

Hospices as Providers of Community-Based Palliative Care: Planning Your Service Strategically

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Objectives

- ❖ Define non-hospice palliative care
- ❖ Introduce the foundational principles of palliative care program design
- ❖ Describe key considerations for hospices planning or delivering palliative care services, including:
 - ❖ Organizational priorities
 - ❖ Business model
 - ❖ Legal and regulatory issues

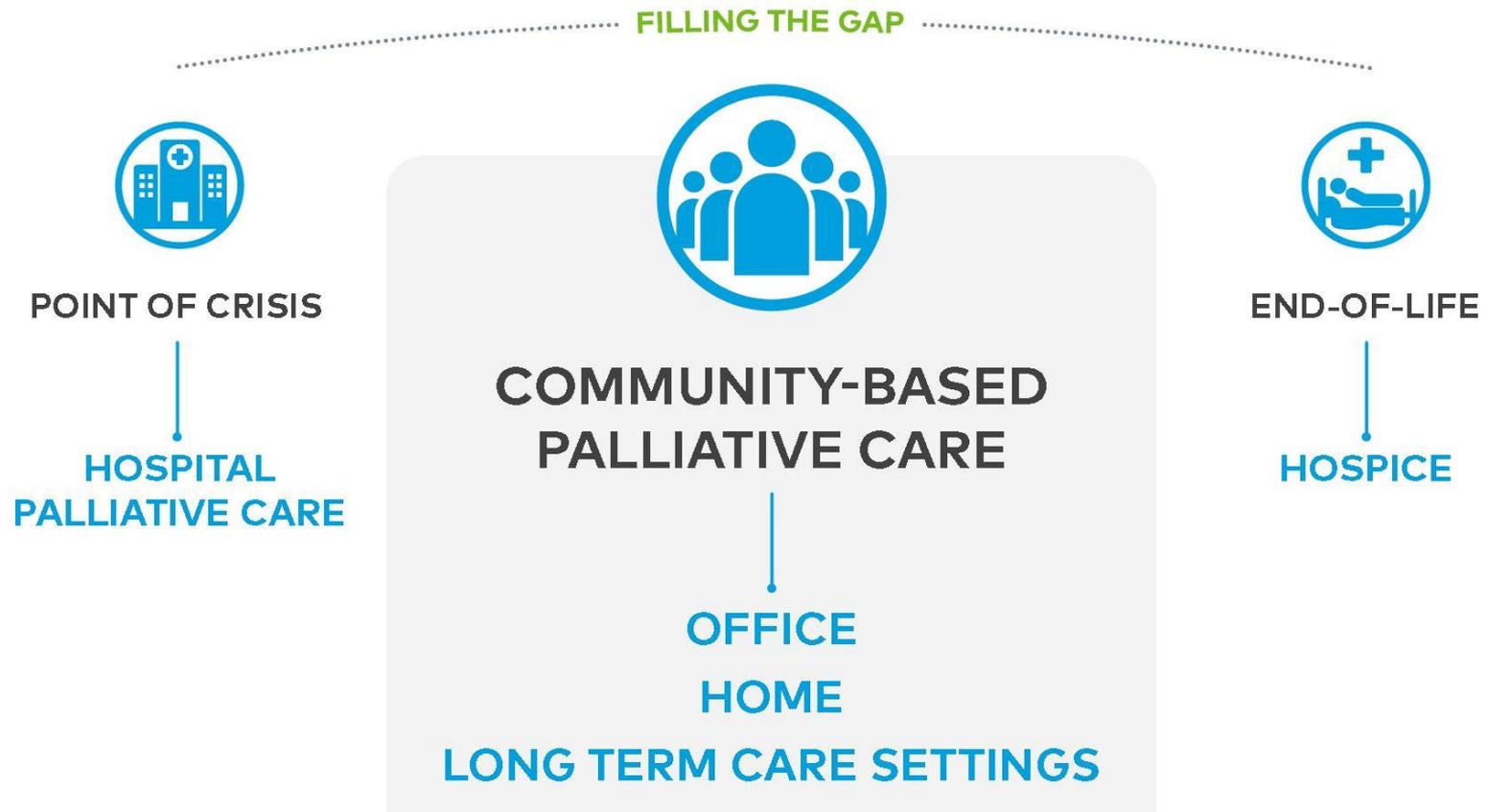


Defining palliative care

- Specialized medical care for people living with serious illnesses.
- Focused on providing relief from the symptoms and stress of a serious illness—goal is to improve quality of life for both the patient and the family.
- Appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment.



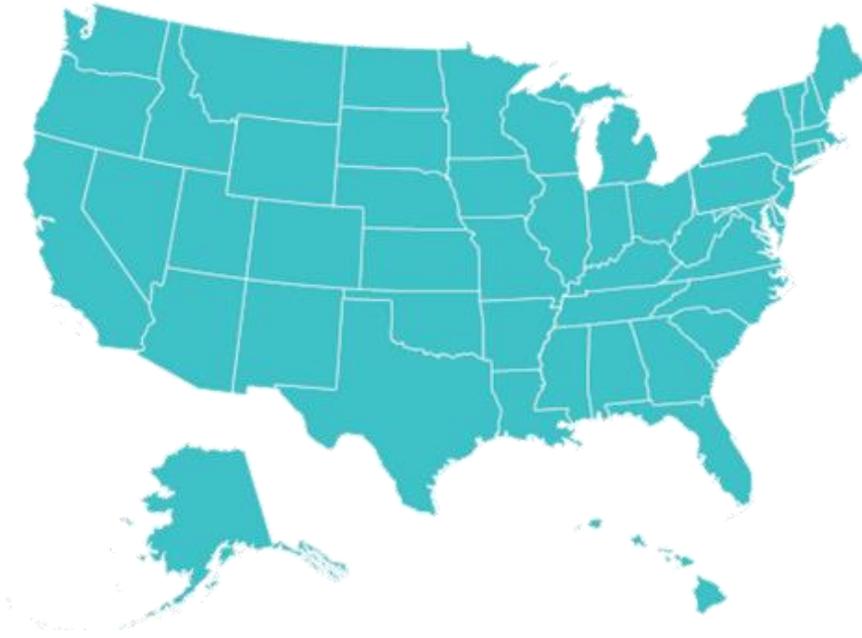
Palliative care across the continuum



U.S. Hospital-based Palliative Care



Introducing...



Mapping COMMUNITY PALLIATIVE CARE

Are you a community-based palliative care program? Put yourself on the map!

A new CAPC initiative to map all palliative care programs providing care in the community across the U.S.

Participating programs will have the option to be included in GetPalliativeCare.org's Provider Directory

Put your program “on the map” today!

Part 1: Considering a Complementary Service Line

Needs Assessment Process: A Means to Understanding Organizational Priorities

- WHY are you considering this now?
- What are the RISKS and OPPORTUNITIES for your Hospice?
- Who are the community or health system stakeholders critical to success, funding, or achieving HOSPICE goals?

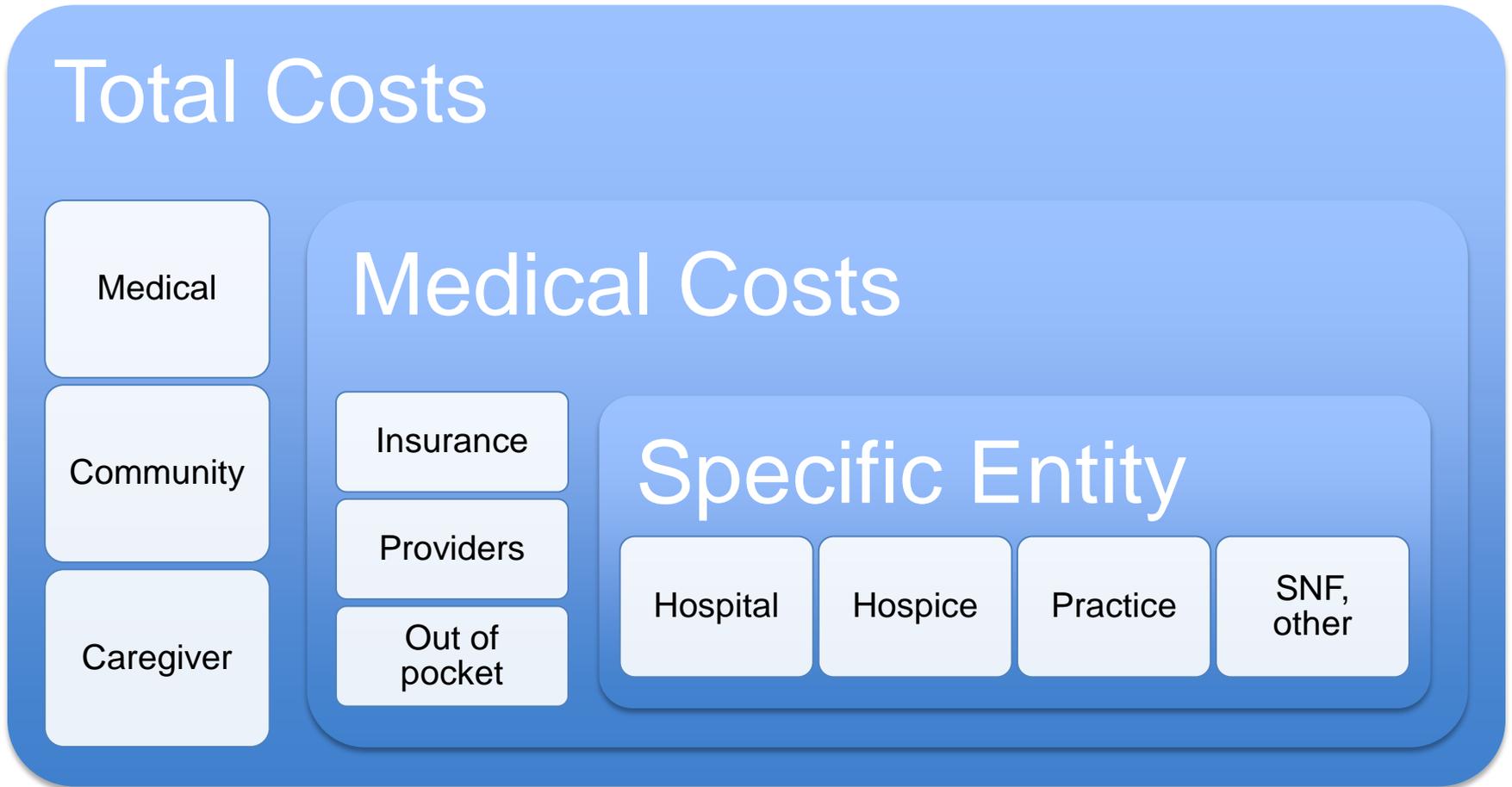


Needs Assessment as a STRATEGY

- What matters
- Who makes decisions
- What problems keep people up at night
- Who can fund
- Baseline data related to gaps and opportunities
- Who is already doing what (Collaborators)
- Process for evaluation of plans (Metrics & Milestones)



Dilemma in CbPC: Alignment of investment & benefit



How to choose? Outline features.

Option 1: Post acute stabilization (Ex: CHF?)	Option 2: Co-management with PCP
Requires rapid response & reliable f/u	May have some flex re initial visit, & f/u frequency
May have frequent activity over short duration (<3 months)	Often has duration >3 months
Can serve more patients / year for shorter period	Fewer patients served, long term benefit

***These are two of MANY possible examples, for illustration.*



Regulatory Definition of Palliative Care

In Federal Regulations

→ **Medicare Hospice Conditions of Participation**

§418.3 Definitions

- **Palliative care** means 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.

→ Definition also adopted by:

- National Quality Forum
- National Consensus Project for Quality Palliative Care

→ **Medicare regulations define “palliative care” [Federal Register, FY2018 Hospice Wage Index Final Rule, page 36639]**



Nursing Home Interpretive Guidelines

Effective November 28, 2017

F684 § 483.25 Quality of care

- **Quality of care** is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:
- **“Hospice Care”** means a comprehensive set of services described in Section 1861(dd)(1) of the Act, identified and coordinated by an interdisciplinary group (IDG) to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and/or family members, as delineated in a specific patient plan of care. (42 CFR 418.3)
- **“Palliative care”** means 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. (§418.3)
- **“Terminally ill”** means that the individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. (§418.3)



State Level Considerations

→ State licensing laws and regulations

- **Hospice:** does the state licensing law or regulations allow a hospice to provide care to non-hospice patients?
 - Is the patient population defined in state law or in regulation?
 - Definition of patient:
 - Terminally ill?
 - 6 months or less prognosis? If not 6 months, then what time frame for prognosis?
 - Serious illness?
 - *Example:* One state's definition: Hospices can provide palliative care to patients who are not terminally ill if they have "advanced and progressive disease," meaning a serious life-threatening medical condition which is irreversible and which will continue indefinitely



State Level Considerations

- If state licensing laws do not allow a hospice to provide non-hospice palliative care or are unclear, consider:
 - Discussions with state licensure agency for interpretation of state regulations to add palliative care under hospice licensure category
 - Changes to state licensure laws or regulations to expand definitions and allow palliative care to be provided under specific licensing categories
 - Joint venture relationship
 - Hospice can unbundle its service and provide non-hospice palliative care jointly with another licensed entity
 - Hospital, nursing home, home health agency, physician practice are all options
 - Hospice staff as trainers for other staff on palliative care concepts



CMS Reference to “Substantially all...”

→ From CMS:

- A hospice may provide non-hospice services and has identified the requirements that apply to such services.
- In defining "hospice," CMS explicitly states it is an organization that "primarily" provides hospice care to terminally ill individuals.
 - (Chapter 2 of the CMS State Operations Manual (SOM), Section 2080A)
- CMS has explained that "primarily" does not mean "exclusively," and stated that a hospice may provide "non-hospice services" to other entities/patients without jeopardizing its Medicare certification
 - CMS State Operations Manual (SOM, Section 2080A)



Considerations at State Level: Home Health

→ State licensing laws and regulations

– Home Health:

- Definition of patient in state law/regulations
- Must patients meet the “homebound” requirement to qualify for palliative care from the state licensure perspective?
- Does the state require Certificate of Need for establishing a new home health agency?
- Licensing requirements for care delivered in the home?
- **Example:** "Nothing in this subsection shall prevent the provision of palliative care for patients with advanced and progressive diseases and for their families by any other health care provider otherwise authorized to provide such care."



Other Considerations at State Level

→ State Corporate Practice of Medicine Laws

- Are there limitations on physician employment by a corporation in the state? How does that impact the delivery of palliative care?

→ Nurse practitioners

- Scope of practice
- Prescriptive authority
- Specific prescriptive authority for Schedule 2 controlled substances

→ State fraud and abuse laws

- Medicaid False Claims Act issues
- Health care False Claims Act issues
- Other anti-kickback or self referral issues



Other Considerations at State Level

→ Fee-splitting arrangement regulations

- Does state law restrict a physician from splitting fees generated in the practice of medicine?

→ Insurance Coverage

- Malpractice
- Workers compensation
- Professional liability insurance
- Protection for workers in the home setting



State Palliative Care Advisory Councils

- Now established in 16 states, 7 more in discussion
- What are the focus areas?
 - Workforce availability
 - Identify existing resources
 - Tracking palliative care availability (inpatient and outpatient)
 - Develop consumer awareness information
- Opportunities
 - Identify champions and other stakeholders
 - Chance to clarify who can deliver palliative care in the home
 - Add resources
 - Be part of the discussion



Part 2: Palliative Care Program Design Considerations

Case Study: Palliative Care Center of the Bluegrass, Inc.

- Established in 1999
- Physician Practice; Joint Commission accredited
- Provider of:
 - Inpatient palliative care consultation services
 - Palliative Care Clinics
 - Home based palliative care
 - Facility based palliative care
- 10,000 patients annually



Case Study: Key Features

- Needs Assessment
- Deep Partnerships
 - Trust
 - Data sharing
 - Goal sharing
 - Cost sharing
 - Board participation
- Evaluation



Case Study: Secrets of Success

- Know your “Why?”
- Change and Evolution
- Have A-Player Partners
- 24/7 Coverage
- Accessible goals of care & plans of care
- Examples:
 - Freestanding Clinic vs. Clinic within Clinic
 - A-Player nursing facility partner

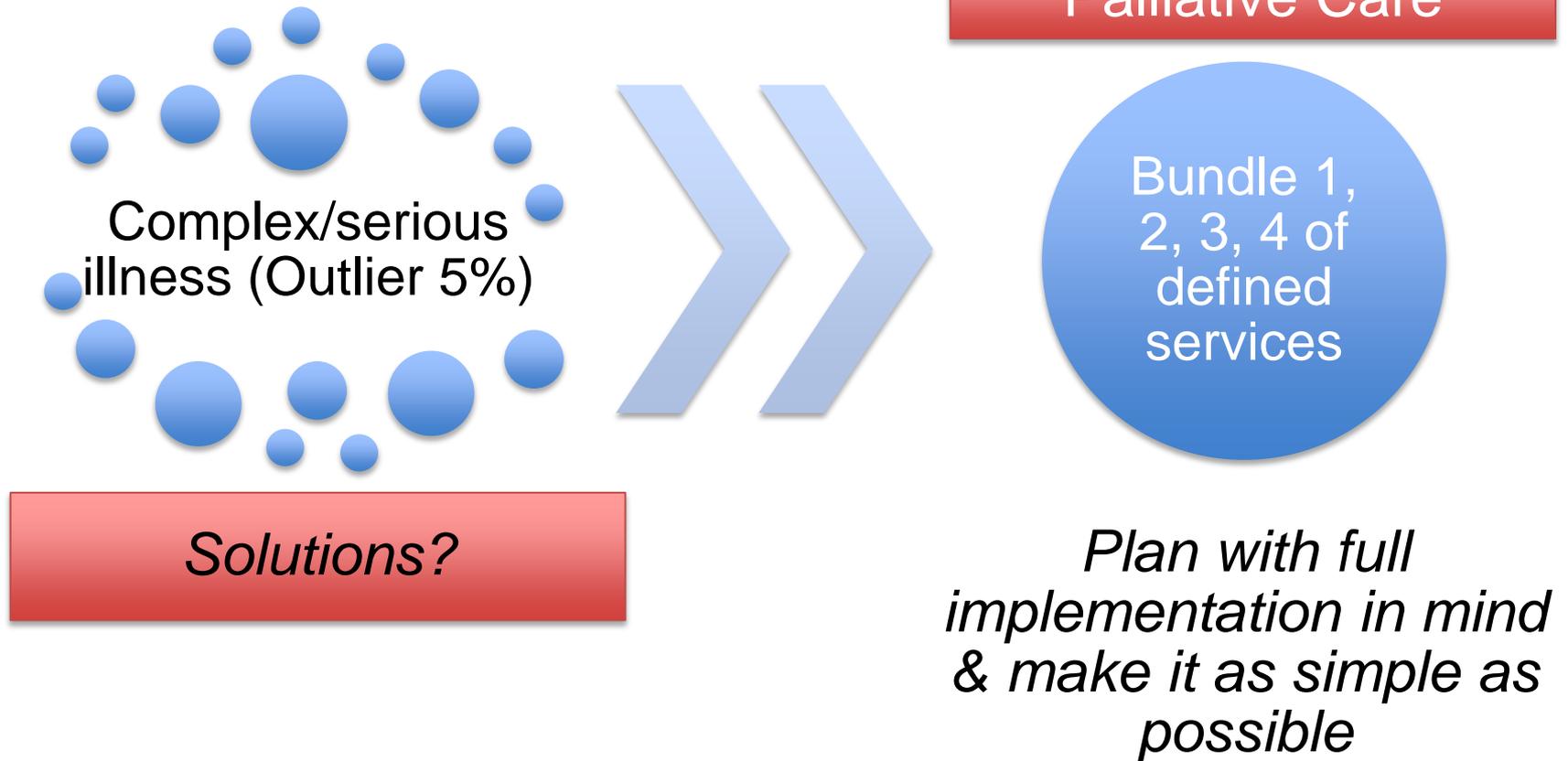


Business Planning Tips

- Identify “service bundles” that solve problems with reliability, vs. planning “visits” only.
- Define the scale of services that is sustainable; evaluate feasibility.
- Then, fund start-up separately.



Define implementation “bundles”



Business Principles in CbPC

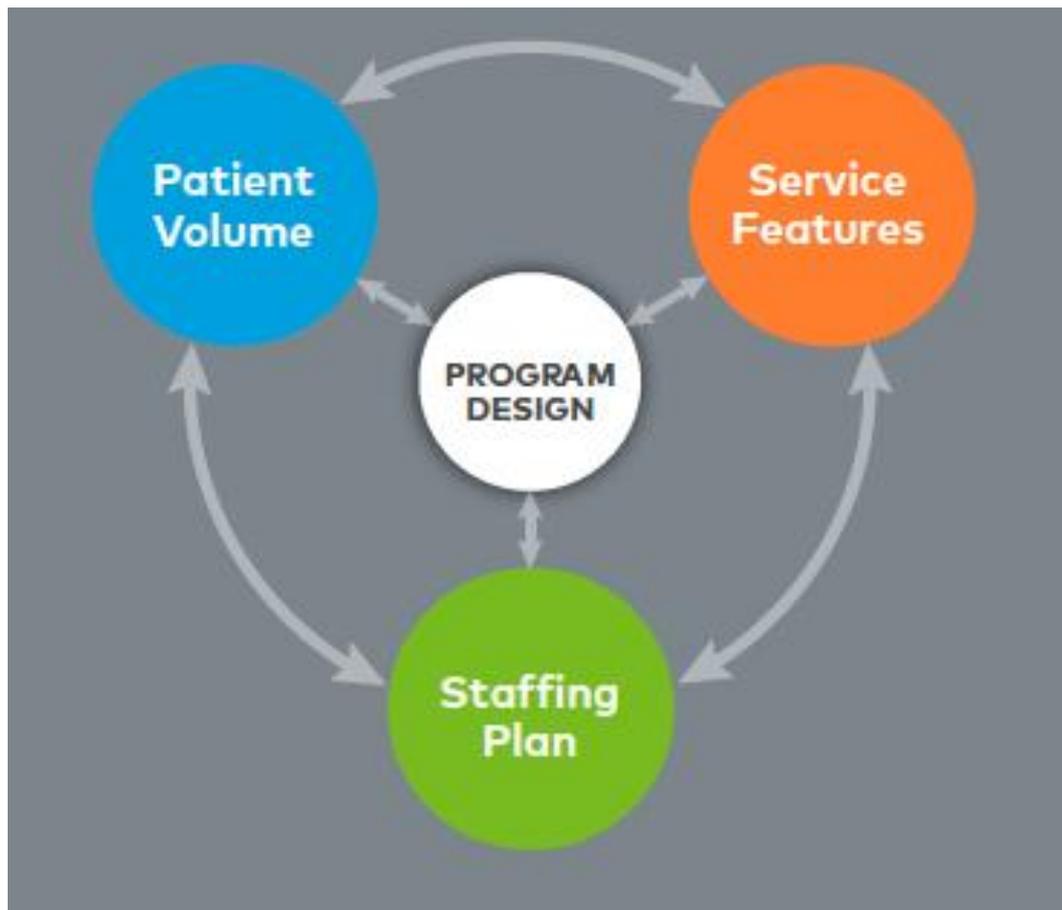
- If you can't define your services
 - Offer performance guarantees or standards (such as response time)
 - Know your costs & how scale impacts your costs



→ **It will be really hard to get paid/funded appropriately.**



Program Design drives Key Variables (and budget & value prop)



Balancing benefit & investment: Making service value explicit

Example: Home Visit Program

- 3 month post-discharge **intensive support**
- 3-6 visits, NP & **SW + telephonic support**
- Cost: assume approximately \$2000 / patient*
- Expected FFS billing net rev - \$600 (+/-)

What are the *options for funding?*

ACO Environment? FFS system?

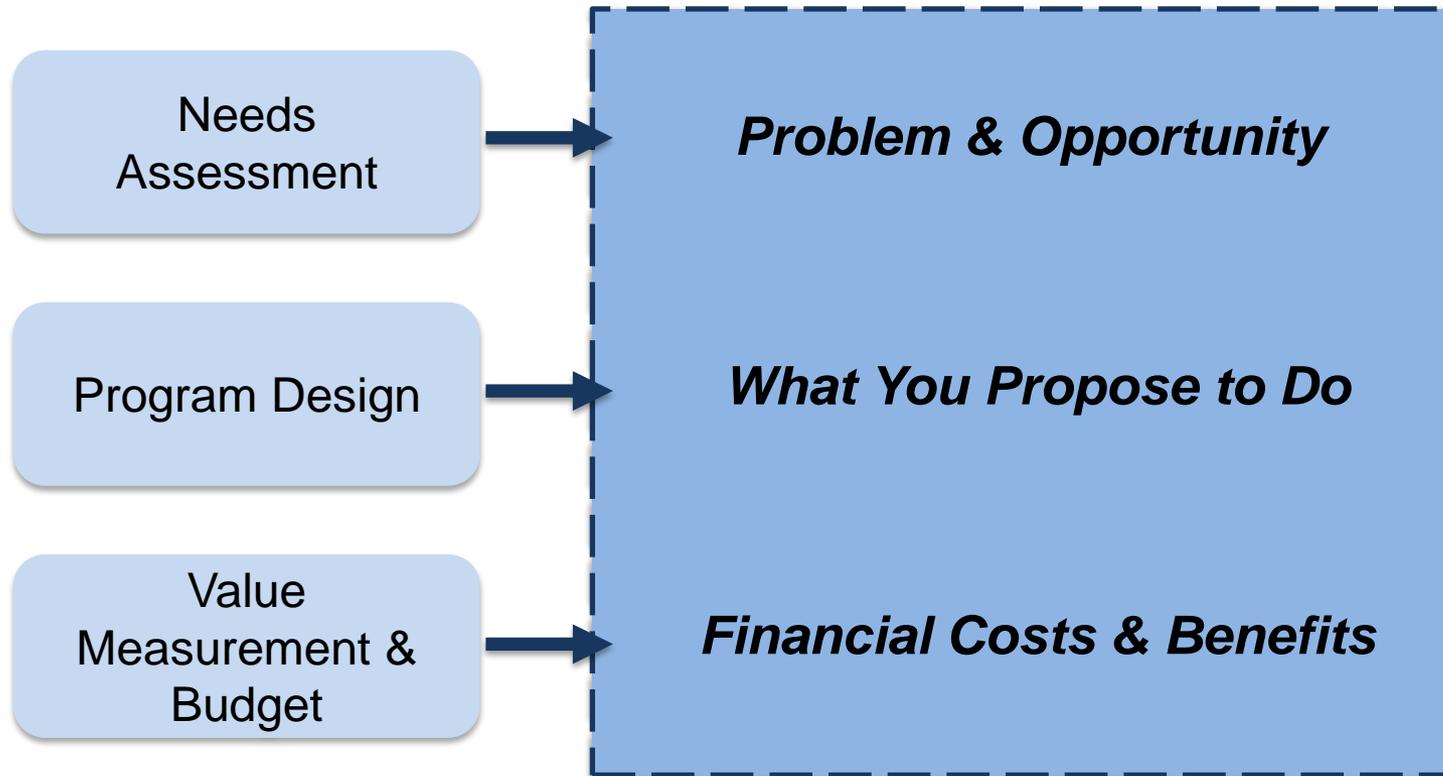
What is your “bundle”?

**Costs & billing are for example only!*



Business Plan Outline

Connecting the dots. Telling the Story. Measuring Results.



Value to Partners > Financial

- **Reliability** (closed process, no gaps, smooth transitions & handoffs, no surprises)
- **Access** (capacity, appointments)
- **SCALE** to have significant impact
- Quality; performance on public indicators
- Other?

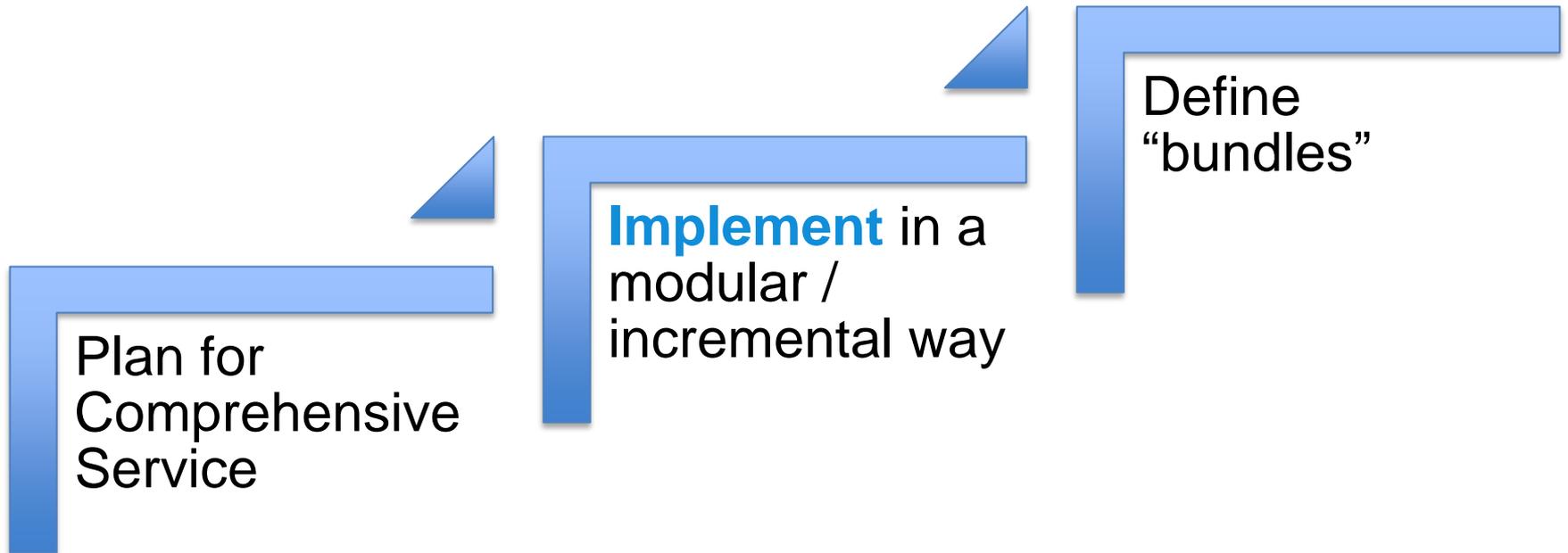


VALUE to Hospice?

- Diversified service lines with contribution margin
- Supports expansion of MD & NP staff
- Strengthen market position / strategic partnerships
- **CHANGE** Hospice referral patterns (trends, sources, timing, costs)



Recommended Approach



Summary

- Get out of hospice box – think about patient needs in community
- Use your strengths to solve your partners' problems
- Use the needs assessment as a strategy to learn what is needed and match your service design



Getting Started

- NHPCO state-specific regulations resource coming soon...
- CAPC Palliative Care Leadership Centers
 - In-person program design training & yearlong mentoring, pclc.capc.org
- Program design toolkits for home, office, and hospital palliative delivery
- NHPCO Palliative Care Resource Series
 - nhpco.org/palliative-care-4



Q&A