Join us for upcoming CAPC webinars and virtual office hours

➔ **Webinar:**

- **Innovative Approaches to Caring for Complex Patient Populations: The Community Paramedicine Experience**
  Thursday, April 21, 2016 from 1:30 - 2:30 PM ET
  Featured Presenter: Dr. John Loughnane, Commonwealth Care Alliance, Inc.

➔ **Virtual Office Hours:**

- **30 min Program Management**
  - Andrew E. Esch, MD, MBA
  - April 15, 2016 at 11:00 a.m. ET (Members Only)

- **Planning for Community-Based Care**
  - Jeanne Sheils Twohig, MPA
  - April 19, 2016 at 1:00 p.m. ET (Members Only)

- **Palliative Care Models in the Community**
  - John Morris, MD, FAAHPM
  - April 19, 2016 at 3:00 p.m. ET (Members Only)

- **Program Staffing and Clinical Protocols**
  - Andrew E. Esch, MD, MBA
  - April 20, 2016 at 1:00 p.m. ET (Members Only)

- **Registry Roundtable: Registry metrics and hospital reports (OPEN TO ALL)**
  - Tamara Dumanovsky, PhD & Maggie Rogers, MPH
  - April 20, 2016 at 4:00 p.m. ET

Objectives

1. Be equipped to utilize a “needs assessment” process to define goals and identify conditions for funding support

2. Identify 3 assumptions that will significantly impact costs and service capacity

3. Define services with clarity (to help grow, evaluate, and fund your program)

4. Identify 3 CAPC tools to help develop a sustainable program
Key Principles of Planning

- Stakeholder Input
  - ID of gaps & goal alignment

Needs Assessment

Plan Comprehensively

- Define best case
- Set expectations

Implement Incrementally

- Build on expectations
- Measure
- Define gaps
Dilemma in CbPC:
Alignment of investment & benefit

Total Costs

Medical Costs

- Medical
- Community
- Caregiver

Specific Entity

- Insurance
- Providers
- Out of pocket

Hospital  Hospice  Practice  SNF, other
Needs Assessment as a STRATEGY

➔ What matters?
➔ Who makes decisions?
➔ What problems keep people up at night?
➔ Who can fund?
➔ Baseline data regarding gaps and opportunities
➔ Who is already doing what?
➔ Process for evaluation of plans
Business Principles in CbPC

➔ There is often a way to do the right thing…

➔ Know your stakeholders and respect their interests

➔ Be creative and define service costs (know your business!)

➔ Align and evaluate benefits
Financial Realities

➔ Best care for complex patients is unlikely to be fully funded by Fee-for-service (FFS) norms

➔ It is likely to be cost-effective “in the big picture” but costly in the small picture

➔ Even risk bearing organizations like ACOs have difficulty reallocating costs

➔ Few organizations are fully risk bearing, so you may serve a “mixed model” patient base
Root Causes of avoidable costs:
Does our service design address some of these?

➔ Reliable, timely, accessible care not available = Use ED, get admitted

➔ Lack of skills/knowledge regarding risk factors and how to address them

➔ Lack of simple and reliable processes to get needs met

➔ Services that ARE covered in hospital are NOT covered elsewhere

➔ Complex discharge care plan = risk of slippage with Rx, follow up, and caregiver support

➔ Silo consultant activity = different stories/ lack of coherent plan of care as consistent goal for all; NO PLAN, PLAN NOT KNOWN

➔ Logistics (transportation, social support, out of pocket $$)
Planning Common Ground: What Patients Want

As asked to rank order what’s most important:

→ 1st - Independence (76% rank it most important)

→ 2nd - Pain and symptom relief

→ 3rd - Staying alive

Fried et al. Arch Int Med 2011; 171: 1854
Survey of Senior Center and Assisted Living subjects, n=357, dementia excluded, no data on function.
Under-recognized Stakeholder: Boards

Hospital board members care about quality, cost, and reputation in community. They are also older adults, vibrant, and vulnerable.

- *Reduced risk of loss of control?*
- *Reduced time in hospital?*
- *Better Q of Life?*

They “get it” and value it.
Payment environment impacts viable options

**FFS**
- Traditional rates & providers
  - Different rates
  - Broader or more flexible IDT

**Case Rate**
- Bundled payment Per Episode or Time Frame
  - Broad or narrow inclusion

**Capitation**
- Bundled services on a Per Member basis (all members vs. utilizers)
  - Risk for incidence & pattern of care

**Salary**
- Own/employ
  - Pay for time, skill, & effort
Implications of Health Care Reform

➔ More value given for longer term and downstream costs (like SNF)

➔ Increased attention to “continuity”, “continuum” and “consistency”

➔ Pressure for full scale, reliable service, potentially in and out of the hospital

➔ Preference given to clear “bundles” with defined processes and outcomes
Business Principles in CbPC

➔ If you can’t define your services
  – Offer performance guarantees or standards (such as response time)
  – Know your costs and how scale impacts your costs

➔ It will be really hard to get paid appropriately.
Connecting the dots. Telling the Story. Measuring Results.

- Needs Assessment
- Program Design
- Value Measurement & Budget
Three Key Assumptions

1. Which patients and how many will you plan to/be able to serve (and why)?

2. What is your service model (and why)?

3. What is your staffing plan (and why)?
Assumptions Drive Business Case

➔ What services to which patients?

➔ How frequently? (Frequency)

➔ For how long? (Duration)

➔ By whom? (Team Composition and use; Billability)

➔ Where? (Travel time, Overhead, etc.)
Dilemma

→ You need to plan the service to know its cost, and to predict its impact

→ Whether you can afford to provide the service will depend on partners, payment methods, and translation of service into VALUE that matches up to specific entity interests

Strategy: Do a DRAFT and TEST it
Interactive Variables
# How to choose?

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

**These are two of MANY possible examples, for illustration.**
## Tool to Organize Assumptions

(From 504 Course Tools – CAPC On Line)

<table>
<thead>
<tr>
<th>New Patients &amp; Visits per Year</th>
<th>Scenario 1</th>
<th>Scenario 2</th>
<th>Your Assumptions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient visit time (in hours)</td>
<td>1.00</td>
<td>1.00</td>
<td></td>
</tr>
<tr>
<td>Documentation, prep, fu time</td>
<td>0.60</td>
<td>0.60</td>
<td></td>
</tr>
<tr>
<td>Travel time (roundtrip)</td>
<td>0.67</td>
<td>0.67</td>
<td></td>
</tr>
<tr>
<td>Total (in hours)</td>
<td>2.27</td>
<td>2.27</td>
<td>0.00</td>
</tr>
<tr>
<td>Available Patient hours / wk</td>
<td>36.00</td>
<td>36.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Capacity / wk</td>
<td>15.86</td>
<td>15.86</td>
<td>0.00</td>
</tr>
<tr>
<td>Weeks/year</td>
<td>44.00</td>
<td>44.00</td>
<td>0.00</td>
</tr>
<tr>
<td>Total Patient Visits/yr</td>
<td>698</td>
<td>698</td>
<td></td>
</tr>
<tr>
<td>Assumption: visits/patient/yr</td>
<td>6</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>Total Patients /yr</td>
<td>116</td>
<td>58</td>
<td>0</td>
</tr>
</tbody>
</table>

**Cost per patient of Scenario 2 is Double, but = on a per visit basis.**
Balancing benefit & investment

Example: Home Visit Program
➔ 3 month post-discharge intensive support
➔ 3-6 visits, NP & SW + telephonic support
➔ Cost: assume approximately $2000 / patient

What are the options for funding?
ACO Environment? FFS system?

What is your “bundle”?
Scale Impacts Capacity, Cost, and Service

- **1 NP**
  - 100 patients, wide geographic spread
  - high travel time
  - lower capacity

- **2 NP**
  - 220 patients, scheduled around regional quadrants
  - lower travel time
  - increasing capacity

*to see more patients*
Value > Financial

→ Reliability (closed process, no gaps, smooth transitions, no surprises)

→ Access (capacity, appointments)

→ SCALE to have significant impact

→ Partner organizations’ loyalty

→ Quality; performance on public indicators

→ Other?
Dilemma: Bottlenecks

Incremental planning

Success

Bottlenecks
Reflections From Experienced Program Leaders

“The single most common problem encountered by palliative care programs is that they have started services incrementally and reactively. They want to meet a patient need…They respond with an incremental FTE…

Eventually the needs grow, the difficulty of juggling becomes problematic, and it is hard to get resources to sustain services. “
Recommended Approach

Plan for Comprehensive Service

Implement in a modular / incremental way

Define “bundles”
Define implementation “bundles”

Complex/serious illness (Outlier 5%)

Solutions?

Plan with full implementation in mind & make it as simple as possible

Bundle 1, 2, 3, 4 of defined services

Palliative Care
New Tools

- Implementation courses (100 & 500 series) & IPAL OP
- Downloadable tools with courses (interview guides, budget templates)
- Virtual Office Hours
Key Components of a Plan

- Executive Summary
- Opportunity
- Proposed Services
- Budget Request
- Value Measurement
Summary

➔ Take the time to think ahead
➔ Consider multiple partners or collaborators
➔ **Do not shrink from designing a great program**
  – Know the costs
  – Find a stakeholder
➔ Use CAPC tools (100, 500 series, IPAL-OP)
➔ Share your learnings!
Questions and Comments

➔ Do you have questions for the presenter?

➔ Click the hand-raise icon (右手) on your control panel to ask a question out loud, or type your question into the chat box.
For a calendar of CAPC events, including upcoming webinars and office hours, visit

Today’s webinar recording can be found in CAPC Central under ‘Webinars: Community-Based Palliative Care’