Session 304:
How to Integrate Palliative Care Into Your Community-based Home Health and Hospice Programs

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Interim Healthcare

Objectives

- Acquire best practices associated with an integrated palliative care program.
- Differentiate between the various models.
- Determine if the model being used or considered is the most appropriate model for your organization.
- Assess barriers to meeting financial profitability.
Caveats

- Individual state professional licensure requirements differ.
- Regulations vary by program type and payer.
- Be careful relying too much upon other’s experience.
- Please don’t take my comments as legal advice.

Who’s in the room?
Palliative Care

“If you’ve seen one palliative care program, you’ve seen one palliative care program”
Definition Elements

- Specialized medical care
- Relief from pain/distressing symptoms
- Integrates physical, psychological, spiritual domains
- Team approach
- Enhance quality of life
- Appropriate at any age and stage of a serious illness
- Provided along with curative treatment

Integration

The process of combining into completeness and harmony.
Barriers

Healthcare silos
- Competing goals
- Exposes patients to fragmented services
Barriers

- Poor transitional care
  - Inadequate communication
  - Poor symptom management

- Reimbursement constraints

- Gaps in knowledge
### Who Are You?

Parker, R. 2011 ©
People Culture

Who are your employees?

How do they align with your corporate vision and mission?

- Home Health vs. Hospice
  - Competing goals
  - Skill set variance
- Task oriented or Comprehensive vision

People Culture

Best practice:

- Do what you do best
- Top down education
  - Corporate alignment first
  - Palliative Champion
- Bottom up support
  - Monthly ongoing education
  - Lessons learned/Case studies
Business Culture

What is your goal?

Who do you want to serve?

What are your practice capabilities?

Business Models
Program Segmentation

- **Highest Utilizers**
  - Risk/Gain Share
  - Payer model

- **Pre/Post Hospice**
  - Bridge
  - Limited scope

- **Disease Management**
  - Segmented populations
  - All with needs

Community-based Models

**High Utilizers:**

- **Payer models**
  - Based on payer needs
  - PMPM (per member per month)
  - Risk/gain share

- **Disease management programs**

- **Clinical complement to member case management**
Community-based Models

High Utilizers - Limitations:
• Can be case management oriented
• Member stratification
  ▪ Highest $$ utilizers
• Greatest financial risk
• Scope creep

Community-based Models

Medicare Part A – bridge episode
• Functional in all 3 segmentation models
• HH specialty disease management programs
• Utilize existing HH nurses
• Hire specialized palliative care nurse
Community-based Models

Medicare Part A – Limitations:

- HH regulations
- Reimbursement constraints
  - Skilled need
  - Homebound status
- HH culture
  - Typically curative mindset
  - Typically lacks palliative skill set

Medicare Part A Model

Risk from external and internal forces

HH or PC Nurse

Hospice Eligible

Live Discharge

Risk
Medicare Part A Model

Hospice Nurse Outreach

No payment model

Risk from external forces

HH Staff

Potential pool

Hospice Staff

Hospice Eligible

Live Discharge

Risk

Community-based Models

Medicare Part B – medical management

- Functional in all 3 segmentation models
- Setting agnostic
- Hire specialized palliative MD or NP
- Separate business line
Community-based Models

Medicare Part B – Limitations:

- Productivity

- Financial constraints
  - MD vs. NP salary

- Reimbursement constraints
  - NP reduced fee for service reimbursement

- Scope creep

Medicare Part B Model
Financial Considerations

Financial Ability?

Medicare Part A
Medicare Part B

Payer
- Contracts
- Credentialing
Financial Culture

Best practice:

• SWAT/Needs analysis
  ▪ Right market, right program

• PROFORMA
  ▪ Establish cost neutral financial model
  ▪ Manage conversions to hospice

• Credentialing – Medicare Part B
  ▪ Medicare first, Medicaid second, payer third
  ▪ Account for time delay

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PROFORMA

<table>
<thead>
<tr>
<th>PC Program A</th>
<th>Month 1</th>
<th>Month 2</th>
<th>Month 3</th>
<th>Month 4</th>
<th>Month 5</th>
<th>Month 6</th>
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<tbody>
<tr>
<td>PC Admissions</td>
<td>10</td>
<td>15</td>
<td>20</td>
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<td>PC AD</td>
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<td>2.50</td>
<td>2.50</td>
<td>2.50</td>
<td>2.50</td>
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Revenue

- $5 / initial encounter $2,338
- $5 / sub encounter $669
- Total $5 $3,007

% Non-Billable 0.5%

$5,003 $8,458 $10,149 $11,481 $13,093

Costs

- Nurse Practitioner $100,000
  ▪ Shared Salary % 30%
  ▪ $8,433 $8,433 $8,433 $8,433 $8,433 $8,433
- Nurse $100,000
  ▪ Shared Salary % 100%
  ▪ $0 $0 $0 $0 $0 $0
- 2nd Nurse Practitioner $100,000
  ▪ Shared Salary % 30%
  ▪ $8,433 $8,433 $8,433 $8,433 $8,433 $8,433
- Travel Costs PPD $183 $560 $941 $1,256 $1,373 $1,706
- Misc Costs PPD $8 0.50

Total Costs

$3,786 $9,261 $9,874 $10,382 $10,606 $10,974

Margin on Palliative Care Program

-5,556 -3,658 -1,417 -2,123 -1,234 -5,942

Add Hospice ABC at 15% Conversion rate

| Future Benefit to Hospice (Not part of Palliative Care Proforma) | 0.8 | 2.6 | 5.3 | 8.3 | 11.3 | 14.3 |

Hospice Revenues per month per converted patient

$4,400 $3,300 $11,500 $23,100 $36,300 $49,000 $62,700

$ (2,236) $7,682 $21,683 $36,087 $50,734 $56,758
Return On Investment (ROI)

Differentiator

New business
- Via reduced re-hospitalization rate
- Safety net for physicians
- Payer partner

Increased volume
- HH episodes
- Timely conversion to hospice

Addressable Market Projections

30% conversion to Hospice
120 patients

120 patients with
a 90 day LOS
$1.6 Million

400 HH episodes per year
$1 Million

INTEGRATED CARE CREATES OPPORTUNITY & DRIVES REVENUE
**Length of Stay**

EBITDA Impact of conversion: $1,523
LOS assumption: 30
Assumes: $145/day reimbursement, 35% Gross Margin, LOS input below

<table>
<thead>
<tr>
<th>Hospice Conversions</th>
<th>YTD Conv</th>
<th>Conv Value</th>
<th>PC EBITDA</th>
<th>Net EBITDA</th>
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<tbody>
<tr>
<td>Palliative Care Program A</td>
<td>91</td>
<td>138,548</td>
<td>(86,946)</td>
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<td>36,540</td>
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**Length of Stay**

EBITDA Impact of conversion: $4,568
LOS assumption: 90
Assumes: $145/day reimbursement, 35% Gross Margin, LOS input below

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<thead>
<tr>
<th>Hospice Conversions</th>
<th>YTD Conv</th>
<th>Conv Value</th>
<th>PC EBITDA</th>
<th>Net EBITDA</th>
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<td>(22,729)</td>
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<td>41,108</td>
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<td>109,620</td>
<td>(137,771)</td>
<td>(28,151)</td>
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Length of Stay

EBITDA Impact of conversion $6,090
LOS assumption 120
Assumes: $145/day reimbursement, 35% Gross Margin, LOS input below

<table>
<thead>
<tr>
<th>Hospice Conversions</th>
<th>YTD Conv</th>
<th>Conv Value</th>
<th>PC EBITDA</th>
<th>Net EBITDA</th>
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<tr>
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<td>146,160</td>
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Goal
- Right Care
- Right Time
- Right Setting
Interim Healthcare’s Model

Four Care Tenants

- Pain and Symptom Management
- Medication Management
- Setting Management
- Medical Goals of Care
If you want to make beautiful music, you must play the black and the white notes together.

Richard M. Nixon

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