state allow for a palliative care entity to independently contract with individuals or entities practicing the profession subject to the prohibition?
- In states that have corporate practice restrictions, how does the state approach management agreements?

What are some examples of corporate practice of professional services prohibitions from key states?

- **New York:** Only a person (including a compliant professional corporation) licensed or otherwise authorized as a physician may practice medicine in New York State. See [N.Y. Educ. Law § 6522](#). Similar restrictions apply to other categories of licensed professionals. However, New York has several exceptions to this prohibition. For example, “a not-for-profit medical or dental expense indemnity corporation or a hospital service corporation organized under the insurance law may employ licensed physicians and enter into contracts with partnerships or medical corporations organized under article forty-four of

the public health law, health maintenance organizations possessing a certificate of authority pursuant to article forty-four of the public health law, professional corporations organized under article fifteen of the business corporation law or other groups of physicians to practice medicine on its behalf for persons insured under its contracts or policies." See [N.Y. Educ. Law § 6527](#).

- **California:** Under California's Medical Practice Act, "[C]orporations and other artificial legal entities shall have no professional rights, privileges or powers." See [Cal. Bus. & Prof. Code § 2400](#).
- **Texas:** It is a violation of the doctrine for a corporation comprised of lay persons to hire licensed physicians to treat patients and receive fees for these services. See [Gupta v. E. Idaho Tumor Institute, Inc.](#), 140 S.W.3d 747 (Tex. App. 2004).
- **Florida:** Although no state statutes or regulations exist that expressly prohibit the corporate practice of medicine, an early Florida Attorney General Opinion appeared to prohibit the corporate practice of medicine. See [Fla. Op. Att'y Gen. No. 055-71 \(Mar. 25, 1955\)](#). However, various Florida case law and Florida Board of Medicine statements and orders have established permitted professional practices by specific business entities. Contact legal counsel for permissive practices related to specific cases.
- **Ohio:** A corporation can practice a profession, but cannot control the professional clinical judgment exercised by the professional in rendering care, treatment or professional advice to the individual patient. See [Ohio Rev. Code Ann. § 1701.03\(D\)](#).
- **Washington:** Neither a corporation nor any unlicensed person or entity may engage, through licensed employees, in the practice of the learned professions. See [Morelli v. Ehsan](#), 756 P.2d 129 (Wash. 1988).

Joint Ventures

Why might I want to form a joint venture in order to create a palliative care offering?

Joint ventures involve the formation of a new business entity or contractual relationship (the "Joint Venture" or "JV") by two or more existing business entities. JVs are usually preferred in order to pool resources (e.g., financing, industry knowledge and specialized staff, industry relationships/goodwill, etc.), increase capacity, and accelerate growth. JVs can also be formed to comply with various state laws. For example, in states with licensing laws that restrict a hospice organization from providing non-hospice palliative care, a JV may be formed to allow the hospice to provide non-hospice palliative care to another licensed entity (e.g., a hospital, home health agency, nursing facility, or physician practice).

What is my role/ownership in this partnership? Do I share the majority of the business risk?

The answer to these questions depends on how the joint venture is structured. JVs can be customized to allocate "control" and/or "business risk" to the parties involved in the JV. This structure is generally governed by an operating agreement.

We note that there can be certain fraud and abuse risks in establishing and operating a joint venture, and therefore recommend that you work with counsel to design a compliant JV.

Specific Questions about State Licensure

Do state licensing laws allow my existing hospice company to provide palliative care to non-hospice patients pursuant to my hospice license?

Under some state licensing laws, hospices are not allowed to provide non-hospice palliative care while in others, state licensing laws require an entity providing non-hospice palliative care to be licensed as a hospice, home health agency or other entity. Therefore, it is important to contact your counsel to get an understanding of your state licensing laws as it applies to non-hospice palliative care.

If state licensing laws do not allow me to provide non-hospice palliative care through my licensed hospice, what other options are available?

If state licensing laws interfere with a hospice's ability to directly provide non-hospice palliative care, you may consider whether to establish a separate entity through which these services can be provided, such as a subsidiary or sibling entity to

the hospice entity. You might also consider creating a joint venture through which palliative care services can be provided. Additionally, if you are a hospice that is part of a larger health system, palliative care may be able to be provided through other licensed entities within the system (e.g., hospital, home health agency, physician group practice) with appropriate arrangements to utilize hospice staff.

Even if you are not a part of a health system, it may be possible to provide palliative care services through contractual arrangements with third-party entities or groups. For example, a physician group practice specializing in palliative care may look to enlist a hospice organization to provide social work services to its patients. There are a number of legal and compliance considerations that you should discuss with your counsel to identify the right approach for you.

What types of health professionals are needed to provide palliative care and at which locations (e.g., facility/office-based vs. home/community-based)?

In broad terms, palliative care generally addresses patient and family physical, psychological, social, and spiritual needs to improve quality of life. Physicians, nurses, social workers, and chaplains can each play a role in providing palliative care. What constitutes “palliative care” and governs the location(s) where it can be provided is ultimately dependent upon the definition employed by payers in framing the scope of their covered services. For example, Medicare regulations set forth a definition of [“palliative care”](#) that is specific to the Medicare Hospice Benefit but does not speak to what types of non-hospice “palliative care” services are covered by Medicare. Individual states may also specify the scope of services that non-hospice palliative care must encompass pursuant to licensure requirements. In addition, the [National Consensus Project Guidelines for Quality Palliative Care, 4th edition](#) has developed guidelines for palliative care that have been endorsed by a broad range of professional and trade associations, including NHPCO.

Medicare Provider Enrollment

What is the process for becoming a Medicare supplier for palliative care services?

Overview

Medicare Part A does not have a dedicated palliative care benefit like the hospice benefit, and therefore palliative care is not reimbursed under Medicare Part A. Medicare does not even use the term “palliative care,” beyond the Hospice Conditions of Participation and the Long Term Care Facilities Final Rule. Medicare reimbursement is dictated by the specific services covered under the standard Medicare Part B benefit, such as physician services.

Therefore, in order to bill and receive payment for covered palliative care services from Medicare, an entity offering palliative care services must enroll in Medicare Part B (or contract with another entity that is enrolled in Part B). The Part B enrollment process includes obtaining a National Provider Identifier (NPI) number and completing one or more Medicare supplier enrollment applications, as outlined below.

Enrollment Basics

- 1. NPI:** If you do not already have one, apply for and obtain an NPI through the National Plan and Provider Enumeration System. The application process for “provider organizations” is online at <https://nppes.cms.hhs.gov> and estimated to take about 20 minutes to complete. You must have an NPI number to submit the Medicare enrollment application. Consult with legal counsel about whether to obtain a separate NPI specific to the palliative care offering.
- 2. 855B:** In order for an entity to bill and receive payment from Medicare for Part B services, the entity must complete and submit an [855B Application for Clinics, Group Practices, and Certain Other Suppliers](#) with all of the required supporting documents as outlined in section 17 of the 855B. We recommend that you consult with counsel regarding the timing of submission of the 855B application relative to the effective date of your billing privileges.
- 3. 855R:** An [855R Application for Reassignment of Medicare Benefits](#) is also required to be submitted for each licensed professional who will be reassigning his or her right to bill Medicare to the palliative care entity. This is the application that allows the palliative care entity to submit claims to, and receive payment from, Medicare for the services each individual professional will be providing to the entity.

4. **855I:** If they have not already done so, physicians and non-physician practitioners who render Medicare Part B services must obtain a Medicare provider number (PTAN). In order to obtain a PTAN, practitioners must complete and submit an [855I Application for Physicians and Non-Physician Practitioners](#) with all the required supporting documents as outlined in section 12 of the 855I.
5. **Submission:** Submit the 855 applications to [your Medicare Administrative Contractor \("MAC"\)](#).

Application Processing Time

Processing of the 855B application by MACs typically takes 60 calendar days in most cases, but can take up to 180 calendar days or more in certain circumstances. For applications that do not require a site visit, the MAC is required to process at least 80 percent of all CMS-855 initial applications within 60 calendar days, 90 percent within 120 calendar days, and 95 percent within 180 calendar days of receipt. Failure to furnish all of the required supporting documents and/or failure to accurately and completely fill out the application will delay Medicare enrollment.

What am I required to do to satisfy Medicare Part B coverage requirements?

Detailed requirements on Medicare coverage rules are issued in the form of national and local coverage determinations, available here: www.cms.gov/medicare-coverage-database/.

If I am providing palliative care through the hospice organization, what are restrictions on how much of my operation can be dedicated to palliative care under Medicare hospice rules?

Provided that state licensure allows it (as discussed above), hospices may provide palliative care either directly or through contractual arrangements to patients who either do not qualify for the Medicare hospice benefit or who do not choose to forgo curative treatment in order to elect the Medicare hospice benefit. However, [Medicare guidance](#) requires that hospices providing palliative care services to patients may do so as long as the hospices are, as an organization, "primarily engaged" in furnishing hospice care. We recommend consulting with counsel to ensure that your palliative care offering comports with this Medicare guidance requirement.

Workforce Management

What are the key questions I should ask my counsel about employment law when establishing my palliative care offering?

Some key questions that hospice organizations should ask counsel when establishing a palliative care offering include:

- How broadly may I draft an enforceable restrictive covenant to protect my client base and/or trade secrets? The rules governing restrictive covenants can vary by state.
- How should I classify the various employee groups in my workforce for Fair Labor Standards Act (FLSA) and benefits purposes? www.flsa.com/coverage.html provides a useful breakdown of the FLSA and the various tests used in making this determination.
- What are the risks of classifying some workers as independent contractors?
- What are the local and federal implications and requirements for independent contractor status relating to tax treatment? [The IRS provides useful guidance for evaluating whether your workers may be classified as independent contractors or not.](#)
- What are the liability implications of designating workers as independent contractors or employees?
- What kind of leave policies will I need to comply with local, state, and federal law? Nearly all states and many municipalities require employers to provide employees with more leave rights than required by federal law. The Society for Human Resource Management provides a helpful chart of private employer leave policies at the state and local level: www.shrm.org/resourcesandtools/legal-and-compliance/state-and-local-updates/xperthr/pages/leave-laws-by-state.aspx (member only resource).

If I want to utilize volunteers, what factors should I consider? Is my organization legally allowed to utilize volunteers?

Under the FLSA, only public sector, religious, charitable, and non-profit organizations are eligible to accept the work of unpaid volunteers. The Department of Labor (DOL) provides that "[i]ndividuals who volunteer or donate their services, usually on a

part-time basis, for public service, religious or humanitarian objectives, not as employees and without contemplation of pay, are not considered employees of the religious, charitable or similar non-profit organizations that receive their service." Under the FLSA, employees may not volunteer services to for-profit private sector employers. For more information on volunteers and the FLSA, see the DOL website at: webapps.dol.gov/elaws/whd/flsa/docs/volunteers.asp.

How can I mitigate treatment related exposure when staffing volunteer patient workers?

Common law or local, state, or federal statutes you may be liable for the mistreatment from your volunteer patient workers. Consider how you can limit this exposure based on how you present volunteer patient workers, the scope of the volunteer's responsibility, and other factors.

How can I ensure that volunteers are not bona fide employees under local, state, or federal law?

Different jurisdictions have different laws governing if or when a volunteer may be deemed a bona fide employee. If volunteer workers are deemed bona fide employees, they may be entitled to benefits ranging from minimum wage to leave time.

Malpractice and General Liability Insurance Coverage

What are some key considerations for managing malpractice and general liability risks?

In general, limiting malpractice (i.e. professional liability) and general liability involves limiting mistakes and improper actions by individuals employed and (sometimes) contracted by the entity. Implementing a strong training and education program, recruitment and hiring process, and quality assurance/performance improvement process all mitigate potential malpractice and general liability risk.

It is also highly recommended that the hospice organization verify with its insurance carrier that palliative care services are covered under the policy. Organizations should inform the carrier in writing regarding the specific nature of the program that the hospice is offering and secure confirmation that coverage extends to non-hospice palliative care.

Why should I have a general liability policy and how much should it be?

Entities should maintain a general liability policy to protect company assets and to be able to sign important contracts that require general liability insurance. Even entities with the best safeguards encounter mistakes. A general liability policy can help with these unexpected lawsuit costs.

The recommended amount for a general insurance policy varies by entity. Reviewing the entity's financial capabilities and risk of encountering an issue (among other factors) are important considerations for determining the policy amount.

If I fail to provide care or am negligent in the care I provide, what type of legal claims could I face?

Negligence, or failing to act with reasonable care, can lead to a few different types of legal claims. Health care entities specifically are subject to medical malpractice claims. Organizations are also generally subject to liability for negligent acts made by employees that are acting within the scope of their employment.

For these reasons, entities offering palliative care services should also ensure that they have adequate professional liability insurance coverage. Some states require licensed professionals (or their employers) to carry minimum levels of medical professional liability insurance. In addition, contracting partners can require minimum levels of professional liability coverage under the terms of the contract. All of these factors should be evaluated with your insurance carrier to establish the appropriate level of coverage.

Federal and State Fraud and Abuse Laws (False Claims, Stark, Anti-Kickback Statute)

How might prohibitions under federal and state fraud and abuse laws apply to my palliative care offering?

Federal fraud and abuse laws, such as the False Claims Act (FCA), Anti-Kickback Statute (AKS), and Physician Self-Referral Law (Stark Law), apply to health care entities and individuals who participate in federal health care programs like Medicare and Medicaid. States also often have similar versions of these federal laws, although the state laws vary by state and can have broader applicability than the federal laws.

The FCA forbids organizations and individuals from knowingly making a “false claim” to the government for reimbursement. Besides expressly fraudulent claims for payment, false claims can also include false “certifications” of compliance with certain material statutory, regulatory, or contractual requirements (e.g., adhering to proper licensing and supervision requirements). See [Universal Health Services, Inc. v. United States ex rel. Escobar](#), 136 S. Ct. 1989 (2016). In addition, retention of a known overpayment can constitute a false claim. Palliative care offerings must ensure they have proper coding and billing practices (e.g., no billing for services at a higher level than actually performed, not performing medically unnecessary services), including practices to identify and return payments are made in error. Palliative care offerings must also comply with various federal and state laws governing the provision and coverage of palliative care services. Otherwise, substantial penalties may follow. The U.S. Department of Justice (DOJ) offers [“The False Claims Act: A Primer”](#) on its website.

The AKS prohibits the knowing exchange of anything of value (e.g., cash, free rent, discounted services, expensive meals) for patient referrals for services or for the ordering of goods or services that are payable by a federal healthcare program. There are several AKS “safe harbors” and exceptions that protect certain arrangements from AKS liability so long as the arrangement fits perfectly within the safe harbor. For example, in the palliative care context, compensation paid to bona fide employees (i.e., the health care providers) is protected from AKS liability as long as the compensation is not determined by the volume or value of referrals. Arrangements whereby the entity offering palliative care services is contracting with other professionals or entities for the provision of health care services (e.g., palliative care physician groups) must adhere to the “personal services and management contracts” safe harbor, which requires, among other things, that the services be compensated at fair market value. See [42 C.F.R. §1001.952\(d\)](#).

Another relevant fraud and abuse law is the Civil Monetary Penalties law (CMP Law) (for more information see: [oig.hhs.gov/fraud/enforcement/cmp/background.asp](#)). One relevant area of prohibited conduct under the CMP Law is beneficiary inducement, which forbids providing anything of value to a Medicare beneficiary that is likely to influence the beneficiary to order or receive items or services from a particular provider. Therefore, hospice organizations setting up a palliative care offering must ensure that the palliative care program is not simply a referral source vehicle for the hospice. Factors to consider with your counsel to avoid risk of beneficiary inducement include: how to demonstrate that the palliative care offering is independently sustainable, and how to ensure that patient choice in hospice providers is respected.

The Stark Law precludes physicians from referring patients to certain “designated health services” (e.g., clinical laboratory services, physical therapy services, etc.; [full list can be found here](#)) where the physician (or immediate family) has a financial relationship. If your palliative care offering involves physician services, or if any physicians may be involved in the ownership of the palliative care entity, we recommend consulting with counsel, as the Stark Law is a strict liability law and violations can arise even without any intent to induce physician self-referrals.

The U.S. Department of Health & Human Services (DHHS) Office of the Inspector General (OIG) also provides a great resource for federal [Fraud and Abuse Laws](#).

At the state level, a number of states have broad prohibitions on “fee splitting.” Fee splitting occurs when a licensed professional (e.g., physician) splits part of his or her fees earned from treating a referred patient with the referring individual or entity as a means of generating additional referrals. These prohibitions vary significantly by state with some being narrowly tailored and others being very broad such that they include fees paid for management and other administrative services, or risk sharing or value-based purchasing arrangements not expressly intended to compensate for referrals. Finally, the American Medical Association has an ethical prohibiting on fee-splitting, [available here](#).

How have federal and state fraud and abuse laws been applied to palliative care arrangements?

As described above, improper arrangements can lead to fraud enforcement.

There is little publicly available information on whether state or federal governments have targeted palliative care providers for fraud and abuse enforcement. As palliative care is a growing segment of the health care industry, we would expect the risk of future enforcement to correspondingly grow as well.

How can I reduce the likelihood of liability under these federal and state laws?

There are several ways to reduce the likelihood of fraud and abuse liability. Some examples include maintaining a robust compliance program (described in more detail below), carefully analyzing any potential referral relationships before entering into contractual arrangements, having leadership promote a "mission-driven" or services-driven palliative care initiative (not one that is referral-driven), and seeking counsel when questions or issues arise.

If I provide palliative care services through a joint venture with a facility (e.g., nursing home, hospital) that is otherwise a source of referrals to my hospice, what are best practices for avoiding any compliance issues under these federal and state fraud and abuse laws?

OIG adopted a safe harbor for joint ventures, commonly called the "Small Investment Interest Safe Harbor." Investment interests (e.g., developing a palliative care offering) made by entities that are not publicly traded may fit into this safe harbor, so long as certain conditions are met. For example, the investment cannot be related to referrals, nor can there be a requirement that referrals must be generated. For more information on this safe harbor, including the remaining conditions, see [42 C.F.R. § 1001.952\(a\)](#).

Compliance Program

What elements, at a minimum, should a compliance program include for a palliative care offering?

The minimal elements that an effective compliance program for a palliative care offering should include are:

- Written policies and procedures to include written standards/code of conduct;
- Effective governance and oversight;
- Effective development and implementation of regular applicable education and training for all affected employees, independent contractors and vendors;
- An effective reporting system such as a hotline;
- Use of audits and or other systemic practices to monitor compliance, identify problems, and implement corrective action;
- Establish disciplinary measures to enforce standards of conduct, address violations and apply applicable sanctions; and
- Implement effective policies that ensure prompt investigations, reporting and corrective actions.

These elements—and other resources for developing a compliance program—can be accessed at the [OIG website](#). The OIG has developed compliance program guidance for specific types of providers. Two that may be most pertinent to a palliative care offering are the ones issued for [hospices](#) and [physician group practices](#). The list of the seven fundamental elements of an effective compliance program with additional detail is [available here](#).

State Consumer Protection and Marketing Laws

Is it necessary for me to develop policies and procedures addressing how services and other aspects of palliative care will be provided and documented? What can I do to ensure consumer protection?

To ensure consumer protection, partnerships should create and implement robust policies and procedures that focus on pain management and treatment of patients. For more detailed feedback, please review the ["Standards of Practice for Hospice Programs"](#) on NHPCO's website, available with member access.

Can my marketing practices trigger confidentiality / privacy issues?

Yes. Organizations must act responsibly to ensure that marketing statements regarding services and outcomes are based on evidence supporting any claims made in these communications and in alignment with regulatory and legal standards. In addition, if patient/family stories and images are used, organizations must carefully monitor the process to ensure patient/family choice and respect for confidentiality and privacy. Providers should be sure they are not violating the Health Insurance Portability and Accountability Act of 1996 (HIPAA) [Privacy](#) and [Security Rules](#).

Telehealth and Remote Patient Monitoring

Does telehealth have any application in palliative care?

Yes. Customary communication and comfort provided in person may be assisted by immediate remote visualization provided by telehealth. This application allows an on-call nurse or physician, or other service provider to communicate remotely with a caregiver or patient. It also allows palliative care specialists to provide services to areas where such services are otherwise not available. Remote patient monitoring is also a promising modality of telehealth for community-based palliative care. Remote patient monitoring technology allows for the collection of patient-generated health data from the home, through devices and mobile health platforms that connect to the palliative care provider or care team. In this manner, a provider can keep track of a patient around the clock, gathering data on health, activity, diet and exercise, the environment, even social determinants, thus filling out a health record that would otherwise focus on the patient's visits to the doctor or hospital.

Can telehealth technology and service address any challenges in my organization's palliative care offering?

Yes. In fact, telehealth provides substantial benefits to palliative care patients living in remote areas with limited access to care. These patients may receive care with minimal disruption to their daily lives. Additionally, they can be provided with individualized interventions from the comfort of their own homes. Such benefits may also apply to patients not living in remote areas, but who prefer to receive care and continuous monitoring at home.

What telehealth requirements should I be paying attention to?

If a provider has not formed a relationship with a patient prior to a telehealth encounter, many state regulations will require certain steps be taken in order to establish a provider/patient relationship. Also, providers must be aware of HIPAA and state privacy requirements, negligence standards related to treatment, standard of care, and licensure, among other things.

Where can I access telehealth requirements within my state?

Telehealth requirements are established by specific state professional boards (e.g. Board of medicine, Board of social work) or health and human services departments. There are a variety of resources that summarize state laws on telehealth, including the [Center for Connected Health Policy 50 state survey](#), and the [EpsteinBeckerGreen 50 state survey of telemental health laws \(including telesocial work\)](#).

Surprise Billing

Are there any laws regarding surprise billing that I should be aware of?

Yes. A number of states have recently sought to enact laws and/or regulations to protect consumers from medical bills for out-of-network (OON) services that they had no choice in selecting, often referred to as "surprise bills" in similar legislation in other jurisdictions. These laws vary in significant ways by state and are a rapidly evolving area of law. Many of the laws impose limits on what providers may bill for services covered by the law, require the use of third party arbitration programs to negotiate charges, require prominent and detailed consumer disclosures by providers, among other provisions.

Are palliative care services subject to surprise bills laws?

Although most palliative care services will likely be outside the scope of surprise bills laws, some may be covered, particularly those involving consulting palliative care physician services in the inpatient setting.

What are some example surprise bills laws?

Please follow these links for summaries of the surprise bills laws in [New York State](#), California ([Part 1](#) and [Part 2](#)), and [New Jersey](#).

Commercial Managed Care and Medicare Advantage Contracting

What are the new opportunities for contracting with Medicare Advantage (MA) Plans for the provision of home-based palliative care through supplemental benefit offerings?

CMS recently finalized regulatory changes that allow MA Plans to offer “targeted” supplemental benefits (benefits that go beyond what is covered by Original Medicare) that are medically related to a specific disease condition, provided that the MA Plan continues to comply with the non-discrimination requirements. MA Plans are now allowed to choose which diagnoses or health conditions will be the subject of these targeted benefits, and they may vary such benefits at the county level. The Bipartisan Budget Act of 2018 expanded the changes further to allow for supplemental benefits targeting Medicare beneficiaries with specific chronic conditions. These new supplemental benefits can cover a wide range of possible services, including home-based palliative care. The supplemental benefits do not need to be expressly health-related, provided that the services “have a reasonable expectation of improving or maintaining the health or overall function of the chronically ill enrollee.” This is a new exception to the long-standing medical necessity rules for Medicare Advantage and allows MA Plans to design supplemental benefits that address social determinants of health and, in some cases, appear more like traditional long-term care services. For more information on the flexibilities, see the CMS announcement at: www.cms.gov/newsroom/press-releases/cms-proposes-medicare-advantage-and-part-d-payment-and-policy-updates-provide-new-benefits-enrollees.

These flexibilities provide a new opportunity for MA Plans to work with hospice providers to help address the palliative care needs of members.

MA Plans are currently interested in partnering with providers for the development and delivery of effective supplemental benefit offerings. Interested entities should consider the populations they currently serve, or can serve, explore which supplemental service offerings best align with their care model and competencies and then take a proposal to the MA Plans in their region. Although MA Plans will not be able to implement the new supplemental benefits created by the Bipartisan Budget Act of 2018 until plan year 2020, MA Plans will be submitting bids defining these services in the coming months, once the CY2020 Call Letter is finalized. Considering the timeline for implementing projects like this, interested entities should immediately begin assessing the potential for their market and work with experienced Medicare Advantage counsel to begin discussions with MA Plans as soon as possible.

What are the key considerations for entering into participating provider agreements with managed care plan to offer palliative care?

Participating provider agreements are complex contracts that govern all of the provider’s obligations and rights regarding the delivery of services to covered members and the reimbursement for those services. Beyond the key business terms related to covered services and reimbursement rates, participating provider agreements include a wide range of legal issues that should be addressed with the support of an experienced attorney.

What are some key terms in the network participation agreement that I should make sure I (and my counsel) closely review?

Among many other important areas, particularly important subject areas are:

- Provisions governing the submission of claims and the process for appealing any disputes;
- Provisions governing the performance of medical necessity determinations, including any process for requesting prior authorization;
- provisions covering the delegation or sharing of risk from the paying plan;
- performance or outcomes measures or targets that the palliative care vendor must meet;
- obligations to submit reports or other data, including the technical specifications;
- provisions addressing the delegation of any administrative responsibilities, such as credentialing or utilization management;
- regulatory compliance obligations that the plan is subject to, often described in a regulatory appendix to the contract.

What are the opportunities for offering palliative care services to MA plans?

Currently, MA Plans may not offer the hospice benefit. For more information on the current policy related to the coverage of hospice for enrollees of MA Plans visit: www.medicare.gov/what-medicare-covers/what-part-a-covers/how-hospice-works. We note, however, that the Centers for Medicare and Medicaid Innovation (CMMI) recently announced the creation of a Value Based Insurance Design (VBID) model specifically designed to include hospice, beginning in 2021. More detail follows below.

MA Plans do offer the full Medicare Part B benefit. Therefore, to the extent palliative care services are covered under Part B, MA Plans contract with providers to render those services. As such, as a part of developing your palliative care services offering, you should explore opportunities to contract with MA Plans to deliver Part B services.

Will MA Plans be able to cover the hospice benefit at any point?

As discussed above, currently, MA Plans do not offer the hospice benefit. However, on January 18, 2019 CMS announced a broad array of innovations for MA Plans that will be tested in the VBID model. One of these pilot programs will be a model to test the inclusion of the hospice benefit within an MA Plan's VBID application, starting in calendar year 2021.

For more information on the MA Plan VBID hospice benefit announcement, see: www.cms.gov/newsroom/press-releases/cms-announces-new-model-lower-drug-prices-medicare-part-d-and-transformative-updates-existing-model.

Future announcements about the MA Plan VBID model will be posted to the VBID website at: innovation.cms.gov/initiatives/vbid.

Disclaimer

The contents of the "Developing a Palliative Care Offering; Key Questions for Hospice Providers" is for informational purposes only and does not constitute legal advice or opinions. Readers of this information should not act upon any information contained on this website without seeking professional legal counsel.

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Credentialing*

Note: This section was written by Bob Parker, DNP, RN, CENP, CHPN, CHP and provides supplemental information about reimbursement credentialing.

Credentialing is a major component for palliative care practices who will bill Medicare Part B for services performed by physicians and non-provider physicians (e.g. nurse practitioner, clinical nurse specialist, physician assistant, licensed clinical social worker). It is important that you understand you are creating a medical practice. Medicare and other payers will not understand palliative care program – at this time they do not credential programs.

Once you have determined how your palliative care practice will be structured (e.g. as part of the existing organization, as a separate legal entity, joint venture between you and another partner), it is critical that you begin the credentialing process.

National Provider Identifier

The first step in this process is to apply for a [National Provider Identifier \(NPI\)](#) number. The quickest application processing and receipt of your NPI number, you can use the web-based application by logging into the [National Plan and Provider](#)

[Enumeration System's](#) website. If you do not already have an account, you can sign up for an account as part of the process. It is critical that you start this first step as soon as possible. You cannot proceed with the credentialing process until you have received your NPI number.

Medicare Enrollment

Once you have received your NPI number you can start the second step – the submission of the three Medicare enrollment applications. It is important that you submit these enrollment applications at the same time to avoid potential delays with Medicare paring up disparate applications. These three enrollment applications establish your palliative care practice (855B), allow providers who may not be enrolled in Medicare Part B to establish themselves individually (855I), and to re-assign payment to the palliative care practice entity (855R).

The 855B

The [855B enrollment application](#) is used to establish your Group Practice (palliative practice), or Clinic with Medicare. The enrollment application and instructions are easy to follow and need to be followed to the letter to avoid delays. Pay close attention to the section titled Avoid Delays in Your Enrollment. This application can be mailed or submitted through the [Medicare Provider Enrollment, Chain, and Ownership System](#) known as PECOS. If you do not already have an account, you can sign up for an account as part of the process. For Section 13: Contact Person be sure to list someone easily accessible at the Corporate level (e.g. billing department manager) to ensure proper communication with Medicare.

The 855I

The [855I enrollment application](#) is used to enroll all eligible providers individually. If your provider(s) already have their own individual Medicare billing number, there is no need to submit the 855I with the 855B unless changes need to be made to their enrollment. The enrollment application and instructions are easy to follow and need to be followed to the letter to avoid delays. Pay close attention to the section titled *Who Should Complete And Submit This Application*. If you have more than one provider, ensure you process each provider with the 855B enrollment application with their 855I if applicable, and their 855R discussed below. If you only submit your 855B enrollment application with one provider, you will need to wait until you receive your Provider Transaction Access Number known as the PTAN before you can submit additional provider information.

The 855R

The [855R enrollment application](#) is used to reassign payment from the individual provider to the palliative care practice. This application allows Medicare to attach your providers billing activity and subsequent payment to your palliative care practice (program) instead of paying the provider directly. At least one 855R must accompany the 855B when submitting your enrollment application.

The reassignment of Medicare benefits does not impact any of their other billing activities that are outside your palliative care practice. When you bill for services provided by one of your providers, Medicare knows to reassign payment to you. If your provider also worked for another entity, when that entity billed for services provided by the individual, Medicare would pay that entity and so on.

Enrollment Status

There are three enrollment status selections. It is important that your providers choose the correct one. They are Participating, Non-participating, and Opt Out. You want to ensure your providers HAVE NOT opted out as they will not be eligible to receive payment for Medicare Part B services. If they opted out and would like to opt back in it is a 2-year waiting period.

- Participating – provider agrees to always accept assignment of claims for services provided to Medicare beneficiaries. By agreeing, you agree to accept the Medicare allowed amounts as payment in full and not to collect more than the Medicare deductible and coinsurance or copayment from the beneficiary.
- Non-Participating – provider can accept assignment or not. If using this enrollment status, when the provider does accept assignment of Medicare allowable amounts there is a 5% reduction in payment.

Medicare pays physicians 80% of the Medicare allowable after the annual deductible (\$185 in 2019) has been met. The patient is responsible for the remaining 20%. Most patients have a secondary insurance that covers this. It is not necessary to credential with each secondary insurance; however, it is very important that you collect this information and submit it with your claims. Medicare will automatically cross walk the 20% to the individual's secondary insurance provider and they will submit payment directly to you. If you fail to include this when claims are submitted, you will have to manually bill the secondary insurance.

For non-physician providers Medicare services billed under their NPI are reduced by 15% (e.g. 85% of the 80%).

Medicaid Enrollment

Once you have established enrollment with Medicare Part B, you can then apply for Medicaid. For Medicaid enrollment applications you will need to check with your individual state provider(s). As a reminder, in some states there are more than one Medicaid payer. If your coverage area crosses coverage areas, you will need to enroll with each Medicaid payer individually.

Commercial Payer Enrollment

This is the last step in credentialing your palliative care practice with payers. Credentialing your practice with payers can be tedious and time consuming. If your organization is able to contract with a credentialing service/business, it may be an option. Often times these credentialing services/businesses also provide billing services. Contracting these services usually costs approximately 4% to 7% of collections. They will usually do the credentialing for no cost. Their incentive is to credential as many payers as possible for you – the more payers they can credential and the more billing that can be submitted.



NHPCO Palliative Care Playbook for Hospices

Determining the Need for Palliative Care

This chapter is also available as a Grab & Go Toolkit:
www.nhpc.org/palliativecare



NHPCO

Leading Person-Centered Care

NHPCO.ORG

Perhaps the most important step in your palliative care program development process is the needs assessment. It provides your organization with data regarding the populations that have unmet needs and ways palliative care can address those needs.

Prior to starting the needs assessment, it's important to clarify what specific questions your organization wants to answer. A palliative care needs assessment may answer all or some of the following questions:

- How does offering palliative care align with our vision, mission, and strategic goals?
- What are the overarching, fundamental, and enduring reasons why palliative care is needed in our community?
- How will our palliative care program improve the care people receive in the community?
- Are we the right organization to provide palliative care?

Tip: Ask key decision makers (CEO, leadership team, and/or board) to answer the following:

What data or information do you need to decide whether and how to develop a palliative care service line?

The answers to these questions shape the needs assessment in terms of who you need to talk to, the type and amount of data you need to collect, and the presentation of the needs assessment results.

Needs Assessment Content

The contents and format of a needs assessment summary will vary, but in general will include:

- Rationale - why the needs assessment was conducted
- A profile of each service area (county, parish, etc.) included in the needs assessment, which includes the following data:
 - Demographic information
 - ▶ Age
 - ▶ Race/ethnicity
 - ▶ Poverty prevalence
 - ▶ Literacy
 - ▶ Housing status
 - ▶ Insurance status
 - Mortality statistics
 - Hospital data
 - Post-acute care data
 - ▶ Physician encounters, referrals to hospice
 - Payers
- Data collected via the stakeholder engagement process
- Opportunities for palliative care
 - Patient population
 - Scope of services
 - Potential referral and/or payer partners
- Next steps

Guidance on how to access and interpret all of this information is provided below.

Needs Assessment Process

The process of conducting a needs assessment consists of the following steps:

1. Assess vision, mission, and strategic alignment
2. Secure stakeholder input

3. Collect data from public and private sources to identify current care gaps and potential partners
4. Make recommendations
5. Verify internal capacity to deliver palliative care

Vision, Mission, and Strategic Alignment

Vision: Aspiration long-term goal

Mission: How you will achieve the goal

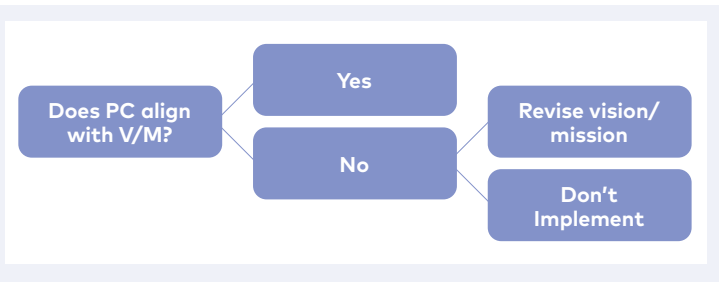
Strategic plan: Measurable objectives, strategies, and action steps to accomplish the vision

For more information: [An Overview of Strategic Planning](#)

The needs assessment process begins with an exploration of the alignment between the goal of developing a palliative care service and your organization's larger vision, mission, and strategic goals. As a hospice program, your vision and mission may:

- Focus on caring for seriously ill people regardless of prognosis
- Center on care for those in the last months of life
- State that the organization focuses on death and dying

If the vision and mission do not extend beyond providing hospice services, the organization has a decision to make:



1. Change the vision and mission of the organization to reflect an expanded population of people the organization will serve or
2. Don't implement a palliative care program

Beyond what's written in the vision and mission, it's essential to determine if your key stakeholders believe palliative care is the right strategy for the organization.

Stakeholder Input

Your organization's stakeholders are those with a vested interest in the work that you do. Stakeholders can include those internal and external to the organization.

Internal	External
Leadership team	Referral sources
Clinical and outreach staff	Payers
Board or advisory committee members	Current partners
Volunteers	Potential partners
Donors	Community influencers

You can convene a small group of patients and families to talk about the need for palliative care or you can include former patients/families in the stakeholder groups listed above. For example, you may have volunteers, donors, or board members who are former patients or family caregivers. You might also work with a partner that serves seriously ill patients if you can meet with a few of them to ask about palliative care.

In the context of the Playbook, partners can include:

- Health systems
- Physician practices
- Long-term care and assisted living providers
- Senior living communities
- Community service providers

Stakeholder Engagement

The stakeholder engagement process serves several purposes:

- Gathering information about the palliative care needs in the community from a cross section of people who interact with your organization and/or those adjacent to your organization
- Identifying people/organizations to include in the engagement process (potential partners, community leaders, etc.)
- Create buy-in for your palliative care development process and the palliative care program among those who can champion or at least not block the new service line
- Build excitement among potential referral sources, partners, payers, and donors who may be willing to actively support the development
- Inform selection of the data you will collect in the next step of the process

You can increase the usefulness and reliability of information you gather from stakeholders if you are careful to speak with a representative and diverse group.

When selecting the stakeholders to include in your process, be sure to consider:

- Demographic diversity (representative of the races, ethnicities, genders, socioeconomic status, and faith/religion groups in the service area)
- Geographic diversity (across your service area)
- Patient population served (diagnoses, age, geography, socioeconomic status, payer source)

Stakeholder engagement doesn't have to be complicated. It typically includes conversations with individuals or small groups, however you might also decide to host larger town hall style meetings or conduct a survey.

Strategy	Strength	Weakness
Individual interviews	<ul style="list-style-type: none"> • Participant anonymity • Ability to provide or ask for clarification 	<ul style="list-style-type: none"> • Time consuming (scheduling, interviewing, analyzing) • Smaller reach
Small group discussion	<ul style="list-style-type: none"> • Can provide or ask for clarification 	<ul style="list-style-type: none"> • Time consuming (scheduling and analyzing) • Smaller reach • Potential for "group think" (one person's opinion sways those present)
Large group meetings	<ul style="list-style-type: none"> • Ability to reach large numbers of people 	<ul style="list-style-type: none"> • Time consuming (scheduling and analyzing) • Potential for "group think"
Survey	<ul style="list-style-type: none"> • Participant anonymity • Ability to reach large numbers of people • Easy to tabulate 	<ul style="list-style-type: none"> • No ability to provide or ask for clarification

For the reasons listed above organizations often utilize a mix of strategies across the stakeholder groups.

Internal	Strategies	External	Strategies
Leadership team	<ul style="list-style-type: none"> Individual interviews Small group discussion 	Referral sources	<ul style="list-style-type: none"> Individual interviews Surveys
Clinical and outreach staff	<ul style="list-style-type: none"> Individual interviews Small group discussion Surveys 	Payers	<ul style="list-style-type: none"> Individual interviews
Board or advisory committee members	<ul style="list-style-type: none"> Individual interviews Small group discussion 	Current partners	<ul style="list-style-type: none"> Individual interviews Surveys
Volunteers	<ul style="list-style-type: none"> Small group discussion Surveys 	Potential partners	<ul style="list-style-type: none"> Individual interviews
Donors	<ul style="list-style-type: none"> Individual interviews Small group discussion Surveys 	Community influencers	<ul style="list-style-type: none"> Individual interviews Small group discussion Large group meeting Surveys

The stakeholder group as well as the strategy(s) selected influence the number and types of questions you ask.

Tool: Palliative Care Needs Assessment Stakeholder Questions

Tip: Always ask the people you speak with if they know anyone else with valuable information to contribute to the needs assessment process.

A synthesis of the interviews is included in the needs assessment and, if requested by the decision makers, the actual responses collected can be added as an addendum. When synthesizing the data, it's important to look for trends as well as specific opportunities. For example:

- 55% of clinic and hospital staff interviewed had a comprehensive understanding of palliative care as a separate service from hospice
- 2 in 3 providers expressed willingness to discuss partnership opportunities to offer palliative care:
 - Two people at XYZ physician practice expressed a need for community-based palliative care to meet the needs of seriously ill patients. Dr Gonzalez, an oncologist in the practice, specifically mentioned that lung cancer patients would benefit from palliative care. A different physician in the practice stated a need for a palliative care practitioner in their office. Additionally, Dr. Hui estimated that 10-20% of their current patients would benefit from community-based palliative, delivered in their homes and/or their offices.
 - Dr Smiles, the CMO at XYZ hospital expressed a willingness to enter into discussions to develop a community-based palliative care program for people discharged from XYZ hospital with complex care needs. She believes community-based palliative care services focused on pain management, both in and out of the hospital, is needed as well as goals of care conversations. She also said they have more 30-day readmissions than they'd like.
 - Dr. Davis at the Federally Qualified Health Center stated there are people who are isolated or who don't have someone who can help them sort the treatment options that align with their goals. He thinks it would be great for patients to hear someone discussing the benefits of comfort care as an option. In addition, Dr Davis stated that people need advocates, help with navigation, and someone to manage their care process.
 - Dr. Johnson stated that office based palliative care to help with advance care planning conversations would be helpful. She also thought palliative care would be a good option in assisted living.
 - Dr. Fibs at the outpatient cancer clinic believes that people need help with short and long-term planning in terms of practical care they will need as they live with their disease as well as goals of care, etc. He believes social workers would be able to provide great support to patients.
 - Ms. Clark at the largest senior living community in the area thinks that seniors who live in independent living could use palliative care.

- Dr Smithson at the ACO stated her belief that physicians in the ACO would be very excited to have community-based palliative care delivered in patients' homes to help improve quality indicators.
- There were many differing opinions regarding populations who would benefit from community-based palliative care as well as the type of services people need.
 - 20% of those interviewed felt that people in senior living communities need palliative care
 - Only 10% specifically referenced assisted living or long-term care
 - XYZ county was referenced by 15% of those interviewed, specifically to support seniors living alone
 - Nearly 50% of people referenced XYZ hospital by name as a potential partner

Data Collection

In addition to the narrative information collected from stakeholders, it is critically important to look at other types of data to ensure that your impression of the community matches the actual composition of the population you hope to serve, the ways that population is currently using health services, care gaps, and potential partners, especially those that are at risk for care costs or are subject to penalties or incentives based on health care use or patient reports of care experiences. There are several categories of data that are helpful to hospices considering building or expanding a palliative care service line:

- Demographics
- Hospital quality indicators
- Acute care utilization data
- Post-acute care utilization
- Physician
- Medicare Advantage
- Hospice

While you may not end up finding free data sources for all of these, you can purchase stand-alone reports or subscriptions for Medicare claims data that isn't available online. A summary of sources for each type of data is included at the end of this section.

Demographics

Recent demographic data and trends can help to identify the population in need of palliative care services today and in the future. It is relatively simple to find free demographic data about the towns, cities, counties, and state(s) that you serve.

Where: American Fact Finder: factfinder.census.gov/faces/nav/jsf/pages/index.xhtml#none.gov

What: A variety of county and city level data is available, including:

- Age
- Gender
- Race
- Household information such as number of households with a relative age 65 and older living in the home, or householder living alone age 65 and older
- Poverty status by a variety of factors, including age 65 and older
- Language spoken
- Veteran status with demographic breakdowns

The image below shows the categories of data available in the left column, with "poverty" selected for Alexandria, VA. Within poverty, the main page shows the data sources and reports available.

United States Census Bureau

AMERICAN FactFinder

MAIN COMMUNITY FACTS GUIDED SEARCH ADVANCED SEARCH DOWNLOAD CENTER

Community Facts - Find popular facts (population, income, etc.) and frequently requested data about your community.

Enter a state, county, city, town, or zip code: **GO**

Alexandria city, Virginia

Individuals below poverty level **10.5%** Source: 2013-2017 American Community Survey 5-Year Estimates

Popular tables for this geography:

2017 American Community Survey

- Poverty Status in the Past 12 Months (Age, Sex, Race, Education, Employment, ...)
- Poverty Status in the Past 12 Months of Families (Family Type and Size, Race, Work, Education, Children, ...)
- People at Specified Levels of Poverty (Age, Sex, Race, Hispanic, Education, Citizenship, Work, Disability, ...)
- Children Characteristics (Poverty, Public Assistance, Age, Race, School Enrollment, ...)

Census 2000

- Selected Economic Characteristics (Poverty, Children, Income, Employment, ...)
- Individual Poverty Status (Age, Sex, ...)
- Compare Cities and Towns for Income and Poverty

Want more? Need help? Use [Guided Search](#) or visit [Census.gov's Quick Facts](#).

The image below details some of the relevant information from the American Community Survey for Butler County, Kansas.

Subject	Butler County, Kansas	
	Total	65 years and over
	Estimate	Estimate
Female	49.5%	55.4%
RACE AND HISPANIC OR LATINO ORIGIN		
One race	97.9%	98.9%
White	93.4%	97.6%
Black or African American	2.2%	0.5%
American Indian and Alaska Native	0.8%	0.2%
Asian	1.2%	0.3%
Native Hawaiian and Other Pacific Islander	0.0%	0.0%
Some other race	0.3%	0.4%
Two or more races	2.1%	1.1%
Hispanic or Latino origin (of any race)	4.6%	1.5%
White alone, not Hispanic or Latino	89.5%	96.4%
RELATIONSHIP		
Population in households	63,593	8,782

Where: County Health Rankings and Roadmaps www.countyhealthrankings.org/

What: A snapshot of county-wide data, with comparisons to other counties in the state. Data includes preventable hospital stays and a range of socioeconomic factors.

The image below shows several clinical care and social and economic factors from the County Health Rankings and Roadmaps. Note the “preventable hospital stays” data.

Clinical Care			
Uninsured	4%	4-5%	6%
Primary care physicians	870:1		1,030:1
Dentists	840:1		1,280:1
Mental health providers	230:1		330:1
Preventable hospital stays	38	37-40	35
Diabetes monitoring	80%	77-82%	91%
Mammography screening	62%	60-65%	71%
Additional Clinical Care (not included in overall ranking)			
Social & Economic Factors			
High school graduation	68%		95%
Some college	80%	79-81%	72%
Unemployment	6.0%		3.2%

There are additional social and economic factors that can help as you define the population that your palliative care program will serve, and the additional community supports and services they might need.

The text box below illustrates how demographic data can be presented to highlight key facts relevant to a palliative care program. For example, if a segment of the population age 60 and older lives alone and many seniors are living below the poverty level, that can influence the design of your palliative care program and the community organizations you may choose to partner with.

Demographic data

According to the US Census Bureau, 20% of YOUR County residents are age 65 and older, which is significantly higher than the rest of the STATE (13.3%).ⁱ Nearly 86% residents are Caucasian, 16% are Hispanic, and 2.9% are African-American.ⁱⁱⁱ Nearly 19% of residents were foreign born. Data from the State Department of Aging shows that minorities represent 13% of all residents age 60 and older and nearly 30% of all seniors in the COUNTY are age 75 and older.^{iv}

Data in the American Human Development Index reports that 5.6% of YOUR County residents age 65 and older live in poverty.^v Given YOUR COUNTY’s relatively high cost of living, the Federal poverty measure doesn’t include COUNTY’s older population with income greater than the poverty level and yet are still economically insecure. According to the Robert Wood Johnson’s County Health Rankings & Roadmaps data 21% of residents experience at least one of the following four factors related to their housing: overcrowding, high housing cost, or lack of kitchen or plumbing.^{vi}

Data from the American Community Survey, YOUR County indicates that 44% of all YOUR County residents age 60 and older live alone, putting them at risk for having unmet caregiving needs if they desire to age in place.^{vii}

Opportunity

The high percentage of YOUR County residents who live alone, 44%, coupled with the higher than average life expectancy, presents a population of individuals who would benefit from in-home palliative care if they have a chronic or serious illness or are frail.

State Data

Where: Varied (see below)

What: Each state tracks data that is relevant to their population, though there is variation in the granularity and quality of publicly available information.

Most states have publicly reported data that can inform a palliative care needs assessment that is often hosted on the state department of health website. The US Department of Health and Human Services healthfind.gov has a [list of all state department of health websites](#). HealthData.gov - aggregates state databases available from a variety of sources.

For example, California has a database that tracks preventable hospitalizations for selected medical conditions, by county. In the example below the number of people age 40 and older admitted to the hospital with COPD in 2017 increased slightly, as did the total population identified as having COPD/Asthma.

Year	County	Description	Count ICD-10	Living with COPD/Asthma
2016	Santa Barbara	COPD or Asthma in Older Adults (40+)	320	189,693
2017	Santa Barbara	COPD or Asthma in Older Adults (40+)	362	190,787

In addition to HealthData.gov, visit the state department of health website as well as the state aging services website. The aging services website may have data specifically related to those over age 60 or 65.

Mortality data can also be found via state websites, for example the [Ohio Department of Public Health](#) has a great database that allows you to build reports based upon your needs. The table below lists the death count and death rate for several diagnoses that can be served by palliative care programs by county.

Leading Cause of Death	Malignant neoplasms		Parkinson's disease		Alzheimer's disease		Diseases of heart	
County	Death Count	Death Rate	Death Count	Death Rate	Death Count	Death Rate	Death Count	Death Rate
Adams	74	1106.1	3	44.8	12	179.4	76	1136.0
Allen	192	790.6	8	32.9	39	160.6	224	922.4
Ashland	93	704.5	7	53.0	48	363.6	139	1053.0
Ashtabula	219	881.4	7	28.2	36	144.9	237	953.8
Athens	87	751.4	4	34.5	10	86.4	78	673.6

If your community includes a large Medicaid population you may want to explore Data.Medicaid.gov to see if any of the information is useful.

Hospital Quality Indicators

Where: Advisory Board Pay-for-Performance Payment Adjustments sca.advisory.com/Maps/Home/MapView?var=p4p

What: Since the advent of The Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) has rewarded and penalized hospitals based on quality measures reported via Hospital Compare (see below).

Each year CMS publishes the data and The Advisory Board has a great resource that allows you to search for providers in your community and see whether or not they are being penalized for things such as 30-day hospital readmissions, 30-day mortality rate, and Medicare spending per beneficiary. This allows you to focus on those hospitals in your service with a potential financial incentive for palliative care in the hospital and upon discharge. Once you have that information, the Hospice Compare database helps to identify which performance measures are triggering the penalties.

Provider Information

Provider ID	060003
Provider Name	Longmont United Hospital
State	CO
Zip Code	80501
Base Operating Amount	\$16,284,618
Medicare IP Revenue	\$19,113,077

Estimated P4P Net Impact

Total Impact (\$)	-\$417,518
Total Impact (%)	-2.18%

Hospital Readmission Reduction Program (HARP)

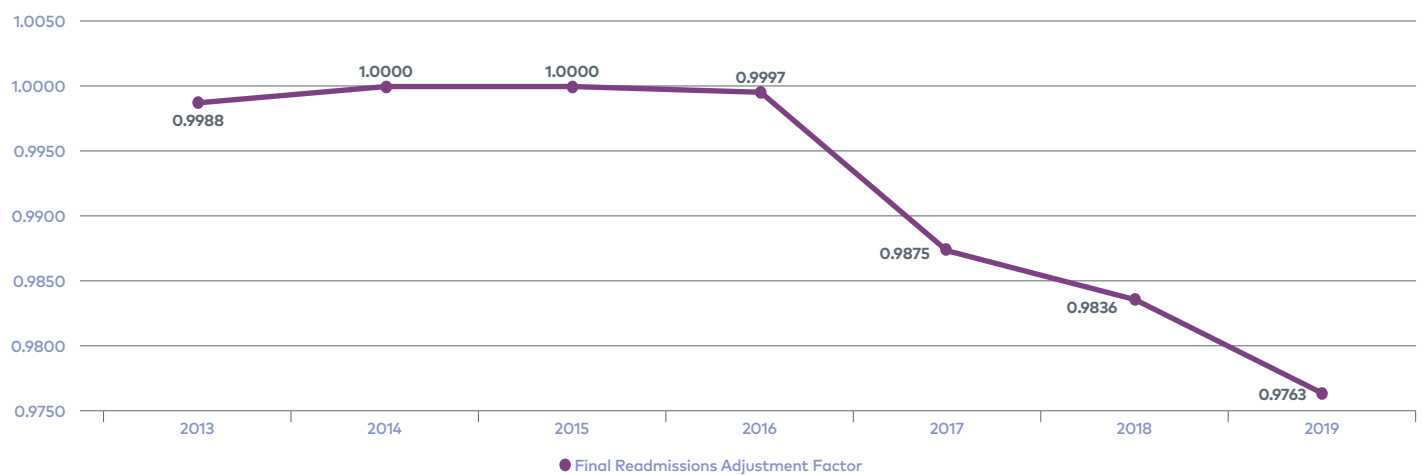
Final Readmissions Adjustment Factor	0.9763
Readmission Impact (\$)	-\$385,945

Value Based Purchasing (VBP)

Final VBP Adjustment Factor	0.9981
VBP Impact (\$)	-\$ 31,573

Hospital Acquired Conditions (HAC)

HAC Penalty Flag	No Data
HAC Impact (\$0)	No Data

Final Readmissions Adjustment Factor




Where: Hospital Compare [www.medicare.gov/hospitalcompare/search.html?](https://www.medicare.gov/hospitalcompare/search.html?search=Longmont+United+Hospital)

What: The Hospital Compare website summarizes a number of quality measures, several of which are directly related to the need for palliative care, such as readmissions, 30-day mortality, and Medicare Spending per Beneficiary. Several items on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) can also be improved through the initiation of palliative care both in the hospital and upon discharge. Data is compared to state and national data and all the indicators contribute to the facility's Hospital Compare score.

Currently Hospital Compare includes 7 categories of data, and a summary of each facility is provided so you can see a snapshot of their strengths and weaknesses relative to each category.

Category	National Average Comparison George Washington Univ Hospital
Mortality	Same as the national average
Safety of Care	Below the national average
Readmission	Below the national average
Patient Experience	Below the national average
Effectiveness of Care	Same as the national average
Timeliness of Care	Below the national average
Efficient use of Medical Imaging	Same as the national average

For each hospital (you can compare up to three at a time), you can view results for specific measures. In the example below, only one of the hospitals had a readmission rate worse than the national average. However, heart failure patients at all of the hospitals had more hospital return dates than average.

	Overall rating ⓘ:  Learn more Distance ⓘ: 4.2 miles Add to My Favorites Maps and directions	Overall rating ⓘ:  Learn more Distance ⓘ: 7.5 miles Add to My Favorites Maps and directions	Overall rating ⓘ:  Learn more Distance ⓘ: 8.3 miles Add to My Favorites Maps and directions
Rate of readmission for heart failure patients	No Different than the National Rate	Worse than the National Rate	No Different than the National Rate
Hospital return days for heart failure patients	More days than average per 100 discharges	More days than average per 100 discharges	More days than average per 100 discharges

Measures to consider as part of a needs assessment (and business case) for palliative care include:

- Readmissions (by selected diagnoses)
- 30-day mortality (by selected diagnoses)
- Medicare spending per beneficiary (with selected diagnoses)
- Selected Patient Experience measures
 - Patients who reported that YES, they were given information about what to do during their recovery at home
 - Patients who “Strongly Agree” they understood their care when they left the hospital

Hospital Compare data can significantly influence which health systems, if any, would be inclined to support the development of an inpatient and/or post-acute care palliative care program. It's important to present both the measures that are leading to financial penalties as well as the amount of money that the hospital is losing each year. The table below illustrates an easy way to showcase the hospital's “pain points” that can be improved through the integration of palliative care.

Category	Measure	Rating Contributed to Penalty?
Patient Experience	• Patients who reported that their nurses "Always" communicated well	Yes
	• Patients who reported that their doctors "Always" communicated well	Yes
	• Patients who reported that yes, they were given information about what to do during their recovery at home	Yes
	• Patients who "Strongly Agree" they understood their care when they left the hospital	Yes
Medicare Spending per Beneficiary	• Spending level exceeds the national ratio	Yes
Payment	• Payment for heart failure patients	Yes
	• Payment for pneumonia patients	Yes
Readmission for stroke patients	• Worse than the national rate	Yes

Acute Care Utilization

Where: Medicare Claims Data or Partner Organizations

What: Hospitals are required to share data specific to the Medicare population (fee-for-service Medicare only) they serve. To get data specific to all patients seen in a hospital, the only source is the hospital itself.

Medicare claims data includes a wealth of information that is helpful when planning a palliative care program, such as hospital admitting diagnoses, hospital length of stay, 30 day and 6-month hospital readmissions. The challenge is accessing the data. To get this information you'd need to work with a third-party vendor, such as [HealthPivots](#) or [Hospice Analytics](#).

The chart below, from HealthPivots, provides post-acute care data for a hospital. This information is very helpful as you work to determine the need for palliative care. The chart shows data for all patients discharged in 2016 as well as the data for those who died within 6 months of initial hospital discharge. Note that only 26.7% of those who died within 6 months were referred to hospice upon discharge. And 29.7% were discharged home without home health care. In all likelihood a significant number of those patients would benefit from palliative care.



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Based on Medicare FFS Claims for 2016 (Through June 2017)

XYZ HOSPITAL - NPI # (2016)

POST-ACUTE CARE SUMMARY BY DISCHARGE STATUS FOR 2016

XYZ HOSPITAL - NPI # (##### PATIENTS SERVED IN 2016)

DISCHARGE STATUS	INITIAL HOSPITAL DISCHARGES IN 2016						DIED WITHIN 6 MONTHS OF INITIAL HOSPITAL DISCHARGE					
	% SHARE OF INITIAL DISCHARGES	INPATIENT DAYS PER PATIENT	% DIED WITHIN 6 MONTHS OF DISCH	% READM IN ≤ 30 DAYS	% READM WITHIN 6 MONTHS	% SHARE OF INITIAL DISCHARGES	INPATIENT DAYS PER PATIENT	% READM IN ≤ 30 DAYS	% READM WITHIN 6 MONTHS	% DIED IN HOSPICE	% DIED IN HOSPITAL	% DIED IN SNF
EXPIRED	2.5%	5.5										
HOME	37.6%	2.4	5%	10%	26%	16.3%	2.9	18%	68%	64%	11%	7%
SNF	21.9%	5.2	15%	12%	32%	29.7%	6.6	41%	65%	61%	20%	14%
HOME HEALTH	19.7%	3.7	4%	7%	22%	7.6%	4.3	38%	62%	77%	0%	8%
HOSPICE	3.4%	4.5	88%	0%	2%	26.7%	4.7			98%	0%	0%
LTCH	0.4%					1.2%						
REHAB	3.6%	4.6	11%	14%	38%	3.5%						
OTHER	10.9%	3.7	15%	31%	46%	15.1%	4.2	58%	73%	62%	12%	4%
ALL	100.0%	3.7	11%	12%	28%	100.0%	5.0	28%	49%	72%	10%	7%

This next chart, also from HealthPivots, lists all discharges as well as those who died within 6 months of discharge, by primary diagnosis. This information about patients who died within 6 months of a hospital stay by diagnosis helps to identify a patient population whose needs are not currently being met.



Based on Medicare FFS Claims for 2016 (Through June 2017)

POST-ACUTE CARE SUMMARY BY DIAGNOSIS CATEGORY FOR 2016

XYZ HOSPITAL - NPI #

PRIMARY DIAGNOSIS CATEGORY (INITIAL HOSPITALIZATION)	% OF TOTAL INITIAL DISCHARGES	MORTALITY RATE IN HOSPITAL	DIED ≤ 6 MOS AFTER INITIAL DISCH.			
			6 MONTH MORTALITY RATE	% READM. WITHIN ≤ 30 DAYS	% READM. WITHIN ≤ 6 MONTHS	% DIED IN HOSPICE
All Diagnoses	100%	2.0%	15%	26%	45%	70%
Diseases of the Circulatory System	24%	2.8%	16%	23%	47%	67%
Musculoskeletal System and Connective Tissue	9%	0.0%	6%	21%	32%	74%
Diseases of the Respiratory System	11%	4.4%	15%	40%	53%	64%
Diseases of the Digestive System	13%	0.6%	11%	25%	49%	65%
Injury and Poisoning	11%	1.0%	16%	18%	43%	59%
Infectious and Parasitic Diseases	7%	6.8%	25%	26%	39%	76%
Diseases of Genitourinary System	8%	0.4%	19%	24%	43%	69%
Malignant Neoplasms	4%	3.1%	42%	21%	40%	87%
Symptoms, Signs, and Ill-Defined Conditions	3%	0.9%	8%			
Endocrine, Nutritional, Metabolic & Immune	4%	0.0%	14%	50%	56%	78%
Diseases of the Nervous System and Sense Organs	2%	2.3%	14%	25%	42%	83%
Diseases of Skin and Subcutaneous Tissue	2%	0.0%	14%			
Mental Disorders	0%	5.9%	19%			
Diseases of the Blood and Blood-Forming Organs	1%	0.0%	28%			
Other Neoplasms	0%					
Supplementary Classifications of Factors	0%					

If you are part of a health system or have a partnership with a hospital they may be willing to share information that can help you predict the census and cost savings for an inpatient palliative care program.

The data that will help your analysis of the need (as well as census projections) includes:

- ICU length of stay
- Percentage of those re-admitted within 30 days
- Percentage of ED visits

The data collected is segregated into three categories -- number of patients who died, number of high-risk survivors, and all other admits. High-risk survivors are defined as:

- Those with the highest category of APR-DRG risk of mortality subscore WITH highest two categories of APR-DRG severity of illness subscore OR
- Those discharged directly to hospice

The data collection spreadsheet would thus capture the same data for all three groups -- those who died, high-risk survivors, and all other admits (Cassel et al., 2013 AAHPM/HPNA, New Orleans).

Tool: Hospital Data for Needs Assessment spreadsheet

	Deaths	High-risk survivors	All other admits	Total
Cases				
% of cases				
DRG weight / case-mix index				
% ICU days				
% total days				
Average LOS				
Direct costs / day				
Direct costs / case				
Direct costs / case (ratio)				
% ICU days				
% ICU length of stay > 7 days				
% ICU length of stay > 10 days				
% ICU length of stay > 14 days				
% ED visits				
% 30-day re-admissions				
% cases with Medicare				
% cases with Medicaid				
% cases with commercial ins				
% cases self-pay				

If your target population includes Medicare enrollees, then it's important to know how many of each category. Medicare specific data to request can include the following:

	Medicare deaths	Medicare High-risk survivors	All other Medicare admits	Total Medicare
Medicare Cases				
% Medicare cases				
Total costs / case				
Reimbursed / case				
Net Margin (sum)				

Tool: Hospital Data for Needs Assessment - BLANK

This data can be used to calculate palliative care referrals, patient days, census, and cost savings.

Estimated volume	Palliative Care Appropriate	Year 1 PC Referrals*	Est. Inpatient PC LOS*	Est. PC Patient Days	Est. PC Average Daily Census	Current Cost Per Day without PC	Average Cost Savings Per PC Day**	Projected PC Costs Per Day	Average PC Cost Savings Per Case	Total Potential PC Cost Savings Per Year
Inpatient deaths	449	90	3.80	341	0.94	1,712	374	1,338	5,086	456,693
High-risk patients	1,390	278	8.37	2,327	6.38	1,304	174	1,130	9,461	2,630,042
	1,839	368	6	2,669	7.31	3,016	548	2,468	14,546	3,086,735

* Center to Advance Palliative Care (2004). A Guide to Building a Hospital-based Palliative Care Program

** Morrison RS, Penrod JD, Cassel JB, Caust-Ellenbogen M, Litke A, Spragens L, Meier DE, Palliative Care Leadership Centers' Outcomes Group. Cost Savings Associated with US Hospital Palliative Care Consultation Programs. Arch Intern Med. 2008;168(16):1783-1790. doi:10.1001/archinte.168.16.1783

Non-Acute Care Utilization

Where: Medicare Claims Data

What: Information about non-acute care providers including physician encounters, hospital discharge status (referrals to home health, SNF, hospice, etc), and hospital primary diagnoses is available in the claims database. To easily get provider-specific data it is advisable to work with one of the vendors referenced above.

Payer - Medicare Advantage

Where: Centers for Medicare and Medicaid Services - Monthly MA Enrollment by State/County/Contract - <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-MA-Enrollment-by-State-County-Contract.html>

What: Enrollment data for each Medicare Advantage plan searchable by state, county, and health plan.

While it's not possible to access Medicare Advantage (MA) claims data (unless you partner with an MA plan), it is possible to see monthly MA plan enrollment data. The Monthly MA Plan by State/County/Contract allows you to easily determine which MA plans have the largest penetration in your county.

The example below contains enrollment data for January 2019 in Volusia County, FL:

County	State	Organization Name	Plan Type	Enrolled
Volusia	FL	Humana Medical Plan, Inc.	HMO/HMOPOS	28,671
Volusia	FL	Health Options, Inc.	HMO/HMOPOS	10,981
Volusia	FL	UnitedHealthcare Insurance Company	Regional PPO	6,787
Volusia	FL	Health First Health Plans	HMO/HMOPOS	5,522
Volusia	FL	Humana Insurance Company	Local PPO	5,500
Volusia	FL	Sierra Health and Life Insurance Company, Inc.	Local PPO	3,375
Volusia	FL	Sierra Health and Life Insurance Company, Inc.	Local PPO	2,702
Volusia	FL	Wellcare of Florida, Inc.	HMO/HMOPOS	2,032
Volusia	FL	Blue Cross and Blue Shield of Florida, Inc.	Regional PPO	1,721
Volusia	FL	Aetna Life Insurance Company	Local PPO	1,681
Volusia	FL	Humana Insurance Company	Regional PPO	1,072
Volusia	FL	Freedom Health, Inc.	HMO/HMOPOS	893
Volusia	FL	Optimum Healthcare, Inc.	HMO/HMOPOS	706

Accountable Care Organizations

Accountable care organizations (ACOs) are formed when physician practices, hospitals, home health agencies, hospice, and other providers come together to provide coordinated care. ACOs are often eager to embrace palliative care because of the design of the Centers for Medicare and Medicaid Services (CMS) ACO program. According to the CMS ACO webpage:

"When an ACO succeeds both in delivering high-quality care and spending health care dollars more wisely, the ACO will share in the savings it achieves for the Medicare program."

Since the ACO is at-risk, hospices have had great success developing relationships with ACOs to deliver palliative interventions to the ACOs beneficiaries. During the needs assessment process, it's important to learn as much as you can about every ACO in your service area. To begin, go to the CMS Shared Savings Program, Program Data webpage <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-data.html>. Here you can look up ACOs via a map as well as a online, searchable and sortable listing, which includes contact information for the chief executive and the name of the chief medical officer. The website also lists the ACO's List of Skilled Nursing Facility (SNF) Affiliates. There is also an online database that lists financial and quality performance data for each ACO.

Resource: If you want to learn more about ACOs and palliative care, visit the CAPC ACO page: www.capc.org/topics/accountable-care-organizations-and-palliative-care/

Similar to long-term care, hospitals, home health, and hospice providers, ACOs are accountable for numerous quality measures. CMS released a new brief (February 2019), Medicare Shared Savings Program Quality Measure Benchmarks for the 2018 and 2019 Reporting Years, that details the quality measures that ACOs that are participating in the Medicare Shared Savings Program must report on.

You can find an individual ACOs performance scores through Physician Compare:

1. Enter the geographic area (city/town)
2. Enter the name of the ACO
3. Click on the ACO or click "Add to Compare"
4. On the general information page, below "Affiliated clinicians" click on "ACO performance informational available"
5. There are two types of data available "Performance scores" and "Patient survey scores" - unfortunately the quality measures currently being reported aren't related to palliative care, so unlike the Hospital Compare data, Physician Compare doesn't provide useful data as you prepare your needs assessment.

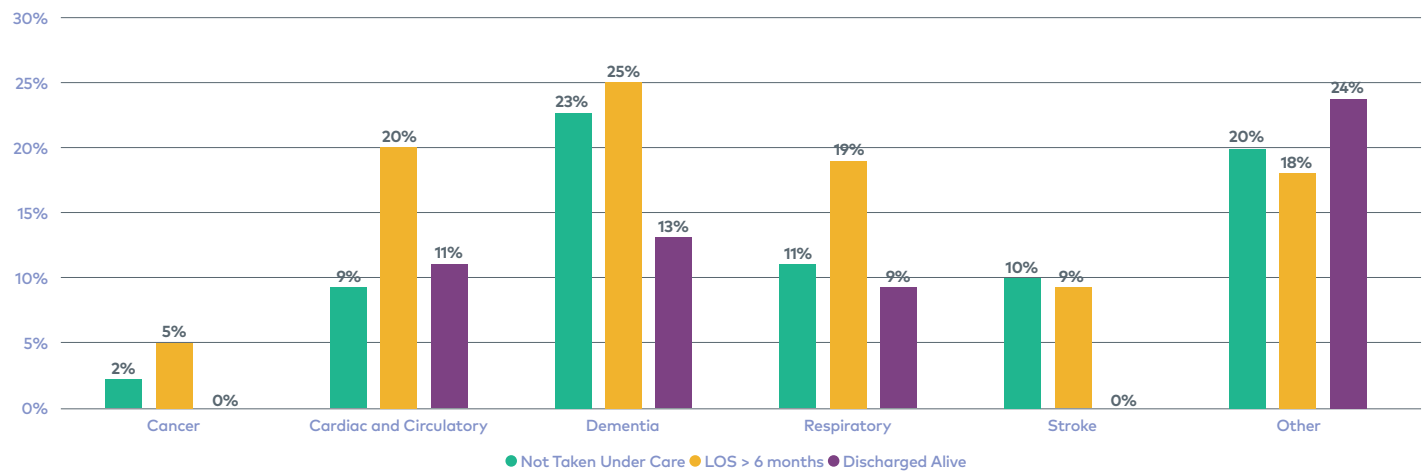
Hospice

Last, but definitely not least, hospice data is analyzed to identify referral patterns and complete the picture of care provided to seriously ill individuals in your community. Your internal data as well as any data you have about competitors, offers a wealth of information to inform your palliative care service design.

The charts below illustrate the type of data to report in the needs assessment to help identify the patient population by diagnosis as well as referring physicians with practice patterns that suggest a need for palliative care:

Figure 1 focuses on the referrals to hospice by diagnoses, specifically the percentage of patients who:

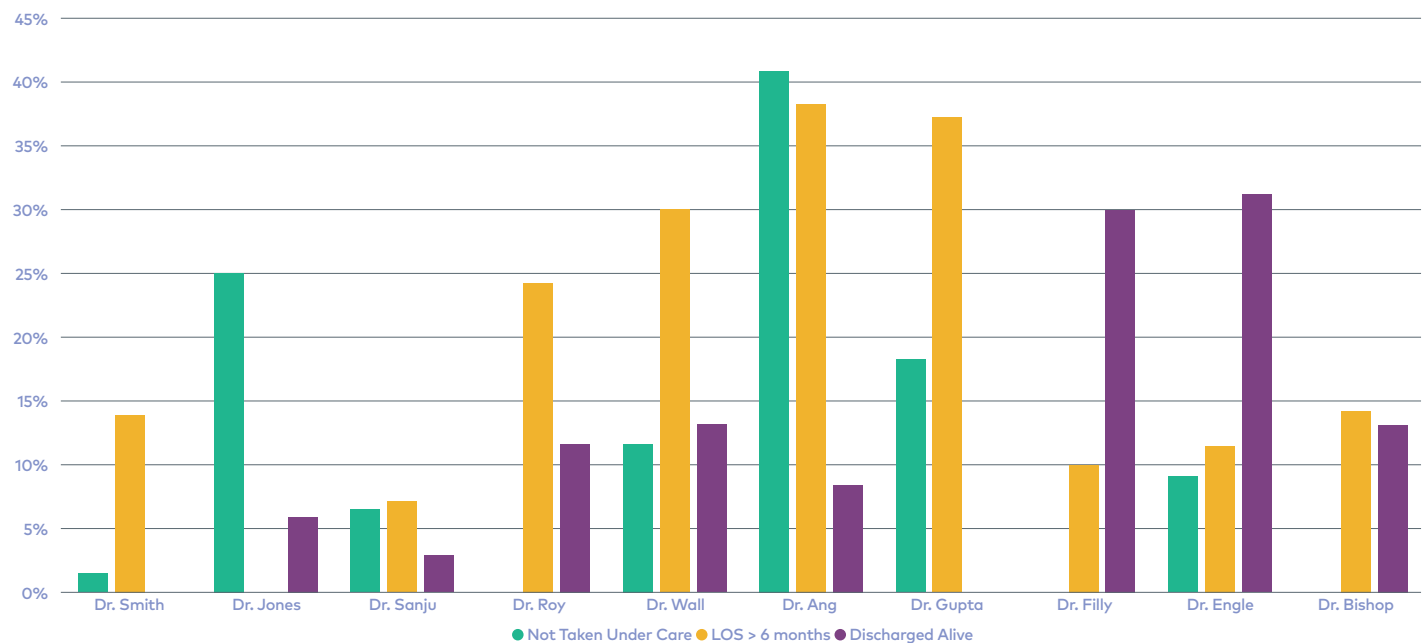
- Aren't admitted
- Have a length of stay greater than 6 months
- Were discharged alive

Figure 1 Hospice Referrals


Initial analysis may be needed to identify why patients were not taken under care to determine the number who were referred to hospice "too soon" or were not ready to accept hospice. These two categories of patients might benefit from palliative care.

Figure 2 focuses on the top 10 physicians based on the number of referrals to hospice. This chart also shows the percentage of patients who:

- Aren't admitted
- Have a length of stay greater than 6 months
- Were discharged alive

Figure 2 Physician Referrals


Similar to Figure 1, this chart identifies patients who may not be ready for hospice, but may accept palliative care. Additionally, physicians referring patients "too early" might be willing to work with you on a palliative care pilot to identify patients in need of palliative care.

Use the Hospice Data Collection spreadsheet to collect your data and prepare charts to insert into your needs assessment.

Tool: Hospice Data Collection spreadsheet

Recommendations

The recommendations section is where you tie the data together to paint a picture of the population(s) in need of palliative care as well as the potential partners identified during the process. Topics covered include:

- Patient populations
 - Diagnoses
 - Care setting/geography
 - Demographic groups
- Partnership opportunities
 - Physician practices
 - Health systems
 - Accountable Care Organizations
 - Senior living communities or facilities
 - Payers
 - Community organizations
- Next steps

Identifying Internal Capacity to Deliver Palliative Care

Palliative care services are different than hospice, and as such it's important not to assume that your organization has the internal capacity to deliver palliative care. One way to evaluate the readiness of your hospice to provide palliative care is to review your organization's alignment with the NCP Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Rather than become overwhelmed with the sheer number of guidelines, specifically focusing on staff training and other infrastructure elements provides an excellent barometer of the elements you need to have in place to provide quality palliative care. Good questions to ask include:

- Are any of our current staff experienced and / or trained in delivering palliative care?
- What is the ethnic / racial / linguistic make up of our staff, and to what extent does that match the characteristics of the population we hope to serve?
- Are we willing and able to invest in recruitment and training of new staff, as needed?
- Would we be able to leverage resources from existing service lines, such as a 24 hour call center, to support a new palliative care service?
- Do we have the financial resources to support new palliative care staff while a referral base is developed? If we are unable to cover such start-up costs with internal resources, are there external resources (for example philanthropic funds) that might be available to us?

Tool: NCP Guidelines Evidence of Practice and Action Plan

Tips:

- Gather perspectives from external and internal stakeholders about the need for a new palliative care service by conducting interviews, focus groups, or surveys
- Access data about the service area to better understand the population you hope to serve
- Review current health care use patterns among seriously ill individuals and look for care deficits that palliative care is likely to be able to help with (readmissions,
- Identify potential partners, such as hospitals or health systems, medical groups, health plans and ACOs that may have an interest in partnering with your organization
- Consider your organization's internal capacity to launch, staff and sustain a new palliative care program

Appendix I. Needs Assessment Data Source Worksheet

Needs assessment element	Your sources
A profile of each service area (county, parish, etc.) included in the needs assessment, which includes the following data:	
• Demographic information	
– Age	
– Race/ethnicity	
– Poverty prevalence	
– Literacy	
– Housing status	
– Insurance status	
• Mortality statistics	
• Hospital data	
• Post-acute care data	
• Physician encounters, referrals to hospice	
• Payers	
Data collected via the stakeholder engagement process	
Opportunities for palliative care	
• Patient population	
• Service gaps/proposed scope of services	
• Potential referral and/or payer partners	

Appendix II. Summary of Data Sources

Type of Data	Sources and features
Demographics	<p>American Fact Finder factfinder.census.gov/faces/nav/jsf/pages/index.xhtml#none.gov County and city level data describing age, gender, race, poverty status language spoken and more</p> <p>County Health Rankings and Roadmaps www.countyhealthrankings.org/ A snapshot of county-wide data, with comparisons to other counties in the state, includes preventable hospital stays and a range of socioeconomic factors.</p>
State Data	<p>Most states have publicly reported data, often hosted on the state department of health website, which can inform a palliative care needs assessment. The US Department of Health and Human Services publishes a list of all state department of health websites: healthfinder.gov/FindServices/SearchContext.aspx?show=1&topic=820</p> <p>HealthData.gov healthdata.gov/</p>
Hospital quality indicators	<p>Advisory Board Pay-for-Performance Payment Adjustments sca.advisory.com/Maps/Home/MapView?var=p4p Collation of CMS data describing the extent to which hospitals were penalized or rewarded as part of the VBP program for 30-day hospital readmissions, 30-day mortality rate, and Medicare spending per beneficiary.</p> <p>Hospital Compare www.medicare.gov/hospitalcompare/search.html? Summarizes several quality measures that may be associated with a need for palliative care, such as readmissions, 30-day mortality, and Medicare Spending per Beneficiary, and responses to several items on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). Data are compared to state and national data and all the indicators contribute to the facility's Hospital Compare score.</p>
Acute Care Utilization	<p>Hospital/Health System Claims Data (all payers) If you are part of a health system or have a partnership with a hospital they may be willing to share information that can help you predict the number and characteristics of individuals who might benefit from inpatient, clinic-based or home-based palliative care services. Data that will help your analysis of need includes information about inpatient deaths, length of stay, costs of care, ICU length of stay, and readmissions, stratified by payer group, for seriously ill individuals.</p> <p>Medicare Claims Data Medicare claims data includes a wealth of information that is helpful when planning a palliative care program, such as hospital admitting diagnoses, hospital length of stay, 30 day and 6-month hospital readmissions. To get this information you'd need to work with a third-party vendor, such as HealthPivots or Hospice Analytics.</p>
Post-acute care utilization	Information about non-acute care providers including physician encounters, hospital discharge status (referrals to home health, SNF, hospice, etc.), and hospital primary diagnoses is available in the Medicare claims database. Provider-specific data can be obtained from vendors such as HealthPivots or Hospice Analytics.
Medicare Advantage	<p>Centers for Medicare and Medicaid Services - Monthly MA Enrollment by State/County/Contract www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDENrolData/Monthly-MA-Enrollment-by-State-County-Contract.html</p> <p>While it's not possible to access Medicare Advantage (MA) claims data (unless you partner with an MA plan), it is possible to see monthly MA plan enrollment data. The Monthly MA Plan by State/County/Contract report allows you to easily determine which MA plans have the largest penetration in your county.</p>
Accountable Care Organizations	<p>The CMS Shared Savings Program, Program Data webpage www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/program-data.html.</p> <p>Searchable and sortable listing of ACOs which includes contact information for the chief executive and the name of the chief medical officer, as well as financial and quality performance data for each ACO. The website also lists the ACO's Skilled Nursing Facility (SNF) Affiliates.</p>
Hospice	<p>An analysis of your own hospice data, analyzed to identify individuals who may have benefited from palliative care as evidenced by:</p> <ul style="list-style-type: none"> • Not being admitted to hospice • A length of stay greater than 6 months • Discharged alive



NHPCO Palliative Care Playbook for Hospices

Developing the Business Case

This chapter is also available as a Grab & Go Toolkit:
www.nhpc.org/palliativecare



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Making the Case for Palliative Care

Creating a comprehensive Business Case provides a blue print for the implementation and sustainability of your palliative care program. This chapter will follow a comprehensive Business Case template. This is one template example. You can find a variety of Business Case templates on line. If you are part of a larger organization, check with leadership to make sure you use the organization's preferred Business Case template. Here are some of the common sections or topics within a Business Case:

Executive Summary
 Project Background and Description
 Strategic Alignment Assessment
 Technology Assessment
 Risk Management Evaluation
 Return on Investment (ROI) Evaluation
 Conclusions & Recommendations

The palliative care Business Case is a detailed description of your palliative care program. Informed by the Needs Assessment, the initial Business Case outlines:

- Why a palliative care program is needed
- What the program will look like
 - Who it will serve
 - Who will provide the care
 - The services that will be provided
- How much the program will cost and the anticipated return on investment
- What success looks like based on a comprehensive evaluation strategy

Established programs may revise the initial or create a new Business Case as you grow or acquire new partners.

Tip: Prior to writing the Business Case, the palliative care development team should complete the Business Case Worksheet to outline the key elements of your palliative care service. If you are part of a larger organization, such as a health system, check to see if the organization has a preferred Business Case template.

Resource: Supportive Care Calculator Worksheet (Appendix A)

Resource: Business Plan Template - Community Palliative APP – CLEAN (Appendix B)

Executive Summary

The Executive Summary provides a brief overview of the content within the Business Case, including key highlights. The reader should be able to ascertain the scope of the project how it aligns with the mission, vision, and values of the organization; and, the value of the project in improving the organization's effectiveness and/or efficiency.

Description:

While the Executive Summary appears at the beginning of a Business Case, it is written last.

The Executive Summary will describe the objectives of the project, the current state of the problem and the resulting opportunity. It outlines the scope of the project in general terms, and briefly describes the competitive environment. The Executive Summary also provides a brief description of the business impact, including the total cost of the project, whether it was budgeted, and the risks of undertaking the project. Finally, it concludes with recommendations and the financial impact of the project expressed in net value and return on investment. The Executive Summary should be able to stand alone as the single source of the overall project purpose, goals, proposed actions, cost/benefits, risks and success criteria. The summary should be kept to a maximum of 2 pages in length.

Checklist for Executive Summary:

1. Will the reader get a clear understanding of the reasons for the project and its outcome by outlining the "Why, What, When, Who, and How" of the project?
2. Does it address the four points of evaluation – Strategic Alignment Assessment, Technology Assessment, Risk Management Evaluation and Return of Investment Evaluation?
3. Does the reader get a clear financial understanding of the project?
4. Does it contain any information that is not contained in the body of the Business Case? If so, then remove that information.
5. Is the Executive Summary less than 2 pages?
6. Can the Executive Summary be treated as a stand-alone document?

Project Background and Description

The purpose of the Project Description Section is to provide the reader with a clear definition of what the project will accomplish (objective), what the project will and will not include (scope), what are the expected results (outcomes) and who are the players (stakeholders). Avoid duplicating information about the project that was already provided in the Executive Summary.

Current Situation and Background

This section provides a synopsis of what is happening currently within the business, if applicable, what has led to the current situation and what is the risk of not acting. Information from the Needs Assessment can be incorporated here. Some organizations complete a SWOT (strengths, weaknesses, opportunities, and threats) analysis and may include a summary here.

This section of the Business Case outlines the problem or need that palliative care will address. The "why" section of your Business Case includes:

- The reason you are considering starting a palliative care program:
 - Meet the needs of a patient population
 - Be "first in market" to have a palliative care program
 - Improve timely access to hospice
 - Diversify revenue stream
 - Establish a new partnership through contracting with health systems, ACOs, payors
- The needs and opportunities identified in the Needs Assessment
 - Patient population
 - Provider
 - Payor
 - Community
- Why us - why will we be successful?
 - Alignment with vision, mission, and strategic goals
 - Expertise (staff training, experience)
 - Infrastructure (IT, policies and procedures, HR)
 - Financial resources
 - Community support
- Why now?
 - Why is palliative care needed now?
 - What will happen if the organization does not launch a palliative care program?

Tip: If possible, include a patient story in this section. The story should talk about how palliative care met the needs of a patient and family in a way that hospice could not.

Project Description

This section provides an explanation of how the project will address the business problems/opportunity identified above. What will the palliative care program look like? What will the implementation require, and will that differ from sustaining the program? If so, how?

This section of the Business Case outlines the programmatic elements of the program. The decisions you make during this step in the process will influence every other aspect of the program. Decisions are made based upon the results of the Needs Assessment, the organization's priorities, and the resources available.

Model

As discussed in the Palliative care Considerations chapter, there are three predominant models of palliative care:

- Consultative
- Co-management
- Case management

Decision point: What care model will you adopt when you launch your program?

Some hospices employ multiple models based upon the needs of the patient population, care setting(s), and partnerships with providers or payors. For the initial Business Case, it is best to adopt one model. You can refine and grow the program over time.

The model you select will depend upon a variety of factors including the patient population, care settings, reimbursement, and staffing.

For example, if the Needs Assessment identified a physician practice interested in integrating palliative care consultations into the care of COPD patients, a consultative model might make sense. If, however, you learn that a hospital is struggling with 30-day mortality and readmissions, a case management model might be most effective.

Here is a program description from an actual Business Case:

Function: The Palliative care program works in consultation with other health providers to enhance health care delivery to patients with serious advanced and/or life-threatening illness. Palliative care is provided by an interdisciplinary team (IDT) that includes physician, NP, RN, LISW, and chaplain with expertise in Palliative Care and Hospice based on additional education in this specialty as evidenced by certification or specialized training. Additional members of the Palliative Care team include, but are not limited to, pharmacist, dietician, therapies, and volunteers.

Project Objectives

Outlines what the project will accomplish in clear and measurable terms within a specified time frame. These objectives can be used in a post-implementation evaluation to review and assess the success of the project. The objectives should be formulated broadly enough so that meaningful alternatives are not ruled out and narrowly enough so that only relevant alternatives are considered, and that costs and benefits can be formulated. Objectives should focus on goals, not operations, and on outputs, not production.

Examples of objectives include:

- Focus on holistic and comprehensive care of seriously ill, including proactively managing symptoms for the seriously ill patient population as evidenced by reduction in ED visits by X%, hospital re-admissions by XX%, hospital length of stay by X days.
- Connect seriously ill to the right service at the right time by ensuring appropriate and timely transitions to hospice care, as evidenced by X% increase in hospice referrals and increased hospice MLOS/ALOS for patients referred from Palliative Care as compared to general hospice patient population, to maximize quality of care for our patients and families and impact healthcare costs for our health system
- Ensure appropriate use of billable Palliative Care services (physician, ANP, LISW) to offset program cost, as evidenced by XX% of charges reimbursed

It is important to ensure that the descriptions for all objectives and goals are easily related to the stated project purpose statement. In addition, ensure that the descriptions are verifiable through some type of formal measurement. As will be seen in a later section, the ability to describe how attainment of these objectives will be verified is a key element in establishing credibility of the project plans.

Scope

This section defines parameters of the project. Specifically, it describes the timeframes, department/organization, function and technology.

Timeframe: Explains specific details about the duration of the project.

Department/Organization: Details the specific locations/sites, if applicable and departments or group of departments who will be involved in the project.

Function: Describes what functions of the department/organization the project involves.

Technology: Defines the boundaries within which the project must work, i.e. use of existing systems, compliance with established standards.

Here is an example from an actual Business Case:

Palliative Care Steering Committee Responsibilities:

1. Provides program strategies and develops the Order Sets and protocols to promote standardization using evidence-based practices by XX/XX/XX.
2. Meets quarterly to review annual key initiatives, review Palliative Care Metric Reports, ensure accountability, and update strategy in alignment with organization's strategy.
3. Promote standardization, evaluate program effectiveness, and identify opportunities for improvement.
4. Provides education to referral sources and the community at large to promote and enhance the utilization of palliative care. The Palliative Care team will identify, educate, and support palliative care champions throughout our healthcare partners to enhance access to palliative care model of care delivery.
5. Updates policies and processes to support evidence-based practice.
6. Reviews of Metric Report to identify areas of opportunity for quality assurance and performance improvement.

Technology:

- The program will utilize standardized electronic documentation tools. (Epic for inpatient and ambulatory by end of 20XX, McKesson for community with transition to Epic by 20XX).
- A Palliative Care access data base has been developed with expectations for all sites to participate in sharing data for reporting metrics to our internal customers (board, health system, clinic, home care, hospice, and hospitals). Data and reporting are based on national recommendations from peer reviewed research articles.
- The Palliative Care Steering Group has access to SharePoint site to store resources, data, reports, etc. (under ACO programs).

Program Expansion:

- As the Palliative Care program gains sophistication, tele-health may be included as an opportunity to impact this population. There is strong evidence-based research to support utilization of tele-health in a palliative care program. Palliative Care Telemedicine pilots will begin in 20XX to include video visits for timely intervention in the patient's home (own or nursing home) to avoid unnecessary ED visits and hospitalizations.
- Expansion into long term care and clinics began as a key initiative in 20XX. Clinic expansion includes visits within an existing clinic (e.g. oncology, cardiology, internal medicine, pulmonology, etc.) or dedicated Palliative Care clinic.
- Palliative Care recognizes the need to support widespread adoption of primary palliative care principals in other strategies for the rising risk and high-risk patient populations. Palliative Care team members support providing education on primary palliative care to enhance the widespread use of these concepts.

Out of Scope

This section includes items or functions that are specifically excluded from the project. The example above has a large scope and includes a growth plan. It could have narrowed the focus to community-based palliative care only or a specific patient population. Some programs identify primary diagnoses of behavioral health or substance use disorder or chronic pain as out of scope.

Patient Population

Rather than start with a “y’all come” approach, it’s helpful for a palliative care program to start with a small, well-defined patient population, allowing you to slowly grow the program after testing all the systems and processes you put in place. This allows you to test your systems and workflows, ensure you have the appropriate staffing model, gather quality data, and improve your services before rolling it out to a larger population.

A partnership with a clinic or physician practice is a great way to pilot the program as long as you limit the patient population. Depending on the size of your community, a practice could send you hundreds of referrals whereas one physician might not have enough patients for you to adequately test your processes and improve care.

Selecting the patient population is more specific than deciding “we’ll admit patients Dr. Young refers to us who have COPD.” It is imperative that you determine the admission criteria adopted so your staff and referring partners will know who you will and will not admit. Some palliative care programs do not admit patients with a primary diagnosis of dementia even though CHF or COPD patients admitted may also have dementia.

Tip: Your Palliative Care program is a finite service. It is more likely you will expand access for patients with the greatest need for your services if you clearly define patient eligibility criteria. Serving the patient population with the greatest needs will demonstrate the program’s value.

For example, your program could decide to partner with Dr. Young, but she and her office staff need to understand the specific criteria for palliative care patients. If you use the California Medi-Cal criteria as a launching pad, your criteria could include:

1. The patients referred by Dr Young, have Chronic Obstructive Pulmonary Disease (COPD) and meet the following admission criteria:
 - a. Documentation of continued decline in health status and is not eligible for or declines hospice enrollment.
 - b. Declining ability to complete activities of daily living
 - c. Two or more hospitalizations for illness within 1 year
 - d. Difficult-to-control physical or emotional symptoms
 - e. Patient, family or physician uncertainty regarding prognosis
 - f. Patient, family or physician uncertainty regarding appropriateness of treatment options
 - g. Conflicts or uncertainty regarding the use of non-oral feeding/hydration in cognitively impaired, seriously ill, or dying patients
 - h. Limited social support in setting of a serious illness (e.g., homeless, no family or friends, chronic mental illness, overwhelmed family caregivers)

California Medi-Cal

Starting in January 2018 Medi-Cal (Medicaid) managed care plans in California were required to provide access to palliative care to eligible patients. The state established both general and disease specific criteria to determine eligibility for palliative care. Some hospices outside of California are using the criteria as a starting place to define the patient population. The criteria can be found starting on page 3 of the California Department of Health Care Services All Plan Letter 18-020 <https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2018/APL18-020.pdf>

Detailed information about this program is available from the California Health Care Foundation, which developed numerous technical assistance resources to help providers and payers during the implementation process.

Resource: Helping Medi-Cal Plans Provide Access to Palliative Care <https://www.chcf.org/project/sb-1004-implementation-resources/>

2. Exhibits the following symptoms related to COPD
 - a. FEV1 < 35% and 24-hour oxygen < 3 LPM, or
 - b. 24-hour oxygen > 3 LPM
3. Lives within Allentown county

Decision point: What patients will you serve?

In defining the patient population, be sure to define:

- **What:** Specific diseases you will/will not serve (e.g., people with COPD)
- **Where:** Geographic area(s) where patients must live and/or receive care (e.g., Allentown County)
- **Who:** Physicians, clinics, hospitals, insurance plans that will refer patients (e.g., Dr Young's patients)
- **When:** Eligibility criteria could include a prognostic time frame (estimated prognosis of 1 year), healthcare utilization data (number of hospitalizations in a specific time) (e.g., two or more hospitalizations for illness within 1 year), and other specific eligibility criteria.

Tip: Avoid a tightly defined prognostic time frame. Forty years of hospice care demonstrates the barrier a prognostic indicator creates. Focus more on indicators of advanced serious illness, increased disease burden, and patient/family needs.

Resource: Patient Identification Assessment Worksheet (Appendix C).

Staffing

The Business Case includes an estimated staffing plan based on your care model and patient population. Can you afford a full team initially? Which positions will be part time and full time? Can you share any staff members with another service? What assumptions should be considered to link Full Time Equivalents (FTEs) to average daily census (ADC) and reimbursement? These assumptions are important for considering when (and what) additional staff is needed. Here is an example from an actual Business Case for a new program pilot that will be partly funded by an ACO contract and partially funded by Medicare B billing. Keep in mind this is only an example and should not be used as a standard formula for staffing.

For Outpatient Community Palliative Care:

- For ADC of 100 patients 0.1 FTE physician, 0.8 FTE ARNP, 2.0 FTE RN and/or LISW (LISW preferred). Note: RN and SW split patient case management based on goals of care. PRN chaplain borrowed from hospice.
- The remainder of the physician FTE (0.9) is in hospice. 0.2 FTE of the nurse practitioner is in hospice to assist with Face to Face visits. RN and LISW as case managers allow the NP to be productive.
- Productivity assumption: NP 4 to 6 visits per day (palliative and hospice) for an average of 20 visits per week. RN 6 to 8 visits per day (including virtual) for an average of 30 – 40 visits per week. LISW 4 – 6 visits per day (including virtual) for an average of 20 – 30 visits per week.
- Reimbursement assumption: 80% of NP visits are billable (allows for non-billable hospice F2F visits).
- Additional staffing assumptions covered by hospice: Administrative support, 24/7 tele-support, data collection and reporting.
- Contract for billing and coding

Include a growth plan:

- When ADC reaches 150, add a second NP
- When census reaches 200, add a second RN or LISW
- Track the strain on the staffing covered by hospice.

Remember, these are assumptions. In the example above, the initial staffing model was able to operate effectively with a higher ADC than originally assumed because they leveraged virtual visits effectively to supplement in-person visits and operated as a highly effective team. The growth plan was revised to reflect this learning. Of course, the reverse could also

have occurred, depending on the patient population. For example, if you are seeing a higher volume of complex patients or a high volume of patients with complex social determinants, productivity expectations may need to be lowered. The growth plan may also need to be adjusted, i.e. adding another SW before a second NP.

If you have been operating a pilot, you can describe why new staff are required and how you will expand your census to justify the staffing. In the Business Case, staffing could be presented as follows:

The _____ requests approval for the recruitment and hiring of 2 new full time Nurse Practitioners (NP) for the newly formed Home Palliative Program. These FTE's will be added to the home palliative care team as we grow this program to be more inclusive in the admission criteria and meet the needs of the geographic service area. It is expected that these nurse practitioners will practice out of the hospice administrative office located at _____ and perform services for the new home palliative program.

The Home Palliative Program is in its infancy, serving patients for the first time in January of 2018. The team currently consists of 1.5 full time nurse practitioners, overseen by our division chief, _____, and utilizes other disciplines within the hospice team as needed to meet patient needs. Criteria for admission to the home palliative program currently is restricted to include only patients with a cardiac diagnosis or COPD residing only within _____ County. Capacity is limited merely by staffing bandwidth as we have only had approximately 28 hours of NP resources dedicated to this program thus far.

In order to include more patients to this new program, additional resources are needed. The demand is high as we enter into more conversations with hospitals and other providers regarding their high cost patients and the goal to reduce readmission rates, especially for heart failure patients. These providers are excited about our positive outcomes and are acknowledging in the value of home palliative care services. We are also eager to include oncology patients as there are many patients identified through our inpatient palliative service and clinic who could benefit from this program.

More information on staffing is provided in the Staffing chapter.

Services

In the Palliative care Considerations chapter, we discuss service models and the types of services typically provided in each:

	Consultative	Co-management	Care Management
Conducting goal clarification and advance care planning conversations	✓	✓	
Providing symptom management recommendations	✓	✓	
Facilitating a discharge or care transitions process from inpatient to outpatient care	✓	✓	
Developing and managing the palliative plan of care, in collaboration with referring providers		✓	✓
Facilitating discharge or care transitions processes		✓	✓
Writing prescriptions and orders		✓	✓
Supporting family caregivers		✓	✓
Providing ongoing symptom assessments for all care needs			✓
Developing and managing a comprehensive plan of care that addresses all the patient's care needs			✓
Psychosocial assessment and symptom management	✓	✓	✓
Spiritual screening and spiritual support	✓	✓	✓

In the Business Case, specify the care model, the care location (home, clinic, etc.) as well as the specific services you will provide to your patients, based upon their care needs and your staffing model. Please note that some of these services can be provided using staff from your hospice on a permanent or as-needed basis. See the Staffing chapter for more details.

Example from Actual Business Case:

Palliative Care IDT Responsibilities:

- 1. Timely responsiveness to referrals.** Goals: 1) Referral follow up within 24-48 hours. 2) On-Call ability to be responsive to other healthcare providers and patient/families 24/7.
- 2. Consulted on:** relief of suffering (physical=symptom burden, emotional/spiritual=life limiting illness), discussions regarding disease process/prognosis/treatment options (goals of care/what matters most), and advance care planning.
- 3. Develop a plan of care with patient/family based on a comprehensive assessment of the patient.** Care is case managed by whichever discipline is appropriate based on services identified as the primary Palliative Care needs of the patient; however, all services are available to all patients as needed. Care plan is shared with other health care teams (Primary Care Provider, specialists, etc.).
- 4. Meet on a regular basis** to evaluate effectiveness of the current plan of care and anticipate changes to plan of care based on patient's goals and disease progression. The IDT meeting is a shared meeting between the inpatient and outpatient Palliative Care team. The IDT meets weekly.
- 5. Communicate clearly with other health care providers throughout the course of providing Palliative Care services** to ensure successful impact of Palliative Care outcomes for the patient, family, and the health system. The team is consultative in a hospital, clinic, or home care episode. The team can be primary case manager if home health services are no longer needed.
- 6. Seamless Care:** following patients across the care continuum (hospital, home and clinic). The hospital and home care have several shared staff positions to allow for continuity of care. There is collaboration with Care Navigator, Care Coordinator, and/or Primary Care Provider.
- 7. Complete accurate and timely documentation** to include assessments, discussions, treatment, response to treatment, education, response to education (including comprehension), plan of care, progress toward goals, IDT meetings, communications (with patient, other health care providers, etc.).

Other:

- Patients that become inactive or are discharged from Palliative Care upon achievement of self-identified goals, improved health and wellness, or transition to hospice.
- Families of patients that die in the Palliative Care program are offered bereavement services.
- The Palliative Care program provides data to allow reporting for operational, clinical, customer satisfaction, and financial and quality metrics. Most of this data should be extractable from the patient's electronic medical record.

Anticipated Outcomes

This section itemizes specific and measurable deliverables of the project. Each outcome includes an estimated time frame of when the outcome/deliverable will be completed (in terms of elapse time from project start).

Decrease re-admissions by 50% in population served by palliative care	Define by what time frame
Decrease hospital mortality rates by __%	Define by what time frame
Increase palliative care conversion to hospice (Conversion goal= __% of palliative care patients converted to hospice): increase hospice volume and ALOS/MLOS	Define by what time frame
Participation in the palliative care programs' patient satisfaction survey: __% Response Rate	Define by what time frame
Achieve advance care planning = 90% of palliative care patients have documented preferences and/or advanced directives	Define by what time frame

Stakeholders (can use list created in Needs Assessment)

Internal customers: Primary

- Palliative Care Steering Committee (if applicable)
- Palliative Care, Home Health Care, and Hospice program leaders and staff
- Health system corporate leadership*
- Home Health Care*
- Hospitals* - particularly units of medical, oncology, ICU, clinic partners, and ED
- Clinic* (including Care Coordinators, Care Navigators, primary care and specialists)
- Analytics team or vendor*
- IT team
- ACO Clinical Collaborative/ACO Steering Committee (My Nurse, Disease Management)

*These stakeholders are internal if you are affiliated with a health system; however, they could be external if you are a free-standing agency. Any vendors would be external stakeholders.

Secondary

- Reducing Readmissions Team Leads
- Efficiency of the Patient Stay Team
- Care Transitions from Hospital to Skilled Nursing Facilities project
- Secondary impact would include an increased volume for hospice programs and decreased volume and testing/treatment utilization for hospitals and clinics. Therefore, hospice programs should anticipate growth, including potential increased utilization of hospice facilities, and potential decreased utilization of hospitals. As the Palliative Care program gains sophistication, there may be increased utilization of tele-health for palliative care and hospice.

External customers: Primary

- Patients/families
- Other health care providers (clinics, mental health, etc.)
- Other community services (e.g. congregate meals, transportation, parish nursing, etc.)
- Payors (Medicare, Medicaid, managed care plans, Veterans Administration, private insurance)
- Community

Checklist for Project Description Section:

1. Is it clear what the project will accomplish?
2. Are the project objectives clear, measurable, and verifiable?
3. Is it clear what is not included in the project and what it will not accomplish?
4. Will the reader know all parties that will be impacted by the project?
5. Are the general requirements of each stakeholder clearly identified?
6. Are the timelines of the project clearly outlined?

Strategic Alignment Assessment

The purpose of the Strategic Alignment Assessment section is to provide the reader with an understanding of how the project aligns with the overall business plan of the organization and how it may impact other initiatives.

Description:

Provide a narrative describing the overall Strategic and Organizational Fit of this project within the current Strategic direction of the company. The project should be described in enough detail to assess its strategic compatibility. This includes descriptions of the following:

- Strategic rationale (e.g. quality, service, growth, financial effectiveness, employees, community)
- Revenue growth or cost reduction rationale and support
- Impact on asset and capital levels

The Strategic Alignment Assessment should also include a specific evaluation of the project's impact on the organization's growth strategy. In particular, evaluation of how the project impacts physicians' and patients' ease of doing business with the organization. Avoid duplication of information already provided in the "Executive Summary" and "Project Background and Description" sections. It is recommended that you reference an earlier section of the narrative instead of repeating certain details.

Checklist for Strategic Alignment Assessment:

1. Does the project align with the organizational direction? Will there be support for this project?
2. Has any indirect impact on other activities been considered and documented?

Example: Providing a collaborative Palliative care model compliments the overall Strategic Plan for XXX organization by improving quality and customer satisfaction and impacting utilization of appropriate services. The collaborative model unifies hospital, home care, clinic, and physician partners in a common goal to provide holistic care to patients and their families living with serious illness. Palliative Care allows for earlier utilization of hospice services to ensure our patients/families receive the right services at the right time, and positively impacts hospital re-admissions, length of stays and mortality rates.

- Strategic rationale: Palliative Care improves quality outcomes and customer satisfaction while promoting more efficient use of services and minimizing futile care through advance care planning. Palliative Care may increase appropriate use of hospice and tele-health which are underutilized.
- Revenue growth or cost reduction rationale and support: Currently reimbursement for Palliative Care is limited. Most often, the value of Palliative Care's impact is seen as cost avoidance (decreased ED visits, re-hospitalizations, futile tests and treatments, hospital length of stay). However, we can improve our financial concerns by maximizing appropriate billable visits of Palliative Care P/NP (volume and time/complexity, ACP and CCM codes) and LISW (counseling for DSM V diagnoses), and increased growth to other services (i.e. hospice = increased volume and LOS).
- Impact on asset and capital levels: Staffing requirements include Palliative Care physician oversight, NP, SW, RN. There is also some need for analytic, technology, and administrative support.

Technology Assessment

The purpose of the Technology Assessment Section is to provide the reader with a clear understanding of the relationship between the technology being proposed and the current organization infrastructure. The project should be evaluated for compatibility with current IT architecture, specific IT strategic direction and industry best practices. This is a frequently overlooked section of the Business Case. However, IT resources have become a major investment for healthcare organizations.

Description:

If electronic medical record architecture has been developed or is being proposed, it should be summarized and describes in this section. Discuss any new or common business services being provided by the organization's technical infrastructure or new services being developed for this project that will be added to the organization's technical infrastructure.

Considerations: If you plan to bill Medicare Part B for applicable clinicians (physicians, physician assistants, nurse practitioners, and clinical nurse specialists), your electronic documentation software needs to meet 2015 Edition Certified EHR Technology requirements for interoperability. Promoting interoperability accounts for 25% weight or 25 Merit-based Incentive Program System (MIPS) points maximum. There are three types of exclusions from MIPS participation:

- Clinicians in their first calendar year of Medicare Part B participation
- "Low-volume exclusion": in a 12-month period, clinicians or group each a) billing \$90,000 or less in Medicare Part B allowed charges for services, b) providing care for 200 or fewer Part B beneficiaries, or c) delivering 200 or fewer covered services to Part B beneficiaries
- Clinicians in entities sufficiently participating in an Advanced Alternative Payment Model

To confirm your EHR vendor's system and modules are certified you can check on the Certified Health IT Product List at <https://chpl.healthit.gov/#/search>

Another consideration is the availability and ease of data extraction for quality reporting and other data collection. There are several vendors that provide data collection technology that layers on top of the documentation software to extract data for quality reporting which is required by Merit based Incentive Payment System, Advanced Alternative Payment Models, CMMI Care Models (Primary Care First and the Serious Illness Population model), and most managed care plans (e.g. Medicare Advantage).

An approved Medicare vendor is required to administer and report the CAHPS (Consumer Assessment of Healthcare Providers and System) survey. The survey is required for clinicians and clinician groups billing Medicare Part B. Most Medicare Advantage and commercial health plans also require some level of patient satisfaction reporting.

Even if you do not plan to bill Medicare Part B or are excluded due to low volume, it is recommended that you still include technology needs in your Business Case. Someone's time and attention will need to be dedicated to documentation enhancement and data collection and analysis. A word of caution: you do not want to waste your valuable clinicians' time to complete data entry!

Appropriate Technology:

In a conscious effort to recognize and eliminate the application of "technology for technology's sake", describe how the technologies proposed on the project were selected and provide the most efficient use of resources. There is sometimes an interest in developing and utilizing the latest technologies without regard for appropriateness. The appropriate use of technology on the project should also be characterized by the utilization of tools for a select user group that meets the goals of the program and organization. Do not hesitate to describe portions of the process that are worthy of preserving in their current (or modified) "low-tech" form to maintain quality, flexibility, individualized service, human decision making, user comfort or other important benefits. The following is an excerpt from an actual Business Case from a large provider:

After extensive discussion and review of national best practices, the Palliative Care Steering Committee determined which data elements should be included and how programs would provide this data and where this data would exist. IT and analytic support has been provided throughout this process and will continue to be a need.

- Electronic documentation continues to be developed with important consideration to data extraction and data elements to support coding and billing.
- It is an expectation palliative care program will document electronically.
- A standard palliative care documentation tool will include evidence-based assessment tools with data elements that can be pulled out for metrics.
- Other technology considerations include the implementation of tele-health for palliative care and hospice patients.
- Further development of risk stratification tools to identify and trigger earlier referral to the palliative care program can have a great impact on program success. Any technology that can promote communication and utilization between hospital, clinic and home services for patients with serious illness should be considered and maximized.
- Additional consideration: implement use of Dragon for all palliative care and hospice physicians and nurse practitioners to maximize efficiency and quality of documentation. Dragon is a software voice recognition product that allows the practitioner to dictate documentation. It can be trained to auto-fill forms. Estimated number of users is 20. Associated costs:

Software License	\$2200.00/user	Total: \$44,000.00
Annual Software Support Fee	\$396.00/user	Total: \$7,920.00
Dictaphone	\$388.00/user	Total: \$7,760.00
Clinician Training and Support	\$665.00/user	Total: \$20,500.00
TOTAL COST		\$80,180.00

Checklist for the Technology Assessment:

1. Necessity of suitable technology in order to achieve program's goals and objectives.
2. Is the technology in compliance with the organization's current technology architecture?
3. Has the appropriateness of the technology been addressed?
4. Implementation time frame and all necessary financial considerations.
5. Identify palliative care program technology users.

Risk Management Evaluation

The purpose of the Risk Management Evaluation is to provide the reader with an understanding of the risks that are related to the project and how these risks may vary by viable alternatives. The objective is to systematically identify and assess risks, determine risk reduction actions, and monitor progress in reducing threats to achieving project objectives. This section should include a risk mitigation strategy for each major risk category as follows.

1. **Technology risk** – includes proven reliability, compatibility, security, implementation barriers or skill shortages
2. **Operational risk** – includes schedule delays, degree of project complexity, uncertainty of cost estimation and internal changes that may affect the project (e.g., resource issues)
3. **Business risk** – includes vendor viability, competitive response, and external factors changing economic conditions
4. **Legal risk** – includes legal, compliance and regulatory issues or concerns. For assessment of legal and regulatory risk, involve a legal consultant at the time the business plan is in early draft stage to identify issues that can be addressed prior to project implementation. (See chapter on Regulation and Compliance).

This section includes any findings from research studies that identify industry trends and best practices. Business Intelligence information should be obtained and utilized to support conclusions, present and expected market conditions, analysis of competition and potential competitive response. This will provide the reader with an understanding of what other organizations have done or are doing to address similar types of issues. Below is an example of potential risks:

1. **Technology risk** – Current Electronic Medical Record (EMR) vendor does not meet 2015 CEHRT for interoperability. Potential risk of reduced payment and delayed communication with health care partners regarding medication and other treatment changes resulting in potential patient safety issues. According to Becker's Hospital Review (2019), disparate EMRs was the number one patient safety issue for 2018.¹
2. **Operational risk** – Potential delay in implementation due to lengthy credentialing process for new nurse practitioners. Average length of time for credentialing process is 90 – 150 days. Use standard credentialing process including checklist

Resource: Staff Credentialing Checklist (Appendix D)

Other risk considerations:

- **Business risk** – includes vendor viability, competitive response, and external factors changing economic conditions.
- **Legal risk** – includes legal, compliance and regulatory issues or concerns. For assessment of legal and regulatory risk, involve a legal consultant at the time the business plan is in early draft stage, so that any issues identified can be addressed well before the project is implemented.

The California Health Care Foundation provides a list of references to support the palliative care Business Case: <https://www.chcf.org/resource-center/community-based-palliative-care/making-the-case/>

Risk of Project and each Viable Alternative, including Status Quo

1. Vaidya, Zimmerman, and Bean. (2019). 10 top patient safety issues for 2018. Becker's Hospital Review. Retrieved from <https://www.beckershospitalreview.com/10-top-patient-safety-issues-for-2018.html>

Description:

Identify all project risks that may relate to the project. A risk is a factor or event that may jeopardize the project from achieving the anticipated benefits or increase the cost of the project. For each project risk, identify the probability of the risk occurring and the impact it may have on each alternative, using the following guidelines:

Probability of Risk

High indicates that the event is high likely to occur

Medium indicates that the event is likely to occur

Low indicates that the event is not likely to occur

Impact of Risk

High indicates that the event has a significant impact to the project

Medium indicates that the event will impact the project

Low indicates that the impact is relatively minor to the project

None indicates that the risk will not impact the project

For each risk, document the risk mitigation strategies that will be employed to manage risk to acceptable levels.

Checklist for Risk Management Evaluation:

1. Have all general project risks been identified?
2. Have all risks specific to each alternative, including the status quo, been identified?
3. For each risk have the specifics of each alternative been taken into consideration when evaluating the probability and impact?
4. Has a risk mitigation strategy been identified for unacceptable levels of risk?
5. Has your legal team been consulted before providing the business plan to decision makers for review?

Project Investment and Return on Investment

The purpose of the Return on Investment (ROI) Evaluation Section is to provide the reader with an analysis of the costs and benefits associated with each viable alternative. The reader can easily understand and compare the initial and on-going expenditures to the expected financial and non-financial benefits for each viable alternative. The Business Case needs to include revenue and expense estimates to demonstrate the potential financial return on investment, even if it shows a loss.

List all possible alternatives that may meet the business problem or opportunity. All alternatives should be considered. Almost any alternative can be made to seem worthwhile if it is compared with a sufficiently bad alternative. Based on a practical and common-sense analysis, narrow the list to include only viable alternatives, stating the reason for excluding an alternative. A viable option usually includes a 'do nothing' option (status quo). Valid alternatives should not be excluded due to funding constraints. Only the viable alternatives will be further detailed and utilized in the following sections of the Business Case.

There are tools to help you calculate your potential reimbursement and cost savings, i.e. the Supportive Care Calculator (SCC) developed by Cassel and Kerr (see Appendix A). The SCC tool provides quantitative and qualitative analysis for this section of the palliative care Business Case.

In the Business Plan Template - Community Palliative APP - CLEAN resource provided, the Business Case showcases the revenue generated by the Medicare Care Choices Model (MCCM) demonstration project. If you are not an MCCM site and do not have any kind of non-hospice service line that aligns with your new palliative care program (such as inpatient palliative care services), then you will calculate estimations based on your referrals and length of stay in hospice for each diagnosis you will serve in your palliative care program.

Cost savings data can come from the hospital directly or through fee-for-service (FFS) Medicare Claims data.

The following was created based on FFS Medicare Claims data collected from HealthPivots (see the Needs Assessment Chapter for more information) for a specific hospital.

The table displays _XXX_ Hospital's Medicare fee-for-service data for patients that died within 6 months of discharge in 201X with diagnoses consistent with palliative care, patient populations that were readmitted within 30 days of initial discharge. Multiple studies demonstrate that depending upon a program's size, location, maturity, and other factors, palliative care programs can expect to receive between 20% to 65% of referrals of a hospital's eligible patients. The table indicates the estimated number of referrals at the low (20%), medium (40%), and high (65%) referral rates.

Based on this data, _____ conservatively estimates the palliative care program can admit 200 patients per year once it is fully mature, if it decides to serve all these patient populations.

All Discharges – Patient Died within 6 Months & Readmitted Within 30 Days

Primary Diagnosis at Initial Hospitalization	% of Readmissions within 30 Days	Patient Population	Potential Annual Palliative care Referrals		
			Low	Medium	High
Diseases of Genitourinary System	34%	456	68	182	296
Diseases of the Blood / Blood-Forming Organs	51%	321	48	128	209
Diseases of the Circulatory System	26%	158	24	63	103
Diseases of the Digestive System	33%	160	24	64	104
Diseases of the Respiratory System	30%	199	30	80	129
Malignant Neoplasms	31%	67	10	27	44
Symptoms, Signs, and Ill-Defined Conditions	21%	21	3	8	14
Patient Population 30-day Readmitted		1382	207	553	898

As shown, this method allows you to estimate the total population using data from a hospital. The caveat is that the data is always at least one year old. If you can obtain this data from hospital, your estimates will be more accurate.

Once you have an estimate of the patient population you can use that data to estimate your Medicare FFS billing revenue. In Business Plan Template - Community Palliative APP - CLEAN there are financial assumptions based on visits per month (100), historical data, and estimated billing data. In this Business Case only two codes are used. A more robust estimate might include advance care planning billing codes and codes for shorter or longer visits, including prolonged visit codes. For example:

Admit Visit Hospital				
E/N Code	% of New Visits	Yearly Visits NP	Mcare Pymt NP	Revenue NP
99221 (30 min)	3%	0	\$88.78	\$0.00
99222 (50 min)	15%	0	\$119.18	\$0.00
99223 (70 min)	82%	0	\$176.49	\$0.00
				\$0.00 NP subtotal
Follow-up in the Hospital				
E/N Code	% of New Visits	Yearly Visits NP	Mcare Pymt NP	Revenue NP
99231 (15 min)	10%	98	\$56.12	\$5,507.19
99232 (25 min)	30%	294	\$63.29	\$18,632.68
99233 (35 min)	60%	589	\$90.61	\$53,350.63
				\$77,490.51 NP subtotal

Admit Visit Hospital	% Visits	Yearly Visits NP	Mcare Pymt NP	Revenue NP
99356 (30-60 min)	10%	0	\$79.91	\$0.00
99357 (ea 30)	2%	0	\$80.20	\$0.00
				\$0.00
				NP subtotal
				\$77,490.51
				NP subtotal

It is important to create a realistic picture of admissions and the revenue you can expect to generate through fee-for-service billing and other revenue you can generate through contracts, grants, etc. This is covered in more depth in the Reimbursement chapter.

Another important consideration is how long you will serve patients in your palliative care program. Some programs are open-ended while others have maximum time frame limits. However, as your program matures, you may need to adopt guidelines to determine when a patient continues to meet the eligibility criteria, processes when a patient no longer meets criteria and/or when a patient should transition to hospice. It is important to recognize when a patient is in the terminal phase in order to provide for a timely hospice admission. An essential skill set of the palliative care team is care coordination. Palliative care programs should track discharge disposition, average length of stay, and median length of stay, not only in the palliative program, but also in comparison to the hospice program. Referrals to and from home health and/or hospice services should also be tracked. The program should define the frequency of re-assessing eligibility for palliative patients, i.e. every 60 or 90 days. One can expect movement of patients in and out of the service. Keeping patients indefinitely in the palliative service reduces access by creating a bottleneck. Part of your program's sustainability depends on moving patients to the appropriate service at the appropriate time. The Business Case should reflect an estimate of the program's impact on other services (home health, hospice, private duty, etc.) as part of the return on investment.

All assumptions used to determine, both quantitative and qualitative, costs and benefits should be clearly documented. These should also be considered in appropriate sensitivity analysis in the quantitative analysis. This would include general assumptions as well as assumptions specific to each alternative.

Checklist for ROI Evaluation:

1. Have all quantitative costs and benefits been identified?
2. Have all qualitative costs and benefits been identified?
3. Is the timeframe appropriate considering the expected life span of the project?
4. Can any of the non-financial items be converted to financial items?
5. Are all the assumptions clearly identified?
6. Have all critical assumptions been described, and the impact of sensitivity analysis described?
7. Have all common/general assumptions been applied consistently to each alternative?
8. Have assumptions been reviewed to identify the sensitivity of their estimate on the impact of the results?
9. Have benchmarks, other organization's experience, industry data been used to validate costs and benefits?

Conclusions and Recommendations

The purpose of the Conclusion and Recommendation Section is to provide the reader with a selected alternative based on an overall evaluation of the alternatives in terms of impact, risk, and cost/benefit. Specific recommendations for moving the project forward are also presented.

Conclusions

Description:

This section will recap each of the alternatives based upon their impact on the organization's strategy, technology, risk and

ROI. Based on these results, the appropriate alternative can be selected.

Alternative	Strategic Impact	Technology Impact	Risk Impact	ROI Impact
Alternative 1				
Alternative 2				
Alternative 3				

Choose the recommended alternative based on the above recap, selecting the alternative that maximizes the effectiveness and efficiency while minimizing risk and cost.

Recommendations

Description: This section will make specific recommendations on proceeding with the project.

The extent of the recommendation may range from recommending approval for full project implementation to recommending a more detailed analysis be conducted to validate key Business Case components.

Project Responsibility

Description: Select a Project Team Lead who will have overall responsibility for managing the implementation project. In addition, discuss others who have contributed to major sections/analysis of the Business Case, i.e. quality staff, the financial analyst, etc.

Project Accountability

Description: Select a Project Executive Sponsor who will have overall accountability to ensure the project is completed timely and based on final implementation plans.

Implementation Strategy

The purpose of the Implementation Strategy Section is to ensure that those approving the Business Case understand the resources they must allocate (people, dollars, time) to complete the recommended next steps of the project.

Description: Outline the proposed implementation plan for the recommended next steps at a high level. Enough detail should be provided for those approving the Business Case understand the resources they must allocate (people, dollars, time) to complete the recommended next steps.

This section should include:

- Major project phases
- High-level work plan, deliverables and target dates for completion
- Costs (\$) required to carry out the implementation plan
- Personnel (departments, roles) required
- Proposed project structure
- Assign responsibility for implementing and monitoring the risk mitigation strategies (Section 3)

Checklist for Project Schedule

If the specific plans are implemented, do we have a clear plan and means to measure results to determine whether we have accomplished the expected returns?

Review and Approval Process

The purpose of the Review and Approval Section is to clearly present the reader with whom and how the Business Case has been reviewed and approved. This section will also contain the final outcome of the Business Case. If the Business Case is approved, the evidence of the approval should be included. If the Business Case is not approved, the business decision behind either rejecting, deferring or modifying the project should be documented.

Review Process

Description: All projects requiring at least \$XXXX of cash outflow must be reviewed in advance of the formal presentation by the Project Lead to executive management and/or Board. It is often helpful to prepare a PowerPoint presentation to highlight the high-level information presented in the Executive Summary when reviewing with a group of people.

Approval Process

Description: What is the approval process in your organization? Does the project need approval by executive leadership before it goes to the Board for approval? Do you have an Executive Committee of the Board that must review and approve before being presented to the full Board?

Business Case Signoff

Description: The Business Case should be signed and dated by the approving person(s) on the Signature Sheet, indicating whether the Business Case is approved. Regardless of final decision, reasons for the decision should be documented.

Attachments

The Palliative Care Business Case should include a section for attachments that have been referenced throughout the document.

Summary of the Business Case process

This chapter provided a comprehensive example of a Business Case template. The Business Case is the blue print for implementation and sustainability of your palliative care program. The Needs Assessment is the foundation for the Business Case. A Business Case may include an Executive Summary, Project Background and Description, Strategic Alignment Assessment, Technology Assessment, Risk Management Evaluation, Return on Investment Evaluation, and Conclusions and Recommendations. The Business Case should be reviewed and updated annually, regardless of the plans to continue status quo or expand. If you are part of a larger organization, check with leadership to make sure you use the organization's preferred Business Case template.

Appendix A: Supportive Care Calculator

Here is the link: <https://coalitionccc.org/tools-resources/palliative-care/> and the Supportive Care Calculator Home is under Tools For Planning & Evaluating Programs

Appendix B: Business Case Template

BUSINESS CASE
(Project Name/Type)
more detailed project information

Prepared for
Business Name
Street Address, City, State, Zip
Attn: Name, title
email address

Prepared By
Your Name
Business Name
Street Address, City, State, Zip
email address
phone number

Contents

Executive Summary	x
Business Problem	x
Analysis	x
Proposed Solution One	x
Goals	x
Deliverables	x
Benefits and Value	x
Human Resources	x
Procurements	x
Estimated Cost	x
Risks	x
Strategic Alignment	x
Proposed Solution Two	x
Goals	x
Deliverables	x
Benefits and Value	x
Human Resources	x
Procurements	x
Estimated Cost	x
Risks	x
Strategic Alignment	x
Alternatives	x
Recommended Solution	x
Feasability	x
Supporting Documentation	x
Charter Authorization	x

Executive Summary

Provide high-level, summary information about the project and why it is needed.

Palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information and choice.² A palliative care program focused on meeting the needs of the seriously ill can achieve the triple aim for this vulnerable population by improving the health and wellness of this population, enhancing the experience and outcomes of the patient and family, while reducing the total cost of care. Palliative care is an effective strategy for the high risk patient population within an Accountable Care Organization's population health strategy.³ Palliative care is an effective service for the seriously ill population as part of a managed care strategy. Hospice providers are experts in palliative care making hospice organizations a logical participant in the provision of palliative care services for all seriously ill individuals and their families. Hospice organizations engaged in palliative care services can offer continuity of care as a subset of seriously ill individuals as they progress to the terminal phase of illness.

Business Problem

Describe the business problem.

Millions of Americans are living with serious illness; however, access to community-based palliative care services is limited.

Analysis

Why does the problem exist?

The number of Americans ages 65 and older is projected to more than double from 46 million today to over 98 million by 2060, and the 65-and-older age group's share of the total population will rise to nearly 24 percent from 15 percent.⁴ Social Security and Medicare expenditures will increase from a combined 8 percent of gross domestic product today to 12 percent by 2050. The increase in life expectancy has also been accompanied by an increase in older Americans living with chronic conditions. The Medicare population currently accounts for 45% of the top 10% of healthcare utilizers based on expenditures.⁵ In 2016, the Medicare Advantage participation Recent studies identify four types of utilization patterns for older adults in the last few years of life.⁶

A proposed project should support the objectives in the strategic plan. List specific strategic plan objectives and describe how the problem is an obstacle to reaching the specific objectives.

Describe business processes that are not operating properly because of the problem.

What is the impact of not implementing the problem?

List all quantitative support in favor of eliminating the problem.

What timeframe must the problem become resolved within?

Proposed Solution One

Describe the proposed solution in detail.

2. Centers for Medicare & Medicaid Services, Department of Health and Human Services. Hospice care. *Code of Federal Register*. 79 FR 50509, August 22, 2014

3. Smith G, Bernacki R, Block SD. The Role of Palliative Care in Population Management and Accountable Care Organizations. *Journal of Palliative Medicine*. 2015;18(6):486-494. doi:10.1089/jpm.2014.0231.

4. Mark Mather, Linda A. Jacobsen, and Kelvin M. Pollard, "Aging in the United States," *Population Bulletin* 70, no. 2 (2015)

5. Zayas CE, He Z, Yuan J, et al. Examining Healthcare Utilization Patterns of Elderly Middle-Aged Adults in the United States. *Proceedings of the International Florida AI Research Society Conference Florida AI Research Symposium*. 2016;2016:361-366.

6. Copyrighted and published by Project HOPE/Health Affairs as M. A. Davis et al., "Identification of Four Unique Spending Patterns Among Older Adults in the Last Year of Life Challenges Standard Assumptions," *Health Affairs*, July 2016 35(7):1316-23. The published article is archived and available online at www.healthaffairs.org.

Goals

List high-level goals of the proposed solution.

Deliverables

List project deliverables. A deliverable is a unique and verifiable product, result, or capability to perform a service that must be produced to complete a process, phase, or project.

Benefits And Value

List the benefits of the proposed solution and the estimated economic value of each benefit.

Benefit	Value
Total Project Value	

Human Resources

List the people from within the organization that might be assigned to the project.

Name	Department/Title	Contact Information	Immediate Supervisor

Procurements

List the known resources which must be procured.

Description	Source	Estimated Cost

Estimated Cost

Provide high-level cost information for implementing the proposed solution.

Resource Description	Estimated Cost
Total Estimated Cost of Proposed Solution	

Risks

From a high-level perspective, identify risks associated with doing nothing.

From a high-level perspective, identify risks associated with implementing the proposed solution.

Strategic Alignment

Describe how the proposed solution supports strategic goals.

Proposed Solution Two

Describe the proposed solution in detail.

Goals

List the high-level goals of the proposed solution.

Deliverables

List the project deliverables. A deliverable is a unique and verifiable product, result, or capability to perform a service that must be produced to complete a process, phase, or project.

Benefits And Value

List the benefits of the proposed solution and the estimated economic value of each benefit.

Benefit	Value
Total Project Value	

Human Resources

List the people from within the organization that might be assigned to the project.

Name	Department/Title	Contact Information	Immediate Supervisor

Procurements

List the known resources which must be procured.

Description	Source	Estimated Cost

Estimated Cost

Provide high-level cost information for implementing the proposed solution.

Resource Description	Estimated Cost
Total Estimated Cost of Proposed Solution	

Risks

From a high-level perspective, identify risks associated with doing nothing.

From a high-level perspective, identify risks associated with implementing the proposed solution.

Strategic Alignment

Describe how the proposed solution supports strategic goals.

Alternatives

List the known alternatives to undertaking either of the proposed solutions and state the pros and cons of each.

Alternatives	Benefits of the Alternative	Reasons for Not Implementing the Alternative

Recommended Solution

Rank the two proposed solutions.

Criteria	Solution One	Solution Two
Benefits (Please list and assign an overall score of 1-10 with 10 being the greatest.)	[Assign a Rank of 1-10]	[Assign a Rank of 1-10]
Estimated Total Costs		
Risks (Please list and assign an overall score of 1-10 with 10 being the greatest.)	[Assign a Rank of 1-10]	[Assign a Rank of 1-10]
Total Score		

Feasibility

Describe the overall feasibility of the recommended solution. What is the likelihood of achieving the desired result? Address whether a feasibility study should be conducted.

Supporting Documentation

Attach any supporting documentation.

Charter Authorization

Date: _____

By initialing each page and signing below, I _____, in my capacity as _____, authorize the recommended solution to begin the Charter process.

(Insert Name of Organization)

By: _____

Signature

Printed Name and Title

For additional project management templates visit www.mypmllc.com/project-management-resources/free-project-management-templates.

Appendix C: Patient Identification Assessment

Exercise and Discussion: Methods for Identifying Eligible Patients

- Most PC providers and their payor partners invest significant effort into ensuring that individuals who qualify for PC services are identified and referred
- Most partnerships use a multi-modal approach that leverages the information, skills, relationships and resources available to the provider organization and the payor.

Common identification strategies

- Mining claims data to identify individuals with the right diagnoses or history of using health care services (retrospective)
- Reviewing lists of individuals admitted to the hospital (real time)
- Participating in concurrent review
- Asking health plan case managers to identify potentially eligible members
- Participating in inpatient rounds when a potentially eligible patient is admitted to the hospital
- Encouraging members to self-refer
- Asking primary care and specialty providers to identify patients
- Working with hospital case managers/discharge plans/utilization management staff

Assessing current approach

It's important to periodically assess the **reliability** of the various strategies used to identify potential patients

- **Regularity:** strategy is utilized as a matter of routine – it is implemented regularly, as expected
- **Standardized:** a preferred approach has been identified and that approach is used (more or less) no matter which individual is doing the work on a particular day
- **Feasibility:** the individuals who are responsible for implementing the strategy have the time, resources and training needed to do their work effectively (set up for success)

Patient Identification Strategy Assessment Exercise: Using the table, list the strategies your partnership is using to identify potentially eligible patients. Please assess the reliability of each strategy and the team's perception of current efficacy. You will be asked to do a brief report out

Strategy (describe)	Assess Regularity (implemented regularly, routine)	Degree Standardized (preferred approach identified and used)	Degree Feasible (staff have time, resources, training)	Current Efficacy 1= not so effective 5=totally awesome

Appendix D: Staff Credentialing Checklist

The credentialing and privileging process is at the heart of healthcare risk management. By periodically reviewing and refining your credentialing methods and policies, you can help improve patient safety, minimize the consequences of provider malpractice allegations and better manage your organization's future.

Standard To Be Measured	Currently Instituted? Yes/No	Date	Comments
Administrative Framework			
The power to credential and appoint is vested in a clinical appointment committee.			
Qualifications and procedures for admission to practice are clearly delineated.			
Clinical privilege categories are well defined and include scope of practice.			
The method of reviewing credentials is clearly stated.			
Ethical standards requiring staff adherence are noted.			
The hearing procedure for denial of staff appointment or other adverse rulings is specified			
The structure of the credentialing process is documented and incorporates specific time frames.			
The credentialing process includes protections against antitrust liability.			
Credentialing criteria comply with state statutes, standards developed by accrediting bodies and Medicare Conditions of Participation.			
Application			
Application forms comply with local, state and federal regulations.			
The pre-screening form requests the applicant's			
• name and address			
• education and training			
• prior employment			
• board certifications			
• current state license and Drug Enforcement Administration (DEA) certification, if applicable			
• current competencies			
• written statement seeking clinical privileges			
• personal and professional references (minimum of three)			

Standard To Be Measured	Currently Instituted? Yes/No	Date	Comments
The application form requests full information regarding			
• loss of medical professional liability coverage			
• loss of DEA number			
• suspension/revocation of privileges			
• past claims history			
• criminal charges			
• prior professional disciplinary actions			
Board of Medical Examiners' investigations			
Applicant executes a written consent and release from liability, to be attached to every reference inquiry.			
Applicant is provided a copy of applicable rules and regulations.			
Applicant agrees in writing to exhaust administrative internal remedies before litigating adverse credentialing decisions.			
Verification and Review			
Verify completion of education.			
Ask the director or other authorized responsible party of the applicant's residency or training program to complete a questionnaire regarding the applicant's performance and capabilities.			
Check dates of employment history and document any gaps in employment or appointment.			
Obtain a copy of applicant's DEA certificate and state medical license, if applicable.			
Query the National Practitioner Data Bank and adhere to the requirements of the federal Health Care Quality Improvement Act of 1986.			
Verify the status of existing clinical privileges at other facilities.			
Check with state and federal regulatory bodies for previous sanctions by Medicare and Medicaid programs.			
Obtain a copy of applicant's current medical professional liability insurance certificate, including verification of limits of coverage and claims experience.			
Verify by telephone all information contained in written references.			

Standard To Be Measured	Currently Instituted? Yes/No	Date	Comments
Delineation of Clinical Privileges			
Applicant provides the clinical appointment committee with a written request for clinical privileges.			
Committee processes the written request for clinical privileges based on established protocols and criteria.			
Committee votes to approve or deny request.			
Administrative leadership receives committee's recommendation and makes final decision.			
Reappointment of Clinical Privileges			
Reappointment process occurs annually or, at minimum, every two years.			
Committee verifies and documents the following information upon request for reappointment:			
<ul style="list-style-type: none"> any changes in certification, appointment, education or professional accomplishments 			
<ul style="list-style-type: none"> verification of current license and DEA certification, if applicable 			
<ul style="list-style-type: none"> any professional disciplinary action taken against applicant 			
<ul style="list-style-type: none"> medical professional liability insurance coverage and claim experience 			
<ul style="list-style-type: none"> status with National Practitioner Data Bank, if applicable 			
Performance appraisal is completed and includes the following indicators:			
<ul style="list-style-type: none"> utilization of services 			
<ul style="list-style-type: none"> drug utilization 			
<ul style="list-style-type: none"> admissions data 			
<ul style="list-style-type: none"> delinquent patient care records 			
<ul style="list-style-type: none"> member/patient satisfaction 			
<ul style="list-style-type: none"> quality improvement findings/outcomes 			
<ul style="list-style-type: none"> clinical peer-review findings 			
Clinical appointment committee reviews reappointment form and performance appraisal.			
Reappointment is granted either without change to prior privileges, or with modified privileges.			
Reappointment is denied, and applicant is notified via a letter, which also provides information about hearing procedures.			

Retrieved from: <http://www.hpso.com/risk-education/individuals/articles/Staff-Credentialing-Checklist>

References for CBPC Business Case

Cassel, J. B., Kerr, K. M., Kalman, N. S., & Smith, T. J. (2015). The Business Case for Palliative Care: Translating Research Into Program Development in the U.S. *Journal of pain and symptom management*, 50(6), 741–749. doi:10.1016/j.jpainsymman.2015.06.013 Retrieve at <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4696026/>

<http://www.commonwealthfund.org/publications/case-studies/2018/jan/sutter-health-aim>

<https://hbr.org/2017/05/giving-seriously-ill-patients-more-choices-about-their-care>

<https://homehealthcarenews.com/2018/03/developing-a-business-case-for-palliative-and-community-based-care/>

<https://homehealthcarenews.com/2017/03/pre-hospice-saves-money-by-keeping-people-at-home-near-the-end-of-life/>

On starting an Limited Liability Company (LLC)

<https://www.rocketlawyer.com/article/why-start-an-llc-limited-liability-company-advantages-and-disadvantages.r>

<http://guides.wsj.com/small-business/starting-a-business/how-to-start-an-llc/>

<https://www.nolo.com/legal-encyclopedia/form-llc-in-your-state-31019.html>

<https://www.wikihow.com/Start-an-LLC>

<https://www.legalzoom.com/articles/how-to-start-an-llc-in-7-steps>

<https://howtostartanllc.com/>

Medicare Advantage Plans by State

<https://q1medicare.com/MedicareAdvantage-PartCHealthPlanMAPDStateOverview.php>

<https://health.usnews.com/health-news/best-medicare-plans/articles/best-medicare-advantage-plans>

<https://www.consumerreports.org/cro/2014/10/how-to-pick-a-medicare-advantage-plan/index.htm>

ACOs

<https://www.healthcatalyst.com/accountable-care-organization-solutions>

<http://hsgadvisors.com/thought-leadership/articles/six-considerations-aco-strategy/>

<https://www.healthleadersmedia.com/strategy/4-ways-think-about-aco-strategy>

<https://www.beckershospitalreview.com/accountable-care-organizations/3-strategies-driving-aco-success.html>

<https://healthpayerintelligence.com/news/successful-accountable-care-organizations-use-3-key-strategies>

<https://www.nejm.org/doi/full/10.1056/NEJMp0909327>

Provider Use File (PUF)

<https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/medicare-provider-charge-data/physician-and-other-supplier.html>

<https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/PUF.html>

<https://catalog.data.gov/dataset/basic-stand-alone-medicare-hospice-beneficiary-puf-f278c>

Reports Vendor

<http://www.healthmr.com/report-descriptions-hospice/#marketprofiles>



NHPCO Palliative Care Playbook for Hospices

Partnerships and Contracting



NHPCO

Leading Person-Centered Care

[NHPCO.ORG](https://www.nhpc.org)

UNDER CONSTRUCTION



NHPCO Palliative Care Playbook for Hospices Staffing

This chapter is also available as a Grab & Go Toolkit:
www.nhpco.org/palliativecare



NHPCO

Leading Person-Centered Care

NHPCO.ORG

As part of the work you will do, or have done through your comprehensive Business Case development, your answers to the various questions (e.g. who will you serve, who will provide care, what services you will provide) will help identify the staffing needs for your program. As discussed in the chapter, Making the Case for Palliative Care, one of the critical decision points is to determine the care model for your organization. Some hospices may want to adopt multiple models based on a variety of factors identified through the needs assessment process (e.g. patient population, location of services, payor source agreements). Each model has its own unique staffing considerations. As stated in this chapter, it is best to focus on one model until your program matures, and you validate your Business Case and SWOT analysis.

This chapter will discuss the importance of setting your staffing metrics efficiently based on the model of care you choose and solutions that can be employed to manage towards best practices associated with team-based palliative care.

The importance of team-based palliative care

The National Consensus Project for Quality Palliative Care's 4th Edition of the Clinical Practice Guidelines for Quality Palliative Care, hereinafter referred to as NCP and NCP Guidelines, promotes the interdisciplinary team in Domain 1: Structure and Processes of Care. Because palliative care is holistic in nature, the NCP Guidelines state programs providing palliative care should include a team of individuals who supports the individual patient and their family through that patient's trajectory of illness. To be successful in this goal, a full complement of clinical and non-clinical staff (e.g. physicians, non-physician providers, nurses, social workers, chaplains and others based on need) is important.

It is important to remember the NCP Guidelines have been developed as a gold standard, and a standard to strive for when providing palliative care. These guidelines are not intended to be seen as an absolute structure of care that must be adopted. Your program may never be able to fully implement all of its recommendations. Depending on the type of model your organization launches and the financial parameters that govern your program, you will determine the most effective and efficient staffing model for your organization. Initially, you may only include one or two members of the interdisciplinary team as employees of your palliative care program; however, there are ways that you can supplement other members of the interdisciplinary team.

Due to reimbursement constraints and the variety of program types the feasibility of individual programs financially supporting an interdisciplinary team can be, very challenging. As you strive to achieve best practice according to NCP Guidelines, there are ways to provide interdisciplinary focus without the financial burden of hiring all clinician types it outlines.

Providing interdisciplinary team care without employing its full complement of staff is possible. At times it takes a little creativity and partnership. The NCP Guidelines outline what the interdisciplinary team could do to support patients throughout its eight domains. It does not say that your program individually provides that care. Through various structural designs of your program, and through developing partnerships within your community and with your community stakeholders, your program can knit an interdisciplinary team together. We will explore these opportunities and options as we review a set of staffing model examples.

Staffing Models

There is no right or wrong way in putting your program's staffing model together; however, it is important to stay as true to the principles of palliative care outlined in the NCP Guidelines as your organization can. As your model of care matures it is important to incorporate additional recommendations into your program structure. We often comment "if you've seen one palliative care program, you've seen one palliative care program". Although true not all incorporate the principles of palliative care outlined in the NCP Guidelines; some are in name only.

For the purposes of this chapter we will look at community-based palliative care programming from the perspective of a free-standing hospice/home health organization. These are typically represented through, or variation of:

- Hospice outreach
- Home health bridge
- Integrated transitions program
- Medicare Part B practice program
- Payer contracted program

It is important that your program considers its staffing needs across the following areas:

- Leadership
- Administrative
- Clinical

Leadership

Determining your leadership framework is critical to the success of your program. These individuals are crucial to ensure governance and sustainability of the program. Your organizational structure may determine the type and scale of your leadership role(s). This may be dependent on the regulations that govern your organization. If your organization is a hospice organization, hospice regulations will likely play a larger role in how you manage your program. If your organization is a home health organization, home health regulations will likely play a larger role.

Leadership roles to consider (not all are necessary):

- Program Director
 - Do you need someone that is a clinician, or a non-clinician?
- Medical Director
 - Do you want to employ or contract this individual?
 - Are there state regulations that govern this relationship?
- Business Manager
- Operational Manager

Each of these may be considered necessary at some stage of your program development. The last two may be positions that you want to develop after your program has matured or its complexity requires additional skill sets to manage (e.g. provider practice, ACO, various payer contracts). Initially, most programs choose to employ a Program Director who can provide day-to-day oversight, implement your structure, manage any regulations, policies and procedures that govern the program, and develop and deliver reports to your stakeholders.

Administrative Staff

There are a host of activities a palliative care program will be tasked to perform on a daily basis. It is critical that your program understand how everything will be accomplished on a daily, weekly, monthly basis. These activities may include, but are not limited to, the following:

- Scheduling
- Billing
- Data collection
- Marketing
- Patient record management
- Provider credentialing
- Payor contracting
- Human resource management

It is unlikely that you will be able to hire one individual who has the skill set to provide support for all these services. This is an opportunity to look more broadly across your organization to determine how you can task existing resources who perform these functions within your hospice and/or home health program to also support your palliative care program.

Example: You have decided to develop a Medicare part B practice program. Your organization develops a shared agreement between your palliative care program and your hospice division to provide the necessary infrastructure to support a number of the tasks outlined above. You work with:

- Hospice to perform scheduling and marketing tasks
- Human Resources to manage program HR tasks
- Billing department to perform billing, contracting and credentialing tasks

If your billing department is unable or does not have the necessary skills to complete the Medicare Part B billing, contracting and credentialing tasks. You may contract with an outside vendor that can provide these services. Vendors can also provide your credentialing and contracting services. By looking more broadly across your organization, you can meet your administrative needs without adding employees.

This example can easily be applied to a hospice outreach, or a home health bridge palliative care program in the same way. How can you utilize resources already within your organization to support your program efficiently without additional labor costs?

Clinical Staff

The type and structure of your program will determine the disciplines and staff needed. This may include one or more of the following:

- Registered Nurse
- Advance Practice Registered Nurse (nurse practitioner, clinical nurse specialist)
- Physician
- Chaplain
- Social Worker
- Care Coordinator/Transitions Coordinator
- Therapy (PT, OT, ST, RT)
- Pharmacists
- Certified Hospice/ Home Health Aides
- Certified Nurse Assistants
- Psychologist/Licensed Clinical Social Worker

Each of these clinicians serves a distinct role/skill set. Your program will determine the type of clinicians needed.

Hospice Outreach.

For this type of program, you may decide to hire a Registered Nurse Care Coordinator. Your goal is likely to provide upstream support to patients who may not be emotionally ready or who are not yet eligible for hospice. This type of program typically provides care management support, working with the patient and family through telephonic contact or through other non-direct care activities. Consider the NCP Guidelines to choose how you will provide interdisciplinary support? This can easily be achieved through the utilization of your hospice interdisciplinary team.

Example: Your RN Care Coordinator determines a patient is clinically appropriate for hospice and is struggling spiritually. You may determine that your Chaplain is best suited to meet with the patient for an informational visit. He or she performs the informational visit and the patient decides to elect his/her hospice benefit, orders are obtained and the hospice RN performs the hospice admission.

Example: Your RN Care Coordinator determines a patient is not clinically appropriate for hospice and is struggling spiritually. Your RN Care Coordinator talks with your hospice Chaplain to determine what resources are available in the community for the patient. This may involve a referral to a psychologist or a licensed clinical social worker.

Both these examples show the appropriate use of members of your interdisciplinary team or resources outside your hospice staff that represent an aspect of your interdisciplinary team. It is important not to overstep your primary program and the regulations that govern it, and the policies and procedure that you have developed that provide programmatic boundaries that guide your program and staff.

In a hospice program, it is important to maintain a non-direct care approach for patients who are not yet on your hospice services. The main reason for maintaining this boundary is that you are not allowed to provide direct patient care outside your hospice license. From a legal perspective, providing care outside your licensure could be viewed as providing free care to solicit referrals.

Team-based Palliative Care		
Palliative Program	Primary Program (Hospice)	Community Partner
RN Care Coordinator	Receptionist	Psychologist
Program Manager	Sales Associate	Licensed Clinical Social Worker
	Chaplain	Chaplain, Priest, Pastor
	Social Worker	Physician
	Medical Director	Pharmacist
	Pharmacy Provider	

Home Health Bridge.

For this type of program you may decide to hire a Registered Nurse Transitions Coordinator. Your goal is likely the same as the hospice outreach program; it is just from a different perspective. Here you are working to provide upstream support to patients who may not be emotionally ready or who are not yet eligible for hospice.

The biggest difference between a hospice outreach, and a home health bridge program is the ability of the home health bridge program to provide direct patient care. This is achieved by incorporating palliative care goals and interventions into the patient's home health plan of care. When a patient is discharged because they no longer meet the requirements for home health services and you feel that individual is appropriate for ongoing palliative care oversight, the approach is no different than that outlined under the Hospice Outreach section. It is important to maintain a non-direct care approach.

Team-based Palliative Care		
Program	Primary Program (HH)	Community Partner
RN Care Coordinator	Receptionist	Psychologist
Program Manager	Sales Associate	Licensed Clinical Social Worker
	Social Worker	Chaplain, Priest, Pastor
		Physician
		Pharmacist

Integrated Transitions Program.

For this type of program you may decide to hire a Registered Nurse Transitions Coordinator. This type of program can be considered a hybrid of the previous two programs. For organizations that have both hospice and home health, it may be preferable to develop a palliative care program that integrates palliative care across the organization.

It is preferable to have the Registered Nurse Transitions Coordinator trained to deliver care in all care settings (e.g. palliative care, home health, hospice). The information outlined in both the Hospice Outreach and Home Health Bridge section continues to apply. The difference is that the Registered Nurse Transitions Coordinator helps to manage patients across your care continuum.

This type of program works well as a standalone department/division; however, you can designate either your home health or hospice as the primary program. The advantage to your program being a standalone department/division is maintaining a neutral perspective that is not overly influenced by budgetary or census goals that your hospice or home health are held accountable.

Team-based Palliative Care			
Program	HH	Hospice	Community Partner
RN Transitions Coordinator	Receptionist	Receptionist	Psychologist
Program Manager	Sales Associate	Sales Associate	Licensed Clinical Social Worker
	Social Worker	Chaplain	Chaplain, Priest, Pastor
		Social Worker	Physician
		Medical Director	
		Pharmacy Provider	

Medicare Part B Practice.

Before you enter into this type of model, it is advised that you seek legal counsel to determine how the Corporate Practice of Medicine Laws may impact your ability to practice medicine, and who you may or may not be able to hire to deliver medical care. There are several other considerations that must be determined prior to implementing a program of this type (e.g. credentialing with payers, billing, consent to treat, malpractice insurance, etc.) that have been outlined in other Chapters.

Programs of this type will either hire a physician, nurse practitioner or clinical nurse specialist who perform medical visits for medically necessary care. Additionally, you may decide to hire a Registered Nurse Transitions Coordinator. Your goal incorporates the information outlined above depending on whether you are set up to provide Hospice Outreach services, Home Health Bridge services, or have an integrated program that lays across your hospice and home health service lines. Its difference, and most important concept to understand is that its primary function is to deliver medical care. This type of program needs to be thought of as a medical practice no different than a physician office practice. Through your provider(s), your program is delivering specialty palliative care to medically complex patients. For many programs, the most cost-effective model is to hire a nurse practitioner coupled with a RN Transitions Coordinator.

The medical care provided is billed through Medicare Part B benefits at a fee-for-service rate. Medicare pays the provider 80% of the billed services, and the organization must bill the patient for the remaining 20%. Providing this care does not impact the patient's ability to access their Medicare Part A benefits (e.g. home health, hospice and skilled nursing).

Team-based Palliative Care			
Program	HH	Hospice	Community Partner
RN Transitions Coordinator	Receptionist	Receptionist	Psychologist
Program Manager	Sales Associate	Sales Associate	Licensed Clinical Social Worker
Provider	Social Worker	Chaplain	Chaplain, Priest, Pastor
		Social Worker	Physician
		Medical Director	
		Pharmacy Provider	

Job Descriptions

Job descriptions are as important as the policies, procedures and guidelines that govern your program. Job Descriptions guide your staff and organization to provide a consistent approach in the care of individuals in your program. No matter the type of palliative care program you implement, the interdisciplinary staff designation should not change dramatically; however, the

duties of their position may change depending on the staffing models discussed above.

At a minimum, a job description for your Program Manager, RN Care Coordinator or Transitions Coordinator. For other interdisciplinary team members that you may utilize from your hospice or home health programs, update their current job descriptions with additional elements that you want them to perform for your palliative care program.

Resource: Appendix A Job Description examples

Education and Skills Development

There are many educational options for clinicians to engage in that will provide ongoing skills development. These options are can be found in many of the national organizations such as the National Hospice and Palliative Care Organization, Hospice and Palliative Nurses Association, Center to Advance Care, and the American Association of Hospice and Palliative Medicine. These associations, along with others, provide specific educational opportunities and skills development for your program's staff.

- National Hospice and Palliative Care Organization
 - Interdisciplinary focused educational modules, program development resources, and the ability to connect your organization with others
 - <https://www.nhpco.org/>
- Hospice and Palliative Nurses Association
 - Nursing focused educational modules for the advanced practice registered nurse, registered nurse, licensed vocational nurse and certified nursing assistant
 - Certifications for advanced practice registered nurse (ACHPN), registered nurse (CHPN), nursing assistant (CHPNA), as well as certifications for pediatric registered nurses (CHPPN), and those associated with perinatal loss (CPLC)
 - <https://advancingexpertcare.org/>
 - Center to Advance Palliative Care
 - Educational resources for staff and program development resources
 - <http://www.capc.org>
- American Association of Hospice and Palliative Medicine
 - Provider focused educational modules for the physician and advanced practice registered nurse
 - Certifications for physicians specializing in hospice and palliative medicine
 - <http://aahpm.org/>

Competencies

The NCP Guidelines defines standards that can be the goals for any palliative care program. Your program competencies should be developed in a way that promote the skills they outline. Depending on the type of model you adopt and implement, the minimum competency to meet your program's structure and objectives is paramount to your organization providing quality palliative care services.

Your program's staff should meet a minimum competency within these four areas. This is not meant to be a comprehensive list.

- Symptom management
 - Assessment
 - Pain
 - Constipation
 - Nausea and vomiting
 - Depression
 - Relief of suffering

- Dyspnea
- Medication management
 - Assessment
 - Prescribing
 - Opioids
 - Conversions
 - Side effects
 - Poly-pharmacy
- Setting management
 - Assessment
 - Right care in the right care setting
 - When is it time to move to assisted living
 - When is it time to move to long-term care
- Communication
 - Assessment
 - Delivering serious news
 - Goals of care
 - Advance care planning
 - Prognosis
 - Community Resources

Resource: Appendix B Skill Assessment examples

Summary

In summary, part of the work completed in your comprehensive Business Case answers various questions (e.g. who will you serve, who will provide care, what services you will provide) that help identify the staffing needs for your program. As discussed in the chapter, Making the Case for Palliative Care, one of the critical decision points is to determine the care model for your organization. Some hospices may want to adopt multiple models based on a variety of factors identified through the needs assessment process (e.g. patient population, location of services, payor source agreements). Each model has its own unique staffing considerations. As stated in this chapter, it is best to focus on one model until your program matures, and you validate your Business Case and SWOT analysis.

This chapter highlights the importance of setting your staffing metrics efficiently based on the model of care you choose and solutions that can be employed to manage towards best practices associated with team-based palliative care.

Appendix A: Job Descriptions

Palliative Care Transition Care Coordinator

Department Name:

Interim HealthCare

Reports to:

Director of Palliative Care

General Purpose:

The Palliative Care Transition Care Coordinator (PTCC) serves as a professional, and qualified registered nurse (RN), or licensed vocational nurse (LVN), with the responsibility to practice his/her profession commensurate with his/her licensure, training and experience in accordance with the laws and regulations governing their practice in the state in which services are performed, and all guidelines of applicable professional and accreditation agencies. The PTCC is responsible to work in collaboration with patients, their families and other caregivers, the patient's primary care physician, and other specialists as appropriate, in an active practice to deliver episodic acute care and chronic medical management for patients with progressive illnesses under the direction of the Palliative Care Advanced Practice Nurse (APN), or as directed by the plan of care and regulations of a patient's home health episode, or hospice episode.

Goal: Support patient and family transitional care needs across care settings (i.e. acute care discharges back to community setting, home health episodes, hospice, etc.), and through disease stage changes in support of the care and/or treatment preferences established through goals of care discussions.

Essential Functions:

Physical Assessment and Treatment:

- Provides and documents medically necessary services in accordance with provider (i.e. physician, APN) orders.
- Assess the patient's and family caregiver's needs and coordinates appropriate services (i.e. DME, home health care, hospice, etc.) as required either prior to the patient's transition home from an acute care stay (hospital, SNF), or at any point in their care continuum post-acute.
- Develops a plan of care in collaboration with the palliative care APN based on his/her treatment plan that maximizes the health potential as part of a patient's home health episode.
- Assists in all facets of care coordination for referrals.
- Provides disease management instruction and education to patients and their families.
- Provides clinical guidance to facility staff relative to patient care issues, assessments and interventions within scope of practice.

Administrative:

- Participates with care setting's interdisciplinary team as appropriate (i.e. clinical standup, QAPI, care coordination, clinical instruction, utilization committee, re-hospitalization committee, etc.).
- Obtains necessary medical information regarding the patient's health status, current medications and goals of care from appropriate sources.
- Acts as a clinical resource to coordinate complex cases for safe and appropriate transition to other care settings.
- Attends required Interim Healthcare Office meetings to enhance team communication, coordination of services and quality of care.
- May coordinate additional services with palliative care APN to assist client and family during any transition.
- Reviews Interim Healthcare's policies and services with referred patients and/ or family caregivers or authorized patient representative and obtains consent for medical care.
- Communicates with the Intake Nurse and the Clinical Manager to determine staffing capabilities.

- Communicates essential patient information to care setting clinicians who will be initiating care.
- Provides training and continuing education for staff.
- Assists in development of clinical practice guidelines/standards in support of quality care.
- May assist with obtaining Physician orders as required.
- Responds to inquiries regarding care services and programs to accurately identify the needs of each patient.
- May have access to and use of personal health information ("PHI") as necessary to fulfill the above duties and responsibilities.
- Performs all functions in compliance with federal, state, local law and regulation, as well the policies, procedures, and practice standards of Interim Healthcare.
- Assists with Insurance eligibility and authorization process, when appropriate.
- Performs other duties as assigned.

Integrity:

- Follows policy and procedures as directed.
- Brings concerns forward appropriately to supervisor.

Compassion:

- Promotes an environment of high integrity and teamwork.
- Works collaboratively with patients and their family caregivers, physicians, supervisors and other staff to facilitate effective transitions from one care setting to another.

Customer Focus:

- Takes appropriate and timely measures to meet the needs of the patient, their family and care setting staff.
- Maintains mature problem-solving approach under stressful circumstances.

Innovation:

- Assists in problem solving strategies with the patient, family, PCP, and setting staff to facilitate safe care of the patient.

Financial Responsibility:

- Works collaboratively with Intake Department in verification of coverage or payment.

Minimum Education & Experience Requirements:

- Valid nursing (RN/LVN) License in the State(s) in which service is provided.
- Minimum of 3 years nursing experience preferred.
- Minimum of 3-5 years of experience with home health, hospice/palliative care strongly preferred.
- Advance certification in hospice and palliative nursing care (CHPN/CHPLN) preferred; required within 18-months of hire.

Knowledge, Skills & Abilities Required:

Professional Requirements:

- Maintain appropriate licensures and certifications.
- Practice within established protocols and provider (physician, APN) orders.
- Adhere to state regulations regarding practice act.
- Maintain a broad base of technical knowledge and skills to perform all assigned clinical/ administrative duties.
- Knowledge of home/hospice regulations, end of life care services, and advance care planning.
- Demonstrate excellent teaching skills to relate medical information to the patient, family and other nursing staff.
- Possess excellent communication, interviewing and counseling skills, and the ability to explain medical problems and treatments in accurate and understandable lay terms.

- Must be able to coordinate and communicate effectively with colleagues, managers, and medical staff, and be able to teach and develop others.
- Must have the ability to prioritize, make decisions and set clear expectations for others.
- May have access to personal health information ("PHI") necessary to fulfill the above duties and responsibilities. Access to use and ability to disclose PHI is further defined by each organization/department.

Other Requirements:

- Computer proficiency including the ability to utilize software programs used by the organization.
- Able to perform and prioritize multiple functions or tasks.
- Able to read and interpret technical instructions related to the care of the patient/ client.
- Able to effectively deal with multiple changes.
- Able to engage in moderate amount of (90%) local travel.
- Able to provide proof of valid driver's license, if applicable.
- Able to provide proof of valid liability insurance if assignments include driving own vehicle.
- Evidence of annual TB test and other state required tests.

Working Conditions & Physical Requirements:

- Works in community care settings (home, SNF, ALF, and hospital).
- Able to stand, bend, stoop, squat, kneel and reach freely.
- Able to freely lift to a maximum of 50 pounds.
- Able to assist patient/client with standing, walking, sitting, and rolling in bed.
- Visual/hearing ability must be sufficient to communicate written and verbally.
- Sedentary physical activity that may require occasional lifting, carrying, pushing or pulling up to 10 lbs. in order to carry out daily job functions and related activities that may be required.

Key	
Occasionally	Activity/conditions exist 0-2.5 hrs./day or up to 30%
Frequently	Activity/conditions exist 2.5–5.5 hrs./day or over 30%
Constantly	Activity/conditions exist 5.5+ hrs./day or over 60%
Sedentary	Lifting/carrying up to 10 lbs.
Light	Lifting/carrying/pushing/pulling up to 20 lbs.
Medium	Lifting/carrying/pushing/pulling up to 50 lbs.
Heavy	Lifting/carrying/pushing/pulling over 50 lbs.
Very Heavy	Lifting/carrying/pushing/pulling over 100 lbs.

Acknowledgment:

I have reviewed my job description and agree to perform all duties to the best of my ability. I understand my job duties may change as the needs of the organization change. I further agree to notify my immediate supervisor if I am unable to complete any of my job duties in a timely manner.

Name _____

Signature _____

Date _____

Appendix A: Job Discriptions (cont.)

Palliative Care Advanced Practice Nurse (APN)

Department Name:

Interim HealthCare

Reports to:

Director of Palliative Care

General Purpose:

The advance practice nurse (APN) serves as a professional, and qualified provider, with the responsibility to practice his/her profession commensurate with his/her licensure, training and experience in accordance with the laws and regulations governing the practice of an APN of the state in which services are performed, and all guidelines of applicable professional and accreditation agencies. The APN is responsible to work in collaboration with patients, their families and other caregivers, the patient's primary care physician, and other specialists as appropriate, in an active practice to deliver episodic acute care and chronic medical management for patients with progressive illnesses.

Delegation of Authority:

The APN performs medical services in collaboration with a physician to diagnose and manage health care problems. The APN also serves as a healthcare resource, interdisciplinary consultant and patient advocate.

Essential Functions:

APN Practice Guidelines:

- Upon hire, annually and as needed for revisions at times other than the annual review; signs, dates and complies with the Delegation Protocol Agreements and protocols that describe prescribing privileges, treatments, tests and procedures that define the scope of APN practice.
- Uses the nursing process as the framework for managing patient care.
- Obtains Medicare and Medicaid provider statutes with the respective state carriers.
- Meets with collaborating physician in accordance with applicable state and federal law.

Physical Assessment and Treatment:

- Provides and documents medically necessary services in accordance with mutually acceptable physician/APN protocols.
- Develops the appropriate treatment plan that maximizes the health potential of the patient including, but not limited to:
 - Ordering and interpretation of appropriate diagnostic tests within scope of practice
 - Identifying appropriate pharmacologic agents
 - Identifying appropriate non-pharmacologic interventions
 - Developing an education plan as appropriate
 - Interpretation of laboratory and radiology tests within scope of practice
 - Ordering of durable medical equipment
- In collaboration with PCP, refers patients to medical specialists as indicated.
- In collaboration with PCP, refers patients to other healthcare services as medically indicated.
- Consult with collaborative physician, consulting practitioner(s), primary care physician and other specialist physicians as appropriate.
- Assists in all facets of care coordination for referrals.
- Provides disease management instruction and education to patients and their families.
- Provides clinical guidance to facility staff relative to patient care issues, assessments and interventions.
- Performs reasonable on-call services as applicable.

Administrative:

- Participates with care setting's interdisciplinary team as appropriate (i.e. clinical standup, QAPI, care coordination, clinical instruction, utilization committee, re-hospitalization committee, etc.).
- Prepares and maintains accurate patient records, charts, and documents to support sound medical practice and reimbursement for services provided, and support of appropriate medication uses.
- Acts as a clinical resource to coordinate complex cases for safe and appropriate transitions to other care settings.
- Comply with applicable laws and regulations with respect to Delegation Protocol Agreements, prescriptive authority, and APN scope of practice.
- Attends required Interim Healthcare office meetings to enhance team communication, coordination of services and quality of care.
- Reviews Interim Healthcare's policies and services with referred patients and/or family caregivers or authorized patient representative, and obtains consent for medical care.
- Provides training and continuing education for staff.
- Assists in development of clinical practice guidelines/standards in support of quality care.

Integrity:

- Follows policy and procedures as directed.
- Brings concerns forward appropriately to supervisor.

Compassion:

- Promotes an environment of high integrity and teamwork.
- Works collaboratively with patients and their family caregivers, physicians, supervisors and other staff to facilitate effective transitions from one care setting to another.

Customer Focus:

- Takes appropriate and timely measures to meet the needs of the patient, their family and care setting staff.
- Maintains mature problem solving approach under stressful circumstances.

Innovation:

- Assists in problem solving strategies with the patient, family, PCP, and setting staff to facilitate safe care of the patient.

Financial Responsibility:

- Works collaboratively with Intake Department in verification of coverage or payment.
- Initiates reimbursement for services rendered.
- Maintains productivity for his/her practice as defined by Interim Healthcare.

Minimum Education & Experience Requirements:

- Graduate of an accredited Geriatric, Adult or Family Nurse Practitioner Master's program.
- Board Certified APN (as a Geriatric, Adult or Family Nurse Practitioner preferred).
- Three years of experience as a nurse practitioner in clinical nursing care of geriatrics, adult/family practice, or oncology preferred.
- Advance certification in hospice and palliative nursing care (ACHPN) preferred; required within 18-months of hire.
- Experience with home health, hospice and palliative care strongly preferred.

Knowledge, Skills & Abilities Required:

Professional Requirements:

- Maintain appropriate licensures and certifications, including current Department of Public Safety (DPS), and Drug Enforcement Agency (DEA) registrations.
- Practice within established protocols for prescriptive authority, including prescribing of scheduled drugs.
- Adhere to state regulations regarding practice agreement with physician.
- Maintain a broad base of technical knowledge and skills to perform all assigned clinical/administrative duties.
- Knowledge of home/hospice regulations, clinical practice, end of life care services, and advance care planning.
- Demonstrate excellent teaching skills to relate medical information to the patient, family and nursing staff.
- Possess excellent communication, interviewing and counseling skills, and the ability to explain medical problems and treatments in accurate and understandable lay terms.
- Must be able to coordinate and communicate effectively with colleagues, managers, and medical staff and be able to teach and develop others.
- Must have the ability to prioritize, make decisions and set clear expectations for others.
- May have access to personal health information ("PHI") necessary to fulfill the above duties and responsibilities. Access to use and ability to disclose PHI is further defined by each organization/department.

Other Requirements:

- Computer proficiency including the ability to utilize software programs used by the organization.
- Able to perform and prioritize multiple functions or tasks.
- Able to read and interpret technical instructions related to the care of the patient/ client.
- Able to effectively deal with multiple changes.
- Able to engage in moderate amount of (90%) local travel.
- Able to provide proof of valid driver's license, if applicable.
- Able to provide proof of valid liability insurance if assignments include driving own vehicle.
- Evidence of annual TB test and other state required tests.

Working Conditions & Physical Requirements:

- Works in community care settings (home, SNF, ALF, and hospital).
- Able to stand, bend, stoop, squat, kneel and reach freely.
- Able to freely lift up to a maximum of 50 pounds.
- Able to assist patient/client with standing, walking, sitting, and rolling in bed.
- Visual/hearing ability must be sufficient enough to communicate written and verbally.
- Sedentary physical activity that may require occasional lifting, carrying, pushing or pulling up to 10 lbs in order to carry out daily job functions and related activities that may be required.

Key	
Occasionally	Activity/conditions exist 0-2.5 hrs./day or up to 30%
Frequently	Activity/conditions exist 2.5–5.5 hrs./day or over 30%
Constantly	Activity/conditions exist 5.5+ hrs./day or over 60%
Sedentary	Lifting/carrying up to 10 lbs.
Light	Lifting/carrying/pushing/pulling up to 20 lbs.
Medium	Lifting/carrying/pushing/pulling up to 50 lbs.
Heavy	Lifting/carrying/pushing/pulling over 50 lbs.
Very Heavy	Lifting/carrying/pushing/pulling over 100 lbs.

Acknowledgment:

I have reviewed my job description and agree to perform all duties to the best of my ability. I understand my job duties may change as the needs of the organization change. I further agree to notify my immediate supervisor if I am unable to complete any of my job duties in a timely manner.

Name _____

Signature _____

Date _____

Appendix B: Nurse Practitioner Skills Checklist / Self Assessment

NP Name _____ Date _____

Please indicate the level of experience/proficiency with each and, where applicable, the types of equipment and/or systems with which you are familiar. Insert letter from the Key below in Level of Competency column below. Complete this self assessment within 30 days of hire.

If additional training is needed, please indicate by inserting a √ mark. Insert Training Date after training has been completed. Additional training as applicable, must be completed within the first 90 days of hire.

Use the following KEY as a guideline:

- A. Theory Only/No Experience - Didactic instruction only, no hands-on experience.
- B. Limited Experience - Knows procedure/has used equipment but has done so infrequently or not within the last six months.
- C. Moderate Experience - Able to demonstrate equipment/procedure, performs the task/skill independently with only resource assistance needed.
- D. Proficient/Competent - Able to demonstrate/perform the task/skill proficiently without any assistance and can instruct/teach.

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Knowledge of Nursing Process:				
Health history and physical exam				
Assesses response to treatment				
Establishes and revises goals of care				
Case Conference Summary				
Discharge planning				
Knowledge of QAPI				
Knowledge of EMR				
Documentation Skills:				
Accurate, complete, legible, timely				
Clinical notes/flow charts				
Summary reports				
Knowledge of Medicare Hospice Guidelines (COPs):				
Criteria for participation				
Levels of care				
Advance directives/patient rights				
Local Care Determination guidelines (LCDs) Determining Terminal Status forms DTS')				
Effective Case Coordination:				
Reports and documents information to physician, facility staff and IDG as appropriate				
Functions as a team member				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Knowledge of community resources				
Attends IDG as requested				
Infection Control:				
Hand washing				
Proper bag technique				
Safe needle technique				
Protective equipment				
Equipment care				
Biohazardous waste disposal				
Patient Vulnerability and Home Safety				
Patient Education:				
Determines learning needs				
Sets objectives				
Develops/implements teaching plan				
Evaluates effectiveness of teaching				
Revises teaching plan				
Documents patient/family response				
Clinical Skills (General):				
Demonstrates principles of aseptic technique				
Vital signs				
Intake and Output				
Medication assessment and teaching				
– Route, dose, frequency				
– Side effects/adverse reactions				
– Home monitoring program				
– Blood levels				
Pulmonary System:				
General exam and auscultation				
Use and care of oxygen				
Nebulizer treatment				
Use of inhalers				
Home ventilator management				
Oral/nasal suctioning				
Foreign body airway obstruction				
Breathing exercises/incentive spirometry				
Pulmonary Pharmacology				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Cardiovascular System:				
General exam and auscultation				
Pulses (apical/radial/femoral/pedal)				
Edema assessment and management				
Supine and orthostatic blood pressure				
NTG/Inhaler use				
NYHA Classifications				
CPR				
Energy conservation technique				
Cardiac Pharmacology				
Neurological System:				
General exam (pulses/LOC/grasps)				
Aphasia care				
Mini mental exam				
FAST Scale				
Seizure precautions				
Neurological Pharmacology				
Gastrointestinal System:				
General exam and auscultation				
Abdominal girth				
Tube feeding				
PEG tube care				
Ostomy care				
- Irrigation				
- Stoma care				
NG insertion, care and feeding				
Dysphagia precautions				
Impaction removal/enema administration				
GI Pharmacology				
Integumentary System:				
General exam				
Sterile dressing change				
Suture/staple removal				
Decubitus care:				
- Assessment and change				
- Prevention				
- Treatments				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
- Documentation of wound care				
Related Pharmacology				
Genitourinary System:				
General exam				
Urinary catheter care education				
Condom catheter				
Ileostomy care				
Incontinence care				
Bladder training				
Bowel training				
GU Pharmacology				
Musculoskeletal System:				
General exam				
ROM (active and passive)				
TED hose				
Devices				
- Walker/wheelchair				
- Transfers/Hoyer Lift				
Related Pharmacology				
Metabolic:				
Diabetes				
- Insulin types/teaching				
- Use/care/teaching of Glucose Monitoring System				
- Diet/exercise/sick-day teaching				
- Skin/foot care				
Coumadin therapy				
- PT/INR interpretation				
Related Pharmacology				
Psychiatric:				
General assessment				
Suicide precautions				
Psychotropic drugs				
Care of patient with dementia/ Alzheimer's disease				
Karnofsky and Palliative Performance Scale				
Home Glucose Monitoring:				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Verbalizes purpose of test				
Specimen collection				
Quality control mechanisms				
Test correctly performed and interpreted				
Other Laboratory Specimen Collection:				
Venipuncture for specimen collection				
Urine				
Stool				
Wound culture				
IV Therapy:				
Sterile technique				
Peripheral IV placement				
Catheter protocols				
- Hickman				
- Groshong				
- Port-a-Cath				
- PICC				
- Other:				
Flushing techniques				
Blood sampling				
Cap change				
Dressing management				
Patient teaching				
IV antibiotic protocols/teaching				
IV pain management protocols/teaching				
TPN protocols/teaching				
Other:				

NP Signature _____ Date _____

Supervisor Signature _____ Date _____

Reviewed with Medical Director (Name) _____ Date _____

Appedix B: Skilled Nursing Facility Nurse Practitioner Skills Checklist / Self Assessment

NP Name _____ Date _____

Please indicate the level of experience/proficiency with each and, where applicable, the types of equipment and/or systems with which you are familiar. Insert letter from the Key below in Level of Competency column below. Complete this self assessment within 30 days of hire

If additional training is needed, please indicate by inserting a √ mark. Insert Training Date after training has been completed. Additional training as applicable, must be completed within the first 90 days of hire.

Use the following KEY as a guideline:

- A. Theory Only/No Experience - Didactic instruction only, no hands-on experience.
- B. Limited Experience - Knows procedure/has used equipment but has done so infrequently or not within the last six months.
- C. Moderate Experience - Able to demonstrate equipment/procedure, performs the task/skill independently with only resource assistance needed.
- D. Proficient/Competent - Able to demonstrate/perform the task/skill proficiently without any assistance and can instruct/teach.

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Knowledge of Nursing Process:				
Health history and physical exam				
Assesses response to treatment				
Establishes and revises goals of care				
Case Conference Summary				
Discharge planning				
Knowledge of QAPI				
Knowledge of EMR				
Documentation Skills:				
Accurate, complete, legible, timely				
Clinical notes/flow charts				
Summary reports				
Knowledge of Medicare Hospice Guidelines (COPs):				
Criteria for participation				
Levels of care				
Advance directives/patient rights				
Local Care Determination guidelines (LCDs) Determining Terminal Status forms DTS')				
Effective Case Coordination:				
Reports and documents information to physician, facility staff and IDG as appropriate				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Functions as a team member				
Knowledge of community resources				
Attends IDG as requested				
Infection Control:				
Hand washing				
Proper bag technique				
Safe needle technique				
Protective equipment				
Equipment care				
Biohazardous waste disposal				
Patient Vulnerability and Home Safety				
Patient Education:				
Determines learning needs				
Sets objectives				
Develops/implements teaching plan				
Evaluates effectiveness of teaching				
Revises teaching plan				
Documents patient/family response				
Clinical Skills (General):				
Demonstrates principles of aseptic technique				
Vital signs				
Intake and Output				
Medication assessment and teaching				
– Route, dose, frequency				
– Side effects/adverse reactions				
– Home monitoring program				
– Blood levels				
Pulmonary System:				
General exam and auscultation				
Use and care of oxygen				
Nebulizer treatment				
Use of inhalers				
Home ventilator management				
Oral/nasal suctioning				
Foreign body airway obstruction				
Breathing exercises/incentive spirometry				
Pulmonary Pharmacology				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Cardiovascular System:				
General exam and auscultation				
Pulses (apical/radial/femoral/pedal)				
Edema assessment and management				
Supine and orthostatic blood pressure				
NTG/Inhaler use				
NYHA Classifications				
CPR				
Energy conservation technique				
Cardiac Pharmacology				
Neurological System:				
General exam (pulses/LOC/grasps)				
Aphasia care				
Mini mental exam				
FAST Scale				
Seizure precautions				
Neurological Pharmacology				
Gastrointestinal System:				
General exam and auscultation				
Abdominal girth				
Tube feeding				
PEG tube care				
Ostomy care				
- Irrigation				
- Stoma care				
NG insertion, care and feeding				
Dysphagia precautions				
Impaction removal/enema administration				
GI Pharmacology				
Integumentary System:				
General exam				
Sterile dressing change				
Suture/staple removal				
Decubitus care:				
- Assessment and change				
- Prevention				
- Treatments				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
– Documentation of wound care				
Related Pharmacology				
Genitourinary System:				
General exam				
Urinary catheter care education				
Condom catheter				
Ileostomy care				
Incontinence care				
Bladder training				
Bowel training				
GU Pharmacology				
Musculoskeletal System:				
General exam				
ROM (active and passive)				
TED hose				
Devices				
– Walker/wheelchair				
– Transfers/Hoyer Lift				
Related Pharmacology				
Metabolic:				
Diabetes				
– Insulin types/teaching				
– Use/care/teaching of Glucose Monitoring System				
– Diet/exercise/sick-day teaching				
– Skin/foot care				
Coumadin therapy				
– PT/INR interpretation				
Related Pharmacology				
Psychiatric:				
General assessment				
Suicide precautions				
Psychotropic drugs				
Care of patient with dementia/ Alzheimer's disease				
Karnofsky and Palliative Performance Scale				
Home Glucose Monitoring:				

Required Skill	Level of Competency	Needs Training	Training Date	Supervisor Signature
Verbalizes purpose of test				
Specimen collection				
Quality control mechanisms				
Test correctly performed and interpreted				
Other Laboratory Specimen Collection:				
Venipuncture for specimen collection				
Urine				
Stool				
Wound culture				
IV Therapy:				
Sterile technique				
Peripheral IV placement				
Catheter protocols				
- Hickman				
- Groshong				
- Port-a-Cath				
- PICC				
- Other:				
Flushing techniques				
Blood sampling				
Cap change				
Dressing management				
Patient teaching				
IV antibiotic protocols/teaching				
IV pain management protocols/teaching				
TPN protocols/teaching				
Other:				

NP Signature _____ Date _____

Supervisor Signature _____ Date _____

Reviewed with Medical Director (Name) _____ Date _____



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Reimbursement



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UNDER CONSTRUCTION



NHPCO Palliative Care Playbook for Hospices

Budget

This chapter is also available as a Grab & Go Toolkit:
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You have completed your needs assessment, defined the model you want to deploy, in the care setting(s) identified, and are ready to develop a budget. Estimating financials for your palliative care program will likely be one of the most challenging activities you and your leadership team will do. Budgeting is a process that states future revenue and expenses to establish financial goals for your program within the organization. This chapter will not focus on the budgeting process; it will focus on various components important in determining what will be considered program revenue and expense.

Today there are a variety of methods for community-based palliative care programs to generate revenue from. It is important to include in your needs assessment how your program will utilize a diversified portfolio to ensure long-term sustainability. A resource to give you a quick overview of payment models is the California Healthcare Foundation's publication: [Five Ways to Pay: Palliative Care Payment Options for Plans and Providers](#). Most programs start out utilizing a traditional fee-for-service reimbursement model. However, with growing understanding of what community-based palliative care is and can offer; and quality-based payment models it is important to plan for how your program can take advantage of opportunities such as shared savings, managed care and capitated based payment mechanisms.

Revenue Types

Your program can be supported through a variety of revenue sources (e.g. fee-for-service, payer per-member-per-month contracting, grant, etc.). Each of these revenue sources may alter the type of program you initially develop and will direct the type(s) of staff and other expenses necessary to provide services.

Fee-for-service.

Many hospice organizations utilize a fee-for-service revenue stream to support their program. This revenue model is relatively easy without assuming too much risk. Programs of this type will either hire a physician, nurse practitioner, or clinical nurse specialist who perform medical visits for medically necessary care. Typically, the medical care provided is billed through the patient's Medicare Part B benefits at a fee-for-service rate. Medicare, and other payers, pay the provider 80% of the billed services and the organization must bill the patient for the remaining 20%. The biggest risk to an organization using a fee-for-service revenue model is generating enough revenue to counter the expense of the provider(s) salary; and other costs associated with travel, supplies and any non-provider staff you may have supporting the program.

Fee-for-service models are limited. They only pay for services provided by a physician and non-physician providers at the fee-for-service fee rate. There are other aspects of a fee-for-service payment model that you should consider as outlined in other chapters. An advantage to employing a fee-for-service payment model is that it provides your program with an opportunity to demonstrate quality outcomes associated with potential savings. This information can then be used to negotiate payer contracts that could begin to diversify your payment portfolio.

Budgeting for fee-for-service payment model is pretty straight forward. You need to determine whether you are hiring a physician, or a non-physician provider. The individual staff, their mileage, and anticipated supplies are your direct cost and supporting infrastructure (e.g. office space, non-provider staff, and other ancillary support) are your indirect costs.

Through experience a fee-for-service payment model should be based on a cost neutral, or break-even budget. As a hospice and home health organization your business goal is to be able to provide increased levels of care to your patient population, increase referrals to your programs, identify patients who are appropriate for hospice services earlier in their disease trajectory, and transition them to hospice so that they can benefit from hospice services longer. This is your return on investment (ROI) and often considered your soft ROI. Soft ROI is the indirect benefit your organization receives through the activities listed above. In a fee-for-service revenue model it is difficult to achieve profitability for your palliative program without considering the soft ROI.

The following proforma is one example of how to budget your fee-for-service program. This proforma was developed for a hospice and home health free standing organization. Their palliative care program was a separate division within the organization. Within 18-months their palliative care ADC was 750 patients across 5 unique locations with 6 nurse practitioners, and 5 nurses supporting care.

Palliative Care				Month 1	Month 2	Month 3	Month 4	Month 5	Month 6	Month 7
Program Name				10	15	20	20	20	20	20
	Palliative Care Admissions			10	15	20	20	20	20	20
	Palliative Care ADC			5	17.5	35	55	75	95	115
	Initial Assessment Visit	1.00		10.0	15.0	20.0	20.0	20.0	20.0	20.0
	Focused visit (1/2 per admission)	0.50		5.0	7.5	10.0	10.0	10.0	10.0	10.0
	Continued Focused Visits (1x/month)	1.00		5.0	17.5	35.0	55.0	75.0	95.0	115.0
	Total Visits			20.0	40.0	65.0	85.0	105.0	125.0	145.0
Revenue										
	Per visit rate	Billed Rate								
	Reimbursement / Initial assessment	\$275	85%	\$2,338	\$3,506	\$4,675	\$4,675	\$4,675	\$4,675	\$4,675
	Reimbursement / focused visits	\$100	85%	\$850	\$2,125	\$3,825	\$5,525	\$7,225	\$8,925	\$10,625
	Total Reimbursement			\$3,188	\$5,631	\$8,500	\$10,200	\$11,900	\$13,600	\$15,300
	% Non-Billable	5.0%		\$3,028	\$5,350	\$8,075	\$9,690	\$11,305	\$12,920	\$14,535
Costs										
	Physician / Nurse Practitioner	\$100,000	Shared Salary %	0%	\$9,583	\$9,583	\$9,583	\$9,583	\$9,583	\$9,583
	Nurse	\$	Shared Salary %	%	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
	Add'l Nurse Practitioner(s)	\$	Shared Salary %	%	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!	#VALUE!
	Travel Costs	PPD	\$	0.60	\$183	\$560	\$961	\$1,258	\$1,373	\$1,739
	Other Costs (supplies etc...)	PPD	\$	0.20	\$92	\$267	\$480	\$671	\$801	\$869
	Total Costs				\$9,858	\$10,411	\$11,024	\$11,512	\$11,756	\$12,191
Margin on Palliative Care Program										
					-\$6,830	-\$5,061	-\$2,949	-\$1,822	-\$451	\$729
					-214%	-90%	-35%	-18%	-4%	5%
Future Benefit to Hospice (Not part of Palliative Care Proforma)										
	Add'l Hospice ADC at 15% Conversion rate:			0.8	2.6	5.3	8.3	11.3	14.3	17.3
	Add'l Hospice ADC at 25% Conversion rate:			1.3	4.4	8.8	13.8	18.8	23.8	28.8
	Add'l Hospice ADC at 30% Conversion rate:			1.5	5.3	10.5	16.5	22.5	28.5	34.5
Hospice Revenue per month per converted patient				\$ 4,800	\$ 3,600	\$ 12,600	\$ 25,200	\$ 39,600	\$ 54,000	\$ 68,400
				\$ (3,230)	\$ 7,539	\$ 22,251	\$ 37,778	\$ 53,549	\$ 69,129	\$ 84,770

For this example; considering all elements are met, the provider would meet their 100-encounter productivity target at month-5 and would provide a break-even return at month-6.

Assumptions:

- No infrastructure costs
 - This organization's hospice and home health divisions provided all infrastructure support as a 'cost of doing business' to their division for the soft ROI gains.
- Month over month increase in your palliative population
- Each provider to achieve 100 consults monthly
- Each provider to achieve 20% new patient and 80% established patient encounters monthly
- Reimbursement on an average of your potential billing
 - Currently set at 85% of 100% billing due to the provider being a nurse practitioner
 - New patient comprehensive encounter payment
 - Established patient encounter payment
 - A 5% non-billable line item
- Nurse practitioner salary
 - If you are sharing your provider with hospice to do face-to-face visits for ongoing eligibility you can adjust a given % out of your costs
- Travel costs/supplies variable

This budget template ends with a section labeled 'Future Benefit to Hospice (Not part of Palliative Care Proforma)' to show the potential soft ROI as the program achieves a 15, 25 and 30% conversion rate.

This program did realize approximately \$3,000 a month profit. They increased their hospice ADC by 200 patients within 1-year with an average days on service of 91-days. Additionally, they increased the referrals to their home health by 33%, and increased their home health's ability to recertify patients by an additional certification period by 38% using palliative care interventions.

Per member per month (PMPM).

Through various payer contracts your program may be supported through PMPM revenue streams. This type of revenue (terms to be established by the payer) typically pays a capitated rate (fixed rate) per enrolled member that is paid to the provider. The amount paid is determined by the range of services that the organization is providing, the number of patients and the period of time services will be provided.

Typically the payer does not direct how care should be provided; however, they will likely determine a list or range of services the organization must provide to their members. These services could range from only requiring a physician or non-physician provider to support that requires an interdisciplinary team. They may direct that a physician or non-physician provider see an individual member at X intervals, or not as often as other resources.

For a PMPM capitated revenue model it is very important to manage your overall cost of care per enrolled patient. It is critical to monitor the utilization of the various services, which patient requires more or less, and how to manage the care needs utilizing the agreed on services to ensure efficiency. You will have some patients who utilize services at a lower margin than others; however you must ensure your overall services support your budgeted margin. Similarly to a fee-for-service revenue model, PMPM revenue models work well when the organization has a volume of patients.

Budgeting a PMPM revenue model simply establishes the per member per month rate to the number of lives serving against the associated costs.

Grants/Other:

Additional revenue sources can be realized through philanthropic grants, research funding, demonstration projects, and other sources. Typically these sources have an expiration date to them. Building a program solely on these types of revenues will not provide long-term sustainability – they are however great ways to diversify your revenue portfolio.

Similarly, to the PMPM discuss, these revenue sources will likely be specifically based on what type of services you will be required to provide against a set revenue over a specific timeframe. Using the Medicare Care Choices Model (MCCM), a Center for Medicare and Medicaid Innovation demonstration initiative; those awarded the opportunity to participate are being paid a set monthly fee for each patient enrolled who meets their criteria. This is very similar to the PMPM revenue model. The program directs the services that are required to participate – your fixed costs, and the payment per patient enrolled – your revenue. It is equally important to ensure you are managing your expenses against the revenue efficiently.

For PMPM, grants and other types of revenue programs you may consider using a staffing calculator to determine budgeting parameters based on census or volume. A staffing calculator can help you scale resources as your volume increases or decreases.

Expenses

Throughout this chapter we have outlined some of the expenses to consider when budgeting for your palliative care program. Similarly, to your hospice budget, you will need to consider your direct and indirect costs, as well as, potential contracted services. Going back to the staffing chapter, we discussed the importance of incorporating National Consensus Project for Quality Palliative Care's 4th Edition of the Clinical Practice Guidelines for Quality Palliative Care into your program design as the gold standard. Again, these guidelines are not intended to be seen as an absolute structure of care that must be adopted and your program may never be able to fully implement all of its recommendations. Depending on the type of model your organization launches, and the financial parameters that govern your program you will need to make decisions on the best way to staff your program. It was suggested that you determine alternate ways to supplement members of the interdisciplinary team in a way that does not result in direct expense to your program.

Staffing costs will be your highest expense line. This is no different than how you budget for your hospice staffing. Depending on the model you choose and the way in which you choose to support your palliative care patients utilizing the interdisciplinary team will direct the various staff members you need to budget for. Other direct patient care expense will include travel

(mileage reimbursement), and any associated supplies that you may be required, or will provide (personal protective equipment, etc.) as shown in the example proforma.

Your indirect cost will come through the overhead, or infrastructure cost associated with your program. The costs associated with the administrator of your palliative care program, office space, phones, receptionist, billing department needs, etc. should all be considered indirect costs of your program. We have outlined one programs use of their hospice and home health division's infrastructure to reduce the program's indirect costs as an investment in towards the soft ROI your program will provide them through increased referrals, etc. Some will argue if you budget in this way you will not fully understand the costs associated with your palliative care program. There is certainly no one way to budget your program's revenue and expenses. The bottom line is that you and your organization must determine what is right for your organization, and your organization's structure.

Resource: Appendix A from Business Case chapter or under Tools for Planning & Evaluating Programs – Supportive Care Calculator Home at <https://coalitionccc.org/tools-resources/palliative-care/>



NHPCO Palliative Care Playbook for Hospices

Policies and Procedures

This chapter is also available as a Grab & Go Toolkit:
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Because a perception exists that there are no regulations governing palliative care, an organization and its palliative care leaders can make the mistake of overlooking the need for policies and procedures. No matter the type of palliative care program you implement, there are regulations that direct those services. It is important your program develops a set of policies and procedures that governs your program based on your program's administrative home. Your policies and procedures will set your program's boundaries that guide your program staff and organization, govern a consistent approach in the care of individuals in your program, and help mitigate financial and legal risk.

The first step in establishing a set of policies and procedures is to understand your administrative home. Your administrative home is the division or department within your organization that houses your palliative care program. As examples; a home health and hospice organization who develops a palliative care bridge program within their home health division is likely structured to have their home health division set as the administrative home, and a home health and hospice organization who creates a specialty provider practice under a separate tax ID (e.g. Medicare Part B billing) is likely structured to have a separate organizational entity as the administrative home. This is important because your administrative home sets your primary set of policies and procedures based on State and Federal regulations that governs that entity.

Using the first example: A home health and hospice organization develops a palliative care bridge program within their home health division – their administrative home is their home health division. This palliative care bridge program must follow all State and Federal regulations that govern home health services (e.g. face-to-face requirement, home bound status, skilled need, etc.). In this type of program, you cannot admit palliative care patients who do not meet the requirements for home health services as directed by Medicare.

For this type of program your organization should adopt a set of policies and procedures that set the scope of your palliative care program within your home health division. These policies and procedures set the palliative care framework within the home health regulatory conditions that would augment your existing home health policies and procedures to include the nuances directed by the scope of your palliative care program. This may be as simple as adding an addendum to an existing policy or procedure or creating a new policy or procedure for a given area.

Many home health organizations also provide outreach services, or telehealth services to patients who may have been on their home health services and have been discharged because they have met their home health goals. Making sure your policies and procedures outline how you will work with this population of patients is very important to ensure everyone knows the services that will be provided (typically phone calls), the frequency of those services, as well as other aspects. One of the biggest risks to a program is that your patients and your staff may believe medical and or nursing care can be provided. In most cases this relationship should remain informational only as there is not consent for care either before or after their home health episode, and there is not an established plan of care that directs the medical and or nursing care to be provided. Remember the administrative home sets the regulatory structure that must be followed.

Using the second example: A home health and hospice organization creates a palliative care Medicare Part B provider practice as a separate legal entity with its own tax ID – their administrative home is the separate legal entity. This palliative care program must follow all State and Federal regulations that govern their billing practices, and non-physician provider (often represented as NPP) collaboration guidelines depending on the state services will be performed in.

For this type of program your organization should adopt a set of policies and procedures that set the scope of your palliative care program as an independent company or division within your enterprise. Although there are fewer regulations that govern this type of program you must have strong policies and procedures that set program boundaries, govern a consistent approach for the care of individuals, and help mitigate risk the same as before.

Unlike the first example, this type of program provides a different regulatory framework for medical and nursing services. It allows your program to medically engage with patients once written consent is provided. Your palliative care non-physician provider, or physician provider can provide billable medical services for care that is medically necessary. A patient does not need to be on home health services to receive this medically necessary care and can continue to receive medically necessary care if also receiving home health services.

Once you have determined your palliative care program's administrative home you can determine how to augment or supplement your program's policies and procedures so that you align them with your intended structure.

The two lists below are not meant to be all inclusive, and may not apply to each type of program, they are intended as examples of policies and procedures you may want to consider adopting.

List of Suggested Policies

1. Definitions

Purpose: To define terms used in your palliative care program.

2. Scope and Practice

Purpose: To define the practice of palliative care and the services your program will provide.

3. Patient Self Determination

Purpose: To ensure that patients and/or their surrogates make informed decisions about proposed medical treatments.

4. Informed Consent

Purpose: To outline the guideline for obtain informed consent for palliative care treatment.

5. Ethics Committee

Purpose: To establish ethics committee and define process for handling ethical issues that may arise.

6. Provider Counseling and Coordination

Purpose: To ensure that patients, their families and/or caregivers receive counseling and coordination of care, and training specific to the patient's medical needs and abilities.

7. Treatment and Care Planning

Purpose: To ensure each patients treatment and/or care planning is individualized, interdisciplinary and based on the assessed needs of the patient.

8. Continuity of Care

Purpose: To ensure continuity of care upon referral to other care settings or at discharge for patients receiving palliative care consultative services.

9. Assessment and Treatment of Physical and Emotional Symptoms

Purpose: To ensure that all patients who are experiencing pain, physical symptoms and emotional symptoms are managed with quality and consistency throughout their care.

10. Pain management

Purpose: To ensure that all patients who are experiencing pain are managed with quality and consistency throughout their care.

11. End of Life Care

Purpose: To define the integration of home health, hospice, and palliative care as a key component of family-centered, compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families.

12. Care of the Imminently Dying

Purpose: To provide a standard of care integrating high-quality, family-centered compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families during terminal end of life.

13. Significant Change in Condition

Purpose: To define communication process with the patient, their family, PCP, and other healthcare agencies and staff as appropriate when a significant change is assessed in patient status.

14. QAPI Committee

Purpose: To outline the roles and responsibilities of the Quality Assurance and Performance Improvement (QAPI) Committee.

15. Documentation Audits

Purpose: To provide a guideline for ongoing review of clinical billing, documentation, quality metrics, and patient and family satisfaction measures.

16. New Hire Billing QA

Purpose: To provide a guideline for ongoing review of provider documentation during probationary period.

17. E&M Coding Guidelines

Purpose: To provide guidelines for coding and reporting services.

18. Billing Patients Not Seen

Purpose: To establish billing guidelines for E&M services when patients are not seen face-to-face and evaluated by providers when the E&M code requires face-to-face evaluation of the patient.

19. Uninsured/Underinsured (Charity)

Purpose: To set consistent process for determining a patient's ability to pay for services.

20. Professional Discounts

Purpose: To establish billing guidelines for services rendered.

21. Collaborative Agreement

Purpose: Provide guideline for Collaborative Agreement.

List of Suggested Processes

1. Intake
2. Admission
3. Provider Admission
4. Follow-up Consult
5. Pre-bill Audit
6. Supportive Care Call Procedure
7. On-call Procedure
8. Care Management Meetings
9. Indication for Patient Visits
10. QAPI Committee
11. Counseling and Coordination

Conclusion

In summary, because a perception exists that there are no regulations governing palliative care, an organization and its palliative care leaders can make the mistake of overlooking the need for policies and procedures. No matter the type of palliative care program you implement, there are regulations that direct those services. It is important your program develops a set of policies and procedures that governs your program based on your program's administrative home. Your policies and procedures will set your program's boundaries that guide your program staff and organization, govern a consistent approach in the care of individuals in your program, and help mitigate financial and legal risk.

The following pages contain examples of palliative care program policies and procedures. It is important for each organization to develop their own policies and procedures based on the administrative home for the program and the model of palliative care selected.

Palliative Care: Scope of Practice

Procedure Statement:

To define the practice of palliative care.

Procedures:

Palliative care team will:

A. Work to optimize patient care through four pillars of care to promote the highest quality of life for each patient and their family.

a. Pain and Symptom Management

- i. Optimize pain and symptom control through evidenced based practice.
- ii. Establish an environment that is comforting and healing to optimize functional status.

b. Medication Management

- i. Optimize medication regime through medication reconciliation and medication migration as patient's diagnoses change from one stage to the next.

c. Setting Management

- i. Promote appropriate referrals to other care types and settings timely.
- ii. Ensure each patient is receiving the right care at the right time.

d. Medical Goals of Care

- i. Educate patients and family to promote understanding of the underlying disease process and expected future course of the illness.
- ii. Promote advance care planning that is framed in the context above.
- iii. Documentation of advance care planning preferences through state sanctioned advance directives.

B. Serves as educators and mentors for staff and referral sources.

C. Assists actively dying patients and their families in preparing for and managing life closure.

The process of providing palliative care services includes:

A. Assessment of the physical and psychosocial problems of each patient, including:

- a. Disease status, treatment history, and expected prognosis.
- b. Comorbid medical and psychiatric disorders.
- c. Physical, psychological and spiritual symptoms and concerns.
- d. Medical goals of care.
- e. Advance care planning preferences.

B. Review of assessment data on a regular basis through patient and surrogate decision maker interviews, review of medical records, discussion with other providers, physical examination, and review of laboratory, and diagnostic tests and procedures.

C. Collaborative development of treatment plan with the patient, their surrogate decision maker, PCP, and other specialists as appropriate.

Palliative Care: Patient Self-Determination

Procedure Statement:

To ensure that patients and/or their surrogates make informed decisions about proposed medical treatments.

Procedures:

The palliative care APRN and/or bridge RN will:

- A. Establish ongoing communication and documentation with the patient and surrogate, the PCP and other specialists that includes discussions of:**
 - a. Health status.
 - b. Current disease(s) and expected future course, including prognosis.
 - c. Treatment options.
 - d. Patient preferences.
 - e. Spiritual and cultural beliefs and values that influence preferences.
 - f. The right of the patient to choose and to change his/her choices at any time.
 - g. The legal options for expressing desires through advance care planning documents/directives.
- B. Begin discussion with the patient and/or surrogate at the time of diagnosis and continue to communicate with the patient throughout the course of care.**
- C. Validate the patient's and/or surrogate's understandings of the information presented and introduce new information and choices as the patient's condition changes.**
- D. Define advance care planning and advance directive terminology, including DNR, POLST, Power of Attorney for Health Care and Living Will, and ensure that all choices are documented on appropriate forms.**
- E. Honor advance directives in accordance to policy and state statutes.**
- F. Provide empathy and support as patients and/or surrogates make decisions.**
- G. Document all communication in the medical record and convey patient and/or surrogate decisions to other health care team members.**

Palliative Care: Informed Consent

Procedure Statement:

To outline the guideline for obtain informed consent for palliative care treatment.

Procedure:

- A. Prior to admission, all patients are given a complete description of the palliative care services.
- B. All patients and/or their legal representative are required to acknowledge that they have been given a complete understanding of the services to be provided by the palliative program.
- C. Patients and/or their legal representatives are informed of the eligibility requirements for palliative care services and that the goal of palliative care is directed toward relief of symptoms of the underlying disease, medical goals of care and advance care planning, medication management, and setting management support.
- D. A copy of the **XX** *Palliative Care Informed Consent* is provided to the patient and/or legal representative for their personal records, regardless of the patient's place of residence.
- E. Care is not provided unless and until a signed consent form is received.
- F. If a patient has been adjudged incompetent, the person appointed pursuant to State law to act on the patient's behalf (surrogate decision maker), signs the informed consent form.
- G. Regular clinical record audits ensure that a consent form has been signed and received from every patient prior to the start of care.

Palliative Care: Ethical Issues and Ethics Committee

Refer to XX in the **XX** Policies and Procedures manual.

Palliative Care: Counseling and Coordination

Procedure Statement:

To ensure that patients, their families and/or caregivers receive counseling and coordination of care, and training specific to the patient's medical needs and abilities.

Procedures:

- A. During each assessment, counseling and coordination of care needs, and cognition/emotional abilities are assessed and documented. The following is a list of common issues to be addressed, depending on the patient's unique clinical circumstances:**
 - a. Pain and symptom management, including side-effect management.
 - b. Medical goals of care and advance care planning discussions.
 - c. Medication management.
 - d. Anticipated future medical needs.
 - e. Transitional care needs.
 - f. Home or institutional support options (e.g., home health, long-term care, home hospice services).
 - g. What to expect in the normal course of the disease trajectory.
 - h. Community services.
 - i. Whom to call for routine and emergency needs.
- B. Counseling and coordination of care needs are routinely assessed and reassessed throughout care and treatment.**
- C. When counseling and coordination of care needs are identified, they are incorporated into the treatment plan.**
- D. If patient is also on a palliative home health episode, the patient's care plan must follow all home health rules and regulations and be implemented in accordance to those policies.**
- E. Age, language, and educationally appropriate educational materials (written, Internet, oral) will be provided to meet the needs identified in the assessment process.**

Palliative Care: Treatment Planning and Care Planning

Procedure Statement:

To ensure each patient's treatment and/or care planning is individualized, interdisciplinary and based on the assessed needs of the patient.

Procedures:

- A. The treatment and/or care plan is based upon an ongoing assessment, determined by goals set with the patient, surrogate decision maker and family, and with consideration of the changing benefit to burden assessment at critical decision points during the course of illness.**
- B. The treatment and/or care plan is developed through the input of the patient, surrogate decision maker and family, the involved health care providers, and the palliative care team with the additional input, when indicated, of other specialists and caregivers (e.g., clergy, friends).**
- C. The treatment and/or care plan process includes structured assessment and documentation including:**
 - a. Physical and psychological assessment, addressing the current disease status, treatment options, functional status, expected prognosis, symptom burden and psychological coping.
 - b. Social and spiritual assessment, addressing the social, practical, religious, spiritual, existential concerns, and legal needs of the patient and caregivers, including but not limited to:
 - i. Relationships
 - ii. Existing social and cultural networks
 - iii. Decision making
 - iv. Work and school settings
 - v. Finances
 - vi. Sexuality/intimacy
 - vii. Caregiver availability and stress
 - viii. Access to medicines and equipment
 - c. Cultural assessment, including, but not limited to:
 - i. Locus of decision making
 - ii. Preferences regarding disclosure of information
 - iii. Truth telling and decision making
 - iv. Dietary preferences
 - v. Language
 - vi. Family communication
 - vii. Desire for complementary and alternative medicine
 - viii. Perspectives on death, suffering and grieving
 - ix. Funeral and burial rituals
- D. Treatment and/or care planning conferences with a patient and family will occur regularly to determine the most appropriate medical goals of care as indicated by the clinical condition and are coordinated by the palliative care APRN and/or bridge RN in conjunction with the PCP and other specialists involved in the patient's care as needed.**
- E. All Medicare Part A care plans must follow all home health rules and regulations and be implemented in accordance to those policies.**

- F. Treatment or care plan changes are based on the evolving needs and preferences of the patient and family over time, recognizing the complex, competing and shifting priorities in medical goals of care.
- G. The palliative care team provides support for decision making, develops and carries out the treatment and/or care plan, and communicates the plan to the patient, the surrogate decision maker, family, and involved health professionals or agencies in the care of the patient.

Palliative Care: Continuity of Care

Procedure Statement:

To ensure continuity of care upon referral to other care settings or at discharge for patients receiving palliative care consultative services.

Procedures:

- A. The palliative care APRN, and/or bridge RN are responsible for working with other health care staff (e.g., social service providers, discharge planners) for coordinating the discharge plan.**
- B. The palliative care APRN and/or bridge RN synthesizes the treatment and/or care plan and works to convert the patient's medical treatment goals into orders that are transferable across care settings.**
- C. The palliative care APRN, and/or bridge RN confirms access to services that can assist the patient, family and healthcare systems:**
 - a. Physician specialists
 - b. Nursing home/intermediate care facilities
 - c. Hospice
 - d. Home health care
 - e. Outpatient palliative care services (for those not confined to home)
 - f. Pain clinic (for those not confined to home)
 - g. Durable medical equipment services
 - h. Rehabilitation services
 - i. Counseling services
 - j. Transportation
 - k. Rehabilitation
 - l. Medications
- D. Referrals to other healthcare settings the palliative care APRN, and/or bridge RN:**
 - a. Confirms that the referred to agencies have received copies of the palliative care APRN and/or physician's orders and any other clinical documentation or relevant information.
 - b. Ensures the referred to agencies understand the patient is still being seen by palliative care services.
 - c. Ensures ongoing collaboration as necessary with referred to agencies.
- E. Patients on Medicare Part B palliative care services should not be discharged unless they have:**
 - a. Requested discontinuation of services
 - b. Moved outside service area
 - c. Been admitted to Hospice
- F. If patient is discharged from palliative care services the palliative care APRN, and/or bridge RN:**
 - a. Ensure the patient, family, and/or caregiver understands the discharge plan and provided with the appropriate discharge information.
 - b. Confirms that the referred to agencies have received copies of the palliative care APRN and/or physician's orders and any other clinical documentation or relevant information.

Palliative Care: Assessment and Treatment of Physical and Emotional Symptoms

Procedure Statement:

To ensure that all patients who are experiencing pain, physical symptoms and emotional symptoms are managed with quality and consistency throughout their care.

Procedures:

A. The palliative care APRN completes a comprehensive medical assessment:

- a. Chief complaint
- b. History (HPI, ROS, PFSH)
- c. Examination
- d. Current treatments, medication profile and side effects
- e. Diagnoses
- f. Patient concerns
- g. Patient, family, and/or caregiver preferences
- h. Spiritual and cultural beliefs and values that influence treatment
- i. Risk of morbidity and mortality

B. Using approved assessment scales, the patient is to characterize their symptom burden at the time of initial assessment and at regularly prescribed intervals following the assessment, and after initiation of therapy.

C. The palliative care APRN:

- a. Proposes a comprehensive treatment plan and confers with the patient and family and confirms plan elements.
- b. Instructs the patient, family, and/or caregiver on any self-care procedures.
- c. If other care settings are actively providing concurrent care for the patient, the palliative care APRN works with nursing staff to ensure the implementation and monitoring of the treatment plan. This includes the palliative bridge RN as appropriate.

D. The palliative APRN, bridge RN, and other nursing staff works with the palliative care APRN to assess the patient's response to treatment, including:

E. Response to medications or non-pharmacological interventions.

F. Symptom relief measured on a consistently utilized scale.

G. Adverse events, reactions, or side effects.

H. Satisfaction with intervention.

I. The treatment plan is modified based on ongoing assessment.

J. The palliative Medicare Part A care plan is updated based on the modified treatment plan.

K. All Medicare Part A care plans must follow all home health rules and regulations and be implemented in accordance to those policies.

L. The palliative care APRN ensures that all assessments, recommendations, interventions and responses to therapy are documented in the medical record, and that changes in the treatment or care plan are communicated to the nursing staff in writing and verbally at the time they occur.

M. Prior to a palliative discharge a plan is established for continuing care requirements and family, and/or caregiver education and support.

Palliative Care: Pain Management

Procedure Statement:

To ensure that all patients who are experiencing pain are managed with quality and consistency throughout their care.

Procedures:

A. Standards for assessment:

B. The fundamental principles of pain management will be followed as defined in *Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain of the American Pain Society*, and the *Palliative Care Consultant Reference Guide*.

C. The patient's culture and age will be assessed upon admission. The assessment and treatment of pain will be consistent with the patient's cultural and age specific needs.

D. All patients will be assessed for pain by using the Pain Assessment Hierarchy:

- a. Self-report of pain.
- b. Presence of pathological condition or procedure that usually causes pain.
- c. Pain behavior.
- d. Proxy pain rating.
- e. Autonomic response.

E. The pain rating tool:

- a. Visual Analog Scale (VAS) that includes a numeric, face, color and/or descriptive scoring scale.
- b. Pain Assessment in Advanced Dementia Scale (PAINAD) based on objective observable indications by the clinician.

F. The pain assessment includes:

- a. Quality and location of pain.
- b. Functional limitations caused by pain.
- c. Expectations and perceptions of patients and their significant others.

G. Pain is the fifth vital sign and will be assessed on admission, and upon self-report of pain, and when pain of the nonverbal patient is presumed.

H. Pain will be reassessed after each intervention and documented as a VAS score or behavior change.

I. A treatment and/or care plan will be established to deal with pain. The plan should involve both pharmacological and non-pharmacological interventions.

J. All Medicare Part A care plans must follow all home health rules and regulations and be implemented in accordance to those policies.

K. The patient's pain goal will be identified (functional improvement and/or VAS score) and will be documented as such so that all palliative care team members and other healthcare professionals will know the expectations of care and will incorporate the pain goal.

Palliative Care: End of Life Care

Procedure Statement:

To define the integration of home health, hospice, and palliative care as a key component of family-centered, compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families.

Procedures:

- A. Meeting patient and family needs is the central focus of care when cure or maintaining the continuum of health is no longer possible.**
- B. Optimal care requires exceptional communication among clinical staff and recognition that a team approach, inclusive of many health care disciplines, is necessary.**
- C. Patients are treated with respect to their individual wishes for care and treatment with consideration of their values, religion and philosophy.**
- D. A request to discontinue treatment will be honored with the same support and respect as the decision to continue treatment.**
- E. The palliative care consultation and bridge service is available to assist with symptom management, prognosis determination, patient and family support, disposition planning and other issues related to end-of-life decisions.**
- F. Home health and hospice services are recognized as an integral part of the continuum of care.**
- G. Patients who are homebound and have skilled need should be offered home health services. These services should include a palliative plan of care as appropriate. The patient's goals of care may include and be focused on:**
 - a. Restorative health goals
 - b. Maintenance health goals
 - c. Comfort goals
- H. Patients can receive home health services and Medicare Part B palliative care services concurrently.**
- I. Patients who have an expected prognosis of six months or less, assuming the disease follows its usual course, should be offered hospice services.**
- J. In the event of questions or differences of opinion among the patient, family or health care team members about the treatment goals, consultation is available from the ethics committee.**

Palliative Care: Care of the Imminently Dying

Procedure Statement:

To provide a standard of care integrating high-quality, family-centered compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families during terminal end of life.

Procedures:

A. In the event that a patient and their family choose not to be admitted to hospice for terminal end of life care; the palliative care APRN and/or bridge RN will provide care to include:

- a. Documentation in the medical record that the patient is "imminently" or "actively" dying.
- b. Communicate with the patient, family and surrogate decision makers that death is imminent.
- c. Prepare patient and family for what to expect during the normal dying process.
- d. Manage pain and other physical/psychological symptoms effectively.
- e. Educate/counsel patients and families concerning the appropriate use of pain and symptom treatments.
- f. Provide treatment of symptoms according to the wishes of the patient or family.
- g. Respect the patient's privacy, values, religion, culture and philosophy.
- h. Involve the patient and family in all aspects of care.
- i. Respond to the psychological, social, emotional, spiritual and cultural concerns of the patient and family, including children and teens affected by the death.
- j. Treat the body post-death with respect according to the cultural and religious practices of the family and in accordance with local law.
- k. Address issues of body or organ donation, autopsy and funeral planning with sensitivity.
- l. Provide bereavement resources through the community.

B. Provide ongoing discussion and options for out-of-hospital care, including home or residential hospice services.

Palliative Care: Significant Change

Procedure Statement:

The APRN will discuss with the treatment options and care plan the patient, their family, PCP, and other healthcare agencies and staff as appropriate when a significant change is assessed in patient status.

Procedures:

A significant change is a major decline in a patient's status that will not normally resolve itself without further interventions by implementing standard disease-related clinical interventions. These interventions should have an impact on more than one area of the patient's health status and requires the patient's treatment and/or care plan to be revised.

A. A significant change reassessment is generally indicated if decline is consistently noted in two or more areas:

- a. Decline in ADLs.
- b. Increase in the number of areas where behavioral symptoms are not easily altered.
- c. Decision-making changes.
- d. Incontinence pattern changes.
- e. Emergence of sad or anxious mood not easily altered.
- f. Emergence of unplanned weight loss.
- g. Emergence of a pressure ulcer or Stage II or higher wound when no wounds were previously present.
- h. Overall deterioration of patient's condition, patient requiring more support.

B. APRN performs follow-up consultation visit, diagnoses the problem(s) and updates treatment plan based on patient and family goals.

C. APRN refers patient for other healthcare support as appropriate.

D. APRN determines next follow-up consult.

Palliative Care: Quality Assurance and Performance Improvement

Purpose:

To outline the roles and responsibilities of the Quality Assurance and Performance Improvement (QAPI) Committee.

Procedures:

- A. The agency palliative care team will form a palliative care QAPI committee that consists of the following members as applicable:**
 - a. Clinical representatives (RN, APRN, MD).
 - b. One representative from administration (Clinical Director or Administrator)
 - c. At large representatives as needed (SW, chaplain, and pharmacist, or corporate leadership).
 - d. Representative from the ethics committee as needed.
- B. The agency palliative care QAPI committee will establish and direct efforts to meet the Palliative Operational and Clinical Quality Standards. These standards are based on the National Quality Forum (NQF) recommendations. As part of this effort, the palliative care QAPI committee is responsible for:**
 - a. Monitoring the palliative care clinical care practices through:
 - i. Evaluation of data concerning pain and other symptom control
 - ii. Advance directives and medical goals of care.
 - iii. Utilization of agency resources.
 - iv. Home health and hospice referrals.
 - v. Patient and family satisfaction.
 - vi. Financial goals.
 - vii. Documentation and billing findings.
 - b. Assisting in the development and implementation of palliative care education initiatives for agency staff, community health professionals that include relevant competency-based metrics.
 - c. Making recommendations to the Governing Body regarding appropriate changes in patient care policies, guidelines, and procedures.
- C. The agency palliative care QAPI committee will establish at least one performance improvement plan (PIP) based on either operational or clinical quality measures that are under performing.**
- D. The agency palliative care QAPI committee will meet monthly*.**
- E. Meeting minutes will be submitted to the Governing Board monthly*.**

** Program should determine the frequency, could be quarterly*

Palliative Care: Documentation Audits

Purpose:

To provide a guideline for ongoing review of clinical billing, documentation, quality metrics, and patient and family satisfaction measures.

It is the policy of XX Palliative Care to conduct routine and random documentation audits that will assess the ICD and CPT coding accuracy, and documentation quality of its providers.

Procedures:

Random Clinical Billing Audits:

- A. Random audits will be conducted for all providers for whom XX bills.**
- B. When possible, audits will be conducted on a prospective basis (unbilled claims).**
- C. A minimum sample of three (3) records will be reviewed for each provider quarterly by the Director of Palliative Care and assesses the following for each provider:**
 - a. Documentation of note for services provided
 - b. Legibility of documentation
 - c. Substantiation of all reported diagnoses in the note
 - d. Accuracy of reported ICD codes
 - e. Accuracy of reported CPT codes, and documentation to substantiate reported CPT codes to include:
 - i. History
 - ii. Examination
 - iii. Medical decision-making components
- D. Findings will be reviewed with each provider.**

Monthly Quality Metrics Audits:

- A. Monthly quality audits will be performed by designated staff members by the XX of each month using the palliative care audit tool.**
- B. The quality metrics will be established for each year to include, but not limited to:**
 - Symptoms
 - Goals of Care/Advance Care Planning
 - Avoidable re-hospitalization rates
 - Consent compliance
 - LOS trends
 - Referrals to home health
 - Conversion rates to hospice
- C. Monthly quality data will be reviewed and included as part of the agency's monthly* palliative QAPI meeting.**
 - a. See QAPI Committee procedures

**Frequency of QAPI meetings as determined by the program, could be quarterly*

Quarterly Clinical Billing Audits:

- A. Quarterly audits will be conducted for all providers for whom XX bills.**

- a. These audits are separate from the required documentation review established as part of the APRN and primary physician collaborative agreement.

B. When possible, audits will be conducted on a prospective basis (unbilled claims).

C. A minimum sample of five (5) records will be reviewed for each provider quarterly by the designated staff and assesses the following for each provider:

- a. Documentation of note for services provided
- b. Legibility of documentation
- c. Substantiation of all reported diagnoses in the note
- d. Accuracy of reported ICD codes
- e. Accuracy of reported CPT codes, and documentation to substantiate reported CPT codes to include:
 - i. History
 - ii. Examination
 - iii. Medical decision-making components
- f. Pre-bill process

D. Overall scores will be evaluated based on:

- a. Process compliance
- b. E&M documentation requirements against billed codes
- c. Quality documentation sufficient to substantiate understanding for medically necessary care.

E. Additional training will be mandated for staff if:

- a. The established processes are not followed (i.e. correct setting/location used, correct billing process followed, diagnoses entered correctly, pre-bill audits process, scanning and attaching records to patients, and others as identified).

F. If a provider has more than one (1) billing error identified within the five (5) records:

- a. an additional five (5) records will be reviewed.

G. If more than 10% of the ten (10) records audited are identified with billing errors:

- a. Additional training will be mandated for the provider whose records were audited.
- b. Five (5) additional clinical billing audits will be done post mandated re-training for two (2) consecutive months.
- c. Threshold of 90% must be met and maintained during this period to be placed back on quarterly review process.
- d. If the provider continues to trend with billing errors:
 - i. The provider will be placed on an action plan.
 - ii. Immediate compliance with billing standards must be met.

H. Weekly review by Clinical Services will provide oversight of re-training, and ongoing compliance.

I. Additional training will be mandated for provider if:

- a. It is determined the quality of their documentation needs to be improved to better enhance the documentation requirements for the three areas of an H&P (i.e. History, Examination, Medical Decision Making), and substantiate medical necessity.

Patient and Family Satisfaction Survey:

A. Patient and family satisfaction survey data must be a component of the agency's monthly QAPI meeting.

B. You need to determine your process on this

Palliative Care: New Hire Billing Quality Assurance and Continued Competency

Purpose:

To provide a guideline for ongoing review of provider documentation during probationary period.

Procedures:

General:

- A. The agency will conduct billing and clinical quality reviews for all providers on a weekly basis during their 90-day probationary period.**
 - a. Use palliative audit tool.
 - b. Scores are reviewed weekly with provider.
- B. The APN's minimum passing threshold of 90% is expected by the end of their probationary period.**
- C. After the 90-day period, and if the provider maintains a passing threshold of 90% during the probationary period, audits will be done quarterly.**
 - a. See Quality Audits

Weekly Documentation Audits:

- A. Weekly audits will be conducted for all newly hired providers for whom XX bills.**
 - a. These audits are separate from the required documentation review established as part of the APRN and primary physician collaborative agreement.
- B. Audits will be conducted on a prospective basis (unbilled claims).**
- C. A minimum sample of three (3) records will be reviewed for each newly hired provider weekly by the designated staff and assesses the following for each provider:**
 - a. Documentation of note for services provided
 - b. Legibility of documentation
 - c. Substantiation of all reported diagnoses in the note
 - d. Accuracy of reported ICD codes
 - e. Accuracy of reported CPT codes, and documentation to substantiate reported CPT codes to include:
 - i. History
 - ii. Examination
 - iii. Medical decision-making components
 - f. Pre-bill process
- D. Overall scores will be evaluated based on:**
 - a. Process compliance
 - b. E&M documentation requirements against billed codes
 - c. Quality documentation sufficient to substantiate understanding for medically necessary care.
- E. Additional training will be mandated for staff if:**
 - a. The established processes are not followed (i.e. correct setting/location used, correct billing process followed, diagnoses entered correctly, pre-bill audits process, scanning and attaching records to patients, and others as identified).
- F. If more than 10% of the records audited are identified with billing errors:**
 - a. Additional training will be mandated for the newly hired provider whose records were audited.

- b. Threshold of 90% must be met and maintained during this period to move out of the probationary period and be placed on quarterly review process.
- c. If the provider continues to trend with billing errors:
 - i. The provider will be placed on an action plan.
 - ii. Immediate compliance with billing standards must be met.

G. Weekly review by Clinical Services will provide oversight of re-training, and ongoing compliance.

H. Additional training will be mandated for newly hired provider if:

- a. It is determined the quality of their documentation needs to be improved to better enhance the documentation requirements for the three areas of an H&P (i.e. History, Examination, Medical Decision Making), and substantiate medical necessity.

Palliative Care: ICD Coding Guidelines for Professional Services

Purpose:

To provide guidelines for coding and reporting services.

Procedures:

- A. It is the responsibility of the provider to document all patient diagnoses in the medical record and for each service submitted for reimbursement.
- B. Because the ICD-10-CM code substantiates medical necessity, and patient complexity, multiple diagnosis codes, including medical conditions, should be submitted by the provider when applicable.
- C. The appropriate code or codes must be used to identify diagnoses, symptoms, conditions, problems, complaints, or other reasons for the visit encounter.
- D. For accurate reporting of the ICD-10-CM code, the documentation should describe the patient's condition using terminology that includes specific diagnoses as well as symptoms, problems or reasons for visit encounter.
- E. Codes that describe symptoms and signs, as opposed to diagnoses, are acceptable for reporting purposes when an established diagnosis has not been diagnosed (confirmed) by the provider.
- F. ICD-10-CM provides codes to deal with encounters for circumstances other than a disease or injury.
- G. The first code should be the diagnosis, condition, problem or other reason for the visit encounter to be chiefly responsible for the services provided.
- H. Do not code diagnoses documented as 'probable', 'suspected', 'questionable', 'rule-out', or 'working'. Rather code the condition(s) to the highest degree of certainty for the visit encounter, such as signs or symptoms, abnormal test results, and other reasons for the visit.
- I. Chronic diseases treated on an ongoing basis may be coded and reported as many times as the patient receives treatment and care for the condition(s).
- J. Code all documented conditions that coexist at the time of the visit encounter and require or affect patient care treatment or management.
- K. Do not code conditions that were previously treated or no longer exist unless they are pertinent to the visit encounter.
- L. For patients receiving only diagnostic services during a visit encounter, sequence the diagnosis, condition, problem or other reason for the visit encounter to be chiefly responsible for the services provided during the visit encounter first.
- M. For patients receiving only therapeutic services during a visit encounter, sequence the diagnosis, condition, problem or other reason for the visit encounter to be chiefly responsible for the services provided during the visit encounter first.

Palliative Care: CPT Coding Guidelines for Professional Services

Purpose:

To provide guidelines for coding and reporting services.

Procedures:

- A. It is the responsibility of the provider to document all services and procedures provided to the patient in the medical record and submitted for reimbursement.**
- B. Each E&M service and or procedure provided and documented should be reported on the claim.**
- C. There should be documentation in the patient's medical record that correlates to each service and/or procedure reported for billing.**
- D. Diagnoses substantiate the reported CPT codes.**
- E. Diagnoses shall be coded in accordance with ICD-10-CM Coding Guidelines established by the AHA, AMA, CMS and National Center for Health Statistics**
 - See ICD Coding Guidelines
- F. E&M services shall be selected and documented in accordance with the most recent version of the CMS/AMA Documentation Guidelines.**
- G. E&M code assignment shall be based upon the patient's medical complexity, which should be substantiated by documentation in the progress note. For specific documentation requirements for each CPT code, refer to the CMS/AMA Documentation Guidelines for E&M Services.**

<http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/EMDOC.html>

E&M Coding:

A. When determining the appropriate E&M code, the following guidelines should be followed:

- a. Determine the location of the service:
 - Home, nursing facility, assisted living facility, ER, hospital.
- b. Determine the patient type:
 - New Patient – those patients new to the 'practice', or those who have not been seen by the provider or practice within the past three years.
 - Established – those patients known to the 'practice'.
 - Initial Patient – those patients being seen in an acute care setting for the first time (ED, Hospital).
 - Subsequent Patient – those patients being seen in an acute care setting for follow-up post initial visit encounter.
 - **Note:** A provider who is covering for, or who is on call for another provider should not classify the patient encounter as 'New' unless the patient has not been seen by a member of the 'practice' within the past three years.
- c. Determine the type of service:
 - Comprehensive assessment, follow-up assessment, self-limited problem (focused), patient/family medical conference, etc.
- d. Review the guidelines found in the Billing Tool Kit.
- e. Assign the CPT code based on the complexity of the patient.
- f. Document the extent of the History, Examination, and Medical Decision-Making components required in accordance with the CPT and CMS/AMA Documentation Guidelines.
 - New patient/Initial visit – require documentation of all 3 key components
 - Established patient/subsequent visit – require documentation of 2 or the 3 key components.

- Interval histories do not require documentation of past family social history (PFSH) unless new data is obtained. The provider should indicate that the PFSH was reviewed with no changes. For the review of systems (ROS) re-documentation of non-pertinent systems is not required; however, documentation of relevant systems should be part of each follow-up visit encounter.
- g. If the visit encounter is driven from time codes, assess the total amount of time spent on the encounter and document on the consult note.
- h. If time is the determining factor because the provider spent great than 50% of the visit face-to-face with the patient providing counseling and/or coordination of care, time must be indicated in the medical records.
 - Time spent by other staff cannot be included in the total amount of face-to-face time.

Time Billing:

- A. Time is the controlling factor when assigning an E&M code only when counseling and/or coordination of care dominated more than 50% of the provider/patient encounter**
- B. When time is used to assign a CPT code, the provider must document the total time spent in the encounter and the counseling and coordination activities**
- C. Counseling and/or coordination of care activities include discussion regarding the following:**
 - Diagnostic results, impressions and/or recommended diagnostic studies
 - Prognosis
 - Risk and benefits of disease management options
 - Instructions for disease management and/or follow-up
 - Importance of compliance with treatment options
 - Risk factor reduction
 - Patient/family education
 - Discussions related to decreasing or stopping life-sustaining treatments

Multiple E&M Services Rendered on Same Day by Same Provider:

- A. In the event the same provider evaluates a patient more than once in a 24-hour period because a change in the patient's status or assessment of a new problem, the provider should combine the services provided into one E&M code.**
- B. Typically, this will result in a higher E&M code based upon review of the medical decision-making components.**
- C. It is the provider's responsibility to ensure appropriate history and examination elements are documented in the medical record if a higher E&M code is reported.**

Multiple E&M Services Rendered on Same Day by Different Providers:

- A. CMS will only reimburse one E&M service per day by clinicians in the same specialty and/or under the same group number.**
- B. If there is documented medical necessity substantiating an additional evaluation because a change in the patient's status or assessment of a new problem, CMS may reimburse both providers in the same specialty and practice.**
- C. The providers should submit the service rendered for payment.**
- D. If there is a denial because multiple E&M service were reported on the same day, the billing department will request copies of the notes and appeal the denial with the carrier.**

Critical Care Services (99291-99292):

- A. Critical care services may be billed when a provider renders care to a critically ill patient.**

- B. Under CPT guidelines, critical care is defined as a 'critical illness or injury which acutely impairs one or more vital organ systems such that there is a high probability of imminent or life-threatening deterioration in the patient's condition'.**
 - a. Examples: organ system failure, renal, hepatic metabolic and/or respiratory failure.
- C. Critical care is used to report the total duration of time spent by the provider providing the critical care service**
- D. In order to bill critical care services, there must be a minimum of 30-minutes of critical care services provided to the patient.**
- E. In the absence of 30-minutes, the provider should bill the services under the appropriate E&M code.**
- F. Documentation requirements for services billed as critical care include:**
 - a. Labeling the note as 'critical care services'
 - b. Total time spent providing critical care services
 - c. Documentation of the services provided to the patient which should reflect the critical nature/status of the patient's condition.

Procedure Services:

- A. Procedures personally performed by the provider should be captured on billing form.**
- B. E&M services should not be billed with a procedure unless an E&M service was performed which is 'separate and distinct' from the procedure.**
- C. Procedures should be sequenced in descending order of the Medicare Fee Schedule.**
- D. Medicare reduces payment for each subsequent procedure when multiple procedures are listed.**
- E. Procedure codes with the greatest amount of work effort should be sequenced first.**

After Hours Services:

- A. After hours reimbursement is available to the provider who responds to a request for services after designated operating hours.**
- B. While Medicare will not reimburse typically for this, other payers will in some instances.**
- C. After hours is reported in addition to the E&M service and/or procedure service code.**
- D. Services provided between 10p and 8a are coded 99053*.**
- E. Services provided on Sundays and holidays are coded 99051*.**

**American Academy of Ophthalmology. (2016). CPT codes for unscheduled patients. Retrieved from <https://www.aaao.org/practice-management/news-detail/cpt-codes-unscheduled-patients>*

**American Academy of Pediatrics. (2017). Coding for visits after hours and in other special circumstances. Retrieved from <https://www.aappublications.org/news/2017/06/21/Coding062117>*

Palliative Care: Billing for Patients Not Seen

Purpose:

To establish billing guidelines for E&M services when patients are not seen face-to-face and evaluated by providers when the E&M code requires face-to-face evaluation of the patient.

Procedure:

- A. It is the policy of XX to adhere to CMS billing guidelines and not charge for E&M services when patients are not seen face-to-face.**
- B. APRNs will complete a daily encounter record that records the total number of patients seen and those where a request or appointment was made that were attempted but not performed due to unforeseen circumstances.**
- C. In the event a provider is called to a facility to evaluate a patient who is unavailable for the consult:**
 - a. Document that the consult was attempted
 - b. Provide a brief statement of why the evaluation was not completed
 - c. Document any discussion with staff
- D. Because the patient was not evaluated, there are no billable services and charges should not be submitted for billing.**

Palliative Care: Professional Discounts

Purpose:

To establish billing guidelines for services rendered.

No individual employed or contracted by XX Palliative Care program may provide free or discounted services as a 'professional courtesy' to any patient, including physicians, their families, employees or a physician's office, nursing facility staff, etc.

Provisions of free or discounted services based on professional courtesy potentially impacts the Medicare Fraud and Abuse laws, the Stark Bill and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Professional courtesy discounts implicate the anti-kickback statute because services at less than 'fair market value' may be viewed as a financial benefit provided as an inducement for the future referral of business by the provider.

The practice of providing free or discounted services would constitute a financial arrangement under the Stark law so that a physician receiving such a discount could not make any referrals for designated health services under the Stark law.

The practice of waiving copayments and deductibles may also be a violation of HIPAA or relevant state statutes which prohibit the submission of false or fraudulent statements to third party payers in connection with delivery of, or payment for, healthcare services.

Procedure:

- A. XX palliative care staff shall not extend professional courtesy, waive deductible or copayments or provide free or discounted services to any patient, including physicians, their families or employees of physician's offices, and employees of nursing facilities.**
 - a. All services provided to such persons shall be billed at established rates adhering to normal billing practices.
- B. Charges for services provided by the APN or other providers may only be adjusted under very limited circumstances**
 - a. The person to be billed for services is indigent or suffering from severe financial hardship as determined by guidelines established in accounting policies.
 - b. There has been a billing error that needs to be corrected.
 - c. The cost of additional collection efforts exceeds the likely financial recovery.
- C. No one should adjust, waive or discount charges without discussion with XX's Compliance Officer, or other responsible individual**
- D. No one should make promises to a patient with respect to the patient's bill prior to consulting with authorized staff.**
- E. Charges that have not been collected will be discussed through the A/R process.**



NHPCO Palliative Care Playbook for Hospices

Documentation

This chapter is also available as a Grab & Go Toolkit:
www.nhpc.org/palliativecare



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There are multiple functions of documentation: communication, record of care (goals of care, care plan: assessment, interventions, response to treatment, etc.), reimbursement, quality assurance and process improvement. Effective documentation can improve the quality of care and patient safety. Effective documentation is comprehensive, accurate, timely, and accessible.

Electronic Health Record Evaluation

Most organizations use an electronic medical record to record documentation. There are a variety of vendors to choose from; some vendors focus solely on community-based services, such as home health and hospice care, others may focus on medical group practice documentation or hospital documentation. Single site focused electronic documentation software is typically called an electronic medical record. A few vendors have a comprehensive suite of products to cover care across the continuum, creating a multi-site electronic documentation software called an electronic health record which is more comprehensive. You are more apt to get program specific software from an EMR vendor; however, you get improved interoperability with an EHR.

Interoperability

The Centers for Medicare and Medicaid (CMS) are encouraging interoperability between electronic documentation software to ensure the provider and consumer have access to the most accurate up-to-date information when adjusting treatments and making care decisions. Proposed and new rules for various CMS reimbursed health care programs require software that meets 2015 CEHRT. For example, a medical group cannot participate in an advanced Alternative Payment Model unless their documentation software meets 2015 CERHT. The recently announced CMS/CMMI new care models require 2015 CEHRT to participate. Programs are allowed a one-year waiver. Incentives to achieve interoperability have been granted to software vendors for hospitals and medical groups, but not to community-based program software vendors. CMS/CMMI are now calling for penalties for providers and programs that do not meet the 2015 CEHRT across health care. It is recommended to select a vendor that meets or is working to meet the 2015 CEHRT requirements. If you are providing palliative care services to patients that are part of a health system or an ACO, check with them about interoperability between your EMR and theirs.

Registries

An EMR can provide functionality to create a panel of palliative care patients, often called a patient registry. Using a registry can help with case management and care coordination. Many palliative care programs operate as a population health management solution. Health management requires an ability to monitor the risk level of the population. Risks can include risk for disease progression, risk for symptom progression, risk for decline in function, risk for emergency room use and hospitalization, and risk for mortality. Some vendors have software programs that sit on top of the EMR to pull data out to inform the patient's risk level. Other applications allow for data extraction for quality reporting. Check with your vendor(s) about capabilities to use a registry for your panel of palliative care patients.

Practitioner Documentation

If your primary billing source will be Medicare B fee-for-service (FFS), it is best to think of your palliative care program as a medical practice. In FFS, the only members of the palliative care team that are billable are the physician and non-physician practitioners (NPPs), such as nurse practitioner, clinical nurse specialist, and physician assistant. These visits and services are billed under Evaluation and Management (E/M). Visits and services must be medically necessary and be provided by an eligible practitioner to be reimbursed. It is important to note that Medicare B does not have a mechanism to reimburse all members of an interdisciplinary team. There are no specific Conditions of Participation for the palliative care services. A medical practice follows the physician fee schedule rules.

There is an additional opportunity for mental health reimbursement if you have a licensed independent clinical social worker. You can also contract for these services. Billing for LICSW visits for individual or family psychotherapy must be based on a DSM V diagnosis code and local coverage determinations (LCDs) as defined by most Medicare Administrative Contractors.

Accurate coding is important to support the rational for services and treatments. Comprehensive documentation and coding paint a full picture of the patient. Palliative care physician and NPP documentation needs to be accurate to reflect the acuity of the patient, the utilization of resources, and ability to report quality. According to CMS, Physician and NPP documentation for E/M must include several elements:

- History*
- Physical examination*
- Medical decision making*
- Nature of the current problem
 - When documenting a specific condition include
 - ▶ Location
 - ▶ Laterality
 - ▶ Severity/stage
 - ▶ Type
 - ▶ Status: current/active or history/resolved
 - ▶ Causal relationships
- Counseling
- Coordination of care
- Time

**Considered the three key components of documentation.*

A couple other essential considerations that should be included in the physician/NPP documentation are

- Why the visit is medically necessary
- All acute and chronic diagnoses under treatment

For a comprehensive resource on physician/NPP documentation and coding, please see the resource created by Jean Acevedo in collaboration with the California Health Care Foundation at <https://www.chcf.org/wp-content/uploads/2019/05/DocumentationCodingHandbookPalliativeCare.pdf>. This resource includes information on documentation for E/M coding, Advance Care Planning coding, Chronic Care Management coding, and risk avoidance. The hospice organization should not assume that physicians and NPPs have a thorough understanding of documentation and coding, even if they have practice experience. Quality assurance to review documentation and coding should be done on a regular basis, either weekly, monthly, or quarterly. Remedial education should be available for practitioners based on the quality of their documentation and coding. The hospice organization should have access to coding expertise either employed or via contract.

Documentation templates should reflect the elements necessary for accurate billing and coding. The templates can guide the behavior of the clinician to ensure completion of comprehensive assessments, diagnosis and treatment, advance care planning and goals of care discussions, symptom and medication management, caregiver assessment and support, care coordination, and development of a care plan.

Resource: Appendix A Samples of Electronic Documentation Templates for Physicians, NPPs, and Social Worker.

Z-Codes

Z-codes are used in conjunction with other diagnosis codes. Z codes replaced V codes in the ICD 10. Depending on the reason for the encounter some Z-codes can be used as the primary diagnoses while others may never be used as primary (e.g. Z51.5. should always be used as a secondary diagnosis code). Z51.5. should be used for all palliative care encounters as a secondary diagnosis code with a primary code for the condition requiring care. (Z51.5. replaces the ICD-9 code V66.7). Use of this code allows for identification of palliative care visits and could allow for reporting of prevalence of palliative care visits if everyone providing palliative care services used it consistently. Watch for ongoing guidance from the American Hospital Association on the use of Z51.5. as it may be allowed as a primary diagnosis for an inpatient stay in the future, depending on the reason for the admission. This could have implications for documentation requirements and claim submissions.

Per the ICD-10 Code book, there are two main reasons to use Z-codes: *“When a person who may or may not be sick encounters the health services for some specific purpose, such as to receive limited care or service for a current condition, to donate an organ or tissue, to receive prophylactic vaccination (immunization), or to discuss a problem which is in itself not a disease or injury.” OR “When some circumstance or problem is present which influences the person’s health status but is not in itself a current illness or injury.”* Based on these reasons, you can see why use of the Z-codes in palliative care is appropriate and beneficial.

Resource: Appendix B Z-Codes for a breakdown of applicable Z-Codes and examples impacting reimbursement.

Merit-based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)

The Center for Medicare and Medicaid Services (CMS) implemented the Quality Payment Program to reward value and outcomes through MIPS and APMs for professional services covered under the Medicare Physician Fee Schedule (PFS) based on the number of Medicare Part B patients served. Clinical performance is measured by data collected and reported in four areas: quality, improvement activities, promoting interoperability, and cost. Participation requirements are based on the volume of Medicare Part B patients or charges per year. Exempt clinicians include those in their first year of billing Medicare, clinicians with a low volume of Medicare Part B patients (< 200) or charges (< \$90,000) or < 200 Medicare Part B services. Please note that clinicians that meet or exceed one or two, but not all, of the low volume threshold criteria can opt-in to participation. The low volume level is calculated at the participation level of the eligible clinician (either group or individual). Over time, the weight of the categories will evolve and shift. There are two hardship exceptions: one for the promoting interoperability category and the other for uncontrolled circumstances (e.g. natural disaster) applicable for the quality, cost, and improvement categories. There is technical assistance available to help rural and small provider practices to participate in MIPS. Reporting is done through claims, qualified clinical data registry, qualified registry, and electronic health records.

To learn more about MIPS and APMs and documentation considerations go to the following links:

- [CMS Quality Payment Program](#)
- [AAFP MACRA Resources](#)
- [Certified Health IT Product List](#)
- [AMA Understanding MIPS](#)
- [SA/Ignite 10 FAQs about MIPS](#)

Interdisciplinary Documentation

When a program is reimbursed for palliative care services by a health plan, they may use other codes to achieve payment. The plan may or may not direct staffing requirements. Staffing and payment methods are part of the contract negotiation. Some organizations negotiate for a per beneficiary per month reimbursement to cover the cost of the entire interdisciplinary team. The organization may negotiate an additional financial incentive for quality reporting and/or quality outcomes. Documentation templates for this type of reimbursement should include all the elements of services the organization has agreed to provide for the health plan beneficiaries. Ideally, these are the same services an organization provides to Medicare B beneficiaries; however, they may utilize other members of the interdisciplinary team to accomplish these tasks, with oversight from the program's medical director. The hospice may be able to use many of the templates already in use for hospice services to meet the documentation requirements for their palliative care program, but these templates need to be housed in a separate service within the EMR.

Depending on the type of program, all members of the interdisciplinary team need access to each other's notes. Check with your EMR vendor to see what functionality exists to achieve access in real time. It may be through a permission level for each individual clinician or an option to join the patient's care team. Find out if notifications can be received for all members of the care team when there are changes to the care plan (e.g. new orders, change in site of service or level of care, etc.). Check with the vendor to see if the patient has an option to have access to their record and if so, what level of access. For example, can they update their advance directives or care goals? Can the team set the level of access or the EMR view the patient has access to? Many vendors now have a patient portal and many health systems allow patients some level of access, including the ability to update portions of their records and ability to communicate directly with their practitioner.

Many programs see value in adding a registered nurse to case manage the panel of palliative care patients. Documentation for the RN should include holistic symptom and medication management activities and engagement activities. Symptom and medication management activities include all aspects of the nursing process: assessment, diagnosis, planning, implementation, and evaluation. Note, these activities should include a holistic approach, including physical, psycho-social, emotional, and spiritual. How else can the RN know when to trigger the need for intervention by other members of the interdisciplinary team? And the other members of the team benefit from the RN's documentation to understand what initiated the trigger. Engagement activities include care coordination, consultation, and collaboration with other members of

the health care team, as well as support, education, and coordination for the patient, family, and caregivers. You can use the same RN templates for your palliative care services that you use for your hospice program and modify to fit the expectations of the RN role within the palliative care model of care. Please refer to the Staffing chapter to review considerations regarding scope of practice and maintaining regulatory boundaries.

Standard assessment tools

A wise physician once said building templates in the EMR allows us to guide the behavior of the clinicians to ensure the quality of care provided. Incorporating evidence-based tools into the team's workflow is one way to accomplish this. Using a shared flowsheet has multiple values: standardizes best practice, creates efficiencies for physician and NPP documentation, ability to trend clinical information, and ease of data extraction for metrics. Ideally, the physician and NPPs on the team should be able to pull elements from the flowsheet into their progress note using a widget or shortcut. Furthermore, aligning the flowsheet rows across EMR modules allows the team to trend symptoms and other data elements across time and across the care continuum. Because the flowsheet is made up of discrete data elements, data can be pulled easily out of the record for quality measurement and reporting. Finally, consider which of these data elements might inform the care plan. Ask your EMR vendor and your IT build team about the ability to build the flowsheet, align it across modules (if applicable), provide a trending or synopsis function to view data over time and care settings, and how it may link to or pull certain discrete elements into the care plan.

Tip: The interdisciplinary team can help build the flowsheet. Start by researching evidence-based tools to identify which tools you want included in the flowsheet. One organization used an excel spreadsheet to list various tools. They divided the tools up to compile research, then came back together to determine which tools they would incorporate into the flowsheet based on several criteria (e.g. research to support validity, valid care settings, valid services/specialties, etc.). Here are some examples of tools you may want to consider:

- ESAS-r
- PPS
- Karnofsky Scale
- ECOG
- MME
- PHQ2 and PHQ9
- FAST
- Braden Scale
- Katz

Resource: Appendix C Copy of Assessment Tools Evaluation

When the tools have been identified, the flowsheet can be built. Ideally there is collaboration between the clinical team and the IT builder or developer. Once the flowsheet is built, testing can begin. Do not get discouraged if further refinement needs to occur. After all, that is the purpose of the testing phase. Testing needs to include all expectations for the flowsheet – alignment of rows across care settings, ability to pull data into physician and NPP progress note, synopsis or trending function, linkage to care plan, and ability extract data elements for reporting. When testing and refinement are completed and before implementation, the tool needs to be embedded in the workflow of various members of the team and a standard operating process or procedure needs to be written. The SOP will be part of the training and retraining phase for successful implementation of the flowsheet.

Resource: Appendix D Palliative Care Flowsheet

Example: UnityPoint Health developed a shared palliative care flowsheet in Epic. Members from the interdisciplinary team met with an informatics/build specialist and identified evidence-based tools to be incorporated into the flowsheet (see screenshot below). All members of the palliative care team should have access to the flowsheet. Physicians and NPPs had the ability to pull data from the flowsheet into their progress note. This created an efficiency and improved team communication. The team developed standard operating procedures and workflows. They agreed on frequency

of completing the flowsheet and which team members were responsible. The team used the synopsis function to trend clinical information which was reviewed at the IDT meeting. The synopsis helped determine when a patient could be discharged from the palliative care service or when they should be moved to hospice (see second screen shot below). Metric definitions identified what data would be pulled when and why and how it would be reported. The team shared their flowsheet build with other Epic users and presented at the annual Epic conference.

Synopsis

Display	Days	All	7/9/2015	8/27/2015	Most Recent Value
Encounter Type					
Encounter Type					Inpatient: Hospital 6/16/2015
Palliative Care Consult Type					
Palliative Care Consult Type					
Gestational Age					
Gestational Age					
Primary Palliative Diagnosis					
Primary Palliative Diagnosis					
Patient Goals					
Patient Goal(s)					test 1/12/2016
Advance Directives					
*Healthcare Directive				Yes AD	Yes AD 8/27/2015
(Calculated MU Data Element)				Met	Met 8/27/2015
Type of Healthcare Directive				Durable power of att...	Durable power of att... 8/27/2015
Information Provided on Healthcare Directives					
Healthcare Agent Appointed					
Power of Attorney for Healthcare Activated (WI Only)					
Healthcare Agent's Name					
Healthcare Agent's Phone Number					
Copy in Chart					
Patient has IPOST/POLST					
Date IPOST/POLST Initiated					
Pre-existing DNR/DNI Order					
Patient Requests Assistance					
Edmonton Symptom Assessment Symptom					
ESAS completed by					Patient 1/12/2016
Pain Score				3	3 8/27/2015
Tiredness Score					4 6/16/2015
Nausea Score					2 6/16/2015
Depression Score					4 6/16/2015
Anxiety Score					7 6/16/2015
Drowsiness Score					4 6/16/2015

The Care Plan

A care plan is broad, overarching, longitudinal blueprint that includes the patients' and the healthcare teams' concerns, goals, interventions, and outcomes. A plan of care is discipline specific with a focus on a set of related problems of health concerns. Several plans of care can be incorporated in a care plan. A treatment plan focuses on a specific health concern and is usually managed by one clinician.¹ We will focus on the care plan since it is the broadest plan and supports the care coordination value of a palliative care team. However, your palliative care service may only use the plan of care or treatment plan depending on the make up of your team and care model.

The care plan should include medical goals and treatment plan, as well as social determinants of health. You may be able to use the same care plan document for your palliative patients that you use for your hospice patients. Much of the care plan elements would be the same. Some things you may want to consider are whether there are elements of documentation elsewhere within the record that should link to the care plan or auto-populate the care plan. These functions allow the care plan to stay current and relevant. Does the patient have access to the care plan? Can they update portions of the care plan? Some EMR software allows access to the care plan through a patient portal. The organization can determine what elements of the care plan the patient can view and update. Another helpful function is automatic notification of members of the healthcare team when the care plan has been updated. Check with your vendor to see if these options are available.

Consider what information you want to be able to share with other members of the health care team (e.g. specialists, primary care physician, etc.). You can create a document for sharing through the state Health Information Exchange. Can the form be auto-populated? What other pieces of information need to be shared (e.g. medication lists)? What information do you need from others? How will you obtain this information? A key role and value of the palliative care team is care coordination and care management.

Here is an example of content in a Person-Centered Care Plan:²

Risk level: (High, Moderate, or Low) Risk is associated with severity of illness and other contributing factors. Work with your health care partners to define risk levels and identifiable factors

Last updated: (this function can be automatic whenever content related to Care Plan is updated elsewhere in the record, or when the Care Plan content is updated directly)

Medical History: (link)

Medications: (link)

Patient Care Team: (link) Some EMRs allow members of the care team to set notifications when Care Plans are updated

Personal Support Team: (Include community contacts, caseworkers, therapists, etc. here, primary caregiver/contact information)

Patient's Personal Goal(s):

Patient's Care Goal(s): (prevention and chronic)

Patient's Self-Management Tools: (include referrals, groups, DME, and education resources here)

Patient's Barriers to Care/Goals: (include any contributing risk factors here, e.g. social determinants of health, behavioral health, functional or cognitive barriers, etc.)

Advance Care Planning: (include link to advance directives, POST, etc.)

1. Patricia C Dykes, Lipika Samal, Moreen Donahue, Jeffrey O Greenberg, Ann C Hurley, Omar Hasan, Terrance A O'Malley, Arjun K Venkatesh, Lynn A Volk, David W Bates, A patient-centered longitudinal care plan: vision versus reality, *Journal of the American Medical Informatics Association*, Volume 21, Issue 6, November 2014, Pages 1082-1090, <https://doi.org/10.1136/amiainl-2013-002454>

2. Patient Centered Primary Care Institute. Examples of shared care plans. Retrieved from: http://www.pccpi.org/sites/default/files/resources/Shared%20Care%20Plans_0.pdf

Team Goals: (prevention and chronic)

For more information on developing a shared care plan go to <https://integrationacademy.ahrq.gov/products/playbook/develop-shared-care-plan> and https://www22.anthem.com/providertoolkit/SS3_UpdatedCarePlanPlaybook_EMPIRE.pdf and article by Dykes, et al. at <https://academic.oup.com/jamia/article/21/6/1082/786980>

Advance Care Planning, Advance Directives, and POST

Great work is done by the palliative care team to engage seriously ill individuals and their loved ones in goals of care and advance care planning conversations. However, patients, their families and even healthcare staff continue to misunderstand the purpose of advance care planning and other elements that support it.

Advance care planning is a process that should be initiated at the time of the initial encounter with the patient. Advance care planning is a communication process that allows the clinician and the patient, along with their family to discuss 'how they want their healthcare to go' based on their understanding of their disease process and their care goals. Advance care planning incorporates other activities, such as, goals of care discussions, advance directives and shared decision-making elements. It is an iterative process that must be established and reviewed at regular intervals. When this does not happen goals of care can become mis-matched with previously documented care goals as seen primarily with advance directive documents.

None of this great work matters if it is not documented and accessible to all the patient's health care partners. Be thoughtful about how your EMR provides opportunity to document these conversations and store Advance Directives and Physician Orders for Scope of Treatment (POST) documents. Many programs identify these conversations and directives as quality measures, so you'll need to have a way to extract them easily from the EMR. More importantly, the patient's wishes and the legal documents need to be readily accessible in the case of an emergent situation. Does your state participate in a cloud-based platform to store AD and POST documents? Do you have a policy and process for documenting ACP, AD, and POST? Do the patient's health partners have timely access to this information? Can your EMR prompt an auto-reminder to share updated information with the patient's healthcare partners?

Conclusion

There are multiple functions of documentation: communication, record of care (goals of care, care plan: assessment, interventions, response to treatment, etc.), reimbursement, quality assurance and process improvement. Effective documentation can improve the quality of care and patient safety. Effective documentation is comprehensive, accurate, timely, and accessible.

Appendix A: Samples of Electronic Documentation

The following are template examples of a variety of palliative care notes. Several of these examples are for inpatient but can easily be adapted for the clinic and home setting. Note the different short cuts and widgets are specific to the EMR software being used; however, these do provide examples of how functionality within the software can be used to optimize the software's capabilities and enhance the documentation tool.

Palliative Care Inpatient Note Examples – Medical provider

Palliative Care Initial Consult Note

Requesting Provider: ***

Unit Location at Time of Initial Consultation: {Select hospital:15267}

Primary diagnosis most pertinent to consult: {Select diagnosis:15268}

Reason for Consult: {Select reason(s):15264}

History Of Present Illness

Information for this consult was obtained from: {Select source(s):15269}

@HPI@

Pain Regimen: {Regimen?:15289}

Review: I have reviewed the {Reviewed:14835} in the electronic medical record and have made updates as needed.

Pertinent Review Of Systems

Pain: {Select Scale:15288}

Nausea / Vomiting: {N/V?:15270}

Dyspnea: {Dyspnea?:15271}

Additional @ROSBYAGE@

Social History / Spiritual

@HHSOCDOC@

Spiritual: { :11685}

Functional Status

@FUNCSTAT@

Physical Exam

Vitals: Temp Trend: @TMAX(24)@

Recent Vitals: @FLOW(6)@ | @FLOW(5)@ | @FLOW(8)@ | @FLOW(9)@ | @FLOW(10)@ | @FLOW(250026)@ | @FLOW(301030)@ | @FLOW(14)@

@PHYEXAMPAL@

Diagnostic Data: {Results Reviewed:13567}

Assessment / Prognosis

Recommendations

Goals of Care: ***

Symptom Management: ***

Psychosocial: ***

Intervention(s) made by team: {Select all that apply:15273}

Spent {Care Coord. Time:13938} out of {Total Time:13941} minutes in care coordination with the medical team and in education of {Patient family members:11427} on prognosis, disease process and symptom management.

{Select for prolonged service - otherwise DELETE:15272}

Palliative Care Follow-Up Note

Subjective

Subjective: ***

Current Medications Reviewed? {YES / NO:13732}

Pain: {Select Scale:15288}

Nausea / Vomiting: {N/V?:15270}

Dyspnea: {Dyspnea?:15271}

Other Symptoms: ***

Additional @ROSBYAGE@

Social History

@HHSOCDOC@

Physical Exam

Vitals:

Temp Trend: @TMAX(24)@

Recent Vitals: @FLOW(6)@ | @FLOW(5)@ | @FLOW(8)@ | @FLOW(9)@ | @FLOW(10)@ | @FLOW(250026)@ | @FLOW(301030)@ | @FLOW(14)@

@PHYEXAMPAL@

@FUNCSTAT@

Diagnostic Data: {Results Reviewed:13567}

Assessment / Prognosis

Recommendations

Goals of Care: ***

Symptom Management: ***

Psychosocial: ***

Intervention(s) made by team: {Select all that apply:15273}

Spent {Care Coord. Time:13938} out of {Total Time:13941} minutes in care coordination with the medical team and in education of {Patient family members:11427} on prognosis, disease process and symptom management.

{Select for prolonged service - otherwise DELETE:15272}

Palliative Medicine Consult

@NAME@

@MRN@

Attending Provider: @ATTPROV@

PCP: @PCP@

Palliative Medicine consult requested by @ATTPROV@ for @NAME@ who is a @AGE@ to:

Clarify patient/family goals of care

Provide symptom management recommendations

Clarify patient's long-term goals

Discuss patient's disease trajectory and overall prognosis

Discuss medical treatment options as it relates to patient/family goals of care

Impression

@RRPROBLIST@

Recommendations

Thank you for this consult and I agree with current interventions.

*** I suggest the following for as part of a Symptom Management Plan for @NAME@ and it includes:

*** Please complete and sign the colored Illinois DNAR form if patient is being discharged as the patient is currently @CODESTATUS@

Subjective

HPI:

@NAME@ is @AGE@ and was admitted @ADMITDT@ with diagnoses of @ADMITDX@.

Review of Systems {ROS; COMPLETE:372162}

Palliative Care specific ROS:

Pain Assessment: (0=none, 1=mild, 2=moderate, 3=severe) ***

Location	
Intensity (0-10)	
Duration	
Description	
Radiates to	
Alleviated by	
Aggravated	
Current analgesic	
Is it working	
On softener/laxative	

Pain Management Interventions: see above

Symptom Assessment: (0=none, 1=mild, 2=moderate, 3=severe)

Dyspnea	***
Constipation	
Nausea	
Vomiting	
Depression	
Anorexia	
Cough	
Insomnia	
Diarrhea	
fatigue	
weakness	
confusion	

Treatment Side effects: ***

Symptom interventions: see above

History

@PMH@

@PSH@

@ALLERGY@

@MEDICATIONHOSP@

@MEDSPTA@

@SOC@

@FAMHX@

Objective:

Vital Signs: @VS@

Physical Exam

General:

Ill appearing patient lying in bed

appropriate affect,

no apparent distress

Awake

Somnolent

Speech fluent

NEURO:

Mental status: Alert, oriented, thought content appropriate. No focal neurological deficits

HEENT:

Eyes: conjunctivae/corneas clear.

Ears: external ear w/o deformities b/l

Nose: Nares normal. No drainage, no discharge

Throat: Lips, Teeth and gums normal;

Neck: supple, symmetrical, trachea midline

Chest:

Expansion equal

Breath sounds vesicular b/l, no adventitious sounds auscultated

CV:

No JVD noted, No S3/S4 gallop, No rubs, Diastole clear

No Peripheral edema

Abdomen:

Soft, non tender, non-distended, Bowel sounds present

Extremities:

All extremities normal, atraumatic no cyanosis or edema, warm to touch

Skin:

turgor normal, no rashes or lesions, no jaundice or ulcerations

Lab And Diagnostic Testing

Labs for 72 hrs

{FIND; LABS72:372210}

Palliative Care Assessment

Medical record reviewed and I spoke with patient's nurse and ***

1. Process Of Care:**Goals of care clarified and include:**

Reduce unnecessary hospitalizations

Maintain and/or increase quality of life

Have symptoms well managed

Discussed treatment options risk and benefits: ***

Provided a copy of "Hard Choices for Loving People" to assist with decision making

Discussed discharge needs and realistic plan of care to meet these needs

*** Referred to Hospice - meets eligibility criteria for:

2. Physical:

Physical exam performed on this patient (see finding).

Symptom management plan established (see recommendations)

Appears comfortable without short of breath or in pain at this time

*** Appears to be in distress due to the following symptoms: ***

3. Psychological:

Social and financial issues discussed.

No Issues identified.

*** Identified:

Anticipatory grief

Increased stress

Decreased coping methods

*** Low, Moderate, High Bereavement risk

*** Negative/Positive Depression screening: "In the past two weeks, how often have you felt down, depressed, or

hopeless?"

Social worker consult ordered for ***

4. Spiritual:

*** No Issues identified.

Chaplain consult ordered for ***

5. Social:

Social and financial issues discussed.

*** No Issues identified.

*** Identified: work/home, financial, intimacy, and caregiver concerns

Lives at/with:

Family:

Social worker consult ordered for ***

Caregiver Distress: Caregiver needs discussed, including the need for respite, issues of guilt, and the intensity of family caregiving.

How to support caregiver and community resources discussed.

6. Cultural:

No Issues identified.

*** Identified:

Language barrier

Concerns about disclosure, truth telling, decision making

An interpreter is needed.

7. Care Of The Dying Patient:

*** Patient not imminently dying at this time although sudden death would not be unexpected in someone with his/her health problems and age

*** Educated family of disease trajectory and signs/symptoms of approaching death

*** Discussed need for family to make funeral home arrangements

*** Funeral arrangements made by family; Funeral home of choice is:

*** Patient is displaying sign of approaching, imminent death.

*** Assessment includes: Apnea, irregular/labored respirations, cyanosis, mottling, unresponsiveness, no intake, decreased output, diminished pulses, agitation/terminal restlessness, and respiration secretions.

*** Emotional supported provided to family.

8. Ethical And Legal:

No Issues identified.

*** Patient has completed Advance Directives and it is on file

*** At time of exam @NAME@ is deemed decisional by this practitioner.

*** is patient's HCPOA Please include HCPOA and patient in any medical decision.

Facilitated discussion about patient's code status and provided literature about "what you should know about CPR"

The patient is @CODESTATUS@ and is so documented in EPIC chart.

Prognosis

Educated patient/family about patient's overall prognosis and disease trajectory (see prognosis)

Patient charted reviewed and based on physical assessment and patient/family interview, the following prognostication tool(s) were completed.

Karnofsky performance status scale

Value Level of Functional Capacity

100	Normal, no complaints, no evidence of disease
90	Able to carry on normal activity, minor signs or symptoms of disease
80	Normal activity with effort, some signs or symptoms of disease
70	Cares for self, unable to carry on normal activity or to do active work
60	Requires occasional assistance, but is able to care for most needs
50	Requires considerable assistance and frequent medical care
40	Disabled, requires special care and assistance
30	Severely disabled, hospitalization is indicated although death is not imminent
20	Hospitalization is necessary, very sick, active supportive treatment necessary
10	Moribund, fatal processes progressing rapidly

Cancer Patients

Palliative Prognostic Index Score

Performance Score

10-20	4.0
30-50	2.5
>60	0

Oral Intake

Severely reduced	2.5
Moderately reduced	1.0
Normal	0

Edema 1.0

Dyspnea at rest 3.5

Delirium 4.0

TOTAL

Median Survival

90 days	< 2.0
61 days	2.1-4.0
12 days	>4.0

Recent Hospitalization in last 6 months

*** YES NO

Previous Palliative Medicine Service Consult:

*** YES NO

Summary

The following was achieved as a result of this Palliative Care encounter:

*** Patient/family verbalizes improved understanding of chronic illness and its trajectory.

Patient/family goals of care have been identified.

Distressing symptoms identified and recommendations made.

Treatment options and plan of care have been discussed and revised.

Advance directives completed

Code status was changed

Referral made to hospice

I have discussed recommendation with Palliative Care attending physician *** and he concurs. Further, I have discussed my findings with patient's nurse, referring provider, social work and case management staff caring for this patient.

*** minutes were spent in total for this visit which consisted primarily of counseling and education dealing with the complex and emotionally intense issues of symptom management and palliative care in the setting of serious and potentially life-threatening illness. Patient/family had opportunity to ask questions.

Palliative Care IP Daily Progress Note

Date of Service:***

Primary Team and Attending: ***

Following for: Goals of care; pain; symptom management, family support, coping,***

History of Present Illness:

*** is a *** Y female with *** who is known to the palliative care team. ***

Review of Systems:

{ROS - COMPLETE:12658} Put palliative review of systems

Physical Exam:

Vitals: I personally reviewed the patient's vitals, relevant findings include:***

{PE PALLIATIVE CARE CC:50093112}

Karnofsky Performance Score

{KARNOFSKY SCALE:5010858}

Data Review / Labs:

Imaging/Labs: I personally reviewed the patient's labs/imaging and relevant results include: ***

Impression: ***

Recommendations:

1) ***

Counseling:

I spent a total of *** minutes unit floor time, of which *** minutes were spent in counseling and coordination of care.

{COUNSELING - PALLIATIVE CARE CC:50923112}

NICU Family Conference Note

Date and time of meeting: ***

Primary Team: ***

Attending MD: ***

Purpose: {IP PURPOSE:50150001}: (goal setting, clinical information sharing, resuscitation preferences, transition to comfort plan, disposition)

Location: patient's bedside, conference room, ***

Patient Participation: (would be in drop down)the patient participated in the discussion, the patient did not participate in the meeting due to ***

HPOA (activated/not-activated)

Family participation:

Family spokesperson and relationship:

Healthcare POA or guardian (if applicable):

Additional family/friends present for the discussion:

Clinical team participation:

Meeting was lead by:

Care team members present for the discussion: (drop down, critical care nurse, case management/social work, resident, fellow, attending, palliative care, primary physician, consulting medical team)

Meeting Summary:***

Patient/Family Goals of Care: (cure, life prolongation, rehabilitation, comfort, ***)

Prognosis:

Resuscitation Status: (full code, DNR, DNR/DNI, treatment limitations)

Next meeting if necessary: Date: *** Time:***

Faculty Attestation:

I participated in family conference along with *** (resident, nurse, fellow) as summarized above and spent *** minutes of face to face time in the unit of which greater than 50% of which was spent counseling, coordinating care and participating in conference.

Palliative Care IP Consult Note

Date of Service: @TD@

Date of Admission: @ADMITDT@

Attending Physician: @ATTPROV@

Primary Care Physician: @PCP@

Reason for Consult: To address pain management in the setting of ***.

Impression/Recommendations:

This is a @AGE@ old * with:**

1. Diagnosis: ***
 - a. Estimated length of life: hours to days, days to weeks, weeks to months, less than 1 year, depends on goals, unknown, no life limiting condition,(Dropdown) ***
 - b. Patient defined goals of care: cure, life prolongation, rehabilitation, comfort, deferred, deferred at primary teams request (Dropdown).
2. Nociceptive/Neuropathic Pain Syndrome secondary to ***:
 - a. Recommend Starting ***
 - b. Recommend Starting ***
3. Symptom (Dropdown):
 - a. Recommend Starting ***
 - b. Recommend Starting ***
 - c.
4. Advanced Care Planning:
 - a. Decision Making Capacity: {DECISION MAKING:50333112}
 - b. POAHC: done, on file; done, not on file; not done; unknown status; deferred; deferred at primary teams request;***
 - c. Limitations on life-sustaining treatments: None—Full Code; No escalation of care; No ICU transfer; No feeding tube, No antibiotics; DNR/DNI; *** (Dropdown)
Community DNR Form/Bracelet: Present; Recommend completion (Dropdown)
 - d. Date of last Family Meeting: None since admission; ***
 - e. Attitude towards place of death: home, hospital, nursing home, Residential hospice, or other *** (Dropdown)
 - f. Funeral arrangements/wishes: ***
5. Coping Style: ***
6. Stressors:
 - a. ***
 - b. ***

7.

History of Present Illness:

@M@ @LNAME@ is a @AGE@ old former *** with a PMH significant for *** and who was admitted to Froedtert Hospital on @ADMITDT@ with ***. The Palliative Medicine Team has been asked by Dr. @ATTPROV@ to see the patient to address ***.

Description of Symptom: ***

Oncological history: if relevant.

Patient's Understanding of the disease: ***

Family's Understanding of the disease: ***

Information Sharing Preferences: may share with

Patient preference for receiving information and decision making: Fully involved, Speak to family, Leave to MD, Unsure.***

Social History:

Spiritual History:

Religious Affiliation: {RELIGION/SPIRITUAL: 17029}

{SPIRITUAL HISTORY - PALLIATIVE CARE CC: 51373112}

Patient Support system: ***

Family Support system: ***

Family coping: ***

Education: ***

Work: ***

Hobbies/Joys: ***

Habits:

Tobacco: {YES NO UNSURE:50343112}

Alcohol: { YES NO UNSURE:50343112}

Recreational drugs: { YES NO UNSURE:50343112}

Patient {ADMITS TO/DENIES:50252007} any previous chemical dependency treatment.

Palliative Review of Symptoms:

(Dropdown – 1. I have completed a 14 point ROS and is negative except for the following; 2. Text below)

Pain Issues: ***

Constitutional:

Fevers/Chills: {YES NO UNSURE:50343112}

Weight Loss: {YES NO UNSURE:50343112}

Nutritional Status, including anorexia: {SEVERITY - EC:5653099}

Confusion: {SEVERITY - EC:5653099}

Eyes:

Vision changes: {YES NO UNSURE:50343112}

HEENT:

Headaches: {SEVERITY - EC:5653099}

Oral symptoms (oral pain, xerostomia, dysphagia, odynophagia): {YES NO UNSURE:50343112}

Respiratory

Dyspnea: {SEVERITY - EC:5653099}

Cough: {SEVERITY - EC:5653099}

Cardiovascular

Chest Pain:{YES NO UNSURE:50343112}

Gastrointestinal:

Abdominal Pain: {YES NO UNSURE:50343112}
 Dyspepsia: {YES NO UNSURE:50343112}
 Nausea/vomiting: {SEVERITY - EC:5653099}
 Constipation: {YES NO UNSURE:50343112}
 Diarrhea: {YES NO UNSURE:50343112}

Genitourinary:

Urinary Symptoms: {YES NO UNSURE:50343112}

Endocrine:

Fatigue: {SEVERITY - EC:5653099}

Neuro:

Sleep disturbance: {YES NO UNSURE:50343112}
 Sedation: {SEVERITY - EC:5653099}
 Myoclonus: {YES NO UNSURE:50343112}
 Numbness/Weakness/Tingling: {SEVERITY - EC:5653099}

Musculoskeletal:

Muscle Weakness: {YES NO UNSURE:50343112}
 Myalgias: {YES NO UNSURE:50343112}
 Arthralgias: {YES NO UNSURE:50343112}

Psych:

Anxiety: {SEVERITY - EC:5653099}
 Depression: {SEVERITY - EC:5653099}
 Restlessness: {YES NO UNSURE:50343112}

Heme: Bleeding issues (epistaxis, hematuria): {YES NO UNSURE:50343112}

Skin: Rashes/pruritis: {YES NO UNSURE:50343112}

Other: ***

Past Medical:

I have personally reviewed the PMH as documented in the H&P; it is pertinent for ***.
 @PMH@

Family History:

I have personally reviewed the family history as documented in the H&P; it is pertinent for ***.
 @FAMHX@

Family history of alcohol/substance misuse: {Yes(relative 50033105)/No:50023105::"No"}

Allergies:

@ALLERGY@

Medications:

I have personally reviewed the medication list documented in the MAR and it is pertinent for:

@IPMEDLIST@

Physical Exam:

I have personally reviewed the vital signs for the last 24 hours and they are significant for:

@IPVITALSLAST@

@LAST3WT@

{PE PALLIATIVE CARE CC:50093112}

Delirium: {YES NO UNSURE:50343112}

Depression: {YES NO UNSURE:50343112}

Capacity for Decision-making: {YES NO UNSURE:50343112}

Karnofsky Performance Score

{KARNOFSKY SCALE:5010858}

ECOG Score:

{ECOG:50203112}

Data Review:

Laboratory: I personally reviewed the patient's labs and relevant results include:

@LAST1CR@

@LAST1LIVERFUNCTIONTESTS@

@LAST1CBC@

Imaging: I personally reviewed the patient's relevant imaging and results include:

Impression/Recommendations: Please refer to the assessment and recommendations documented at the top of the note.

The patient history and recommendations were discussed with ***.

@THANKYOUFORCONSULT@

@METIMESTAMP@

Counseling: (dropdown for inpatient/outpatient)

I spent a total of *** minutes unit floor (vs face to face) time today, of which >50% of minutes were spent in counseling and coordination of care. *** minutes were spent F2F.

{COUNSELING - PALLIATIVE CARE CC:50923112}

.**these are outpatient based **

I counseled the patient today about opioid use, side effects and toxicities. The patient was instructed to call our clinic immediately if having uncontrolled pain, constipation, sedation, frequent PRN use, or any other concern with their pain management.

I counseled the patient today about hospice care and its philosophy focusing on comfort, safety and family support. The general levels of service hospice can provide including the home, inpatient and respite settings were included in this discussion.

The patient was given instructions on how to contact our team during both regular hours and after hours; and was instructed to call at any time with new symptoms, questions or other issues

Palliative Care Assessment

Referring Physician:	***
Primary Physician:	@PCP@
Primary Diagnosis:	(Change to principal prob)
Secondary Diagnosis:	***

Reason for Consult: {Reason:20219}

Source Of Information: {INFORMATION SOURCE PALLIATIVE CARE:21032} ***

Patient Profile And Understanding Of Medical Condition:

Met with patient and family in conjunction with Palliative Care Provider, ***. Please refer to ***'s consultation note.

Living Situation/Support Services: ***

Home medical equipment: ***

Services in home: ***

Functional Assessment: {NUMBERS 0-100% (BY TEN %):21028}

Based on Palliative Performance Scale

(INSERT PPS SMARTLINK)

Advance Directives:

(INSERT SMARTLINK FOR SEC_MODEL_IP_DIRECTIVES)

Code status reviewed: {yes no:314532} Advance directive education provided: {Yes/No-Ex:120004}

Communication And Family Dynamics: ***

Cognition: {COGNITION PALLIATIVE CARE:21030}

Emotional Status / Psychological Symptoms: {PAL UPH EMOTIONAL STATUS/PSYCH SX PALLIATIVE CARE:30410001}

(INSERT PHQ2/4 AND PHQ9 SMARTLINK)

Anticipatory Grief: {yes no:314532}

Symptoms (INSERT SMARTLINK FOR ESAS - EACH ROW)

Spiritual-Cultural:

(INSERT SMARTLINK FROM DEMOG. FOR COMMUNITY OF FAITH)

(INSERT SMARTLINK FOR SPIRITUAL-CULTURAL SCREENING FS)

Patient and/or Family's Goals Of Care: ***

PLAN OF CARE based on patient's goals, values and preferences: ***

RECOMMENDATIONS for care, treatment and services: ***

Referral communicated to Patient Care Coordinator for: (INSERT SMARTLINK FOR REFERRALS MADE FLOWSHEET ROW)

Information regarding consult and plan of care communicated to: {PALLIATIVE CARE REFERRAL INFO COMMUNICATED TO:21034}- WITHIN LIST - CHANGE PHYSICIAN TO PROVIDER, ADD FAMILY ***

Palliative Care Team will follow during current hospitalization. ***

@ME@

@TD@ @NOW@

Palliative Care Consult

Name: @NAME@

Date of Birth: @DOB@

@ADMITDT@

@RRHLOS@

@ATTPROV@

MRN: @MRN@

CSN: @CSN@

Referring Physician:	***
Primary Physician:	@PCP@
Primary Diagnosis:	(Change to principal prob)

Reason for Consult: {Reason:20219}

Source of Information: {INFORMATION SOURCE PALLIATIVE CARE:21032} ***

History of Present Illness:

@NAME@ is a @AGE@ @SEX@ admitted ***

@PROBL@

@PMH@

@HXPSH@

Meds:

@CMED@

Social History: ***

Advance Directives:

(INSERT SMARTLINK FOR SEC_MODEL_IP_DIRECTIVES)

Code status reviewed: {yes no:314532}

Advance directive education provided: {Yes/No-Ex:120004}

ROS:

Review of Systems - {ros master:310782}

Symptoms: (INSERT SMARTLINK FOR ESAS - EACH ROW)

Exam:

@VSRANGES@

@LASTENCWT@

Emotional Status / Psychological Symptoms: {PAL UPH EMOTIONAL STATUS/PSYCH SX PALLIATIVE CARE:30410001
(INSERT PHQ2/4 AND PHQ9 SMARTLINK)}

Labs/Diagnostics:

General:

{IP IHS GENERAL LABS:20242}

Heme:

{Hemelabs:304101015}

Pertinent Testing:

Functional Assessment: {NUMBERS 0-100% (BY TEN %):21028}

Based on Palliative Performance Scale

(INSERT PPS SMARTLINK)

Cognition: {COGNITION PALLIATIVE CARE:21030}

Assessment/Plan:

@HPROBL@

Plan: ***

Patient Profile and Understanding of Medical Condition:

Met with patient and family in conjunction with ***. Please refer to ***'s assessment note.

Thank you for the consult and opportunity to participate in the care of your patient.

@ME@

@TD@ @NOW@

Time: *** minutes in evaluation of patient with greater than 50% spent in counseling/discussing goals of care and care coordination.

Palliative Care Note

Encounter: {PALLIATIVE CARE ENCOUNTER:21021}

Purpose of this encounter: {PALLIATIVE CARE ENCOUNTER PURPOSE:21022}

Symptoms (rated on a scale of 0-10): {SYMPTOMS PALLIATIVE CARE:21023}

Emotional Needs: {EMOTIONAL NEEDS PALLIATIVE CARE:21024}

Referral made to: {PALLIATIVE CARE REFERRALS MADE TO:21025}

Spiritual Support: {SPIRITUAL SUPPORT PALLIATIVE CARE:21026}

Discharge Plan: {DISCHARGE PLAN PALLIATIVE CARE:21027}

Note: ***

Information regarding plan of care and recommendations communicated to: {PALLIATIVE CARE REFERRAL INFO COMMUNICATED TO:21034}

Palliative Sign Out Note

Code Status : @RRCODESTATUS@

Diagnosis: ***

Patient/Family Goal: ***

Symptom Management:***

Spiritual Care: ***

Disposition:***

Plan:***

Examples of PC Social Work Notes:

Palliative Care Initial Social Work Consult Note

Requesting Provider: @DBLINK(EPT,5610)@

Unit Location at Time of Initial Consultation: {Select hospital:15267}

Primary diagnosis most pertinent to consult: {Select diagnosis:15268}

Reason for Consult: {Select reason(s):15264}

Persons interviewed and their relationship to patient: {Select source(s):15269}

History of Present Illness

Information for this consult was obtained from: {Select source(s):15269}

Reason for hospital admission: ***

Course of hospital stay: ***

Pertinent Review Of Symptoms

Pain: {Select Scale:15288}

Nausea / Vomiting: {N/V?:15270}

Dyspnea: {Dyspnea?:15271}

Other Symptoms {Other symptoms:13940}

Social History / Spiritual

@HHSOCDOC@

Patient lives: {Living arrangements:60532}

Spiritual Considerations: { :11685}

@FUNCSTAT@

Palliative Performance Scale

{PPS:11426}

Prior PPS: {Prior PPS%:114261}

Assessment

Patient Mental Status: {MENTAL STATUS:30415512}

Patient Emotional Status: {EMOTIONAL STATUS:30415514}

Family Emotional Status: {EMOTIONAL STATUS:30415514}

Strengths related Coping: {COPING:30415513}

Confounding Factors: {Palliative Confounding Factors:109113}

Support System: {EXCELLENT/GOOD/FAIR/POOR:14807}

Needs: {NEEDS:30415515}

Patient person strength: {PATPERSTR:13638}

Sources of Support: {SourceofSupport:13644}

Reaction to Health Status: {HealthStatReaction:13646}

Understanding of Condition: {UnderstandCondition:13647}

Assessment / Problems Identified: ***

Recommendations

Advance Directives: {Palliative ADV DIR:10915104}

Intervention(s) Made by Team: {Select all that apply:15273}

Patient/Family Goals of Care: ***

Recommendations: ***

Anticipated disposition: {Living arrangements:60532}

Palliative Care Social Work Progress Note

Date of Admission: @ADMITDT@

Purpose of Visit: {VISIT PURPOSE:30415511}

Subjective

Person(s) interviewed and their relationship to patient: {Select source(s):15269}

Palliative Performance Scale

{PPS:11426}

Pertinent Review Of Symptoms

Pain: {Select Scale:15288}

Nausea / Vomiting: {N/V?:15270}

Dyspnea: {Dyspnea?:15271}

Other Symptoms {Other symptoms:13940}

Social History / Spiritual

@HHSOCDOC@

Assessment

Patient Mental Status: {MENTAL STATUS:30415512}

Patient Emotional Status: {EMOTIONAL STATUS:30415514}

Family Emotional Status: {EMOTIONAL STATUS:30415514}

Strengths related Coping: {COPING:30415513}

Narrative:

Recommendations

Advance Directives: {Palliative ADV DIR:10915104}

Intervention(s) Made by Team: {Select all that apply:15273}

Patient/Family Goals of Care: ***

Recommendations: ***

Anticipated disposition: {Living arrangements:60532}

Palliative Care Program Psychosocial Assessment Worksheet

Patient Name: @PNAME@

Room Number: @ROOMBED@

Patient Age: @AGE@

Sex: @SEX@

Marital Status:

of Children:

Patient/Family Learning ability: {LEARNING BARRIERS:30411113}

Comments:

Patient/Family reported chief concern:

Patients Hopes/Goals:

Caregiving Assessment:

Patient lives: {Living arrangements:60532}

Primary caregiver/relationship/telephone:

Secondary caregiver/relationship/telephone:

Support System: {ADEQUATE INADEQUATE:30415506}

Financial issues/concerns:

Referral Made: {REFERRAL MADE:30415507}

Patient/Family Adaptive State:

Pt/Family aware of diagnosis/prognosis: {YES/NO/UNKNOWN:74}

Communication Pattern:{OPEN CLOSED:30415508}

Diagnosis/Prognosis: {PROGNOSIS:30415509}

Comments:

Legal Issues:

Living Will: {YES / NO:13732}

Carelink Indicates: {YES / NO:13732}

Living Will - Date: ***

Healthcare Surrogate: ***

Secondary Surrogate: ***

Life-prolonging treatment to be withheld: {YES / NO:13732}

Artificial nutrition/hydration to be withheld: {YES / NO:13732}

POA in Record: {YES / NO:13732}

Carelink Indicates: {YES / NO:13732}

Healthcare POA: {YES / NO:13732} Financial POA: {YES / NO:13732}

Date of POA: ***

POA Name:

Secondary POA:

Discharge Planning

Patient to return to: {RETURNING TO:30415510}

Additional Comments/Concerns:

@ME@ @TD@

Palliative Care Psychosocial Assessment

Purpose of Visit:{VISIT PURPOSE:30415511}

Diagnosis: @DIAG@

Mental Status: {MENTAL STATUS:30415512}

Ethnicity:

Marital Status:

Spiritual/Faith:

Patient Coping Status: {COPING:30415513}

Family Coping: {COPING:30415513}

Support System: {ADEQUATE/ INADEQUATE:12159}

Emotional Status: {EMOTIONAL STATUS:30415514}

Needs: {NEEDS:30415515}

Advance Directives: {advanced directive:12455}

Family Decision Maker:

Relationship:

Main Contact #

Code Status:

Living arrangements prior to hospitalization:

Anticipated disposition:

Veteran: {YES / NO:13732}

Branch:

Employment History:

History of abuse/habits:

Mental Health History:

Bereavement risk factors:

Other family/friends involved:

Interpreter needed: {YES / NO:13732}

Goals of Care:

@ME@

AdvancedCare Social Work Assessment Flow sheet

Informant Name:

Informant relationship to patient:

Patient's Primary Health Concern: (Open text)

Patient Perception of Illness: (Open Text)

Caregiver/family Perception of illness: (Open Text)

Language:

☐ English spoken/understood

☐ Interpreter needed _____

Military History

☐ none

Branch of Service _____ Combat ☐ Yes ☐ No

Dates of Service _____

Special Spiritual/cultural Needs related to treatment:

☐ No ☐ Yes _____

Ability to Express thoughts/needs/Feelings

☐ Expresses thoughts/feeling/needs without difficulty

☐ Requires extra time or cuing

☐ Speech limited to single words

☐ Uses only gestures (eyes blinking/eye or head movement/pointing)

☐ Unable to express thoughts/feeling/needs (speech unintelligible or inappropriate)

Living Arrangements:

☐ Patient's own home

☐ Home family member/friend

☐ Boarding home

☐ Assisted Living/retirement center

☐ Skilled nursing facility

☐ Long term care facility/nursing home

☐ shelter/homeless

☐ Other

Stability of current living situation:

☐ Permanent

☐ Stable

☐ Temporary

☐ At risk

Notes: _____

Members of Household:

☐ Patient Lives Alone

Name:	Relationship:	Age:	Actively Involved:	
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Family Members/significant others not part of the household:

Name:	Relationship:	Age:	Actively Involved:	
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No
_____	_____	_____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

Relationship of Primary Caregiver:

- ☐ No primary caregiver
- ☐ Spouse/Significant other
- ☐ Natural child
- ☐ Step child
- ☐ Sibling
- ☐ Parent
- ☐ Friend/neighbor
- ☐ Community church/volunteer
- ☐ Paid help
- ☐ Other

Notes _____

Caregiver limitations (potential or actual)

- ☐ None
- ☐ Vision
- ☐ Hearing
- ☐ Speech/language
- ☐ Mobility/endurance
- ☐ Alcohol/substance abuse
- ☐ Conflict with patient
- ☐ Concurrent treatment for own illness
- ☐ Limited coping skills
- ☐ Difficulty with own ADLs
- ☐ Availability
- ☐ knowledge/understanding of illness/diagnosis
- ☐ Other

Notes: _____

Support System

- ☐ Excellent - three or more willing family members/friends
- ☐ Good -two or less willing family members/friends
- ☐ Fair- one willing family member or friend
- ☐ Poor – no willing family members of friends

Knowledge of Disease Process:

- ☐ Excellent
- ☐ Good
- ☐ Fair
- ☐ Little

Education needs _____

Burden of Care

- ☐ None evident
- ☐ Physical caregiving responsibilities
- ☐ Emotional stress
- ☐ Financial strain
- ☐ Role conflict
- ☐ Change in family lifestyle
- ☐ Sleep disturbance
- ☐ Coping with Patient's behavior
- ☐ Other _____

Notes: _____

Abuse/Neglect(risk):

- ☐ history of abuse/neglect
- ☐ Lives alone or without concerned relatives
- ☐ Cognitive impairment
- ☐ Physical disability
- ☐ Intellectual disability
- ☐ Unsafe environment (ie guns/drug uses/history of violence in home)

Notes: _____

Abuse/Neglect (actual):

- ☐ No signs of abuse/neglect
- ☐ Physical
- ☐ Emotional
- ☐ Financial
- ☐ Sexual
- ☐ Inadequate or delayed medical care
- ☐ Other _____

Description _____

- ☐ Referral to protective services

Alertness

- ☐ Alert/oriented
- ☐ Lethargic
- ☐ Responds to verbal stimuli

- ☐ Responds to tactile stimuli
- ☐ Responds to Pain
- ☐ Unresponsive

Notes: _____

Sleep Pattern:

Hours per day ____ Time to onset of sleep ____

Perception of Sleep : ☐ Normal ☐ Too much ☐ too little

Ability to concentrate:

- ☐ No concern ☐ Difficulty concentrating

Energy Level:

- ☐ Low ☐ Average ☐ High

Memory:

- ☐ Intact ☐ Impaired

Notes: _____

Cognitive

- ☐ Negative for cognitive impairment
- ☐ Positive for cognitive impairment

Notes: _____

ADL's

I= Independent A=Assistance needed D=Dependent

Eating ____ Bathing ____ Dressing ____ Toileting ____ Transfers ____ Mobility ____

IADL's

Meal Prep ____ Money Mgmt ____ Medication Mgmt ____ Transportation ____

Telephone use ____ Housework ____ Shopping ____

Functional Impairments:

- ☐ Speech ☐ Hearing ☐ vision ☐ Ambulation ☐ SOB ☐ Endurance ☐ Amputation
- ☐ Other _____

Mood:

- ☐ Euthymic ☐ Depressed ☐ Anxious ☐ Angry ☐ Euphoric ☐ Irritable

Affect:

- ☐ Congruent with mood ☐ Full ☐ Constricted
- ☐ Flat ☐ Labile ☐ Blunted ☐ Unable to assess

Thought Process:

- ☐ Logical/goal oriented ☐ Abstract ☐ Concrete ☐ Vague
- ☐ Tangential ☐ Perseverating ☐ Flight of Ideas

Mental Health History:

☐ NA
 Psychiatrist _____
 Therapist _____
 Diagnosis _____
 Hospitalization _____
 Notes: _____

Substance Use/history

☐ None
☐ Alcohol Last used: _____ Frequency: _____
☐ Drugs Last used: _____ Frequency: _____
☐ Nicotine Last used: _____ Frequency: _____
☐ Other _____

Sources of Stress in addition to Illness

☐ Financial ☐ Employment change/job loss ☐ Career/job change ☐ Lifestyle change

<input type="checkbox"/> Child care	<input type="checkbox"/> Marriage within last year
<input type="checkbox"/> death of a child	<input type="checkbox"/> Separation/divorce
<input type="checkbox"/> death of a parent	<input type="checkbox"/> Legal Issues
<input type="checkbox"/> death of a spouse	<input type="checkbox"/> Transportation
<input type="checkbox"/> Housing	<input type="checkbox"/> Moved
<input type="checkbox"/> Family/marital discord	
<input type="checkbox"/> Other _____	

Notes: _____

Stress level reported:

☐ 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

Financial:

Source of Income: ☐ Employed ☐ Retirement ☐ SSD ☐ SSDI ☐ SSI ☐ medical disability/employer

Notes: _____

Financial Concerns expressed: _____

Leisure Activities:

What limits leisure activities: _____

Identified Strengths: _____

Unique Needs and Issues: _____

Community Resources:

	Using	Needs
Home Health	<input type="checkbox"/>	<input type="checkbox"/>
Meal Assistance	<input type="checkbox"/>	<input type="checkbox"/>
Homemaker	<input type="checkbox"/>	<input type="checkbox"/>
Medicaid	<input type="checkbox"/>	<input type="checkbox"/>
SSI/SSDI	<input type="checkbox"/>	<input type="checkbox"/>
LTC Placement	<input type="checkbox"/>	<input type="checkbox"/>
ALF Placement	<input type="checkbox"/>	<input type="checkbox"/>
VA Benefits	<input type="checkbox"/>	<input type="checkbox"/>
Hospice	<input type="checkbox"/>	<input type="checkbox"/>
Respite	<input type="checkbox"/>	<input type="checkbox"/>
Adult Day Care	<input type="checkbox"/>	<input type="checkbox"/>
Emergency response system	<input type="checkbox"/>	<input type="checkbox"/>
Support Group	<input type="checkbox"/>	<input type="checkbox"/>
HME	<input type="checkbox"/>	<input type="checkbox"/>

Advanced Directives:

☐ Living Will ☐ Durable POA ☐ IPOLST/IPOST

Screening Tools Used:

☐ GAD-7 ☐ SAD ☐ SLUMS ☐ Mini Cog ☐ PHQ-9 ☐ ESAS

Assessment/Summary

Patient/ Family Expectations:

Interventions:

- ☐ Provide Crisis Intervention
- ☐ Assist with community Resource planning/Referral
- ☐ Counseling regarding need for short term problem solving
- ☐ Counseling regarding need for long-range planning and decision making
- ☐ Psychiatric referral
- ☐ Psychotherapy referral
- ☐ Education _____
- ☐ Other _____

Appendix B: Z-Codes

- Z-codes capture status or problem impacting the patient other than a disease or external cause, including socio-economic issues. However, a Z-code should not be used if an assigned ICD-10 code includes the status (such as a "complication of ...")
 - Z00 – Z13 Health services for exams
 - Z14 – Z15 Genetic carrier and genetic susceptibility to disease
 - Z16 Resistance to antimicrobial drugs
 - Z17 Estrogen receptor status
 - Z18 Retained foreign body fragments
 - Z20 – Z28 Potential health hazards related to communicable diseases
 - Z30 – Z39 Health services in circumstances related to reproduction
 - Z40 – Z53 Encounters for other specific aftercare
 - Z55 – Z65 Potential health hazards related to socioeconomic and psychosocial circumstances
 - Z66 Do not resuscitate
 - Z67 Blood type
 - Z68 Body mass index
 - Z69 – Z76 Health services in other circumstances
 - Z77 – Z99 Potential health hazards related to family and personal history and certain conditions influencing health status
- ○ Z43 should be used when routine care, adjustment, or fitting is done to an artificial opening (e.g. tracheostomy, colostomy, fistula, etc.). This is not just about status of the opening, but about care. Documentation should indicate whether care was provided for the opening or if it is self-maintained.
 - Z43.0 - Encounter for attention to tracheostomy
 - Z43.1 - Encounter for attention to gastrostomy
 - Z43.2 - Encounter for attention to ileostomy
 - Z43.3 - for attention to colostomy
 - Z43.4 - Encounter for attention to other artificial openings of digestive tract
 - Z43.5 - Encounter for attention to cystostomy
 - Z43.6 - Encounter for attention to other artificial openings of urinary tract
 - Z43.7 - Encounter for attention to artificial vagina
 - Z43.8 - Encounter for attention to other artificial openings
 - Z43.9 - Encounter for attention to unspecified artificial opening
- Z55 – Z65 address potential health hazards related to socioeconomic and psychosocial issues. Links between the social determinants of health and disease management and prognostication continue to be explored and supported by research. Use of these codes continues to support research and explain issues related to the patient's disease process or treatment. For example, look at the proliferation of information on trauma-informed care. Below are Z-codes related to a history of abuse and neglect:
 - Z62.810 - Personal history of physical and sexual abuse in childhood
 - Z62.811 - Personal history of psychological abuse in childhood
 - Z62.812 - Personal history of neglect in childhood
 - Z62.819 - Personal history of unspecified abuse in childhood
- Family Issues:
 - Z62.820 - Parent-biological child conflict
 - Z62.821 - Parent-adopted child conflict
 - Z62.822 - Parent-foster child conflict
 - Z62.890 - Parent-child estrangement NEC
 - Z63.0 - Problems in relationship with spouse or partner
 - Z63.1- Problems in relationship with in-laws
 - Z63.31 - Absence of family member due to military deployment

- Z63.32 - Other absence of family member
- Z63.4 - Disappearance and death of family member
- Z63.5 - Disruption of family by separation and divorce
- Z63.6 - Dependent relative needing care at home
- Z63.71 - Stress on family due to return of family member from military deployment
- Z63.72 - Alcoholism and drug addiction in family
- Z63.79 - Other stressful life events affecting family and household
- Housing and Resource Problems:
 - Z59.0 - Homelessness
 - Z59.1 - Inadequate housing
 - ▶ Lack of heating
 - ▶ Restriction of space
 - ▶ Technical defects in home preventing adequate care
 - ▶ Unsatisfactory surroundings
 - Z59.2 - Discord with neighbors, lodgers and landlord
 - Z59.4 - Lack of adequate food and safe drinking water
 - Z59.5 - Extreme poverty
 - Z59.6 - Low income
 - Z59.7 - Insufficient social insurance and welfare support
 - Z59.8 - Other problems related to housing and economic circumstances
 - ▶ Foreclosure on loan
 - ▶ Isolated dwelling
 - ▶ Problems with creditors
 - Z59.9 - Problem related to housing and economic circumstances, unspecified
 - Z60.2 - Problems related to living alone
- Z66 Do Not Resuscitate (DNR) may be used when it is documented by the physician or NPP that the patient has a DNR any time during the stay. Note: Each state has different regulations regarding the validity of a DNR outside of the hospital setting. If a POLST document is completed that includes a DNR order, this can suffice
- Z68 Body Mass can be used whenever weight is an issue, such as morbid obesity, cachexia, or malnutrition. The physician or NPP should document the diagnosis associated with a high or low BMI. The BMI can be obtained the documentation of other members of the interdisciplinary team (e.g. nurse or nutritionist).

Obesity

- Z68.30-Body mass index (BMI) 30.0-30.9, adult
- Z68.31-Body mass index (BMI) 31.0-31.9, adult
- Z68.32-Body mass index (BMI) 32.0-32.9, adult
- Z68.33-Body mass index (BMI) 33.0-33.9, adult
- Z68.34-Body mass index (BMI) 34.0-34.9, adult
- Z68.35-Body mass index (BMI) 35.0-35.9, adult
- Z68.36-Body mass index (BMI) 36.0-36.9, adult
- Z68.37-Body mass index (BMI) 37.0-37.9, adult
- Z68.38-Body mass index (BMI) 38.0-38.9, adult
- Z68.39-Body mass index (BMI) 39.0-39.9, adult

Morbid Obesity

- Z68.41- Body mass index (BMI) 40.0-44.9, adult
- Z68.42 - Body mass index (BMI) 45.0-49.9, adult
- Z68.43 - Body mass index (BMI) 50-59.9, adult
- Z68.44 - Body mass index (BMI) 60.0-69.9, adult

- Z68.45 - Body mass index (BMI) 70 or greater, adult

Low weight issues: i.e. underweight, cachexia, malnutrition, anorexia

- Z68.1 - Body mass index (BMI) 19 or less, adult
 - ▶ Use for BMI under 19 and from 19 – 19.9

Here is a comparison of reimbursement impacted by whether the Z code is used with ICD 10 codes. The first example does not include the Z code:

ICD-10-CM Diagnoses				
#	GF	Code	POA	Description
1		J44.1		Chronic obstructive pulmonary disease with (acute) exacerbation
2		Z68.1		Body mass index (BMI) 19 or less, adult

ICD-10-CM Diagnoses				
#	GF	Code	POA	Description
1		J44.1		Chronic obstructive pulmonary disease with (acute) exacerbation
2	CC	Z68.1		Body mass index (BMI) 19 or less, adult
3		R63.4		Abnormal weight loss
4		Z51.5		Encounter for palliative care
5		I10		Essential (primary) hypertension
6		E03.9		Hypothyroidism, unspecified

ICD-10-PCS Procedures						
#	GF	Code	Description	Episode	Provider	Date
1						

CPT/HCPCS Procedures							
#	Code	Description	Modifiers	Units	Ep	Provider	Date
1							

DRG: 191 Chronic obstructive pulmonary disease w CC MDC: 4 MS-DRG ver.33.0, Medicare IPPS/Medicare Managed Care -

Weight: 0.9321 AMLOS: 4 GMLOS: 3.3 Cost Outlier: N Reimb: \$8,707.23

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- Opportunistic infections are fairly common in the seriously ill patient population. When an infection is resistant to antibiotic treatment a Z code can be used. First, code the infection. Then code the type of organism
 - MRSA and MSSA are combined into the organism code
 - B95.61 Methicillin susceptible staphylococcus aureus as the cause of diseases classified elsewhere
 - B95.62 Methicillin resistant Staphylococcus aureus infection as the cause of diseases classified elsewhere
- Resistance to other agents:

- Z16.2 Resistance to other antibiotics
 - ▶ Z16.20 Resistance to unspecified antibiotic / Resistance to antibiotics NOS
 - ▶ Z16.21 Resistance to vancomycin
 - ▶ Z16.22 Resistance to vancomycin related antibiotics
 - ▶ Z16.23 Resistance to quinolones and fluoroquinolones
 - ▶ Z16.24 Resistance to multiple antibiotics
 - ▶ Z16.29 Resistance to other single specified antibiotic
 - » Resistance to aminoglycosides
 - » Resistance to macrolides
 - » Resistance to sulfonamides
 - » Resistance to tetracyclines
 - ▶ Resistance to other antimicrobial drugs (excludes Z16.1-, Z16.2-)
 - » Z16.30 Resistance to unspecified antimicrobial drugs / Drug resistance NOS
 - » Z16.31 Resistance to antiparasitic drug(s) Resistance to quinine and related compounds
 - » Z16.32 Resistance to antifungal drug(s)
 - » Z16.33 Resistance to antiviral drug(s)
 - » Z16.34 Resistance to antimycobacterial drug(s) Resistance to tuberculostatics
 - ◆ Z16.341 Resistance to single antimycobacterial drug / NOS
 - ◆ Z16.342 Resistance to multiple antimycobacterial drugs
 - » Z16.35 Resistance to multiple antimicrobial drugs Excludes Resistance to multiple antibiotics only (Z16.24)
 - » Z16.39 Resistance to other specified antimicrobial drug
- For example, a 83 year old woman diagnosed with a UTI with ESBL E> Coli would be assigned the following codes:
 - ▶ N39.0 urinary tract infection
 - ▶ B96.20 escherichia coli
 - ▶ Z16.12 extended spectrum beta lactamase (ESBL) resistance
- Health service in other circumstances Z69 – Z76 are used to describe confinement, difficulty accessing another level of care, or need for relief care.
 - ▶ Care Dependency Codes include
 - » Z74.01 Bed confinement status
 - » Z74.09 Other reduced mobility
 - » Z74.1 Need for assistance with personal care
 - » Z74.2 Need for assistance at home and no other household member is able to render care
 - » Z74.3 Need for continuous supervision
 - » Z74.8 Other problems related to care provider dependency
 - » Z74.9 Problem related to care provider dependency, unspecified
 - » Z75.0 Medical services not available in the home
 - » Z75.1 Person awaiting admission to adequate facility elsewhere
 - » Z75.2 Other waiting period for investigation and treatment
 - » Z75.3 Unavailability and inaccessibility of health-care facilities
 - » Z75.4 Unavailability and inaccessibility of other helping agencies
 - » Z75.5 Holiday relief care
 - » Z75.8 Other problems related to medical facilities and other health care
 - » Z75.9 Unspecified problem related to medical facilities and other health care
 - ▶ Potential health hazards related to family and personal history and certain conditions influencing health status are covered by Z77 – Z99
 - » For example, Z85 is used when a previous primary malignancy has been excised or eradicated from its site and there

is no further treatment and no evidence of any existing primary malignancy. An extension, invasion, or malignancy to another site is coded as a secondary neoplasm to that site. The secondary site can be listed first as the principal with the Z85 used as a secondary code. Personal history of malignancy codes includes the following:

- ◆ Z85.01 Personal history of malignant neoplasm of esophagus
- ◆ Z85.020 Personal history of malignant carcinoid tumor of stomach
- ◆ Z85.028 Personal history of other malignant neoplasm of stomach
- ◆ Z85.030 Personal history of malignant carcinoid tumor of large intestine
- ◆ Z85.038 Personal history of malignant neoplasm of large intestine
- ▶ A case example: A 55-year-old woman with history of breast cancer. Had mastectomy and chemotherapy with eradication of primary site. Now cancer has spread to intra-abdominal lymph nodes and bone. C77.2 secondary malignant neoplasm of intra-abdominal lymph nodes; C79.51 secondary malignant neoplasm of bone; Z85.3 personal history of malignant neoplasm of breast.
- Category Z95-Z97 include a multitude of codes for devices placed in a patient: cardiac, orthopedic, nervous system, etc. These codes are not used for complications related to devices.
 - Heart devices:
 - » Z95.810 Presence of automatic (implantable) cardiac defibrillator
 - » Z95.811 Presence of heart assist device
 - » Z95.812 Presence of fully implantable artificial heart
 - » Z95.818 Presence of other cardiac implants and grafts
 - » Z95.820 Peripheral vascular angioplasty status with implants and grafts
 - » Z95.828 Presence of other vascular implants and grafts
 - » Z95.2 Presence of prosthetic heart valve
 - » Z95.3 Presence of xenogenic heart valve
 - » Z95.4 Presence of other heart-valve replacement
 - » Z95.5 Presence of coronary angioplasty implant and graft
- Codes for dependence on external medical devices to manage a disease include:
 - Z99.0 Dependence on aspirator
 - Z99.11 Dependence on respirator (ventilator) status
 - Z99.12 Encounter for respirator (ventilator) dependence during power failure
 - Z99.2 Dependence on renal dialysis
 - Z99.3 Dependence on wheelchair
 - Z99.8 Dependence on other enabling machines and devices
 - Z99.81 Dependence on supplemental oxygen
 - Z99.89 Dependence on other enabling machines and devices

Here is an example comparing not using these Z codes:

ICD-10-CM Diagnoses				
#	GF	Code	POA	Description
1	SP, RP	I50.33		Acute on chronic diastolic (congestive) heart failure
2	R2	J44.9		Chronic obstructive pulmonary disease, unspecified
3	S3, R2	J96.11		Chronic respiratory failure with hypoxia
4		Z51.5		Encounter for palliative care
5		I10		Essential (primary) hypertension

ICD-10-PCS Procedures			
#	GF	Code	Description

CPT/HCPCS Procedures					
#	Code	Description	Modifiers	Units	Ep

DRG: 194 Heart failure MDG: 5 SOL: 2 ROM: 2 APR ver.32.0 (HAC), APR Weights and Trims (Simple Pricing) -
 Weight: 0.6127 Long Stay: 11 Short Stay: 1 AMLOS: 3.57 GMLOS: 3.03 Cost Outlier: N Reimb: \$4,103.25

To using these Z codes (note the difference in reimbursement is an additional \$2,319.84 with Z codes):

ICD-10-CM Diagnoses				
#	GF	Code	POA	Description
1	SP, RP	I50.33		Acute on chronic diastolic (congestive) heart failure
2	S2	J44.9		Chronic obstructive pulmonary disease, unspecified
3	S3, R2	J96.11		Chronic respiratory failure with hypoxia
4	S2, R2	Z99.81		Dependence on supplemental oxygen
5		Z51.5		Encounter for palliative care
6		I10		Essential (primary) hypertension

ICD-10-PCS Procedures			
#	GF	Code	Description

CPT/HCPCS Procedures						
#	Code	Description	Modifiers	Units	Ep	P

DRG: 194 Heart failure MDC: 5 SOL: 3 ROM: 2 APR ver.32.0 (HAC), APR Weights and Trims (Simple Pricing) •
Weight: 0.9591 Long Stay: 17 Short Stay: 1 AMLOS: 5.36 GMLOS: 4.46 Cost Outlier: N Reimb: \$6,423.09

- There are Z codes to describe organ status such as transplant or absence.

- Z94.0 Kidney transplant status
- Z94.1 Heart transplant status
- Z94.2 Lung transplant status
- Z94.3 Heart and lungs transplant status
- Z94.4 Liver transplant status
- Z94.5 Skin transplant status
- Z94.6 Bone transplant status
- Z94.7 Corneal transplant status
- Z94.81 Bone marrow transplant status
- Z94.82 Intestine transplant status
- Z94.83 Pancreas transplant status
- Z94.84 Stem cells transplant status
- Z94.89 Other transplanted organ and tissue status
- Z94.9 Transplanted organ and tissue status, unspecified

- Z codes used for the absence of an organ or body part include:
 - Z89.511 Acquired absence of right leg below knee
 - Z89.512 Acquired absence of left leg below knee
 - Z89.611 Acquired absence of right leg above knee
 - Z89.612 Acquired absence of left leg above knee
 - Z90.410 Acquired total absence of pancreas
 - Z90.411 Acquired partial absence of pancreas
 - Z90.49 Acquired absence of other specified parts of digestive tract
 - Z90.5 Acquired absence of kidney
- For presence of an artificial opening not requiring care use these Z codes:
 - Z93.0 Tracheostomy status
 - Z93.1 Gastrostomy status
 - Z93.2 Ileostomy status
 - Z93.3 Colostomy status
 - Z93.4 Other artificial openings of gastrointestinal tract status
 - Z93.50 Unspecified cystostomy status
 - Z93.51 Cutaneous-vesicostomy status
 - Z93.52 Appendico-vesicostomy status
 - Z93.59 Other cystostomy status
 - Z93.6 Other artificial openings of urinary tract status
 - Z93.8 Other artificial opening status
 - Z93.9 Artificial opening status, unspecified
- Category Z79 indicates the patient is being treated with medications on a long-term basis. Not to be used for toxic or adverse effects of a drug. Codes from this category should not be used for any medication being administered for a brief period of time to treat an acute illness or injury (e.g. course of antibiotics to treat an infection).
 - Z79.01 Long term (current) use of anticoagulants
 - Z79.02 Long term (current) use of antithrombotics/antiplatelets
 - Z79.1 Long term (current) use of non-steroidal anti-inflammatories (NSAID)
 - Z79.2 Long term (current) use of antibiotics
 - Z79.3 Long term (current) use of hormonal contraceptives
 - Z79.4 Long term (current) use of insulin
 - Z79.51 Long term (current) use of inhaled steroids
 - Z79.52 Long term (current) use of systemic steroids
- Non-compliant patients can increase resource use, including readmissions. Managing non-compliant patients can be difficult. There are Z codes that describe the reason for, or type of, non-compliance.
 - Z91.11 Patient's noncompliance with dietary regimen
 - Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
 - Z91.128 Patient's intentional underdosing of medication regimen for other reason
 - Z91.130 Patient's unintentional underdosing of medication regimen due to age-related debility.
 - Z91.138 Patient's unintentional underdosing of medication for other reason
 - Z91.14 Patient's other noncompliance with medication regimen
 - Z91.15 Patient's noncompliance with renal dialysis
 - Z91.19 Patient's noncompliance with other medical treatment and regimen
- Underdosing as defined by taking less of a medication than is prescribed by a provider or a manufacturer's instruction is a relatively new concept with ICD 10. Z-codes should be used if the reason for the hospitalization or service for the relapse of the condition under treatment is caused by underdosing or underdosing is a contributing factor. Supportive documentation provides a clear picture for readmissions/revisits. The physician or NPP must document the impact on the condition under

treatment or the condition that the underdosing caused; the fact that underdosing occurred; and the reason the underdosing happened.

- Intention Underdosing
 - ▶ Z91.12 Patient's intentional underdosing of medication regimen
 - » Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship
 - » Z91.128 Patient's intentional underdosing of medication regimen for other reason
- Un-intentional Underdosing
 - ▶ Z91.13 Patient's unintentional underdosing of medication regimen
 - » Z91.130 Patient's unintentional underdosing of medication regimen due to age-related debility
 - » Z91.138 Patient's unintentional underdosing of medication regimen for other reason
- Unspecified Underdosing
 - ▶ Z91.14 Patient's other noncompliance with medication regimen
 - » Patient's underdosing of medication NOS
- Example: A patient is being treated with prednisone for bone pain from metastatic bone cancer from the primary right lower lobe lung cancer. The patient stopped taking the medication due to forgetfulness from brain metastasis and developed secondary adrenal insufficiency.
 - ▶ E27.40 Adrenocortical insufficiency
 - ▶ T38.0X6A Underdosing of glucocorticoids and synthetic analogues
 - ▶ Z91.138 Patient's unintentional underdosing of medication regimen for other reason
 - ▶ Additional codes: lung cancer, secondary bone cancer, secondary brain cancer, neoplasm related pain
- Example: An elderly patient is admitted with acute on chronic diastolic CHF. The physician documents that the exacerbation occurred because the patient did not have enough money to buy the medications.
 - ▶ 150.33 Acute on chronic diastolic (congestive) heart failure
 - ▶ T50.1X6A Underdosing of loop (high-ceiling) diuretics, initial encounter
 - ▶ Z91.120 Patient's intentional underdosing of medication regimen due to financial hardship

Appendix C: Assessment Tools Evaluation

Assessment Tool	Evaluator Volunteers	Sites currently using	Domain	Presence of research that supports the validity of the tool	Valid in these care sites (aligned w research)	Valid with these Services / Specialties	Source of info?	Required by a VBC or regulation (payer source if Yes)	Informs Risk Stratification (currently used or being considered for inclusion in Risk Strat algorithm)	Is integrated into EHR	Can be integrated into EHR	Access via portal	Data entry attributes / burden (minutes to complete)
				Yes	Hospital	Hospice	Patient		Yes	Yes	Yes	Yes	2
				No	Home	Palliative Care	Family member		No	No	No	No	5
					Clinic	Behavioral Health	Physician						10
					SNF	Oncology	Other provider						30
					All	Pulmonary	Other staff						
					ICF	Cardiac							
						Pain Clinic							
						NA							
ACE - Adverse Childhood Experiences		1	Psychosocial										
Anxiety (PROMIS, GAD-7)		9	Psychosocial										
Borg Dyspnea Scale		5	Physical										
Braden Scale– Pressure Ulcer Risk Assessment		8	Physical										
Cognitive Assessment (Mini-Cog, Montreal Cognitive Assessment)		10	Psychosocial	Yes	All	All	Patient		Yes		Yes	No	3
Colorado Bereavement Risk Tool		0	Psychosocial										
Delirium Scale (CAM)		1	Psychosocial										
Distress Scale (Kessler Psychological Distress Scale, Subjective Units of Distress Scale)		1	Psychosocial										
ESAS-r - Edmonton Symptom Assessment System Revised		7	Comprehensive	Yes	All	All	Patient or PCG		No	Yes		Yes (pot)	2 or 5
FAST - Functional Assessment Screening Tool		6	Physical	Yes	All	Dementia only	Physician		Yes				
Ferrans & Power Quality of Life tool (assesses multiple domains)			Comprehensive										
Functional Status Questionnaire		10	Physical										
Hamilton Depression Scale			Psychosocial										
HRA - Health Risk Assessment		4	Comprehensive										
LCD - Local Coverage Determination guideline for Hospice		3	Comprehensive	Yes (old)	All	Hospice	Other provider & staff		No	No	?	NA	30+
MAHC-10 – Missouri Alliance for Home Care (fall risk)		3	Comprehensive	Yes	Home	HC, Hospice	Other staff		Yes	Yes			2
NCCN Distress scale			Psychosocial										
Pain Assessment / Scales (WILDA, PQAS, Wong-Baker, 1-10 numeric)		19	Physical										
PAM - Patient Activation Measure		0	Comprehensive										
Pediatric Population Ages and Stages		10	Comprehensive										

Assessment Tool	Evaluator Volunteers	Sites currently using	Domain	Presence of research that supports the validity of the tool	Valid in these care sites (aligned w research)	Valid with these Services / Specialties	Source of info?	Required by a VBC or regulation (payer source if Yes)	Informs Risk Stratification (currently used or being considered for inclusion in Risk Strat algorithm	Is integrated into EHR	Can be integrated into EHR	Access via portal	Data entry attributes / burden (minutes to complete)
PHQ2 - Component of the Patient Health Questionnaire for Depression		12	Psychosocial	Yes	All	All	Physician or other staff		Yes	Yes			2
PHQ4 - Component of the Patient Health Questionnaire for Depression and Anxiety		1	Psychosocial	Yes	All	All			Yes	?			2
PHQ9 - Component of the Patient Health Questionnaire for Depression		11	Psychosocial	Yes	All	All			Yes	Yes			2 or 5
PPS - Palliative Performance Scale		7	Physical	Yes	All	All	Physician or other staff		Yes	Yes		NA	2
SF12 - Quality of Life Survey		1	Comprehensive										
SF36 - Quality of Life Survey		1	Comprehensive										

Appendix D: Palliative Care Flowsheet

Current Request for Palliative Care Flowsheet Enhancement

Palliative Care Assessment Flowsheet:

Encounter Type	
Encounter Type	
Edmonton Symptom Assessment System	
Pain Score	
Tiredness Score	
Nausea Score	
Depression Score	
Anxiety Score	
Drowsiness Score	
Appetite Score	
Wellbeing Score	
Dyspnea Score	
Other Problem Score	
Palliative Performance Scale	
Palliative Performance Scale Score	
Functional Assessment Staging of Alzheimers Disease	
FAST Stage Assessment	

Orientation	
What YEAR is it?	
What SEASON is it?	
What MONTH are we in?	
What DAY of the week is it?	
What is today's DATE	
What COUNTRY are we in?	
What STATE are we in?	
What CITY are we in?	
What building are you in?	
What floor of the building are you?	

Registration	
Name these 3 objects - APPL E, PENNY, TABLE. 1 second to say each. Then ask the person to	
Attention and Calculations:	
Begin with 100 and count backward by 7 (Stop after 5 answers): 93, 86, 79, 72, 65. if the patient will	

Recall

Ask for the names of all three objects given to remember in Q3. Score 1 point for each correct answer

Language:

Show the person a "PENCIL" and a "WATCH". Have the person name them as you point. Score 1

Have the person repeat the phrase - "NO IFS, ANDS, or BUTS". Score 1 point for a correct repetition.

Have the person follow a 3 stage command. Take the paper in your right/left hand. Fold it in half once

Read and obey the message. CLOSE YOUR EYES Score 1 point if the person closes their eyes.

Ask the person to write a sentence of his/her own choice. The sentence should contain a subject and

Ask the person to copy the design. Score 1 point if all sides and angles are preserved and the

Total Score**Depression Screening**

Have you felt little interest or pleasure in

Have you felt down, depressed or hopeless

PHQ-2 Total Score

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Little interest or pleasure in doing things

Feeling down, depressed, or hopeless

Trouble falling or staying asleep, or sleeping

Feeling tired or having little energy

Poor appetite or overeating

Feeling bad about yourself - or that you are

Trouble concentrating on things, such as

Moving or speaking so slowly that other

Thoughts that you would be better off dead

PHQ-9 Total Score

If you checked off any problems, how

Non ICU Delirium Assessment (CAM)

1. Acute Onset or Fluctuation Course

2. Inattention

3. LOC

4. Disorganized Thinking

5. Delirium Suspected?

ICU Delirium Assessment (CAM-ICU)

CNA Step 1: Acute onset or Fluctuating course

CNA Step 2: Inattention

CNA Step 3: Altered LOC

CNA Step 4: Disorganized Thinking

CNA Step 5: Delirium Present?

*Morse Fall Risk

History of Falling

Secondary Diagnosis

Ambulatory Aids

Intra'IE!nous Therapy/Heparin/Saline Lock

Gait/ransferring

Mental Status

Score

Psychosocial

Psychosocial (WOL)

Stress Factors

Patient Stress Factors

Family Stress Factors

Coping Response

Patient Coping

Family

Spiritual-Culture:

8. Who are the significant people in your life: family, friends, community or faith, minister)
9. What are the most comforting spiritual practices in your life? (prayer, scripture, music , sacraments, nature)
10. How is your faith and/or support system affected by your illness?
11. What concerns, feelings or thoughts do you have about your illness?
12. Would you like spiritual care visits from a hospital chaplain while in the hospital? Yes/no
13. Would you like to contact your community or faith minister or spiritual care provider?

_____Patient declines need for s piritual care supportatthis time.

Referrals Made

Referrals Made

Decision to Forgo Treatment

Decision to Forgo Treatment

Team Impact

Team Impact

Discharge Disposition

Discharge Disposition

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NHPCO Palliative Care Playbook for Hospices

Quality and Data



NHPCO

Leading Person-Centered Care

[NHPCO.ORG](https://nhpc.org)

As a hospice provider you already engage in continuous quality assurance and process improvement (QAPI) as required by the Centers for Medicare and Medicaid Services (CMS) [Hospice Conditions of Participation](#), and the contours of the hospice benefit drive specific QAPI activities. While hospice is a well-defined benefit under Medicare, Medicaid, and most commercial insurance plans, there is no standard, broadly utilized palliative care benefit, and individual palliative care services vary greatly in the scope of services offered, the types of patients served, and care models that are employed. Even though this variation can make quality assessment and process improvement in palliative care somewhat challenging, there are still many compelling reasons to monitor quality through routine data collection, analysis, and reporting.

1. Proving value is essential to the sustainability of a palliative care program. The value proposition is the relationship between the benefits and costs of delivering health services.¹ Palliative care programs that improve quality (by improving patient experience of care or reducing the number of avoidable admissions, for example) at a reasonable cost provide value to their stakeholders. Data collection, analysis, and reporting help define the baseline (what is happening now) and allow for assessment of how things change when palliative care is added as an additional layer of support.
2. Palliative care programs that bill for provider (physician, nurse practitioner, etc.) services should track and report data to participate in the [Merit-based Incentive Payment System](#) (MIPS) or an [Alternative Payment Model](#) (APM). The CMS Quality Payment Program rewards value and outcomes through these programs. Providers that participate receive payment increases and avoid future payment reductions.
3. Contracts with health plans or other payers usually require the palliative care provider to collect and report data describing the services that were delivered, how the provided care aligned with best practices, and some patient outcomes. Contractual requirements range from simply being asked to collect and report data, to reimbursement incentives that are triggered by hitting process or utilization targets.
4. New opportunities continue to evolve through the Centers for Medicare and Medicaid Innovation. Do not wait for these demonstration projects to be announced to begin collecting, analyzing, and reporting data.

Western Reserve Navigator (WRN) is a palliative care program offered by Western Reserve Care Solutions. WRN, established in 2002, provides comprehensive palliative care, consistent with the National Consensus Guidelines for Quality Palliative Care.² They participate in MIPS generating excellent outcomes resulting in reimbursement incentives.

Assessing Quality in Palliative Care

The Institute of Medicine (IOM) uses a six-part framework to assess quality, specifying that quality care is safe, effective, patient-centered, timely, efficient and equitable.³ You should consider all of these domains when assessing the quality of care your program delivers.

IOM Quality Domain	Application to a palliative care program
Safe	Do program practices improve safety of patients, or introduce new dangers or risks? For example, high-dose opioids carry risks – how is their use managed for optimal safety?
Effective	Are the treatments and techniques used by the team evidence-based? Are the right treatments used for the right patients?
Patient-centered	Is the care provided consistent with the patients' values, preferences, goals, desires? How are these documented, accessed, and honored?
Timely	When does the program reach patients, relative to disease course or death? Are there delays between referral and first contact with the team?
Efficient	Does the program employ resources wisely and efficiently? Does the program increase the efficiency of care overall?
Equitable	Are patients treated without disparity? How are potential barriers (e.g., language, rural settings, insurance status) overcome?

1. White, F. J. (2018). "Can the Value Proposition Work in Health Care?" *Inquiries Journal*, 10(10). Retrieved from www.inquiriesjournal.com/a?id=1743

2. www.nationalcoalitionhpc.org/ncp/

3. <https://cahps.ahrq.gov/consumer-reporting/talkingquality/create/sixdomains.html>

Types of Measures and Focus Areas

Your program should use a mix of structure metrics (items that describe the features of the palliative care service), process metrics (items that describe what the palliative care service does) and outcome metrics (items that describe the impact of delivering palliative care.) Each type of metric can be used to answer important questions about care quality. For example, the structure metric “percentage of providers that are certified in palliative care” says a lot about your team’s ability to deliver good care, and demonstrates adherence to an important National Consensus Project recommendation. You will also want to use process metrics that describe what your program does, again with an emphasis on demonstrating adherence to best practices. Process metrics address everything from response time, to use of standardized screening tools to assess symptoms, to proportion of patients for whom goals of care were elicited and documented. Outcome metrics, typically the most resource intensive to collect, look at how the care your service provided impacted patients (for example, reduction in symptom burden), those around the patient (for example decreased stress and distress for caregivers/families), as well as efficiency measures, such as reduction in total cost of care.

Structure Metrics

- Describe the program
- Example: Available 24/7

Process Metrics

- Describe how care is delivered
- Example: Interval between referral and first visit

Outcome Metrics

- Describe the impact of the program
- Example: Change in pain scores

In addition to a mix of types of metrics, your evaluation program should include metrics that look at a range of palliative care focus areas. A balanced evaluation program would include operational metrics that describe how much service was delivered, timeliness, frequency of contacts, etc.; screening and assessment metrics that describe adherence to best practices related to anticipating, identifying and addressing sources of suffering; planning and preferences metrics that address service attention to advance care planning, including documenting patient preferences; hospice and end-of-life care metrics that describe care delivered towards the end of life, including use of hospice; and utilization and fiscal metrics that address impact on how enrolled patients are using health care services, and the cost of care. Examples of each type of metric are presented below.

Metrics used by community-based palliative care services

Operational: metrics that describe how much service was delivered, timeliness, frequency of contacts, etc.

- # patients referred, % with scheduled visits, % actually visited
- Average (and range) # visits per patient in enrollment period
- Average (and range) # days from referral to initial visit
- % seen within 14 days of referral
- Referral reason
- Use of tele-visits
- % visits where interpreter was used

Screening and assessments: metrics that describe adherence to best practices related to anticipating, identifying and addressing sources of suffering.

- % for which spiritual assessment is completed
- % for which functional assessment is completed

- Symptom burden as measured by ESAS, initial visit vs follow up visits
- % for which medication reconciliation is done with 72h of hospital discharge

Planning and preferences: metrics that address service attention to advance care planning, including documenting patient preferences.

- Proportion of patients with advance care planning discussed
- % surrogate decision maker identified
- % with advance directive or POLST completed

Hospice and end-of-life care: metrics that describe care delivered towards the end of life, including use of hospice services.

- % remaining on service through end of life
- % death within one year of enrollment
- % enrolled in hospice at the time of death
- Average/median hospice length of service
- % dying in preferred location

Utilization and fiscal: metrics that address service impact on how enrolled patients are using health care services, and the cost of care.

- Per member per month cost of care, enrolled patients vs comparison population
- Health care utilization/costs 6 months prior to enrollment compared to 6 months after enrollment:
 - # acute care admissions
 - # total hospital days
 - # ER visits
 - Total cost

Assembling the right measurement plan

There is no universally accepted or feasible set of metrics that is required for or used by all community-based palliative care programs. The right metrics are the ones that are feasible to implement and that meet the information needs of key stakeholders. Keeping a few core principles in mind will simplify the process of deciding what to measure, how to measure, and how you will share your results.

1. **Balance your measurement portfolio.** As noted above, a balanced measurement portfolio covers a range of focus areas and comprises a mix of structure metrics, process metrics, and outcome metrics. The portfolio should also be balanced in the effort required to access and analyze data, since most programs have limited resources to devote to such tasks.
 - Start simple and build
 - Consider data that are essential to the daily operations of your palliative care program, then determine how those data can be used in structure, process or outcome metrics that are important to your stakeholders.
 - For example, you are probably already gathering information about surrogate decision-makers, and that information can be used in a process measure that addresses the planning and preferences focus area (“percent of patients for whom surrogate decision-maker was identified and documented”)
 - Seek input from key stakeholders and measure what matters to them
 - How will your stakeholders measure success?
 - How do measurement priorities align or differ across stakeholders?
 - Ideally you should have a core set of metrics that will satisfy multiple stakeholders (board members, CMS MIPS or APM, commercial health plan, etc.) If this is not yet the case, negotiate to achieve greater consistency, making sure stakeholders understand the cost of gathering and analyzing data, and of generating reports.

- Evaluate the benefit versus the burden of obtaining specific data
 - Start with the low hanging fruit – data that are essential and easily accessible (e.g. the dates of service), and select measures that use those data (e.g., number of visits per patient.)
 - Expand by adding measures that are important and moderately accessible (e.g., the number of individuals with surrogate decision-maker documented)
 - Avoid gathering new data that are otherwise unneeded for clinical care delivery unless doing so would allow you to use a measure that an important stakeholder requires. Even then, you should consider incorporating the cost of gathering that additional data into the estimated cost of delivering palliative care

Tips: Make sure all stakeholders agree with your metric definitions! Also, don't recreate the wheel; use existing metrics whenever possible. (See section Reporting Opportunities via Vendors below for existing measures)

Tool: Metrics Balance Check Worksheet

2. Optimize electronic health records for data extraction and analysis

- Data elements within the electronic health record need to be input and stored in discrete fields, if you hope to use those data in metrics. For example, monitoring “percent patients with surrogate decision-maker identified and documented” can be difficult if that information is buried in a visit note, or even if the information may appear in any of several spots in an EHR.
- Prepare a list of measures you want to use, and a corresponding list of the specific data elements that you will need for each measure. For example, if you want to measure “number of patients where first visit was within 7 days of referral”, you need to know the day of the referral and the day of the first visit. Conduct this reverse-engineering exercise for all your proposed metrics, and share this information with your EHR team, so that data input and storage fields are aligned with your measurement plans
- Using evidence-based tools within clinical documentation can make analysis and interpretation easier. Some examples include the Edmonton Symptom Assessment System Revised, the Palliative Performance Scale, and the Mini Mental State Examination.
- Also see the Playbook chapter on Documentation.

3. Determine report frequency

- Stakeholders often have different requirements/preferences for reporting frequency
- Most data – from symptom scores gathered in patient visits to responses to satisfaction surveys – are gathered continuously, but are only aggregated and analyzed intermittently (for example, annually or quarterly.)
- You will need to reconcile report demands with information availability.
- Begin by considering the needs of your stakeholders – who needs to know what, at what frequency?
- Consider negotiating alterations in report contents and frequency to create as much alignment as possible across reporting requirements.
- It is usually fairly easy to “roll up” the same data into different time units; for example, a report that monitors monthly discharges to hospice can easily be made into a report that reports on hospice discharges for a quarter or year.
- Mature programs with effective EHRs have the option of moving from retrospective descriptions of amount and quality of services into real-time interventions that support clinical activities.
 - If you refresh data nightly, you can leverage real time information to triage visits by urgency, or trigger completion of important tasks (for example, to alert a provider to conduct a medication reconciliation for a patient who was discharged from the hospital two days prior)

Note: The MIPS Performance Year begins on January 1 and ends on December 31 each year. Program participants must report data collected during one calendar year by March 31 of the following calendar year.

- Direct Technical Assistance is available to participate in MIPS or APMs

4. Consider resources needed to implement your measurement plan

- Monitoring quality requires resources – to gather data, to input that information into the EHR or a separate program, to analyze data, and generate reports. You should consider how you will conduct all of these quality assessment tasks and who will do the work. The ideal scenario is that all data needed for your measurement plan is already being gathered in the normal course of care delivery, and that you have a nimble and easy to use EHR that automates the process of aggregating information and generating reports. Most of us do not have that luxury, so you need to think through what extra effort is needed, and who will be tasked with doing the work.
- A central question is if you have access to staff with analytic skills
- The staff responsible for data analytics can be employed or contracted, but either way that effort needs to be included in your budget.
 - Unless all data needed for your measurement plan are already being gathered and input into an EHR in the normal course of care delivery, we strongly caution against using clinical staff to carry out supplemental data collection and data entry work. The result is an inefficient use of clinical staff that can cost your program much more than it saves.
 - It is often more cost effective to have a non-clinical employee or contractor perform these services.

5. Optimize report design

- Once you have selected the metrics you will use and figured out who will do the work to assemble the information needed to use those metrics, you should consider carefully how your information will be displayed, to maximize efficacy.
- Consider why each stakeholder wants the information included in a report, and make sure the data presentation aligns with those priorities and needs.
- Standardized reports – having a predictable set of content displayed in a consistent way– can make it easier to generate and interpret results. Reinventing report contents continuously can eat up lots of resources and makes it harder to interpret performance over time. Instead, settle on a format that everyone is (mostly) happy with and use that.
 - Reports can be built using desktop spreadsheet or relational database programs. While this may be the easiest way to generate a standardized report for a new or small program, in the long run it can be quite labor intensive if reporting requires extracting, cleaning and merging data from multiple sources.
 - The ideal is to minimize manual data entry and data analysis effort.
 - Software products such as Tableau and MicroStrategy provide data analysis and interactive reporting displays.
 - There are costs for securing licenses for these tools, as well as training to become proficient at using them, but they may still be more cost-effective than a DIY approach using generic desktop applications.

Reporting Opportunities via Vendors

There are several data registry and quality reporting products that serve palliative care programs. Though NHPKO as an organization has not endorsed any vendors or products, we highlight some examples below, to support members in evaluating their options. One benefit of participating in registries is that the work of identifying and developing measures has been done for you, and analytics and reporting capabilities are automated. This can translate into significant cost savings for your program. Other benefits are the alignment with measures that have been endorsed or recommended by national organizations such as the National Quality Forum and the National Committee for Quality Assurance, something that is valued if not required by CMS, health plans, and policy makers. Using a national vendor also allows you to benchmark your program against peer programs across the country. Additionally, palliative care programs will likely have to partner with an external vendor for quality reporting to participate in any serious illness alternative payment model (SI APM) demonstration pilots. Those that are already engaged with a national vendor have an advantage for SI APM selection and for contracts with health plans.

Center to Advance Palliative Care

The [Palliative Care National Registry](#), a joint project between the Center to Advance Palliative Care (CAPC) and the National Palliative Care Research Center (NPCRC), provides actionable data that programs can use to secure, expand, and retain

resources for the delivery of high-quality palliative care, or to support the establishment of new palliative care programs. Through a series of surveys, the Registry collects program-level data on all service settings (e.g. hospital, office or clinic practices, long-term care, patients' homes). Participation is free and open to all programs across the continuum of care.

What are the benefits of participation? Participating programs can compare their program to peers on key metrics, track their program's development over time, contribute to comprehensive reports for the field, access key palliative care metrics, definitions, and findings, and receive a premium listing in the Provider Directory on getpalliativecare.org for patients and families.

Note: The Palliative Care National Registry's primary focus is on operational and financial metrics.

Global Palliative Care Quality Alliance (GPCQA)

The Global Palliative Care Quality Alliance uses [QDACT](#), a prospective, standardized, quality-based monitoring system for real-time data collection applicable to a spectrum of palliative care organizations, medical specialties, and initiatives. Data collected at point of care is input into a registry database that outputs useful information that can support clinical decision-making and drive quality improvement. Metrics include the [Measuring What Matters](#) quality measures, the [Joint Commission Palliative Care Accreditation](#) quality measures, and outputs that describe program operations. Users can run custom reports and generate cost savings estimates for hospital-based consultation services. Participants must enter a minimum of 25 patient encounters annually but have freedom to choose which data elements to include. There is an annual participation fee (2019 cost is \$4,000) but this is negotiable, based on type of organization and other variables.

What are the benefits of participation? GPCQA leaders note there is a strong sense of community, as members participate in quarterly calls that focus on collaborative problem solving. Assistance is available for programs that are conducting research. There is no limit to the number of users, and the entire interdisciplinary team can input data. Currently, electronic health record integration is available with Epic and Cerner, at an additional cost. Other benefits include:

- Real-time, point-of-care patient information entry capabilities
- Web-based application to assure that QDACT can be used on any device or platform
- User-friendly interface that can be incorporated into multiple practice settings
- Incorporation of decision support via color-coded clinical decision alarms
- Meets strict web-based security and HIPAA compliance standards
- Organizational level report generation

Note: GPCQA also has a product for Family Practice providers' MIPS reporting: The PRIME Registry includes seven palliative care measures. Cost in 2019 is \$99.00 per provider, annually.

Palliative Care Quality Network

The Palliative Care Quality Network ([PCQN](#)) is a continuous learning collaborative committed to improving the quality of palliative care services provided to patients and their families. The Palliative Care Quality Network strives to help sustain and grow palliative care by providing teams with all the tools, data, and support they need to demonstrate value, build strong teams, and promote resilience in their clinicians. Member organizations collect a standardized set of data that establishes benchmarks and allows for direct comparisons to peer organizations. These data serve as the basis for quality improvement and provide information about the characteristics of patients seen, the processes of care, and the outcomes that result.

Core dataset items are designed to be:

- Feasible to collect prospectively in the course of usual patient care;
- Helpful at the point of care;
- Targeted at key processes and outcomes; and
- Consistent with national standards.

Palliative Care Quality Network member teams collect and enter data in one of the three following ways:

- On a template paper card with data entered later into the secure web-based database;
- Directly into the web-based PCQN database in real time by using a laptop, tablet, or smartphone; or
- Within the electronic health record (EHR) with data subsequently extracted and uploaded to the PCQN database.

Data are available for analysis as soon as they are entered. Members can generate five types of reports in real time for any period that they want to analyze with comparisons to the entire PCQN. The five data reports include:

- Summary Reports that provide a comprehensive analysis of demographic data, processes, and outcomes;
- Trend Reports that show performance over time;
- Member Comparison Reports that provide site-by-site data for a given measure revealing variation in performance;
- Cross-Tab Reports that analyze the relationship between two variables; and
- Patient Queries that generate a list of patients who meet certain criteria.

Participants are encouraged to enter all core data elements (there are additional optional data elements) on all patients seen. Participation cost in 2019 ranges from \$3,900 to \$6,000 depending on the organization type.

What are the benefits of participation? The Palliative Care Quality Network addresses the needs of palliative care teams through the following suite of activities:

- Collection of a standardized set of data that include clinical outcomes for each patient seen;
- Data analyses with robust reports that members can generate in real time to monitor their practice and benchmark outcomes to other teams;
- Quality Improvement collaborative that supports members to learn QI methods and engage in QI projects;
- A community of palliative care professionals that provides a forum for expert-level education as well as professional and personal development activities; and
- A tool that can analyze an individual team's financial impact.

American Academy of Hospice and Palliative Medicine and Hospice and Palliative Nursing Association Measuring What Matters

Measuring What Matters (MWM) is a consensus recommendation for a portfolio of quality indicators for hospice and palliative care programs to use for program improvement. Starting in 2013, the American Academy of Hospice and Palliative Medicine (AAHPM) and the Hospice and Palliative Nurses Association (HPNA) convened expert panels representing a broad array of stakeholders in quality and hospice and palliative care to evaluate relevant published measures and select a concise set that matters most for patients receiving palliative care and hospice in any setting. The intention was to drive voluntary adoption of these measures broadly in hospice and palliative care and lay the groundwork for benchmarking and meaningful comparison.

The Technical Advisory Panel assessed measures based on their relevance and technical strength, including reliability and validity. The Clinical User Panel further prioritized the measures based on whether they were meaningful to patients and families, actionable for providers and likely to have a large impact on quality of care. The findings and recommendations of the consensus project were published in the *Journal of Pain and Symptom Management*. More information about the [Top Ten Measures](#) can be found on the [AAHPM MWM Webpage](#).

The ongoing goal of MWM is to identify, promote, and refine measures of care quality for patients with serious illness. The AAHPM and HPNA have created two working groups. The Technical Specifications for electronic Clinical Quality Measures (eCQMs) Working Group's goal is partnering with EHR vendors and other stakeholders to develop eCQMs that matter for patients with serious illness and their families that can be meaningfully utilized by providers. Some eCQM National Resources include:

- The Joint Commission's *Palliative Care Performance Measurement Implementation Guide* (January 2017), created for TJC's Advanced Certification in Palliative Care; and
- The CMS's eCQI Resource Center: a one-stop shop for the most current resources to support Electronic Clinical QI (ecqi.healthit.gov/ecqms).

The Quality Improvement (QI) Education and Strategies Working Group's goals include development of QI Education tools, webinars and modules to improve patient care and meet new requirements for value-based reimbursement that also meet CME and MOC requirements.

Developing the Palliative Care Quality Collaborative: With the support of a grant from the Gordon and Betty Moore Foundation, five organizations are jointly creating the Palliative Care Quality Collaborative (PCQC). The PCQC will develop and use a unified registry that will capture both program- and patient-level quality data to improve the care of patients with serious illness, including those receiving palliative care. The five organizational partners are:

- [American Academy of Hospice and Palliative Medicine](#)
- [Center to Advance Palliative Care](#)
- [National Palliative Care Research Center](#)
- [Global Palliative Care Quality Alliance](#)
- [Palliative Care Quality Network](#)

The goal of PCQC is to advance the field of palliative care, bridge gaps in knowledge, promote research and development, improve quality of care, support quality improvement projects, and better align quality measurement with accreditation and value-based payment models. The collaborative and new unified registry will advance opportunities for:

- Quality measurement, benchmarking, and practice improvement
- Learning health systems and co-creation of care
- Value-based purchasing and payment reform
- Accreditation and accountability

For more information, view the [Going Further Together presentation](#) from the Quality Matters Conference.

Measure Development Projects: The American Academy of Hospice and Palliative Medicine, in collaboration with the American Medical Group Association, OptumLabs, and the NQF Measure Incubator, was awarded funding from the American Association of Retired Persons to develop and test a new pain treatment measure in a seriously ill population using a commercial clinical and claims database. The goal of this project is to advance quality measurement in palliative care by testing new ways of identifying patients with serious illness for inclusion in quality measures.

In addition, AAHPM, in collaboration with the National Coalition for Hospice and Palliative Care and the RAND Corporation, was awarded a three-year grant from the CMS to develop patient-reported outcome performance measures (PRO-PMs) for community-based palliative care. The measures are intended for use in CMS's Quality Payment Program (QPP), including MIPS and APMs. The deliverables of the Palliative Care Measures Project are two fully-specified and tested PRO-PMs on pain/symptom management and communication, ready for NQF endorsement and implementation into the Quality Payment Program. The patient-reported outcomes in palliative care will include: 1) the adequacy and appropriateness of symptom management, and 2) the experience of feeling heard and understood.

Patient Satisfaction Survey: [Strategic Healthcare Programs](#) (SHP) is a performance improvement software product built for the modern post-acute care provider, hospital, physician group and Accountable Care Organization. The automated, real-time data analytics and benchmarking reports provide actionable performance metrics that drive daily decisions.

Features include the ability to track palliative care patient survey results, and 24/7 secure Web access to automatically generated reports and control charts. Data are translated into standardized measures that can address accrediting body requirements.

The Strategic Healthcare Programs palliative care product features:

- Local reports: Reports looking at just your organization's data
- Comparative reports: Reports comparing your data with the data from the SHP national data repository
- Patient satisfaction reports: Award-winning automated patient satisfaction surveying and reporting

What are the benefits of participation? The Strategic Healthcare Programs for palliative care is web-based software that allows you to easily benchmark and track patient satisfaction results. The reports, available 24 hours a day from their secure website, give you the tools you need for effective contracting, tracking, quality improvement, accreditation, and regulatory compliance.

Accreditation and Certification

Another way to promote quality within your organization is through accreditation of your program and certification of your staff. Several organizations provide palliative care accreditation (e.g. Joint Commission, Community Health Accreditation Partner, Accreditation Commission for Health Care). Some health plans require proof of accreditation as a condition for contracting. Nurses at each licensure level can obtain certification through the HPNA, Social Workers through the [National Association of Social Workers](#), chaplains through the [National Association of Catholic Chaplains](#), and for physicians through the AAHPM. Certification in the specialty of hospice and palliative care demonstrates a level of expertise well beyond basic competency. Certification is a gold standard and signifies a commitment to quality for the individual and the organization. The percentage of staff that are certified in hospice and palliative care is often used as a quality measure.

Accreditation

The Joint Commission: The Joint Commission [Palliative Care Certification](#) is flexible and customized to reflect the unique structure of your home care organization. The CBPC certification can reflect an entire home-based organization devoted to community-based palliative care services or a component within an existing home health or hospice organization. The Joint Commission is also nationally recognized by CMS for Medicare certification and by many states for licensure requirements.

Community Health Accreditation Partner Palliative Care Certification: The Community Health Accreditation Partner [Palliative Care Certification's](#) standards are informed by providers of palliative care and the National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition.

Palliative care certification is available to palliative care programs that area:

- Service of an existing setting such as a physician practice, Assisted Living Facility, or SNF, etc.
- Service of a currently accredited hospice or home health agency, or
- Independent provider of palliative care.

Accreditation Commission for Health Care: The Accreditation Commission for Health Care's [Palliative Care Distinction](#) focuses on patient and family centered care that optimizes quality of life throughout the continuum of illness by addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. The Accreditation Commission for Health Care (ACHC) Palliative Care Standards are based on the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care. The provider must have ACHC Home Health Accreditation to earn a Distinction in Palliative Care.

Certification

Physician: The AAHPM can provide you with the most up-to-date information on certification for hospice and palliative medicine physicians. For more information visit the [American Academy of Hospice and Palliative Medicine \(AAHPM\)](#) website.

Nurse: The [Hospice and Palliative Nurses Association](#) offers specialty certification to hospice and palliative nurses at all levels of licensure. Offered via the Hospice and Palliative Credentialing Center, there are five distinct certification exams the Advanced Certified Hospice and Palliative Nurse (ACHPN) for advanced practice nurses, the Certified Hospice and Palliative Nurse (CHPN) for registered nurses, the Certified Hospice and Palliative Pediatric Nurse (CHPPN) for pediatric palliative nurses, the Certified Hospice and Palliative Nursing Assistant for nursing assistants, and the Certified in Perinatal Loss Care for those dealing with perinatal loss. They also maintain two other hospice and palliative credentials for licensed practical/vocational nurses and administrators who previously tested prior to 2018.

Social Worker: The Advanced Certified Hospice & Palliative Social Worker (ACHP-SW) is available through the [National Association of Social Workers](#). The ACHP-SW was created in 2008 with the support and partnership of the National Hospice and Palliative Care Organization (NHPCO) at the MSW level. It is tailored to capture the specialized knowledge, skills, and abilities of professional social workers in hospice and palliative care settings, and is the premier credential for social workers in end-of-life care.

Chaplain: The Board Certified Chaplain Inc. designation is available through the [National Association of Catholic Chaplains](#). It recognizes the expertise, specialized skills, advanced education, and unique experience of professional palliative care and hospice chaplains.

Key Points and Recommendations

- There is no standard set of metrics that works for all palliative care programs; the right metrics are the ones that are feasible to use and that meet the information needs of key stakeholders
- Develop a balanced portfolio of metrics that features a mix of metrics types and focus areas
- Consider the priorities and preferences of your most important stakeholders as you select metrics and settle on reporting practices
- Review and consider measures that have been developed or endorsed by experts in the field
- Optimize your EHR for data extraction and analysis
- Consider existing registries and other products
- Accreditation of your program and certification of your staff are both tools for promoting quality and indicators of quality

Other Resources

[Palliative Care Measures Menu](#) Designed for palliative care leaders, quality professionals, and administrators, the Palliative Care Measure Menu simplifies the task of reviewing possible measures, enabling users to quickly and efficiently select a feasible, balanced portfolio of measures that mirror the scope and focus of a given palliative care program.

[Measures and Outcomes](#) Assessing quality and measuring the impact of community-based palliative care services is essential for identifying and addressing gaps in care. The resources on this website provide information on metrics endorsed by national quality leaders and clinical experts. Tools that support selecting metrics for a comprehensive evaluation plan are available in the Tools section.

Tool: Metrics Balance Check Worksheet



NHPCO Palliative Care Playbook for Hospices

Branding, Messaging, Outreach, and Marketing

This chapter is also available as a Grab & Go Toolkit:
www.nhpc.org/palliativecare



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Every hospice has one or more people, teams, or departments responsible for education, outreach, and marketing to providers and the community. This chapter focuses on leveraging those resources to market all your service lines, including palliative care.

Branding

Thinking of all your service lines, does your current brand name accurately reflect your full continuum of care? Many providers originally established their organizations solely with hospice care, and their brand names still focus on hospice.

A brand name that features hospice can be a barrier for patients and referrers who are seeking services upstream from end-of-life care or "aren't ready for hospice." Numerous organizations have attempted to remedy this situation by changing their brand name from "Hospice" to "Hospice & Palliative Care." The trouble with this structure is that it lumps hospice and palliative care together, and there's already much confusion about differences between the two. Plus, "Hospice" is still prominent in the brand name, complete with the barriers it can cause for non-hospice services.

Another approach has been to give palliative care and other non-hospice services a different brand name to separate them from hospice care. Some difficulties with that approach are that organizations then need the resources to support and promote two or more brands ... and different names can be an obstacle in facilitating transitions from one service line to the next along the continuum. For example, organizations build a relationship with its brand name for palliative care then want to transition patients when appropriate to their hospice services, but the client/patient does not have the same or perhaps any relationship with the different brand name.

So, what's the solution to this challenge? One viable approach is to create an umbrella brand.

Structurally, brand names have two components: (1) The actual trademarkable name or "first name" of the brand; and (2) a descriptor that identifies the type of product or service. The structures of some well-known consumer brands include Oreo® Cookies, Kleenex® Tissues and Goodyear® Tires. The "umbrella" part comes in when you extend the equity of a brand to cover multiple products or services. For instance, Reese's established a reputation for its Peanut Butter Cups. Over time, they've made "Reese's" the umbrella brand for Reese's Pieces, Reese's Puffs (peanut butter-flavored cereal) and Reese's Peanut Butter (sold by the jar). Each of the latter products succeeded on the reputation of Reese's for delicious peanut butter flavor.

In the hospice and palliative care world, a growing number of organizations are following this umbrella strategy as they expand their continuum of care. For instance, Hospice of Wake County (based in Raleigh, NC) originally tried separate brands for non-hospice services – Horizons Palliative Care and Horizons Home Health. In 2014, they consolidated all services under a new umbrella brand – Transitions LifeCare. All of their services now have the consistent umbrella brand name – Transitions HomeHealth, Transitions PalliativeCare, Transitions HospiceCare, Transitions GriefCare, and so on. This structure builds the relationship with the brand at whatever point along the continuum patients enter (and the earlier, the better). Then transitioning patients along their own continuum is easier because they already have a relationship with the brand. Since changing to an umbrella brand supported by operations and marketing, Transitions LifeCare has experienced significant growth – especially in hospice and palliative care.



What is the current status of your brand structure? Does it aid or impede engagement with your non-hospice services? Of course, changing a brand name is a big deal and requires a substantial investment. If your hospice brand has a longstanding, strong relationship in the community, you may not want to have to start over to establish relationships with a new brand. But consider the implications of your brand name for growth over the long term. An umbrella brand provides the structure for utmost consistency, cohesiveness, and connection.

Messaging

After solidifying your brand name, the first step in all outreach and marketing is identifying the key message(s) you want to convey. This is something you do already for hospice, however the messages for palliative care are different. Palliative care serves a different need, the payment model is different, typically the extent of services is different, and the objectives are different. And because you are providing palliative care now, your messaging for hospice will also need to change to reflect the distinct benefits of hospice.

There are four steps to the messaging process:

1. Identify/elicit needs/fears of your target customer or customers (patients, families, providers, etc.)
2. Communicate the unique value you offer in response to those needs
3. Check to see if you've correctly matched your services to their needs/fears
4. Repeat

Needs and Fears

Messaging begins with identifying the needs of your customers. Begin by securing answers to these questions specific to the community providers.

- Are you familiar with palliative care? Can you explain what you understand palliative care to be?
- What are you worried about?
- What is your decision-making process?
- What criteria will you use to make a decision?
- Who influences your decision to contact palliative care (hospice)?
- What keeps you up at night?
- Who do you trust to provide information?

Do not guess how they feel and what they think. Find ways to get answers to these or similar questions from a variety of provider stakeholders. Then do the same with seriously ill patients and family caregivers. Some of this can be done during a needs assessment if you do interviews or focus groups. Hiring a neutral third-party researcher or facilitator may be helpful as you conduct these roundtables to avoid injecting your personal or organizational bias or advanced understanding of hospice & palliative care into the conversation, allowing you to glean more actionable insights.

Below are the questions you can ask providers and a format that can help you compare and find similarities between the responses each provider gives you.

	Provider #1	Provider #2	Provider #3
Do you know what palliative care is? What is your definition of palliative care?			
What are you worried about?			
What is your decision-making process?			
What criteria will you use to make a decision?			
Who influences your decision to contact hospice?			
Who influences your decision to contact palliative care?			
What keeps you up at night?			
Who do you trust to provide information?			

It's also important to understand what your customers already think about your organization and the types of services you offer (hospice, palliative care, private duty, etc.). Below is an example of a table you can use to identify what the customers think (not what you think they think) about each service line (or potential service line) you operate.

What Providers Think	Hospice	Palliative
What is the reputation?		
Best aspects		
Key words		

Below is the same table filled out for a generic hospice with a palliative care program. If you have more services, such as Medicare Care Choices Model, private duty, home health, and so on, be sure to list those as separate columns.

What Providers Think	Hospice	Palliative
What is the reputation?	Excellent program for those who are dying	May know palliative care -- may confuse with hospice
Best aspects	<ul style="list-style-type: none"> • Expert pain and symptom management • Care coordination • Family decision-making and support 	
	<ul style="list-style-type: none"> • 24/7 • Comprehensive benefit - meds/DME 	<ul style="list-style-type: none"> • Resolving conflict • Available to all seriously ill patients
Key words	<ul style="list-style-type: none"> • Symptom management • Counseling 	
	<ul style="list-style-type: none"> • Comfort • Care • Compassion • End of life 	<ul style="list-style-type: none"> • Advanced serious illness • Point of diagnosis, on • As needed, when needed

Communicate the Unique Value

Once you've identified the needs of your audience you must delineate how your services uniquely meet those needs. The information collected in the process outlined above, helps you understand the needs of the audience and match the value-add your program offers to match their need. The next table is for you or your team to complete using the input from your stakeholders.

Key Questions	Physicians
How can palliative care uniquely meet their needs?	
Why is palliative care the best choice to meet the needs?	
What is the added value to them of palliative care?	
What can palliative care provide that hospice can't?	

Here's an example with some wording to help you craft your messages. Yours should be specific to your services, so be sure not to just use this language.

Key Questions	Physicians
How can palliative care uniquely meet their needs?	<ul style="list-style-type: none"> • What you love about hospice while continuing treatment • We help resolve conflicts between patients / families regarding achievable care goals
Why is palliative care the best choice to meet the needs?	<ul style="list-style-type: none"> • We are specially trained in to manage pain and symptoms associated with treatment • We address social, emotional, and relational suffering
What is the added value to them of palliative care?	<ul style="list-style-type: none"> • Patients have 24/7 access to our on-call • We provide holistic, supportive care so you can focus on medical treatment • We coordinate with other providers • You refer, we'll determine if they qualify or identify another solution
What can palliative care provide that hospice can't?	<ul style="list-style-type: none"> • Concurrent care • No prognostic barrier = Care for seriously ill individuals with greater than 6 months to live

Check to See if You You've Got It Right

Checking to make sure you've correctly matched your messaging with the customer's needs/hopes/fears is a critical step that should not be skipped. If you get your messaging wrong, it could seriously damage your brand and the service line's success. For providers, pick a few trusted, long-time partners or referral sources and asking them to respond to your messaging. You can do the same testing with a focus group of community members as prospective patient/families. Ask them:

- Does our messaging resonate?
- Does it match your experience of us?
- Does it give you confidence we can meet your needs?
- Does it inspire you to contact us?

Then tweak as needed before you invest in extensive marketing materials or roll-outs.

Decision point: Are you interested in promoting the entire organization and the range of services you offer and/or each individual service line? The umbrella brand approach described at the beginning of this chapter can allow you to do both. But if you want to stick with your current brand structure, there are benefits to both approaches:

Promote	Pro	Con
Entire organization	<ul style="list-style-type: none"> Promotes range of services Presents a unified, integrated continuum of care Facilitates transition from one service line to the next from the same trusted provider 	<ul style="list-style-type: none"> Confusing messaging - "XYZ Hospice provides palliative care" Service line differentiation can be lost May create confusion between organization brand and individual service line brands Some families may not want non-hospice services from a hospice provider
Individual service lines	<ul style="list-style-type: none"> Build on name recognition of first established brand (e.g., hospice) Allows you to differentiate palliative care from hospice for those who may associate it with actively dying or withholding treatments. 	<ul style="list-style-type: none"> Diluting the potency of your brand identity Having to establish or forgo a connection of trust among the two or several service lines

Clarifying Key Messages

All these questions, roundtables, and decisions about how to define your service offerings will eventually lead you to define your key messages. This process may not be straightforward and will require significant discussion and analysis of what your provider stakeholders and seriously ill patients and their families have told you is important to them.

Key messages are not unlike an organization's mission and vision statements. They are the north star for how you talk about your agency and the service offerings you provide in every setting. At their core, your key messages are the main points of information you want your stakeholders to understand and remember. They succinctly and accurately describe the value you offer, how it is different or better, and why your audience should care. In fact, your key messages should reflect your mission and vision: The two are intricately tied together. Any new service line or offering should be grounded in the mission, vision, and values of your organization. Tying the palliative care program back to your core principles allows your staff and leadership teams to understand why palliative care is an extension of the work your organization is doing in hospice or home health. It aligns every member of your team to your organization's higher purpose, regardless of their role or division within your company.

Take time with your leadership team, clinical team, and trusted community stakeholders to develop these key messages. Analyze the results of your roundtables and look for themes and repeated phrases. For example, did the providers you interviewed in your roundtables consistently say that what influences their decision to refer to a particular palliative care provider is that they give consistent feedback and patient updates? If so, you may want to develop a key message about how your palliative care program emphasizes coordinated multidisciplinary care for the patients you serve. It will take time to develop these messages, and there are many online tools to help facilitate their creation. But defining them early ensures that every marketing effort that follows is strategic and ties back to the community needs your research has identified to be the most important.

The key messages you develop are useful tools, but only if you use them and weave them into all communications about your palliative care offerings. Every pamphlet or flyer you develop to educate patients, families, or referral sources should clearly and concisely reflect the value proposition you have developed in your key messages. The same applies for the language your clinicians and community liaisons use when talking about your program in any form of communication.

Outreach

Community education and outreach aren't optional parts of your palliative care strategy. This isn't "Field of Dreams": Just because you build it, doesn't mean they'll come! A comprehensive outreach plan is a core part of both your palliative care startup and your ongoing operations.

What form this takes will ultimately depend on your local community needs, your budget, and the services you'll be offering. However, there are some commonalities across many types of palliative care programs:

Education

With the definitions of palliative care differing from professional to professional and the community still evolving, education is a key component of your outreach efforts. Identify your main referral sources and learn from them how they'd like to receive education, including:

- **In-Person Inservices:** Many hospitals, skilled nursing facilities, and physician practices have conference rooms with A/V capabilities where you can give in-person trainings. Developing strong inservices for your upstream partners in caring for patients is a worthwhile endeavor. It allows them to gain a deeper understanding of the benefits of palliative care for their patients and positions you as an expert on palliative care delivery. Take time to develop a series of inservices that fill the knowledge gaps you see in your communities. While not always feasible, you should consider taking the time to have your inservices certified and approved for CE / CME. If you can offer this value to physicians, social work discharge planners, or RNs, you're more likely to be able to secure their valuable time so you can educate them on the benefits of palliative care. Potential topics might include:
 - Palliative care 101: basics and definitions
 - Medication reconciliation and pain management in palliative care patients
 - Advance directives and how physicians can bill for having ACP conversations
 - Grand rounds: complex case management and how palliative care can support these patients

Written Materials

Consider the value of developing collateral specifically for healthcare practitioners who may refer a patient to your palliative care. This may take the form of a referral form or pad with your fax or intake number, or perhaps a flyer highlighting your specific differentiators. An attractive, well-written "What Is Palliative Care?" fact sheet that providers can use to educate their patients would likely be very welcome.

Person-to-Person Encounters

If you have a particular physician or referral source who tends to wait too long to refer to palliative care or who serves a seriously ill population, proactive one-on-one encounters over coffee or even at the nurses' station can be valuable teachable moments that can lead to a greater understanding and utilization of the services you can provide to their patients. This may also be a good place to utilize your own physician team for "doctor to doctor" conversations/education.

Community Engagement

Many palliative care referrals come from healthcare professionals who understand the value of palliative care to those living with advanced illness. However, there are people in many other roles who may interact with people who may need palliative care services, including social work caseworkers, patient advocates, religious or community organizations, or volunteer groups like Meals on Wheels. By reaching out to these individuals or organizations and offering to partner or provide them with education or inservices, you can develop ties to groups that can serve as your eyes and ears with a larger patient population for your community-based palliative care program.

Remember: Throughout any educational offering, engagement, marketing material, or other event, always view the content you've created through the lens of your key messages for consistency and potency.

Marketing

When developing your business plan, your leadership team should consider dedicated resources for marketing your palliative care offerings. The ultimate shape this may take will depend on your strategy, external partnerships, goals, and targets. However, every program should consider having either a full- or part-time staff member dedicated to marketing your palliative care service line. As mentioned above under outreach, proactively working to inform the community of your offerings and benefits is a key part of marketing. Having a robust palliative care team does you no good if patients, referral sources, and the community aren't aware that you exist!

Considerations for Staffing Your Marketing Program

Clinical versus non-clinical

Having someone in a marketing role with a clinical background such as an RN or social worker can be very useful. Marketers with clinical backgrounds can speak from their lived experiences to assist referral sources with determining whether palliative care may be right for a patient. However, their experience may come at a higher price point than a nonclinical marketer would command. New hires from either background will require intensive training: non-clinical hires in the clinical aspects of palliative care and the structures of healthcare environments; clinical hires in the techniques of marketing, communication, and sales.

Roles and responsibilities

Clearly defined expectations are critical to the success of the marketer. With the assistance of the leadership team, they should develop quarterly or semi-annual business plans that reflect the larger goals of your program. Business plans should include action items and expected results such as:

- Anticipated numbers of referrals needed to make the program sustainable
- Targeted areas and referral sources to market services toward, in alignment with larger business plans. Geographic area, case mix/acuity of patient population, local understanding and acceptance of palliative care should all be factored in.
- Inservices, health fairs, and community event presence

Daily activities

A marketer works autonomously because they are traveling between various physician practices, clinics, skilled nursing facilities, and hospitals. Having clear expectations for productivity allows them to be successful and understand exactly what is required of them as a part of your palliative care team.

Setting realistic goals for your marketer and developing ways to track their activities will ensure they are contributing in a sustainable way to your operations. Consider using customer relationship management (CRM) software so that your marketer can enter the visits and activities they've done on behalf of your program and can also make notes about their interactions. A CRM can also be helpful for strategically analyzing future marketing efforts. For example, if your marketer has delivered 2 inservices and made 15 visits to a physician practice in a 6-month period, but that practice hasn't made any palliative care referrals, it may be worth discussing if you should focus your marketing efforts elsewhere.

Education and collateral

The marketer should also have a basic understanding of how to educate referral sources and tailor their tactics to fit the types of situations they may encounter. Ensuring that a referral source knows how to make a referral, where to send it, and what information needs to be included are all critical parts of your operations, and your marketer should expect to routinely educate on these points.

As mentioned above in the outreach section, your marketer should have ample collateral that describes your service offerings, defines key terms, and lists the process for making a referral. All collateral will benefit from utilizing your key messages and should also have a consistent, identifiable branded design and easy-to-find phone and fax numbers.

Depending on the structure of your program, marketers may also meet directly with patients and families who are interested in palliative care. Your marketer should have training in how to facilitate these discussions, and your program should have dedicated collateral explaining your palliative care offerings to patients and families.

Patient updates

Marketers can and should assist their clinical counterparts in providing updates to referral sources about the patients your program is serving. If a patient's status improves, if they decide to elect hospice, or if your team helped create a meaningful moment for the patient via your palliative care, that is an excellent reason to reach out to the referring physician. Many referral sources will be more open to these communications than they might be to pure marketing efforts. They'll be thankful for the update as a part of the coordinated plan of care you've created, and it's an opportunity for your marketer to reinforce

the value of your partnership in a soft-marketing manner. Time should be built into a marketer's schedule to provide these updates.

Ethics and compliance

While marketing efforts are essential to the sustainability of a palliative care program, it is important to develop a culture of compliance with local, state, and federal regulations around your efforts. Practices such as giving gifts or money for referrals should be strictly avoided for any patient-focused program. Similarly, high-pressure sales techniques or management of sales staff through expectations purely focused on revenue or volume can easily run afoul of local or national regulations. Ensure your in-house counsel or legal consultants review the roles and responsibilities of your marketing team, and make sure you provide your team with well-documented ethics and compliance training on a regular basis. NHPCO has a list of ethical principles for marketing, and while many of them specifically apply to hospice, they are a good foundation to build a similar culture of ethical marketing for your palliative care program.

Understanding the credentialing process

Many hospitals require marketers to be credentialed before they can visit patients or referral sources within their facilities. Some of these processes can take time to complete, so insure you have factored this time, effort, and potential cost into your business plans.

The Role of Data in Marketing

Your palliative care marketing plan will benefit by being informed by actionable data. With an increasing focus on fee-for-value within healthcare, it's critical to understand what data payors and risk-bearing entities look at, and how a well-run palliative care program can help them manage risk and cost, while increasing quality.

- **Publicly reported data:** [Hospital Compare](#), [Physician Compare](#), and [Nursing Home Compare](#) contain troves of information that can help guide your marketing efforts. If a hospital has higher-than-average readmission or mortality rates, focused attention on marketing your services there may lead to more referrals for your program, and better outcomes for the hospital. Similarly, if a physician participates in an advanced payment model or quality reporting program, they may be interested in the holistic, wrap-around care that a palliative team can provide their high-acuity patients. All these data points (and many others) are reported by the Centers for Medicare and Medicaid Services, and understanding how these sites work is critical to informing your business plans.
- **Proprietary data:** If you have a health system, Accountable Care Organization, Managed Care Organization, or skilled nursing facility as one of your main payors for palliative care services, they will have extensive patient-level data beyond what is publicly reported. Take time to meet with your partners and examine this data. Often it can be used to "hotspot" physicians or referral sources with larger-than-average patient costs who may be good targets for education on your palliative care offerings. Data can also be used to identify patients who may not have advance directives, have multiple chronic conditions, or have multiple rehospitalizations; all of whom are ideal candidates for palliative care.
- **Your data:** As your program grows, you'll be able to use your own data to drive your marketing efforts. If you can track statistics that prove the value of your offerings, these can be used in conversations with health systems or payors. How many patients do you convert to DNR in less than two weeks and/or two consults? How many ER visits do you prevent for patients receiving your palliative services? How many of your patients aren't re-hospitalized within 60 days after starting palliative care? How quickly do you drive down Self-Identified Threshold symptom scores for your patients? Understanding the data your own electronic health record can provide will give you actionable data to use to responsibly expand your program.

Linking Palliative Care to Quality and Performance Measures for Referrers

Another factor in marketing the value of your palliative care program is in communicating how it can support quality and performance measures of your referral sources.

As noted above, tracking your own performance data can show how you can help a referrer improve their outcomes and performance scores. For instance, you can quantify how referring patients to your home-based palliative care program can help a hospital or health system:

1. Reduce hospital re-admissions for the same condition within 30 days, avoiding Medicare penalties
2. Reduce ER visits, which often lead to a hospital admission or re-admission
3. Reduce ICU bed usage
4. Reduce hospital inpatient mortality rates

As your data set becomes deeper over time, you can even track performance by disease state and offer targeted solutions if a referrer is experiencing special challenges with diagnoses such as COPD or CHF.

When you demonstrate the value of your palliative care program, it may even open doors for you to become a preferred provider beyond home-based care. For example, numerous hospitals and health systems have no formal palliative care program or it's limited to only an inpatient consult because of the current reimbursement structure from CMS. However, two of the main criteria of HCAHPS scores for hospitals are centered specifically on pain management and transition of care to home – two areas where robust palliative care can have a very positive impact. A growing number of palliative care agencies are contracting with hospitals to provide inpatient palliative care as an extension of the hospital team, then following the patients home to help with ongoing pain management, as well as a smooth transition in keeping patients home after discharge.

Extending Palliative Care Performance to Your Hospice Quality Measures and Evaluations

Another advantage of palliative care is that it can begin strong relationships with patients and families upstream from hospice care – especially with palliative care's appeal of not having to discuss "six months or less to live" and no need to give up curative treatments. As the relationship and trust deepen with families benefitting from palliative care, it can be easier to discuss a transition to hospice care as early as appropriate. And the attributes your brand establishes during palliative care can become great marketing tools and performance standards for your hospice services.

Consider, for instance, featured categories of CAHPS Hospice surveys and scores:

1. Communication with family
2. Getting timely help
3. Treating patient with respect
4. Emotional and spiritual support
5. Help for pain and symptoms
6. Training family to care for patient
7. Rating of this hospice
8. Willing to recommend this hospice

Family expectations and criteria for these performance areas can be firmly established at the pre-hospice palliative care stage. In fact, the two areas where palliative care should be making the greatest impact are the same areas that are tied for the lowest national average scores among CAHPS survey categories: The median ratings for "Help for pain and symptoms" and "Training family to care for patient" were 75 and 76, respectively, out of a possible 100.¹ Survey questions in the latter category specifically mention training to recognize side effects of medications and knowing if/when to give more pain meds. If best practices are established at the palliative care stage and continued into the hospice stage, providers can realize improvements in CAHPS scores (Hospice Item Set metrics, too) and Hospice Compare ratings to ultimately strengthen their hospice marketing as a halo effect.

1. The CAHPS survey items are scored on a 0/100 value, where the top (best) response is scored as 100 and all the other responses are scored as 0. (Parast, L., Haas, A., Tolpadi, A., Elliott, M. N., Teno, J., Zaslavsky, A. M., & Price, R. A. (2018). Effects of caregiver and decedent characteristics on CAHPS Hospice Survey scores. *Journal of Pain and Symptom Management*, 56(4), 519–529. Retrieved from <https://hospicecahpsurvey.org/globalassets/hospice-cahps/scoring-and-analysis/5-30-19-updates/cahps-hospice-survey-national-percentiles-q4-2016---q3-2018-final.pdf>

Every Member of the Team is a Marketer

Finally, it's important that regardless of whether you decide your program requires a dedicated marketer in any capacity, your team understands that everyone has a role in marketing.

Every touchpoint or conversation with a referral source has implications for future referrals. Patient updates or discussions about plans of care are critically important moments to reinforce the value of your program and your desire to support and serve the seriously and chronically ill populations in your area. Making sure your entire PC team knows they need to always have a customer service-oriented attitude provides for better patient outcomes and contributes to the sustainability of the program.



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Resources



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Program Considerations and Design

California Health Care Foundation: Weaving Palliative Care into Primary Care: A Guide for Community Health Centers
www.chcf.org/publication/weaving-palliative-care-into-primary-care-a-guide-for-community-health-centers/

Center to Advance Palliative Care: Designing a Home-based Palliative Care Program
www.capc.org/toolkits/starting-the-program/designing-a-home-based-palliative-care-program/

Center to Advance Palliative Care: Designing a Long-Term Care Palliative Care Program
www.capc.org/toolkits/starting-the-program/designing-a-long-term-care-palliative-care-program/

Center to Advance Palliative Care: Designing an Office or Clinic Palliative Care Program
www.capc.org/toolkits/starting-the-program/designing-an-office-or-clinic-palliative-care-program/

Center to Advance Palliative Care: Designing an Inpatient Palliative Care Program
www.capc.org/toolkits/starting-the-program/designing-an-inpatient-palliative-care-program/

CSU Institute for Palliative Care: Building a Community-Based Palliative Care Program
csupalliativecare.org/organizations/roadmap/

Regulations, Licensure, and Credentialing

American Health Lawyers Association: AHLA Corporate Practice of Medicine: A Fifty State Survey
store.lexisnexis.com/products/ahla-corporate-practice-of-medicine-a-fifty-state-survey-ahla-members-skuusSku20740358

Centers for Medicare and Medicaid Services: Medicare Coverage Database
www.cms.gov/medicare-coverage-database/

Federal Small Business Administration: Choose a Business Structure
www.sba.gov/business-guide/launch-your-business/choose-business-structure

National Academy for State Health Policy: Advancing Palliative Care for Adults with Serious Illness: A National Review of State Palliative Care Policies and Programs
nashp.org/wp-content/uploads/2018/12/Palliative-Care-Brief-Final.pdf

National Coalition of Hospice and Palliative Care: National Consensus Project (NCP) Clinical Practice Guidelines for Quality Palliative Care, 4th edition
www.nationalcoalitionhpc.org/ncp/

National Hospice and Palliative Care Organization: Standards of Practice for Hospice Programs
www.nhpco.org/press-room/press-releases/revised-standards-practice-released

US Department of Health and Human Services, Office of Inspector General: Compliance Resource Portal
oig.hhs.gov/compliance/compliance-resource-portal/

U.S. Department of Justice: The False Claims Act: A Primer
www.justice.gov/sites/default/files/civil/legacy/2011/04/22/C-FRAUDS_FCA_Primer.pdf

Payer

California Department of Health Care Services: Palliative Care and SB 1004
www.dhcs.ca.gov/provgovpart/pages/palliative-care-and-sb-1004.aspx

California Health Care Foundation: Payer-Provider Partnerships for Palliative Care
www.chcf.org/resource-center/payer-provider-partnerships-for-palliative-care/

Catalyst for Payment Reform and the Center to Advance Palliative Care: How-to-Guide: Integrating Palliative Care into Your Purchasing Strategy www.catalyze.org/product/palliative-care-purchaser-resources/

Center to Advance Palliative Care: Population Management and Palliative Care
www.capc.org/toolkits/population-management-and-palliative-care/

Center to Advance Palliative Care: Strategies for Health Systems, Health Plans, and ACOs
www.capc.org/topics/accountable-care-organizations-and-palliative-care/

CSU Institute for Palliative Care: Developing Partnerships with Payers
csupalliativecare.org/organizations/roadmap/payers/

Quality and Data

California Health Care Foundation: Palliative Care Measure Menu
www.chcf.org/publication/palliative-care-measure-menu/

California Health Care Foundation: Measures and Outcomes
www.chcf.org/resource-center/community-based-palliative-care/measures-and-outcomes/

Center to Advance Palliative Care: The National Palliative Care Registry
registry.capc.org/

Accreditation

Accreditation Commission for Health Care: Palliative Care Distinction
www.achc.org/home-health.html

Community Health Accreditation Partner: Palliative Care Certification
chapinc.org/palliative-certification/

The Joint Commission: Palliative Care Certification
www.jointcommission.org/certification/palliative_care.aspx

Certification

American Academy of Hospice and Palliative Medicine: Certification for Hospice and Palliative Medicine Specialists
aahpm.org/career/certification

Hospice and Palliative Nurses Association: Certification
advancingexpertcare.org/HPNA/Certification/HPCC/CertificationWeb/Certification.aspx?hkey=993a4764-2575-4c2e-ac38-203812fc7a0f

National Association Catholic Chaplains: Palliative Care and Hospice Advanced Certification
www.nacc.org/certification/palliative-care-and-hospice-advanced-certification/

National Association of Social Workers: Advanced Certified Hospice & Palliative Social Worker (ACHP-SW)
www.socialworkers.org/Careers/Credentials-Certifications/Apply-for-NASW-Social-Work-Credentials/Advanced-Certified-Hospice-and-Palliative-Social-Worker



NHPCO Palliative Care Playbook for Hospices

Tools



NHPCO

Leading Person-Centered Care

[NHPCO.ORG](https://nhpc.org)

Determining the Need for Palliative Care

- Palliative Care Needs Assessment Stakeholder Questions
- Hospital Data for Needs Assessment
- Hospital Data for Needs Assessment - BLANK
- Hospice Data Collection Spreadsheet
- NCP Guidelines Evidence of Practice and Action Plan
- Needs Assessment Data Source Worksheet

Quality and Data

- Metrics Balance Check Worksheet



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NHPCO

National Hospice and Palliative
Care Organization