

# How to show your administrators that your palliative care program improves value

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# Join us for upcoming CAPC events

## → Webinar:

- **A Population Health Approach to System-Wide Palliative Care:** Tuesday, April 4, 2017 | 1:30-2:30 PM ET

## → Virtual Office Hours:

- **Team Health and Wellness with Phil Higgins, PhD, LICSW**
  - Thursday, March 23, 2017 at 12:00 pm ET
- **Palliative Care Models in the Home with Donna Stevens, BS**
  - Thursday, March 23, 2017 at 1:00 pm ET
- **Palliative Care in Long Term Care Settings with Katy Lanz, DNP, ANP, GNP**
  - Monday, March 27, 2017 at 12:00 pm ET
- **Measurement for Community-Based Palliative Care with J. Brian Cassel, PhD**
  - Tuesday, March 28, 2017 at 11:00 am ET
- **Home Health Agencies Delivering Palliative Care in the Community with Bob Parker, DNP, RN, CENP, CHPN**
  - Tuesday, March 28, 2017 at 2:00 pm ET

## → CAPC Payment Accelerator: Supporting Palliative Care Programs in Value-Based Payment and Contracting

- To learn more about this opportunity please visit <https://www.capc.org/topics/payment/> or contact the Accelerator Coordinator with any questions at [seema.satia@mssm.edu](mailto:seema.satia@mssm.edu)

# How to show your administrators that your palliative care program improves value

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# Disclosures

1. I received \$5100 to travel to Seoul Korea to lecture at an industry conference from GEOMC, Inc.
2. I have grant or research funding to Johns Hopkins University Sidney Kimmel Comprehensive Cancer Center from
  - RO1 NCI: RCT of PC for Phase I patients (Ferrell, Smith)
  - RO1 National Institute of Nursing Research: HIV caregivers. (Knowlton PI)
  - PCORI: advance care planning for pancreas ca pts undergoing Whipple procedure (Aslakson PI)
  - Avon Foundation (randomized trial of Scrambler Therapy for chemo-induced peripheral neuropathy, CIPN)
  - Ho-Chiang Foundation (Scrambler Therapy for pain of pancreas cancer)
  - Lerner Foundation (fellowship in palliative medicine)
  - Milbank Foundation to assess impact of chaplains
  - Allegheny Health Foundation for placebo-controlled trial of topical 6% gabapentin for chemo induced neuropathy
  - Ho Chiang Foundation for teaching oncologists PC skills and tools

## Disclosure of ABIM Service: Thomas Smith, MD

- I am a current member of the Test-Writing Committee on Hospice and Palliative Medicine.
- To protect the integrity of certification, ABIM enforces strict confidentiality and ownership of exam content.
- As a current member of the Test-Writing Committee on Hospice and Palliative Medicine, I agree to keep exam information confidential.
- As is true for any ABIM candidate who has taken an exam for certification, I have signed the Pledge of Honesty in which I have agreed to keep ABIM exam content confidential.
- ***No exam questions will be disclosed in my presentation.***

# Objectives

1. We can all take good care of people.
2. Proving that we contribute to the bottom line is key.  
“Mission alignment.”
3. Basics
  - Who
  - What
  - Where
  - When
  - Why
  - Remember, to get these results you must do “full contact” PC
4. How to present the data.

We do understand PCU volume, LOS, OP visits, charges we dropped, right?

And this is where you need the Financial Analysis people!

Program Level Data Abstracted																					
Type of Program	Breakdown by charge bucket (e.g., drug, lab, radiology)	Referrals to the program	Number of patient encounters	Average length of stay	PCU Volumes	Occupancy Rate	Charge	JHU Net Revenue	JHH Net Revenue	JHU Variable Direct Cost	JHU Variable Indirect Cost	JHH Variable Direct Cost	JHH Variable Indirect Cost	JHH & JHU Variable Net Margin	JHU Fixed Direct Cost	JHU Fixed Indirect Cost	JHH Fixed Direct Cost	JHH Fixed Indirect Cost	Total Cost	JHH & JHU Profit (Loss)	Net Margin
Palliative Direct (patients directly transferred into the PCU follow hospital admission)	X	N/A	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Palliative Transfer (patients transferred into the PCU from elsewhere in the hospital)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Pre-Transfers In (care that patients received before being transferred into PCU)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Anticipated performance from the 2012 Business Plan		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
The professional fees for the hospital per department from January 2013-March 2014. Data includes invoice, charge, allocation of payment, controlled allocation of payment							X		X			X	X				X	X	X		

“Easy! Just get your VIndCOST data!”  
“Huh?”

**JHH FY2015 Palliative Care Analysis**  
**Palliative Care & Pre-Transfer Summary**

**Averages per Encounter**

	Encounter	Avg PC Days	Avg PrePC Days	Charge	NetRev	VDirCost	VIndCost	FDirCost	FIndCost	Total Cost	VarNetMargin	VNM %	NetMargin	NM %
Palliative Direct	55	7.49	-	\$22,036	\$20,473	\$7,979	\$2,626	\$2,481	\$8,226	\$21,312	\$9,868	48%	(\$839)	-4%
Palliative Transfer	104	6.07	-	12,891	11,287	5,347	1,809	1,554	5,667	14,377	4,131	37%	(3,090)	-27%
<b>Total Palliative Care</b>	<b>159</b>	<b>6.56</b>	<b>-</b>	<b>16,054</b>	<b>14,465</b>	<b>6,257</b>	<b>2,092</b>	<b>1,875</b>	<b>6,552</b>	<b>16,776</b>	<b>6,116</b>	<b>42%</b>	<b>(2,311)</b>	<b>-16%</b>
<b>Pre Transfer</b>	<b>104</b>	<b>-</b>	<b>14</b>	<b>\$59,409</b>	<b>\$54,219</b>	<b>\$21,709</b>	<b>\$5,432</b>	<b>\$6,829</b>	<b>\$17,014</b>	<b>\$50,984</b>	<b>\$27,079</b>	<b>50%</b>	<b>\$3,235</b>	<b>6%</b>
<b>Variance (Pre Transfer - Palliative Transfer)</b>				<b>\$46,518</b>	<b>\$42,932</b>	<b>\$16,361</b>	<b>\$3,623</b>	<b>\$5,275</b>	<b>\$11,347</b>	<b>\$36,606</b>	<b>\$22,948</b>		<b>\$6,325</b>	

**Averages Per Day**

	Encounter	Total PC Days	PrePC Days	Charge	NetRev	VDirCost	VIndCost	FDirCost	FIndCost	Total Cost	VarNetMargin	VNM %	NetMargin	NM %
Palliative Direct	55	412	-	\$2,942	\$2,733	\$1,065	\$351	\$331	\$1,098	\$2,845	\$1,317	48%	(\$112)	-4%
Palliative Transfer	104	632	-	2,122	1,858	880	298	256	933	2,367	680	37%	(509)	-27%
<b>Total Palliative Care</b>	<b>159</b>	<b>1,044</b>	<b>-</b>	<b>2,446</b>	<b>2,203</b>	<b>953</b>	<b>319</b>	<b>286</b>	<b>998</b>	<b>2,555</b>	<b>932</b>	<b>42%</b>	<b>(352)</b>	<b>-16%</b>
<b>Pre Transfer</b>	<b>104</b>	<b>-</b>	<b>1,232</b>	<b>\$4,284</b>	<b>\$3,910</b>	<b>\$1,565</b>	<b>\$392</b>	<b>\$492</b>	<b>\$1,227</b>	<b>\$3,676</b>	<b>\$1,953</b>	<b>50%</b>	<b>\$233</b>	<b>6%</b>
<b>Variance (Pre Transfer - Palliative Transfer)</b>				<b>\$2,162</b>	<b>\$2,052</b>	<b>\$685</b>	<b>\$94</b>	<b>\$237</b>	<b>\$294</b>	<b>\$1,310</b>	<b>\$1,273</b>		<b>\$742</b>	

**Total Palliative Care**

	Encounter	Total PC Days	PrePC Days	Charge	NetRev	VDirCost	VIndCost	FDirCost	FIndCost	Total Cost	VarNetMargin	VNM %	NetMargin	NM %
Palliative Direct	55	412	-	\$1,211,956	\$1,126,029	\$438,837	\$144,435	\$136,473	\$452,403	\$1,172,147	\$542,758	48%	(\$46,118)	-4%
Palliative Transfer	104	632	-	1,340,623	1,173,875	556,102	188,157	161,628	589,350	1,495,236	429,617	37%	(321,361)	-27%
<b>Total Palliative Care</b>	<b>159</b>	<b>1,044</b>	<b>-</b>	<b>2,552,579</b>	<b>2,299,904</b>	<b>994,938</b>	<b>332,591</b>	<b>298,101</b>	<b>1,041,753</b>	<b>2,667,383</b>	<b>972,375</b>	<b>42%</b>	<b>(367,479)</b>	<b>-16%</b>
<b>Pre Transfer</b>	<b>104</b>	<b>-</b>	<b>1,442</b>	<b>\$6,178,525</b>	<b>\$ 5,638,794</b>	<b>\$ 2,257,693</b>	<b>\$ 564,918</b>	<b>\$ 710,242</b>	<b>\$ 1,769,454</b>	<b>\$5,302,307</b>	<b>\$ 2,816,183</b>	<b>50%</b>	<b>\$ 336,487</b>	<b>6%</b>
<b>Variance (Pre Transfer - Palliative Transfer)</b>				<b>\$4,837,902</b>	<b>\$4,464,919</b>	<b>\$1,701,591</b>	<b>\$376,761</b>	<b>\$548,614</b>	<b>\$1,180,104</b>	<b>\$3,807,071</b>	<b>\$2,386,566</b>		<b>\$657,848</b>	



ReCAPs (Research Contributions Abbreviated for Print) provide a structured, one-page summary of each paper highlighting the main findings and significance of the work. The full version of the article is available online at [jop.ascopubs.org](http://jop.ascopubs.org).

Johns Hopkins Bloomberg School of Public Health; Johns Hopkins Health System; Johns Hopkins Medical Institutions, Baltimore, MD; Sunnybrook Odette Cancer Centre; University of Toronto; and Canadian Centre for Applied Research in Cancer Control, Toronto, Ontario, Canada

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Disclosures provided by the authors are available with this article at [jop.ascopubs.org](http://jop.ascopubs.org).



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## Impact of a New Palliative Care Program on Health System Finances: An Analysis of the Palliative Care Program Inpatient Unit and Consultations at Johns Hopkins Medical Institutions

Sarina R. Isenberg, Chunhua Lu, John McQuade, Kelvin K.W. Chan, Natasha Gill, Michael Cardamone, Deirdre Torto, Terry Langbaum, Rab Razzak, and Thomas J. Smith

**QUESTION ASKED:** We attempted to discern the financial impact of both a palliative care inpatient unit (PCU) and palliative care (PC) consultations on patients in other inpatient units for a large academic health medical center, the Johns Hopkins Medical Institutions (JHMI) in one fiscal year. This analysis was done as JHMI prepared to expand the PCU from six to 11 beds and increase inpatient PC consultation capacity.

**SUMMARY ANSWER:** The PCU and PC program had a favorable impact on JHMI, while providing expert patient-centered care. The total positive financial impact of the PC program was \$3,488,863.10. The PCU saved JHM \$353,645.17 savings in variable costs, or \$452.33 per transfer. Cost savings for PC consultations in the hospital, 60% with cancer, were estimated at \$2,765,218. \$370,000 was collected in professional fees savings.

operation. The start-up costs were minimal as the nursing unit was already established, the additional education expenses were minimal, and we maintained the same nursing-patient ratios and hours. The PC team itself had no experience at other institutions and we used data only from JHMI. The results may be generalizable. At the time of the study, Maryland did not reimburse palliative care per diem reimbursement. Maryland has since switched to a per diem reimbursement model, which may increase cost reductions even more important. Furthermore, this analysis compares variable costs for 153 palliative care patient encounters, not patients. As such, if a patient was in the unit twice, he/she would be counted as two separate encounters thereby undermining the assumption of independence in our model.

**REAL-LIFE IMPLICATIONS:** The intent of

PCU saved \$453 per person transferred. PC consults saved \$2.7M. Pro fees added \$370,000.

Total \$3.4 M

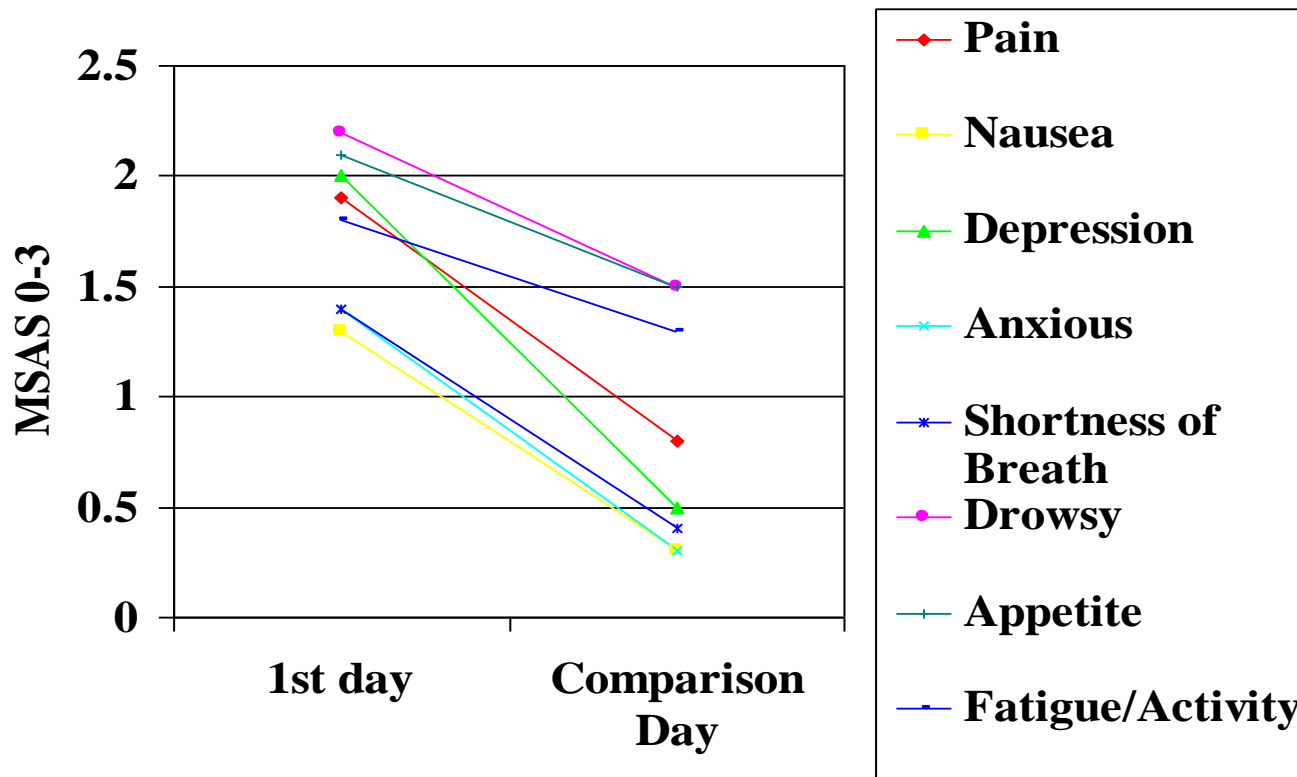
The WHO - clinicians needed to see that we could help *them*

## Cancer patient symptoms are improved by PC consultation or transfer, with no change in mortality

Memorial Symptom Assessment Scale, Condensed

30 pts with at least 2 consult days and symptoms > 0

Khatcheressian J, Coyne P, Smith T. Oncology September 2005



The WHO - *administration* needed to know we would not cost them too much

## Next, we showed that palliative care programs save money for hospitals and health systems...

### A High-Volume Specialist Palliative Care Unit and Team May Reduce In-Hospital End-of-Life Care Costs

THOMAS J. SMITH, M.D., PATRICK COYNE, R.N., M.S.N., BRIAN CASSEL, Ph.D.,  
LYNNE PENBERTHY, M.D., ALISON HOPSON, R.N., M.S.N.,  
and MARY ANN HAGER, R.N., M.S.N.

#### ABSTRACT

**Background:** Current end-of-life hospital care can be of poor quality and high cost. High volume and/or specialist care, and standardized care with clinical practice guidelines, has improved outcomes and costs in other areas of cancer care.

**Methods:** The objective of this study was to measure the impact of the palliative care unit (PCU) on the cost of care. The PCU is a dedicated 11-bed inpatient (PCU) staffed by a high-volume specialist team using standardized care. We compared daily charges and costs of the days prior to PCU transfer to the stay in the PCU, for patients who died in the first 6 months after the PCU opened May 2000. We performed a case-control study by matching 38 PCU patients by diagnosis and age to contemporary patients who died outside the PCU cared for by other medical or surgical teams, to adjust for potential differences in the patients or goals of care.

**Results:** The unit admitted 237 patients from May to December 2000. Fifty-two percent had cancer followed by vascular events, immunodeficiency, or organ failure. For the 123 patients with both non-PCU and PCU days, daily charges and costs were reduced by 66% overall and 74% in "other" (medications, diagnostics, etc.) after transfer to the PCU ( $p < 0.0001$  for all).

Comparing the 38 contemporary control patients who died outside the PCU to similar patients who died in the PCU, daily charges were 59% lower ( $\$5,304 \pm 5,850$  to  $\$2,172 \pm 2,250$ ,  $p = 0.005$ ), direct costs 56% lower ( $\$1,441 \pm 1,438$  to  $\$632 \pm 690$ ,  $p = 0.004$ ), and total costs 57% lower ( $\$2,538 \pm 2,918$  to  $\$1,095 \pm 1,153$ ,  $p = 0.009$ ).

**Conclusions:** Appropriate standardized care of medically complex terminally ill patients in a high-volume, specialized unit may significantly lower cost. These results should be confirmed in a randomized study but such studies are difficult to perform.

Daily charges were  
59% lower,  
total costs were  
57% lower  
\$2358 -> \$1095  
P=0.009

This may have given PC a shot in the arm when it needed it – 2004. CEOs read this.

# THE WALL STREET JOURNAL.

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WEDNESDAY, MARCH 10, 2004 - VOL. CCXLIII NO. 48 - ★★ \$1.00

## Final Days

### Unlikely Way to Cut Hospital Costs: Comfort the Dying

**\$7000 less in last 5 days of life if PC involved.**

**With equal survival.**

**And better symptom control.**

### Care, Not Cure

Average cost for terminally ill patients in palliative and nonpalliative programs during their final five days at one hospital

	NON-PCU	PCU
Drugs and chemotherapy	\$2,267	\$511
Lab	1,134	56
Diagnostic imaging	615	29
Medical supplies	1,821	731
Room & nursing	4,330	3,708
Other	2,152	278
<b>Total</b>	<b>\$12,319</b>	<b>\$5,313</b>

Note: PCU stands for palliative care unit. Each figure represents average cost of last five days for a cancer patient aged 65-plus, prior to in-hospital death. Figures are for 2001 and 2002.

Source: Virginia Commonwealth University medical center

KINS

“I want to send a team down to learn how to do this palliative care....”





The WHO: all data are LOCAL. It only matters if it is from your shop.

Know your audience.

Hard working PhD student with 3 years financial consulting experience

Cathy Lu, JH FAU analyst, and her boss

Senior Director, Financial Planning & Analysis for Johns Hopkins Medicine (JHM), \$8 Billion

Administrators for ONC and PC



ReCAP

ReCAPs (Research Contributions Abbreviated for Print) provide a structured, one-page summary of each paper highlighting the main findings and significance of the work. The full version of the article is available online at [jop.ascopubs.org](http://jop.ascopubs.org).

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Johns Hopkins Bloomberg School of Public Health, Johns Hopkins Health System; Johns Hopkins Medical Institutions, Baltimore, MD; Sunnybrook Odette Cancer Centre; University of Toronto; and Canadian Centre for Applied Research in Cancer Control, Toronto, Ontario, Canada

Corresponding author: Sarina Isenberg, Johns Hopkins Bloomberg School of Public Health, 1800 Orleans St, Carnegie Building, Suite 280, Baltimore, MD 21287; e-mail [sisenbe2@jhu.edu](mailto:sisenbe2@jhu.edu).

Disclosures provided by the authors are available with this article at [jop.ascopubs.org](http://jop.ascopubs.org).

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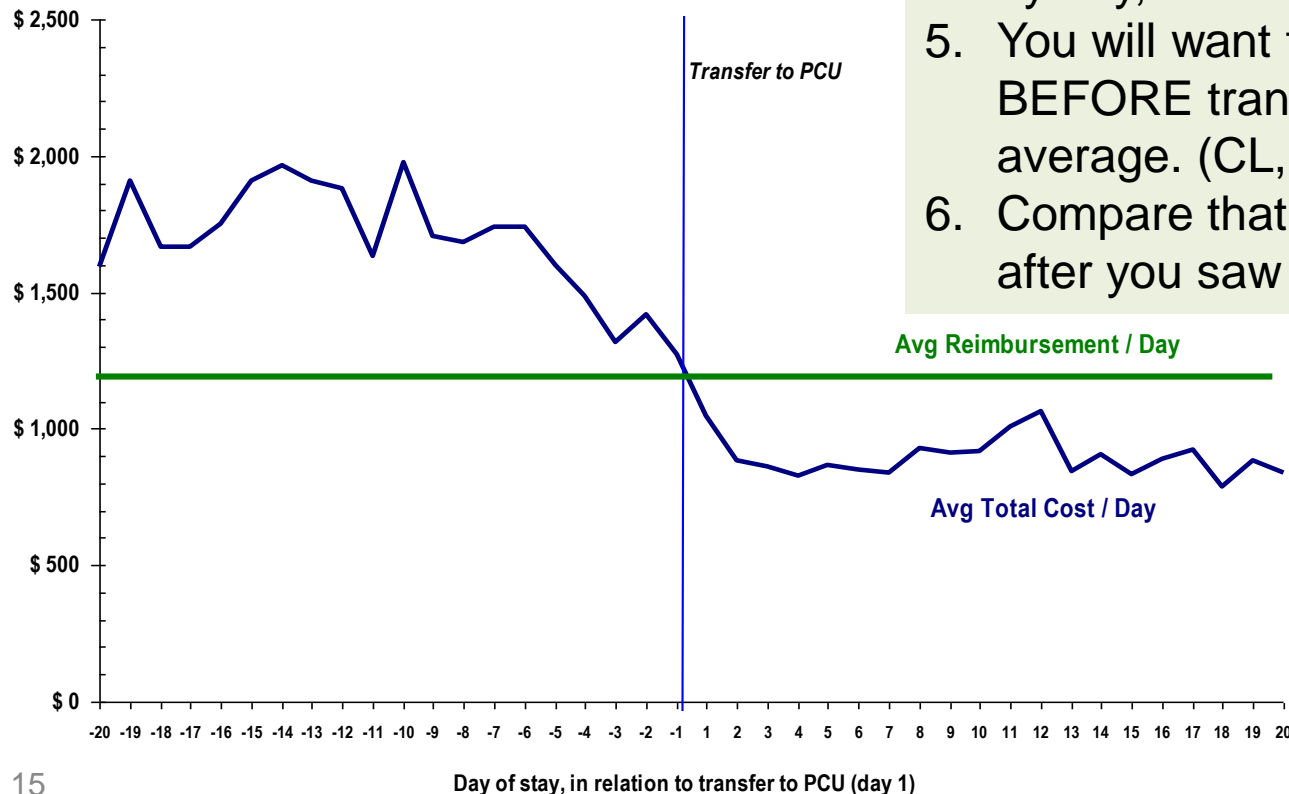
# Objectives

1. We can all take good care of people.
2. Proving that we contribute to the bottom line is key.  
“Mission alignment.”
3. Basics
  - Who
  - What – the cost savings + the professional fees
  - Where
  - When
  - Why
4. How to present the data.

# You want to know if the amount you are spending is LESS than the amount you are getting reimbursed.

Smith T, J Pall Med 2003; Morrison S, et al. Arch Int Med 2008

1. Make a Table of all the patients you saw during that time. (NG)
2. Look up their MR#. (NG)
3. And the dates of service. (NG)
4. Get your FA people to download all bills, by day, for admissions.
5. You will want to look at the 2 days BEFORE transfer or consult, an average. (CL, JM, MC)
6. Compare that to the average per day after you saw them. (CL, SI)



Before transfer,  
charges \$4284/day  
After \$2,162

JHH FY2015 Palliative Care Analysis  
Palliative Care & Pre-Transfer Summary

The Net Margin is  
\$742 per patient.  
6% better than  
negative.

Averages per Encounter

	Encounter	Total PC Days	PrePC Days	Charge	NetRev	VDirCost	VIndCost	FDirCost	FIndCost	Total Cost	VarNetMargin	VNM %	NetMargin	NM %
Palliative Direct	55	412	-	\$2,942	\$2,733	\$1,065	\$351	\$331	\$1,098	\$2,845	\$1,317	48%	(\$112)	-4%
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<b>Pre Transfer</b>	<b>104</b>	<b>-</b>	<b>1,232</b>	<b>\$4,284</b>	<b>\$3,910</b>	<b>\$1,565</b>	<b>\$392</b>	<b>\$492</b>	<b>\$1,227</b>	<b>\$3,676</b>	<b>\$1,953</b>	<b>50%</b>	<b>\$233</b>	<b>6%</b>
<b>Variance (Pre Transfer - Palliative Transfer)</b>				<b>\$2,162</b>	<b>\$2,052</b>	<b>\$685</b>	<b>\$94</b>	<b>\$237</b>	<b>\$294</b>	<b>\$1,310</b>	<b>\$1,273</b>		<b>\$742</b>	

Total Palliative Care

	Encounter	Total PC Days	PrePC Days	Charge	NetRev	VDirCost	VIndCost	FDirCost	FIndCost	Total Cost	VarNetMargin	VNM %	NetMargin	NM %
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<b>Variance (Pre Transfer - Palliative Transfer)</b>				<b>\$4,837,902</b>	<b>\$4,464,919</b>	<b>\$1,701,591</b>	<b>\$376,761</b>	<b>\$548,614</b>	<b>\$1,180,104</b>	<b>\$3,807,071</b>	<b>\$2,386,566</b>		<b>\$657,848</b>	

And multiplied by  
patient days, is  
considerable



Chg8Bucket	Per Day Analysis						
	CONVOL	Charge	NetRev	T_A	t_A	FDIRCOST_A	FIndCost_A
Drug	30	202	185	85	1	19	4
Lab	16	458	419	158	22	18	68
O.R.	9	138	125	42	14	11	43
Other	7	286	260	64	15	52	46
Radiology	3	457	418	84	36	29	113
Routine	1	2,232	2,035	885	266	225	832
Supplies	10	214	195	109	11	124	35
Therapies	3	297	271	139	27	15	85
Unregulated	0	0	0	-	-	-	-
<b>Total</b>	79	4,284	3,910	1,565	392	492	1,227

Chg8Bucket	Per Day Analysis			
	CONVOL	Charge	NetRev	VDIRCOST_A
Drug	24	113	103	70
Lab	2	38	33	11
O.R.	1	5	5	3
Other	0	26	23	1
Radiology	0	48	43	11
Routine	1	1,785	1,554	746
Supplies	1	23	20	3
Therapies	1	84	77	35
Unregulated	0	0	0	0
<b>Total</b>	30	2,122	1,858	880

Charges cut in half  
Costs cut in half  
Much under our control

 Actionable PC targets

# Go after the PRO FEES as appropriate. Justify. Bill. Give people feedback.

JHH Palliative Medicine FY15-16 Productivity Summary							
Provider	FY15 YTD			FY16 YTD November			
	Charges	CPT Volumes	Adj Work RVUs	Charges	CPT Volumes	Adj Work RVUs	
A	\$ 54,701	206	449	\$ 26,048	99	212	
B	\$ 167,245	541	1,320	\$ 73,083	255	577	
C	\$ 53,874	256	446	\$ 65,932	320	547	
D	\$ 57,524	198	405	\$ -	-	-	
E	\$ 575	3	5	\$ -	-	-	
f	\$ 6,472	35	53	\$ 53,359	225	432	
g	\$ 218,703	732	1,741	\$ 97,092	369	773	
h	\$ 227,583	758	1,759	\$ 102,645	346	776	
i	\$ -	-	-	\$ 64,123	240	535	
	\$ 43,964	192	180	\$ 15,759	84	152	
	\$ -	-	-	\$ 8,690	33	84	
	\$ 117,973	583	414	\$ 98,040	369	875	
Total:	\$ 948,614	3,504	6,772	\$ 604,771	2,340	4,963	

Source: IDX Service Analysis, MedVitals

1. Agree on work targets.
2. Give people wRVU targets.
  - 2000 MD
  - 1500 APN
3. Look for mismatches in CPT Volumes, wRVUs and \$.
4. PC people tend to under bill.
  - \$296 vs \$188 per visit for the same work

# Go after the PRO FEES as appropriate. Justify. Bill. Give people feedback.

## JHH Palliative Medicine

FY16 November YTD Adjusted Work RVUs

Month: 5

Annual Adj wRVU Target (1.0 FTE): **2,827**

Provider	FTE	FYTD Nov 2015			FY16 Annualized		
		FYTD Nov 2015 Actual Adj wRVU	FYTD Nov 2015 Adj wRVU Target	Actual and Target FYTD Nov 2015 Adj wRVU Variance	FY16 Annl Adj wRVU	FY16 Adj wRVU Target	Annl and Target FY16 Adj wRVU Variance
	0.05	212	59	153	509	141	367
	0.50	577	589	(12)	1385	1,414	(29)
	1.00	547	1,178	(631)	1313	2,827	(1,514)
	1.00	432	1,178	(746)	1037	2,827	(1,790)
	1.00	773	1,178	(405)	1855	2,827	(972)
	0.50	776	589	187	1862	1,414	449
	1.00	535	1,178	(643)	1284	2,827	(1,543)
	0.10	152	118	34	365	283	82
	0.70	84	82	2	1260	1,237	23
	0.70	875	825	50	2100	1,979	121
<b>TOTAL</b>	<b>6.55</b>	<b>4,963</b>	<b>6,973</b>	<b>(2,010)</b>	<b>12,970</b>	<b>17,775</b>	<b>(4,805)</b>

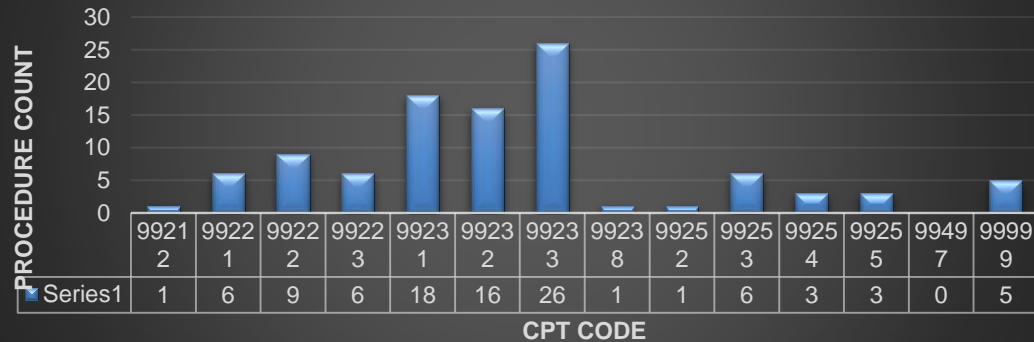
Not seeing enough patients, or not billing appropriately. Or both. Or grants if not full time FTE.

Reduces pro fees and consult savings.

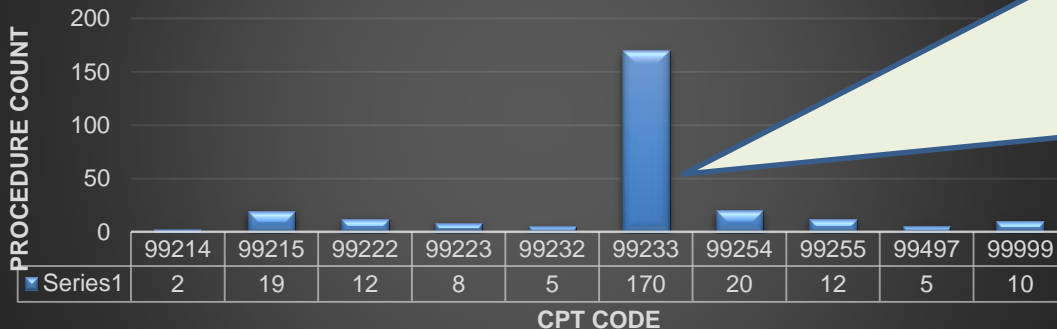
Source: IDX Service Analysis, MedVitals

# Go after the PRO FEES as appropriate. Justify. Bill. Give people feedback.

## Procedure Count by CPT Codes Q1 - 2017



## Procedure Count by CPT Codes Q1 - 2017



Most pall care patients are highly complex. Make sure you do the work, and document it. Bill on complexity.

Should look more like this.

If you don't maximize pro fees, you can't hire more people.

# How many people should I see in clinic?

Muir JC, et al. JPSM 2010; Jul;40(1):126-35.

Scheffey et al. JPSM 2014

To break even with salaries + benefits:

- Half Day: 2 news and 4-6 follow ups
- 5 days a week
- Demands efficiency
- Only pays for APN and MD, not team

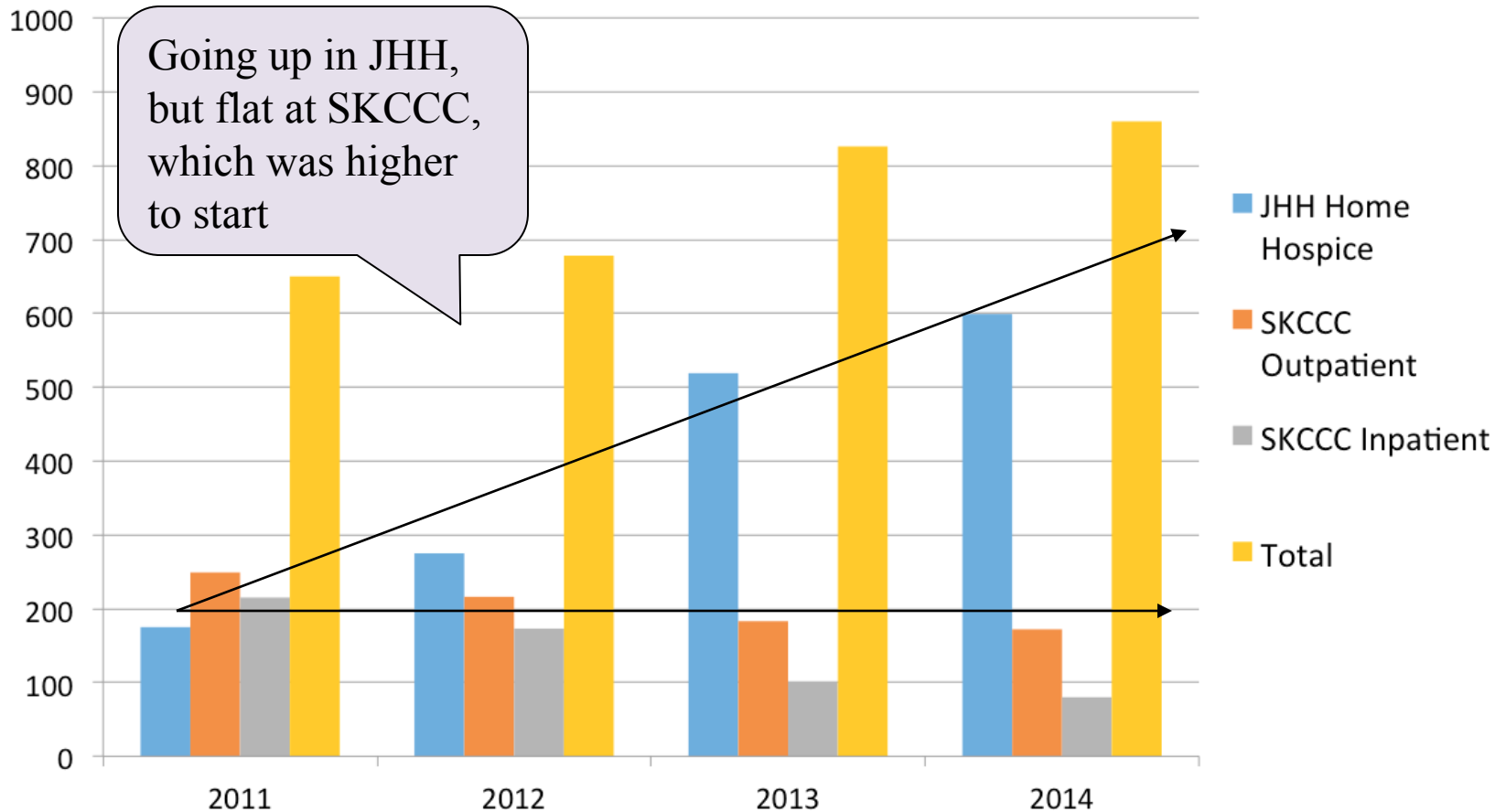
This saves the oncology practice 4 weeks and improves their patient's symptoms, satisfaction, and "throughput". (121 new patients to a small practice)

- Increase LOS in hospice 15 → 24 days.

# Objectives

1. We can all take good care of people.
2. Proving that we contribute to the bottom line is key. “Mission alignment.”
3. Basics
  - Who
  - What – your performance
  - Where
  - When
  - Why
4. How to present the data.

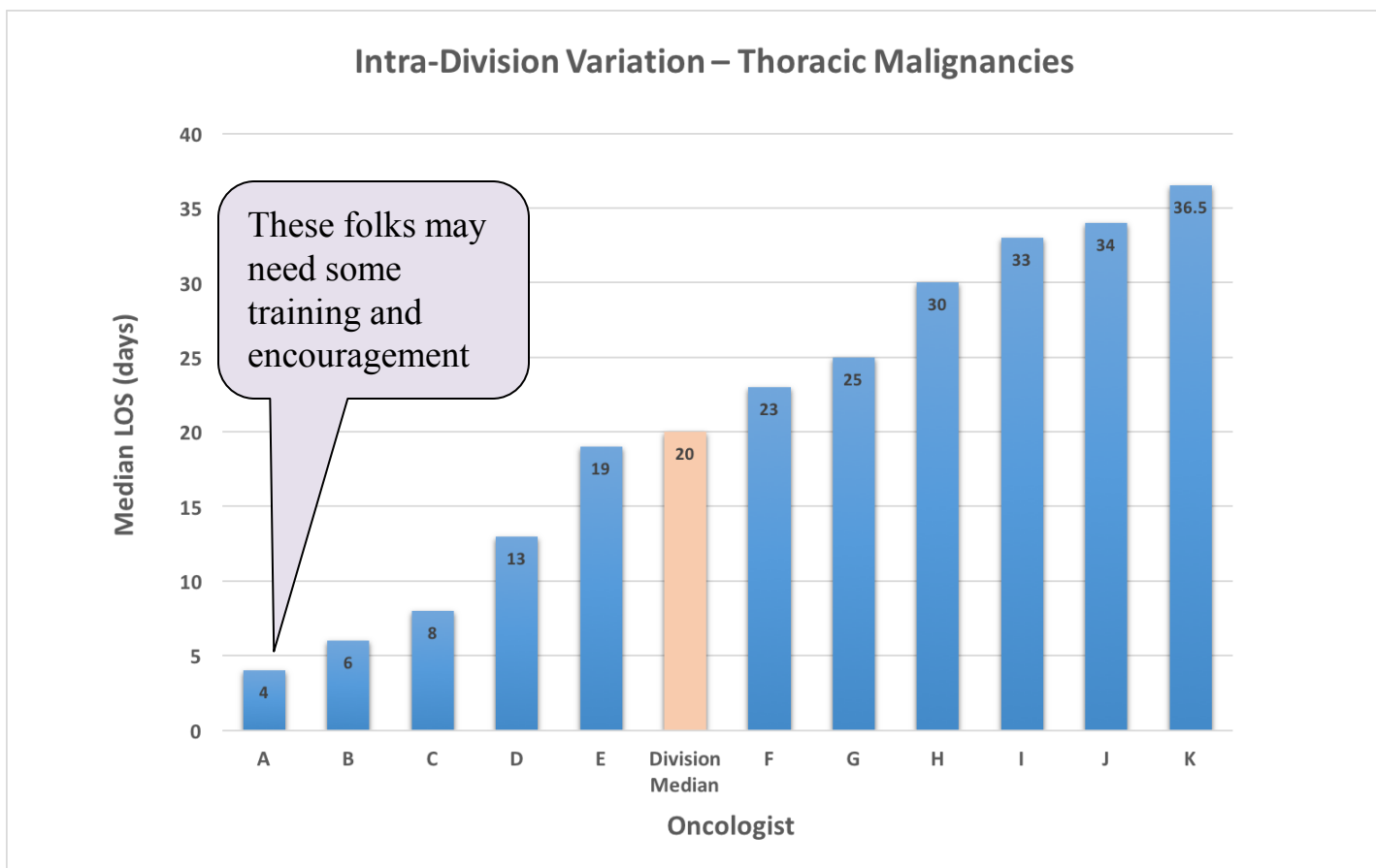
# Hospice Use Patterns: how many people are you getting to hospice?



# Divisional Data

## Division of Thoracic Malignancies

Wang X, et al. J Oncol Practice, in press.





# Program data GBM

Kuchinad K, et al. J NeuroOnc, in press

**Table 3: Documentation of psychosocial assessments at >50% of clinic visits**

	<b>N=100</b>	<b>%</b>
Performance status	54	54%
Pain	12	12%
Dyspnea	66	66%
Emotional well-being	17	17%
Spiritual-assessment	0	0%

# Program data: GBM patients

Kuchinad K, J Neuro Onc, in press.

**Table 2: some NQF/QOPI measures**

	n	%
Advanced Directive	17	17%
Code Status	40	40%
Hospice Referral	76	76%
Use of Chemotherapy in last 4 weeks of life	17	17%
Hospitalization during last four weeks of life	37	37%
Average length of stay per hospitalization	8.75	--

## Full contact vs touch palliative care

...if palliative care consultation was done, the 30 day readmission rate was 10%, compared to 15% if no consultation was obtained.

Consultations that involved goals of care discussions were associated with a lower readmission rate (AOR 0.36, 0.27-0.48;  $p < 0.001$ , or a reduction from 15% to 5%), but symptom management consultations only were not.

O'Connor NR, Moyer ME, Behta M, Casarett DJ. The Impact of Inpatient Palliative Care Consultations on 30-Day Hospital Readmissions J Palliat Med. 2015 Nov;18(11):956-61. doi: 10.1089/jpm.2015.0138. Epub 2015 Aug 13.

# Full contact vs touch palliative care

The patient is a \_\_\_ y.o. male with a history of pancreas cancer and pain.  
INFO wants FULL

**Advance Care Planning/Goals of Care: DNR, I if dying from his cancer.**

- will fill out MOLST for him.
- AMDs in chart under "media"

**Psychosocial assessment and dynamics: "demoralized" but not depressed.**

**Spiritual Care: Episcopal. Important to him.**

**Code Status: DNR/I**

MOLST Completed: Not yet

Hospice Information Visit: Not yet.

## **Problem List:**

- 1. Cancer pain due to**
- 2. Invasive pancreas cancer**
- 3. Massive weight loss 60 #**

**Thank you** for allowing us to participate in the care of your patient.

## Other things to think about

1. Don't assume that Palliative Care has to be inefficient and slow.
2. Be ruthless about getting your work done, clinically and documentation-wise.
3. Take notes, document quickly later.
4. Remember to ALWAYS send a letter to the referring doctor. Takes 3 minutes in EPIC or Cerner.
5. Use templates, Smart Phrases, and anything else that makes you more efficient.
6. Dictate IF possible and affordable.
7. Scheduling: 1 hour for new, ½ hour for follow-ups.
8. Don't measure anything you have not been asked to measure.
9. \_\_\_\_\_
10. \_\_\_\_\_

# Objectives

1. We can all take good care of people.
2. Proving that we contribute to the bottom line is key. “Mission alignment.”
3. Basics
  - Who
  - What
  - Where – anywhere you can, to the administrators.
  - When – as often as you can.
  - Why – you should have a compelling
4. How to present the data.



# Palliative Care Program Update

Tom Smith

Deirdre Torto

Gaurav Singh

# Palliative Care at JHH and Imperatives

## Three general types of Palliative Care:

Inpatient palliative care units 

### Palliative Care at JHH

Meyer 9, 4-11 bed-unit

- NCCU, ICU transfers
- OPENED 12/14/16

Inpatient palliative care consults 

JHH IP Consult Team  
WBG IP Consult Team

- NCCU-Adam Schiavi
- ECMO-CVSICU team

Outpatient concurrent palliative care alongside acute management 

JHOC, WBG

- Increased # to Gilchrist Medicare Choices



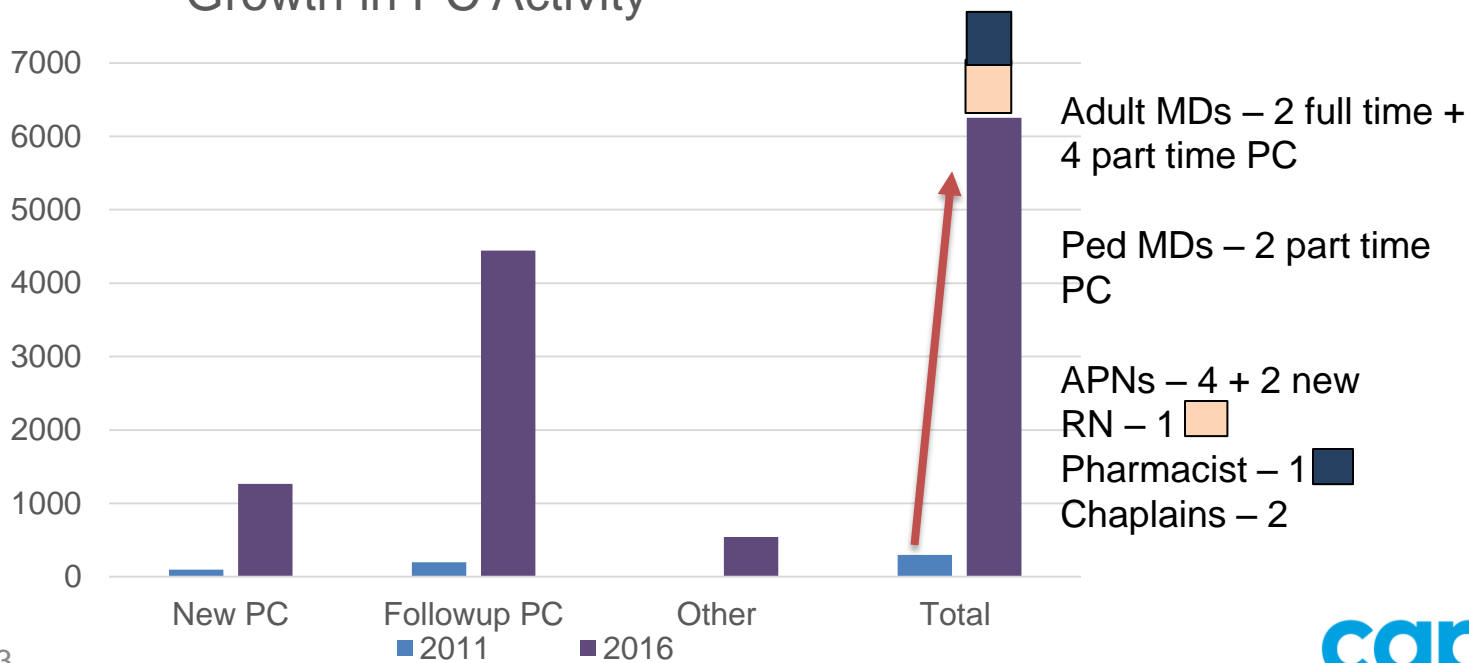
# We only count as “palliative care” those seen by the palliative care billable team

- Does not count chaplain or pediatric/NICU/PICU visits

→ PC activity FY 2011-present steady and accelerating

- Majority of activity is inpatient consults, and IP follow-ups; home care 2018 FY
- New initiatives in CVSICU, NCCU, all ECMO patients

Growth in PC Activity



# In 5 years service volume has more than *quadrupled*

2011	2012-3	2013-4	2014-5	2015-6	2016-7
3 ½ day day ONC clinics	3 ½ day ONC clinics  1 ½ day non- ONC clinic  Hospital wide PC coverage	3 ½ day ONC clinics  1 ½ day non-ONC clinic  Hospital wide PC coverage  Inpatient unit 6 beds on Marburg Pavilion, opened 3/1/13	3 ½ day ONC clinics  1 ½ day non-ONC clinic  Hospital wide PC coverage  Inpatient unit 6 beds on Marburg Pavilion  JH Bayview Med Center Full PC service	3 ½ day ONC clinics  1 ½ day non-ONC clinic  Hospital wide PC coverage  Weinberg Cancer Hospital PC coverage  <b>Clinical Community of 5 JH hospitals PC</b>  Medicare Choices  JHARAMCO Palliative Care Consult Service	3 ½ day ONC clinics  1 ½ day non-ONC clinic  Hospital wide PC coverage  Weinberg Cancer Hospital PC coverage  <b>Clinical Community of 5 JH hospitals PC</b>  Medicare Choices  JHARAMCO Palliative Care Consult Service  <b>Inpatient beds, 4 on Meyer 9 with MEG</b>  Outpt at JBMC, Sibley, Suburban, Howard Cty - maybe

# Education has been growing steadily at every level

2011-2	2014	2015	2016	2017
<p>Rotations Med students Resident s ONC fellows Other fellows</p> <p>HPM Fellowshi p, opened 7/1/12, first in Maryland .</p>	<p>4 HPM FELLOWS</p> <ul style="list-style-type: none"> <li>• 2 VAMC fellows</li> <li>• 1 Lerner Fndn Fund fellow (\$500,000/3 years)</li> <li>• 1 Hearst Fndn funds (\$37,500) ½ geri-PC Fellow</li> <li>• 1 ARAMCO Fndn Funds fellow a year</li> </ul>	<p>5 HPM Fellows</p> <ul style="list-style-type: none"> <li>• 2 VAMC fellows</li> <li>• 1 Lerner Fndn Fund fellow (\$500,000/3 years)</li> <li>• 1 by private donor (Rosenbloom Fndn)</li> <li>• 1 ARAMCO Fndn Funds fellow a year</li> <li>• Dy S, et al. Measuring what matters. AAHPM</li> </ul>	<p>3 HPM fellows 2 Pediatric HPM Fellows</p> <ul style="list-style-type: none"> <li>• ASCO National Clinical Practice Guideline update</li> <li>• NCCN Clinical Practice Guideline update</li> </ul>	<p>3 HPM Fellows 1 pediatric fellow</p> <p>Going to _____ Foundation for larger gift; Rosenbloom Fndn</p> <p>Last of JH ARAMCO</p>

# Research in palliative care (slide 1 of 3)

Program	Clinical trials/Questions	Research support
<i>Health services research</i>		
PCORI PI Aslakson Utilizing Advance Care Planning Videos to Empower Perioperative Cancer Patients and	Randomized trial of patient-centered video to inform advance care planning with Whipple patients.	PCORI
1 R01 CA177562-01A1 : Integrating and Evaluating Clinic Based Palliative Care PIs Ferrell C of Hope, Smith JH	RO1 to do randomized trial of PC vs usual care in Phase I new cancer drug patients	RO1
1 - R01 NR014050 01SUSTAINING PALLIATIVE CARE TO DRUG USERS WITH HIV/AIDS & HEALTH DISPARITIES. PI Knowlton JHSPH	Multi-D and community support, long term cohort	RO1
Evaluate clinical and COST effect of chaplain (\$100K x 2 years)	Effect of chaplain on families Effect of chaplain on health care providers Effect on EOL care and \$ used	Milbank Fndn
EOL care for brain tumor patients	How does JH SKCCC compare to ASCO and NQF standards?	JH SOM
Hospice use by division and by doctor with direct feedback "QOPI lite"	How does JH SKCCC compare to ASCO and NQF standards?	JH SOM
Patient ap for question prompt list using "Smith form" Claire Snyder, Zack Berger PIs		NCCS
Assessment Tools for Palliative Care Dy, Sidney and Aslakson, Rebecca	summarize the evidence for use of palliative care assessment tools	AHRQ
PCORI Engagement Award (Aslakson & Pitts)	UNITED in Faith, Health, and Strength - Facilitating Strategic Partnerships Advanced Illness Care among African American Faith Organizations	PCORI
Scrambler Therapy for chemo induced neuropathy	Does ST work compared to sham?	Avon

# Impact on the health system this FY (estimates)

Financial impact	Cases/year projected 2016	Financial Impact per case	Contribution (\$/year)	5 year total Contribution
IP PCU Margin (1)			\$ 100,000	\$ 500,000
IP PCU Cost \$1595 savings/transfer (2)	154	\$1,595	\$ 245,630	\$ 1,228,150
PC IP Consult Cost Savings per Case, \$2,374 for patients discharged alive (3)	1355	\$2,374	\$ 3,216,770	\$ 16,083,850
PC IP Consult Cost Savings per Case, \$6,871 for decedents, 11% died (4)	167	\$6,871	\$ 1,147,457	\$ 5,737,285
<b>JHFU vetted savings</b>			<b>\$4,709,857</b>	<b>\$23,549,285</b>

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<b>JHFU vetted savings</b>			<b>\$4,709,857</b>	<b>\$23,549,285</b>
Early PC OP Consult Cost Savings per case (5) \$5198/case	297	\$5,198	\$ 245,630	\$ 34,355,000
Hospice referrals Cost Savings per case, \$3400/case (6) Assumes half of the actual savings of \$6800	800	\$3,400	\$ 2,720,000	\$ 13,600,000
Professional fees, 50% collection rate (7)			\$ 500,000	\$ 2,500,000
Improvement in HCAHPS (2% of Medicare reimbursement in 2017).			?	
Increased ICU bed availability leading to revenue			?	
Reduction in 30 day readmissions			?	
Goodwill; impact on disparities			?	
<b>Total impact</b>			<b>\$ 8,175,487</b>	<b>\$ 74,004,285</b>

# Challenges in Palliative Care

- The JH program has grown but so has the demand
  - Over 1,500 consults in the coming year
  - Expanded to 2 teams to cover JHH and SKCCC
  - Inpatient unit opened Dec 2016 with 4 beds
- Requests to integrate into outpatient specialty clinics
  - E.g. Pulmonary Hypertension, Liver Clinic
  - Required: LVADs and Heart Transplant Teams
- Home palliative care program in the works...creating a clinical and business plan for 2018.
- **Need to hire 2 MDs and 3 APNs by July 2018.**

# Conclusions

A successful financial and clinical analysis is possible in any health system that bills. Or not.

Involving the right and interested people is KEY.

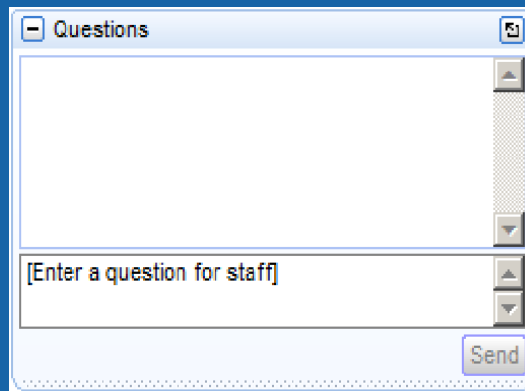
Use the data wisely:

- ✓ Clinicians – all about service
- ✓ Administrators – service at a cost we can afford.
- ✓ If you are going to claim the benefits, then make sure you do the work.
- ✓ Advance care planning
- ✓ Hospice referrals early (and track)



# Questions and Comments?

Please type your question into the questions pane on your webinar control panel.



A screenshot of a web-based interface titled "Questions". It features a large empty text area for input, a smaller text area below it containing the placeholder text "[Enter a question for staff]", and a "Send" button at the bottom right. The interface includes standard scrollbars and window controls.