NHPCO Palliative Care Playbook for Hospices

Developing the Business Case

This toolkit is part of NHPCO's comprehensive Palliative Care Playbook that is available to members as a benefit of membership. Learn more about Community-Based Palliative Care Resources at www.nhpco.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, 2.0FTE 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		

Feasability

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 managementstaff

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:			
• any changes in certification, appointment, education or professional accomplishments			
• verification of current license and DEA certification, if applicable			
• any professional disciplinary action taken against applicant			
• medical professional liability insurance coverage and claim experience			
• status with National Practitioner Data Bank, if applicable			
Performance appraisal is completed and includes the following indicators:			
• utilization of services			
• drug utilization			
• admissions data			
• delinquent patient care records			
• member/patient satisfaction			
• quality improvement findings/outcomes			
• 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

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NHPCO
National Hospice and Palliative Care Organization