Developing a Business Plan for your Outpatient Palliative Care Program: A Technical Assistance Monograph from the IPAL-OP Project

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Table of Contents

Goals for this document

- User can define Business Plan, Business Case, Value, Work Plan, and Budget
- User will know how to link a needs assessment with a business plan
- User will be able to list the core components of an outpatient business plan
- User will ID resources to develop assumptions for 3 key variables (patient capacity, appointment schedule development, and staffing)
- User will understand concept of scalability and how to anticipate and plan for growth

Introduction

The health care reform environment is creating new opportunities for palliative care expansion. As organizations have more patients in risk products like ACOs or Medicare/Medicaid managed care, they can invest in palliative care for the broader downstream benefits and can shift away from focus on fee-for-service billing revenue. Organizations are in a state of transition living in both payment worlds, but they are looking for strategies to impact quality and cost for their most complex patients. This creates a good climate to take a more strategic, proactive approach to planning to match palliative care services with organizational needs. This document is intended to take the mystery out of the business plan process for outpatient planning.

Many palliative care leaders are being asked to start or expand outpatient palliative care services. The requests often assume that palliative care can do this quickly, incrementally (adding the work onto existing inpatient consult service team members), and without additional funding. It is tempting to "just say yes" and get started. However several principles have been learned by early adopters and strongly reinforce the need for a comprehensive planning process, resulting in a Business Plan that efficiently captures the service design, funding commitment, and operational assumptions.

Principles to support sustainable, high quality programs:

- Conduct a Needs Assessment. (Use tools on the IPAL-OP website) This is the best way to identify the services needed, outcomes that are valued and to prioritize program development to locations or services that are likely to be funded and sustainable. It also builds engagement before you ask for specific support.

- Avoid "Incrementalism". It is attractive in the short run but is not a good strategy. Take the time to be proactive and look at the potential need for services to provide optimal care to patients.
    - What you do incrementally and without defined resources is unlikely to be funded "later."
    - Defining the service by the amount that you can do now incrementally ("We can go over there 2 half days a week now that we have a second advance practice nurse…") ***is not a plan***. Demand will likely outstrip your capacity, and either your team will suffer or your service to patients will suffer, or both.

- Ask for what you need. Construct the plan for the program that is needed, vs. the one that is incrementally possible. Build a staged plan to get there. Sometimes the bigger picture is more compelling, and the environment now is ripe for this. You have leverage to do things right when people are asking for your services.

- Match service promises with support levels. Offer staging options. Include realism and coping strategies for the situation when a sponsor organization says, "You can only lose xxx dollars," or "We can only fund xxx now." Say "yes" but in a manner that matches expectations with resource constraints; sometimes this means a pilot or a limited launch. Being prepared and knowing your business assumptions will allow you to say "yes" and set realistic expectations while building support for expanded services.

- Define and include baseline measures such as readmission rates or patterns of utilization of the Emergency Department, so that you can demonstrate impact. Do not wait until you have already changed patterns of care.

Section 1: Definitions Critical To Getting Started

Business Plan, Business Case, Work Plan, Budget, and Strategic Plan

As program leaders get started in building the plan for any service, including outpatient palliative care, there is often confusion about business plan requirements. Organizations, leaders, and finance staff use the same terms to mean different things; before getting started and doing more work than needed, or investing in the "wrong" work, probe carefully for clarification about required documents and justification. This section will help you think about the different possibilities, and seek clarity.

Business Plan refers to the document that pulls together the rationale for the service, the operational plans for start-up, and the budget implications. However, some organizations will expect a full *Strategic Plan* with considerable data and research included, and others are looking for a simple *Budget* and *Budget Narrative*. Often the requirements vary depending on the size of the request or on the perceived risk of the project. For example, a request for $50,000 for a half time advanced practice nurse to add services in the CHF clinic may have a different level of scrutiny than a request for $500,000 to start up a separate clinic with 5 day per week services. Unlike a major capital project, neither of these scenarios has significant potential for risk beyond the annual costs, and therefore may not require or justify the level of planning and documentation involved in bigger projects. There are experts in the organization who prepare such documents; you need their help.

Business Case usually refers to the cost-benefit justification for an investment. The justification may be directly financial ("If we invest this in year 1 we expect revenues to pay it back by year 3") or indirectly financial, which is a significant part of the palliative care justification. Revenue generated from services is rarely sufficient to fully justify investments in palliative care. However, avoided costs such as reduced hospitalization rates or shorter lengths of stay are also justifications and can be translated into dollars.

A Work Plan is often included in a business plan. It may be a short conceptual summary of the work to be done to get from here to there. At some point there needs to be a more detailed work plan that is an operational road map to start up. This includes the tasks of recruitment, training, office setup, systems setup, and developing the relationships that will make the program successful. Even though the tasks and timelines may change regularly, it is very useful to create a draft work plan early in your process of preparing a business plan. Forcing yourself to think through all of the steps and parallel tasks (who will process billing, who answers the phone for patients who need refills, etc.) will help you develop a realistic timeline and budget by helping define roles and amount of work. It is much better to figure this out and match assumptions about promised services with assumptions about staffing needs up front, and include them in the budget and plan.

A Budget is the financial summary that pulls together the assumptions into an organized picture of the proposed activity. It can be a simple one-page summary of resource requests, expected revenues, and subsidy needed, or it can be a complex interactive document that helps model various scenarios for your plans. Where possible it should include some assumptions about context, such as "based on a 5 day a week clinic for 45 weeks of the year, staffed by 1 APRN and 0.5 MD/DO per day with capacity for 20 new patients per month". When these assumptions are included, it is easier to match funding decisions with service promises

Usually a *budget narrative* accompanies a budget. This is a very tactical document to explain the assumptions used in developing the budget. For example, it may document the employee benefits rate, or the salary increase assumed in future years, or document the source of the cost estimates. Often there is a standard format required by administrators for the budget and narrative; the budget tells the story of the plan with numbers - try and keep it simple.

A Strategic Plan will usually include all of the above pieces, with a focus on multi-year goals, and include explicit tie in to organizational mission and strategic priorities. A strategic plan will likely be for the whole palliative care service (inpatient, outpatient (all settings), educational priorities, research strategy if applicable, leadership structure, etc.). It should also include revenue strategies including philanthropy.

Table: Terminology

Terms	Overview Description
Business Case	Emphasis on WHY it should be done. High impact vs. risk. Investment vs. benefit. Why NOW?
Business Plan	Emphasis on what is proposed, how you will do it, what is required, planned services and scale. Goals and metrics. Timetable to start up, key assumptions.
Work Plan	More tactical and detailed version of the business plan. It is the operational road map or "to do" list for the design and implementation process.
Budget	Included in Business Plan and implicit in Business Case. Investment needs to be proportional to scale and impact. It defines the necessary investment to deliver the services and identifies risk factors and assumptions.
Strategic Plan	Big version of business plan: aligned well with org strategy. More re vision/goals/longer term.

Section 2: Defining Value and demonstrating Impact

Value, like beauty, is in the eye of the beholder. All organizations care about money, but may value it differently compared to other issues such as peer ranking, board member engagement, or community reputation. Sometimes changing an organizational culture to reduce moral distress in the nursing staff or to improve patient communication skills is so important that palliative care will get senior administration support.

Many high impact value contributions do not require you to define the exact financial consequences. An example would be a decrease in the inpatient mortality rate: This has intrinsic reputational value as well as potential impact on quality outcomes that collectively have a significant financial value. Focus your efforts on identifying the likely impact on mortality, not on defining its dollar value.

Value is also context-sensitive. If the competitor just opened a new cancer center, or a damaging article about mortality rates hit the local paper – these types of special events can raise the value perception of your efforts. Just as you evaluate price, quality, convenience, and brand identity when you make a retail purchase, leadership will evaluate costs, expected benefits, reliability (low risk) and leadership credibility (your track record) when deciding to fund a project.

Improvements in patient satisfaction and quality indicators can also convert into dollars, given the incentive structure of some of the national measures with CMS and local measures with insurance companies. Do not underestimate the importance of these measures, which sometimes drive millions of dollars in additional or lost revenues for hospitals and health systems. The business case should include expected impact on non-financial measures, and part of the Needs Assessment process should be clarifying how these contributions will be converted into tangible support for services.

Non-Financial Value Examples

Topic / Outcome	Commentary
Reduced admissions, crisis, ED use	Value depends on type of admission, payment environment, and predictability. May be worth $10k each for avoided admission, or may be a negative # (if all admissions are viewed as revenue generators)
Improved status, duration in research study, survival	May increase research effectiveness by managing symptoms & enabling patients to stay in trials longer, future research $, patient participation
Accessibility / continuity relationships	May promote patient loyalty, reduce resource use, and help with market share.
Reduced crisis & better time use for specialty teams	Improved capacity (for new patients with $$ treatment) and smoother operations, shorter waits
Reduced inpatient mortality	Rankings may matter; alternative pathways to best care, less <30 day readmissions or ED use, less crisis
Earlier enrollment in hospice	Depending on contractual relationship, earlier use of hospice may be both cost effective and revenue generating.

The translation of indirect benefits and non-financial indicators into financial terms should usually be done with or by the finance staff. For example, they may credit an avoided admission for an ACO patient (where the organization benefits from all cost savings) at a higher rate than they will value credit an avoided admission for a FFS patient. If the financial staff have involvement in defining the value, they are more likely to support it in the business plan.

Concept Highlight – How does your Story Compare?

A key concept in a business plan or a business case is that the proposed initiative is evaluated within a context of other desirable projects, not in a vacuum. Given that each project takes staff effort and organizational mindshare, organizations are looking for the "best" mix of effort to yield, with low risk and high likelihood of alignment with strategic objectives. Therefore the business plan and the business case need to include facts and rationale that differentiate the proposed service based on these criteria.

The context also includes *perception of urgency*. If your program is a "nice to have" but not urgent, there is a tendency to give preference to more urgent needs. Therefore it is important to find credible ways to demonstrate the costs of not acting (the *opportunity cost*) and to create tension that when funding is available, services can be delivered, vs. the tendency to try and do it anyway.

Section 3: The Critical Link between a Needs Assessment and a Business Plan

Assume that the first request for outpatient services came from a specialty colleague. That is a good starting point to define interest, but it does not indicate that the highest and best use of your team's time will be providing services to that specialty. You do not yet know what other needs are out there, and you need a process to clarify expectations with the specialist who opened the door to you.

Even when working in a responsive manner with one request, the needs assessment process will help you design a mutually satisfying service by providing an objective process to clarify expectations. This will help you anticipate broader service needs and be more strategically aligned within the organization.

The Needs Assessment documents on the IPAL site are thorough. Use them! They will help you answer questions that are critical to your Business Plan:

- What is the problem you are trying to solve?
- Who are you solving it for? [Who will need to fund your investment in a solution?]
- Who is the target patient population for the service? This is the basis of your service design.
- What is the baseline of the problem and what impact do you expect to have? Quantify the gap in care that needs to be closed. This is the basis for your financial or value justification.
- What metrics will demonstrate improvement? These are core to your measurement strategy.
- What services could close the gap or meet the need? This is the basis for your expense budget – staffing and related costs.

If you conduct a thorough Needs Assessment process, one that is inclusive of others, guided by a leadership workgroup, and which builds awareness of a gap, data about opportunities, and interest in solutions, you will have most of the information you need for a Business Plan. **Often the Needs Assessment is 50% or more of the total work effort of planning a new service.**

Section 4: Building a Business Plan

After you complete the Needs Assessment and work with your planning group to define the purpose for the service and the plan for implementation, you are ready to take the information and turn it into a business plan.

Advice: It is very useful to define what you are <u>not</u> going to do in your business plan. By being clear about your patient strategy, purpose, and methods of delivering care, you can also say that this plan does not include resources for x, y, and z that are important, but will be part of a subsequent plan. This protects you from scope creep in expectations and starts to create a dialog about the other services for the future.

The document itself should be concise; a 1-3 page Executive Summary with attachments and budgets may be all that is required. Do not wait for a perfect product; develop a draft and have leadership review it and give input as to changes needed.

<u>Think of the document as your own implementation work plan and not just be a document created to get approval;</u> you are a key customer of the plan. If it is thorough and makes sense, you will be able to successfully use it to simplify your implementation process and to reduce risks. If you do not see the utility of it, then question your design.

The following table includes some suggestions for Business Plan elements to include; modify based on local custom.

Outline of a Business Plan

Section	Description
Executive Summary (1-3 pages)	This is the most important part as it is most likely to be read. It needs to highlight the Need (from Needs Assessment), the gap, the proposed solution, and the requirements and implications of the solution. It can include a summary of financial assumptions, such as total funding request, number of staff, patients to be served, etc.
Plan Body • **Background & context** • **Case examples to anchor the story** • **Proposal for action** • **Resource Needs & expected results**	This can include more detailed info about strategic objectives, findings from the needs assessment, what is going on nationally, what best practices are in the field, etc. Describe the opportunity for improvement; use a case or two to drive it home. What exactly do you plan to do? Why? What problem does it solve, and what options did you consider? Be explicit about the scale of proposed operations and why this scale is recommended. What resources do you need? If you get those resources what results can you deliver? Define risks and uncertainties and contingency plans.
Organizational chart	Describe reporting relationships, funds flow, governance
Budget (and budget narrative)	Costs (staff, support, space, travel, insurance, etc.), revenue (billing, stipends, philanthropy, grants), and support needs
Work Plan	Operational implementation outline
Timeline or Flow chart	May be part of the work plan or a separate item – budget assumptions should match the timeline.
Inventory of key positions and roles	Optional, but may be helpful to match staffing requests and assumptions with the work plan and scope.
Measurement plan or proposed dashboard	Keep it simple – better to have a few measures in each domain of clinical, customer, operational, and financial, and to have a plan for tracking these than many pie in the sky measures you can't track.
Appendixes	Consider this as a good place to inventory the work you did to develop your plan, without trying to fit it all into the plan. For example: • List of interviewees • List of workgroup or planning members • Major themes from needs assessment

Section	Description
	• Background articles or reference points • Interviews with outside experts; links to related websites. • Modeling of data to predict volume or impact, especially any work that defined patient screening criteria or expected need • Variable assumptions re workload, schedule, etc. – example of a day or week in the clinic. Example of the expected utilization pattern of a patient over time. Example of clinician duties including non-billable roles.

Section 5: Operational Decisions that drive the Business Plan and Budget

If the business plan and the budget tell the story of the planned activity, then it should be obvious that operational design decisions will drive the budget assumptions. Yet, often these are developed in separate silos and the assumptions are not crosschecked. For example, if your justification for the program is that you will reduce 30-day readmissions, but you do not design sufficient capacity to be able to reliably schedule new patient appointments within a short time of discharge, you are unlikely to have that impact. It may be ok to schedule a month out for goals-of-care appointments for referrals from a primary care clinic. It is probably not ok to schedule a month out for a recent discharge. Developing a schedule and capacity plan to ensure that access matches your assumptions and promises is critical. Running a program based on individual work-arounds ("We did not have an open appointment for 3 weeks but we agreed to work this patient in…") is not a reliable service likely to achieve promised goals.

The needs assessment tools on the IPAL website will help you evaluate and choose your model of care and define the patient populations that are the focus of your services. Then you will need to look at referral sources, expected volume of patients per year, and any trends (such as new patients increasing month to month). The following table will help you anticipate some of the decisions that are important to clinic operations and important to the budget.

Table of Key Variables That Drive Budget Estimates

Note that these variables are not specific numbers in the budget. Clarity about the delivery model and the operational design are critical to a reasonably accurate budget. **Including descriptions of these variables and their related assumptions should be part of the business plan appendices.**

Variable	Why it is important
Type of patient, source of patient, purpose of clinic, & expected pattern of use of visits	Some clinics see a patient 1 or 2 times post discharge and are "done". Others follow patients at least monthly during the last 1 to 3 years of life. These differences have huge impact on appointment use for new vs. existing patients over 1, 2, or 3 years. Some clinics focus on earlier engagement with patients for goals of care planning or for periodic symptom management. Others co-manage on a monthly basis or assume significant responsibilities for late stage management. These roles require different appointment schedule priorities. Your total patient capacity is a function of 1) schedule design; 2) proportion of new to established patients; 3) time slots for new vs. established; 4) expected duration of care or frequency of visits.
Number of <u>new patients</u> each year and <u>number of total patients</u> cared for each year (some may be continuing from prior year)	For this purpose, "new" = new to the palliative care clinic, whether or not it can be billed as a new patient[1]. *[There may be a difference between the volumes of new patient visit slots you need vs. the amount of billing revenue you will collect for new visits, given the definition for billing purposes.]* It is highly likely that your value/impact/cost avoidance justifications will be based on <u>the total number of patients impacted each year</u>. Therefore if 1000 hours of appointments are used for 200 patients seen 5 or more times, or 500 patients seen twice, it will impact your assumptions. Plus, new patients usually require more time in the initial visit. If you are not careful, by year 3 almost all of your appointment slots are used for f/u appointments for patients accumulated in prior years, and then your # of new patients goes down and your wait time for an appointment goes up. Thus modeling out the expected pattern and monitoring it closely is important.

[1] A new patient (for CMS billing purposes) is one who has not received any professional services from the physician/qualified health care professional or another physician/health care professional of the **exact** same specialty **and subspecialty** that belongs to the same group practice, within the past three years. Source: Julie Pipke, Outpatient Billing Document Draft July 2013.

Variable	Why it is important
Team roles and design – which team members see which patients and when	This will impact your staffing budget. Do you have two people involved during each new visit? Together or sequentially? Are other team member's ad hoc or covering multiple services or dedicated? How much support staff is needed? There needs to be a compelling story detailing how you will use the resources to tie together the staffing needs with the appointment capacity with the new patient capacity. Will you need funded staff positions, such as RNs, for important but non-billable work such as managing patient refill requests and doing phone triage?
Location and overhead/ support services	If you carry all of your own costs (as an independent practice) this may be 50% of total costs. If you are not being charged for these services, then you may only need to budget for direct staff costs. Acknowledge how other services are being provided and give thanks for space, support, billing, insurance, etc.
Billing logistics	Which staff on the team can bill for services? Will you focus only on billable services or spend significant time in cost effective but un-billable services such as phone calls or education? Who will do the billing? Is there a fee? This will impact the calculation of expected billing revenue. Where your clinic is located and who employs your staff can also impact the definition of a "new" patient for billing purposes.
Proportion of funded FTE time that is available for appointments	Schedules matter. Is a 0.4 FTE available for 16 hours of appointments 52 weeks of the year or for something less than this? How is vacation handled? Defining the general expectations and assumptions will help you be realistic in planning for capacity.

The variables listed above are critical planning considerations for successful service design. Taking the time to develop several options, consider their logical implications, and define the service agreements that will be necessary to implementation will save you many later headaches. And, being able to outline your approach and show how your budget numbers directly relate to the assumptions about these service variables will strengthen the credibility of your business plan.

Identifying Partners, Collaborators, and Expert Resources

A significant factor in the evaluation of your business plan will be an assessment of who you worked with on it, and whether you have active support from a variety of other managers and stakeholders. Use your plan development process to begin or expand collaborative relationships and to stimulate active support for your plan. Active support usually results from clear alignment of goals and personal engagement.

It is also ok to "ask for help". Doing so can strengthen your credibility and the confidence of leadership that you can accomplish your goals. Logical partners and collaborators include:

- The practice administrator or manager of a practice you are considering for affiliation. If you are not working directly with an established practice, either ask leadership to identify a mentor in this area from another practice, or get a referral from physician colleagues and pay for advice. They will either be able to help you or have experts on specific topics, particularly for developing appointment schedules and capacity assumptions, and for insights into other workload issues, such as RN management of prescription refills or phone triage, or billing.

  For an example of administrative issues that need discussion, sometimes a palliative care program might decide that the best time to do clinic hours is 3 pm to 7 pm, because it fits patients' needs and physician schedules. But the host clinic or shared support staff do not work those hours and must use overtime to cover the clinic. You want to iron these things out up front.

- Finance or decision support staff members often have roles to support business plan development. Ask if there is someone who has done project-planning work for outpatient programs and if you can get them assigned as part of the planning project. They will expedite access to standard information and simplify tasks such as determining what you will need for electronic records or billing.

  Try and find out which finance staff have significant credibility with leadership, and engage them. Test your assumptions and plans with them. You want these folks as your "adjunct team"; their support and personal identification with your program vision will help you for years to come.

- Senior medical director or administrator or designee: you need someone who knows the standard workload, leave policies, and norms of the outpatient practices. Even though palliative care is a different specialty and the flow of the work will be different, your expectations re: staffing workload and norms needs to be as consistent as possible with others. This is a function of the professional norms for your clinical staff and the administrative norms of the clinics.

- Consultants: if you ask you will find that many organizations have planning consultants, billing consultants, etc. and that funding may be available for a planning project. Do not hesitate to ask for what you need to do a good job on planning, and then work with leadership to find the expertise.

Section 6: Planning for Growth and Managing Expectations

If you have done a Needs Assessment process that looks ahead at optimal service design, then you have a reasonable estimate of future demand. Several things will push you toward growth:

- Repeat customers – patients who you see this year, particularly if they are not end of life patients, will return either periodically or more frequently as their illnesses progress.
- Pressure to provide services in additional venues – either other clinics, satellite locations, or in patient's homes, nursing homes, etc. When a patient you have seen cannot come to the office any more, what will you do?
- New referral sources – good news will travel, and your network will expand.
- Health system expansion or market demographics.
- Bright ideas from your team.

Growth is hard on logistics but good for program health.

It is hard on logistics because resources often need to be added in stair steps (add a 50% FTE, vs. add 2 appointments per week), and there are often inefficiencies to matching resources to growth. In addition, growth may strain the support relationships of a host clinic, or in-kind support for billing, appointments, or other functions. It also may strain the team as roles change, it is harder to provide continuity to patients, or as team members are asked to travel or take on new tasks. It takes planning, discussions, meetings, and communication with others.

It is good for program health because it is easier to demonstrate new value and secure sustainable support when you can tell the story of success and growth. Also it helps refresh your patient base with new patients, diversify your referral sources and reduce your dependence on a few supporters. You will have a more diversified portfolio of patients and supporters. It also creates career opportunities for staff, increases the likelihood that you can fund a full time administrative manager, and reduces your vulnerability to staff turnover.

The most important advice from experienced programs is to:

Expect growth and plan for it. Manage internal and external expectations to help match the pace of service commitment growth with the funding reality. Use good planning processes to keep people engaged with you over time, not just at budget time. Repeat a Needs Assessment process at least every other year. Build systems that can help you manage growth successfully. Define metrics that help you monitor your progress.

One strategy to help you plan for growth is to include operational metrics that help you identify trends. For example, tracking the number of new patients per month can be supplemented by tracking:

- Number and proportion coming from inpatient sources vs. outpatient
- Tracking proportion of total appointment time used for new patients and also per new patient
- Tracking the average number of total visits per patient per year

Section 7: Summary - Strategies for Success

A business plan is a living document that tells the story of your planned service and links it concretely to the mission of the organization. It derives its strength from the coherence with which you can articulate

- The Problem (the gap that exists, why it is urgent to close it),
- The Solution (why the proposed service can and will close the gap and the measures that will be used),
- The Investment (the costs of the Solution), and
- The expected Benefits (the direct financial or indirect financial and quality outcomes as well as the specific measurement strategy).

All of the detail, the results of the Needs Assessments, and the planning documents support this story. The business plan needs to clearly state the risk factors, and then clearly state in the Executive Summary how much new money is being requested, and for what level of new service. It is important to be specific, and to give the likely trajectory over at least 2 to 3 years. Leadership wants to know what to expect next year if they say yes this year.

Leadership will evaluate a request based upon:

- Alignment with strategic priorities
- Political support – have you engaged others and do you have strong support from clinical leaders and from administrative/finance leaders?
- Track record of the program leader – reputation and relationship
- Urgency
- Balance of investment vs. positive impact
- Measurability of results
- Quality of plan

The order of importance of these factors will vary depending on the organization and the decision process. However, it is important to recognize that the political support and track record of palliative care program leadership are often more important than a perfect plan. However, the due diligence of the plan can be of great assistance to you (the leader).

YOU are the main customer of the business plan. It helps you know what you can promise, what you will need to be able to do, and it is a vehicle for building the alignment and political support that you need.

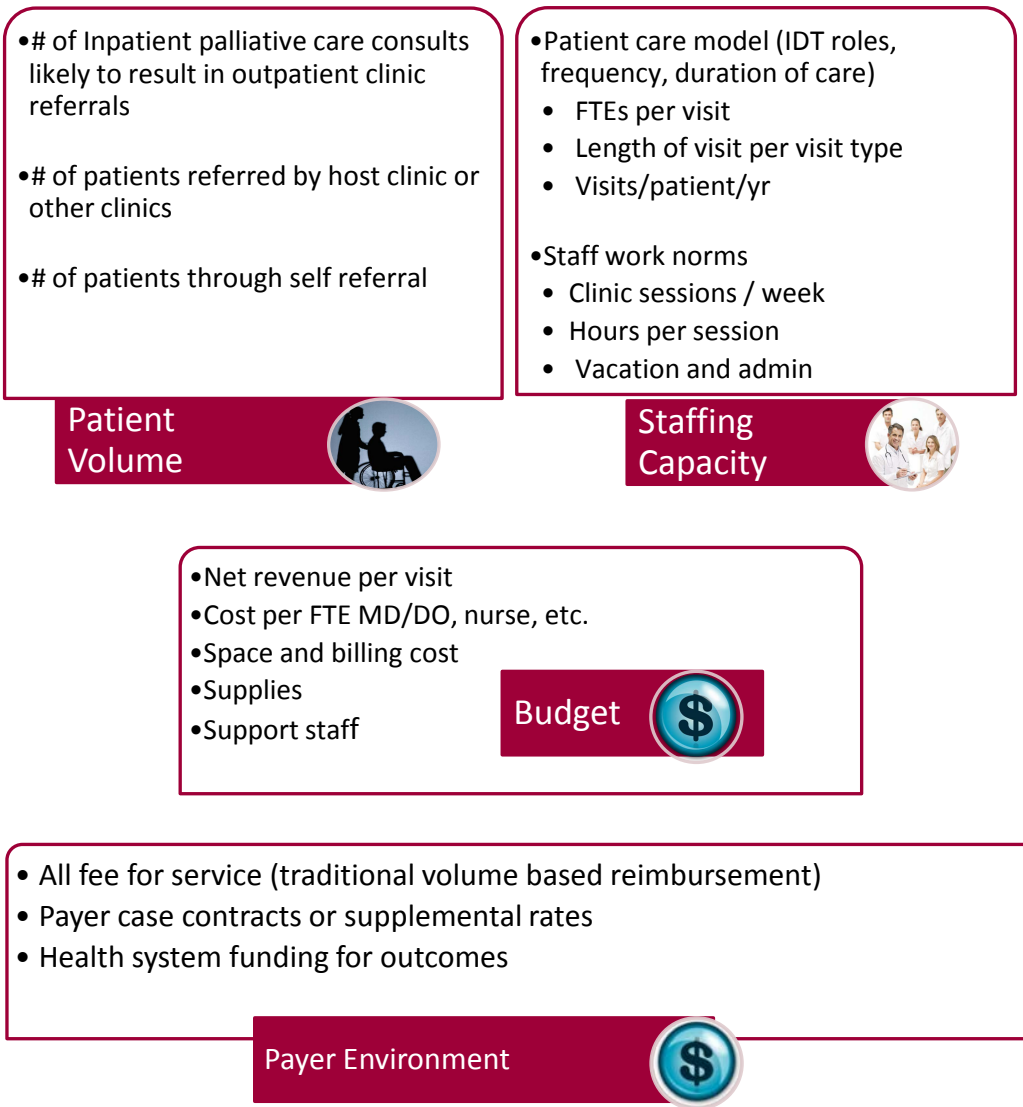
Appendix 1: Tools for Building an Outpatient Palliative Care Clinic Budget

Overview of Appendix 1:

- ✓ Conceptual Model (linking Patient Visit Planning with Staffing Capacity for Budget)
- ✓ Overview of a simple budget template example
- ✓ Checklist for data collection
- ✓ Budget Tool (separate Excel file – Budget and Modeling Workbook for Outpatient.xlsx)

Conceptual Model

Patient volume & service design drive staffing capacity. Payer environment determines revenue options for supporting services. Knowing costs of services helps negotiate rates that balance investment of resources, desired services, and outcomes.



Overview of Simple Budget Template Example (see Excel file for more detail)

This is a very simple overview for a budget. The accounting budget will not have the shaded sections, but they need to be included in some manner to link together the plans for scaling up the services and the rationale based upon desired impact.

Budget Category	**Year 1**	**Year 2**	**Year 3**
Patient Volume Assumptions o New Patient Visits o Established Patient Visits (F/U, which will include patients from prior years also) o **Total Visits/year** o **Total Unique Patients / year** (this is useful for value & impact assessment)			
REVENUE			
Professional Part B billing revenue assumption for net collections (do not use charges) o New Patient volume x Medicare Rate for most frequent code x 85%[2] o F/U visits x Medicare Rate for most frequent code x 85% o Net Patient Care Revenue			
o Other Revenues (stipends, medical director fees, etc.) o Other Revenues (grants) **Total Revenue (before subsidy or special contracts)**			
EXPENSES			
Staffing Expenses by job category (MD/DO, APRN, SW, Chaplain, Pharmacist, RN, Manager, Volunteer Coordinator, etc.) with related salary estimate, benefits rate, and FTE*			
Other Expenses – Office expenses if charged to practice (such as rent, licenses, fees, technical support, equipment, supplies, etc.)			
Other Expenses – Team related expenses such as travel, conferences, consultants, educational materials, organizational fees and memberships, marketing materials, budget for meals or meeting expenses or promotional activities. Also supplies for patients and families, such as magazines and books.			
Total Expenses			
Net Income or Loss (this is the amount that will indicate what subsidy is needed or what contracted rate is needed)			
Income or Loss per Unique Patient per year (net income or loss / total unique patients)			
Expected benefits, value propositions, or outcomes to justify subsidy if needed**			

**A separate staffing schedule that shows salary, benefits, FTE, and roles is usually attached.*

***The value proposition should be described in the plan, and some portion may be appropriate for the budget.*

[2] Assuming payers average out to Medicare rates may be reasonable. The 85% assumption could represent expected rate for APRNSs or could indicate some discount for write-offs or uncollected copays. This is an assumption not a recommendation. CMS rates for your locale can be found at the CMS website, http://www.cms.gov/apps/physician-fee-schedule/overview.aspx

Checklist for Data Needed to Prepare a Good Budget

Description	Data	Explanation or Example
Staffing (for each discipline such as MD/DO, APRN, etc.) o **Weeks per year expected for clinical work** o **Hours per week for clinical work** o **Standard pay rate or salary** o **Standard benefit rate** o **Planned FTEs**		o Weeks: For example, if a physician has 3 weeks of vacation, 7 paid holidays, 3 float holidays, and 5 days for CE, the maximum available is 46 weeks. Often this shrinks more if there are un-bookable days for outside meetings (board meetings, presentations at regional or national meetings, committees, etc.) o Hours per week: Some orgs have norms like "30 hours of clinic time per week" or "7.5 bookable hours per day" or "1 day off per weekend of call". Take these into account.
Appointment Norms o **Length of new patient appointments** o **Length of f/u visits** o **How many providers/visit** o **Other patient care tasks not in visits** o **Hours for appointments per day or session or week**		o If a new patient appointment is 1 hour and includes 2 FTEs, it will use 2 hours of capacity. If f/u are 30 minutes and 1 provider, then 1 new is equivalent to 4 f/u. o Daily and weekly meetings for IDT work, time daily in phone calls to patients or specialty rounds or team meetings o Norms vary re whether to block time for documentation and post visit work or whether this occurs outside of clinic time as described in the staffing session. o Your goal is to define as much appointment capacity as is realistically available but not to overstate it.
Billing revenue (FFS) o **CMS rates for common codes** o **Visit volume predictions** o **Provider mix (visits by MD/DO vs. APRN vs. other)**		It is pretty simple to calculate the expected revenue using the CMS rates at either 100% or 85%. The CMS fee schedule is what they will pay and is not comparable to hospital charges. If your org collects on average more or less than Medicare, the finance folks can give you an adjustment factor. Don't get too hung up on coding mix. Pick the middle or most frequently used codes and use these as proxies.
Office Costs (if any) o **Rent & Utilities** o **Support staff** o **Contracted functions (IT, Billing)** o **Supplies** o **Insurance** o **Computers, cell phones, software**		In many cases the clinics are set up with or through other clinics and these overhead expenses are contributed "in kind" to the palliative care service. Keep in mind that these are not free. Meet with managers who can tell you what will be charged and what will not, and what the conditions are. Who will pay for computers, cell phones, software? Some of these may be capital budget items.
Other Costs (team related vs. office related)		Travel, conferences, consultants, educational materials, organizational fees and memberships, marketing materials, promotional activities. Also supplies for patients and families, such as magazines and books.
Overhead		Find out if a standard overhead charge will be assessed. This is particularly relevant for academic practices.

Appendix 2: References & Resources

Moving Upstream: A Review of the Evidence of the Impact of Outpatient Palliative Care.
Rabow M, Kvale E, Barbour L, Cassel JB, Cohen S, Jackson V, Luhrs C, Nguyen V, Rinaldi S, Stevens D, Spragens L, Weissman D. J Palliat Med. 2013 Nov 13 [Epub ahead of print].

CMS.gov physician fee schedule lookup is available for CPT codes, RVUs, and geographically specific rates. Go to: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSLookup/index.html?redirect=/pfslookup/.

The CAPC Guide to Building a Hospital-Based Palliative Care Program, http://www.capc.org/capc-resources/capc_publications/the-guide [Although focused on inpatient planning, many of the principles and advice are relevant to outpatient planning.] Accessed November 3, 2013.

Needs Assessment Tools on the IPAL-OP section of the CAPC website, http://www.capc.org/ipal/ipal-op/monographs-and-publications Accessed November 3, 2013.

Kerr K, Cassel JB. Quality and Fiscal Incentive Alignment for Community-Based Palliative Care (August 2013) Coalition for Compassionate Care of California (CCCC). Available at http://coalitionccc.org/documents/CBPC_biz_case_Aug_2013.pdf Accessed November 3, 2013.

Nathan E. Goldstein, R. Sean Morrison, Evidence-Based practice of Palliative Medicine (2013); Lynn Spragens, "Chapter 70; Financial Aspects of Palliative Care" 407-420. Elsevier Saunders Publishers.

J. Brian Cassel, PhD, Amber B. Jones, Med, Diane E. Meier, MD, Thomas J. Smith, MD, Lynn H. Spragens, MBA, and David Weissman, MD, "Hospital Mortality Rates: How is Palliative Care Taken into Account?" Journal of Pain and Symptom Management, Vol. 40 No. 6 December 2010.

Ward, W.J. Jr., Spragens, L.H., Smithson, K. Building the Business Case for Clinical Quality, Healthcare Financial Management, December 2006.

