Managing the "BIG 5" : Finances for Clinical Leaders

Jennifer Hale, MSN RN CHPN
VP, Quality and Standards
Carla Roberts, BS
Executive Director
Mountain Grove/Lebanon/West Plains, MO

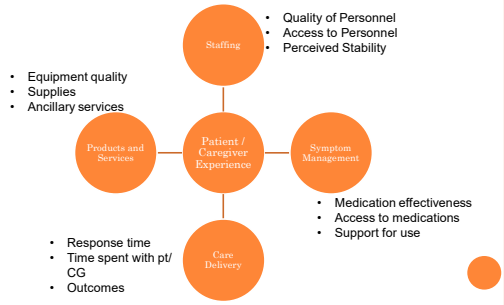
Purpose

- To provide a financial picture to the clinical leader for balanced financial stewardship and successful patient support

Learning Outcomes

- Identify the "Big 5" areas of financial concern to the clinical leader
- Describe the relationship between good patient care, quality care outcomes, and the financial management of the "Big 5"
- Apply new knowledge or insight through analysis using mock information at the end of the session

What are we managing?



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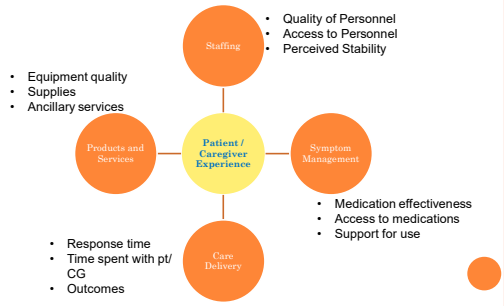

Terms to Know

- PPD = per patient day
- DOS = day or date of service
- DOC = day or days of care
- EBITDA = Earnings before Interest, Taxes, Depreciation and Amortization
- Accrual = holding a place for expenses or reimbursements in the months they are supposed to be received
- Actual = entering expenses or reimbursements in the month they are actually received

A REFRESHER ON MATH

Numbers used are not based on actual financials

What We Pay For	Per Patient Day Cost
Daily Reimbursement (based on level of care and CBSA)	+$170.00/ ppd
Patient Care Expenses (Variable Expenses)	
• Labor = 48%	- $81.60
• Pharmacy = 21%	- $35.70
• Medical Supplies = 2%	- $3.40
• DME = 12%	- $20.40
• Employee Mileage = 3%	- $5.10
• Purchased Services = 2%	- $3.40
Fixed Expenses (Overhead)	
• Rent/Utilities = 1%	- $1.70
• Administrative Labor = 5%	- $8.50
• Education/Training = 1%	- $1.70
• Office Equipment/Supplies = 1%	- $1.70
• ~~IT/ HR/ LEGAL/ Corporate overhead = 1.5%~~	~~- $2.40~~
EBITDA	+ $ 6.80

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What We Pay For	Per Patient Day Cost
Daily Reimbursement (based on level of care and CBSA)	+$170.00/ ppd
Patient Care Expenses (Variable Expenses)	
• Labor = 55%	- $93.50
• Pharmacy = 4%	- $6.80
• Medical Supplies = 1.5%	- $2.55
• DME = 3%	- $5.10
• Employee Mileage = 2%	- $3.40
• Purchased Services = 1%	- $1.70
Fixed Expenses (Overhead)	
• Rent/Utilities = 2%	- $3.40
• Administrative Labor = 15%	- $25.50
• Education/Training = 1%	- $1.70
• Office Equipment/Supplies = 1%	- $1.70
• IT/ HR/ LEGAL/ Corporate overhead = 1.5%	- $2.55
EBITDA	+ $22.10

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So, why does all that matter?

- Kaiser Family Foundation study 2017
  - 71% of people want to die at home but only 41% of them expect to do so
  - 71% of people believe the most important function of the health care system when people are terminally ill is to help people die without stress and discomfort
  - The #1 most important issue of concern for people with advanced illness is not being a financial burden

As hospice providers, our FIRST JOB is to recognize that we stand in the gap for people who WANT to die at home and EXPECT us to help them do it as comfortably and with the least amount of stress for them or their family as possible.

Hamel, L; Wu, B; Brody, M; 2017; Views and Experiences with End-of-Life Medical Care in the US: Report by the Kaiser Family Foundation

Connecting the dots…

- The patient's experience of our care and the family's experience of our care are usually very different.
  - Perspectives
  - Expectations
  - Locus of control
  - Fears/ Worries
  - Physical vs Psychosocial
  - Support after death

- Standard instrument for measuring caregiver experience of our care = CAHPS
- How do CAHPS and cost management intersect and what does this do to improve experiences?

Evidence-Based Practice

- What is it?
- Why is it important in this discussion?
- Who is responsible for ensuring it's being provided?
- What kind of evidence do you need?

Evidence-Based Practice

- In 1996, the term "evidence-based practice" was defined by Dr. David Sackett as
  - "the conscientious, explicit and judicious use of current best evidence in making decisions about the care of the individual patient. It means integrating individual clinical expertise with the best available external clinical evidence from systematic research."
  - In 2002, he updated this definition to include the experiences and expectations of patients who bring their own ideas to conversations about care delivery.

DL Sackett, W Rosenberg, J Muir Gray, RB Haynes, WS Richardson. BMJ 1996; 312 doi: http://dx.doi.org/10.1136/bmj.312.7023.71
downloaded 7/2/18 from https://guides.mclibrary.duke.edu/c.php?g=158201&p=1036921

Evidence-Based Practice

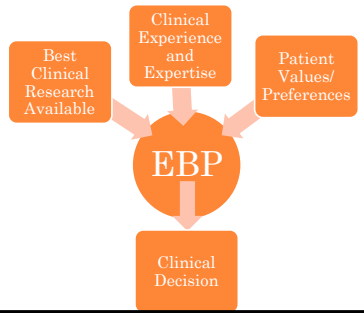
- So, why is this important when talking about managing the BIG 5?
  - Recommendations for changes to any practice can be scary and sometimes having the foundation of evidence to support why you want to make a change is a key factor in helping others adopt the change
  - If you are recommending changing a patient's medications, scientific research can often be the best support tool available – especially for medications related to pulmonary and pain management
  - Utilization of various therapies such as radiation or oral chemotherapy may have good evidence to support how and why they are useful for a limited time

Qaseem A, Snow V, Shekelle P, Casey DE, Cross JT, Owens DK, et al. Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea, and Depression at the End of Life: A Clinical Practice Guideline from the American College of Physicians. Ann Intern Med. 2008;148:141–146. doi: 10.7326/0003-4819-148-2-200801150-00009

Fine, P. Palliative radiation therapy in end-of-life care: Evidence-based utilization. Am Jour Hosp Pall. 2002;19:3:166-170 https://doi.org/10.1177/104990910201900307

Evidence-Based Practice

- Clinicians should all be familiar with EBP and how to consider the decision-making process from that lens



WHAT DO YOU INFLUENCE?

- Patient Care Expenses
  - Labor
  - Mileage
  - DME
  - Supplies
  - Pharmacy
  - Purchased Services

QUESTIONS TO ASK

1. Does the patient NEED it? (what is the evidence?)
2. Does the patient WANT it? (what is the benefit?)
3. Is it part of the plan of care? (what is the goal/intervention/outcome?)
4. Is it reasonable and necessary? (would Medicare pay for it outside of hospice?)

LABOR

- Patient care labor is the highest percent of cost we manage
- We are required to have adequate staffing to meet the needs of our patients and families
- We are required to staff registered nurses, social workers and spiritual counselors as well as provide nursing assistants, volunteers, bereavement services and other ancillary support (therapy, etc)

LABOR

- The answer is NOT "add more staff"
- The answer is ***usually*** "utilize the staff you have more wisely"
- Innovation and creativity are OK – within a few reasonable parameters
  - Have to work within labor laws of your state
  - People have to be qualified for the role
  - If using one person for multiple roles, should have training/ job description/ support for each role

LABOR

- Tools to manage labor expense
  - Staffing model
    - Established to meet industry norms and based on VISITS or CASE LOAD
  - Productivity expectations
    - Industry norms and division of tasks
  - Scheduling
    - Interdisciplinary work to maximize patient support
  - Salaried vs hourly determinations
  - Efficiency and effectiveness of your labor pool CAN be achieved

LABOR

- Case Load
  - Standard number of patients managed by that discipline
  - Should be flexible to account for acuity, windshield time, level of care, location of care
- Visits
  - Standard expectation for number of visits per day per discipline
  - Accounts for assessment time, documentation time, drive time, time for IDG, time for phone calls (pharmacy, DME, physician, caregiver, community resources, etc)

Labor

Case Load

- There are standard models out there
- Tailor to your geography, travel needs, referral sources, average case mix, and the strengths/ knowledge of your staff

Visits

- How many visits are planned according to your visit frequencies?
- How long does an average visit take for assessment?
- How long does documentation take on average?
- Include non-productive time (time spent driving, attending meetings, making phone calls, etc)

Labor

- What about "On Call" labor?
  - When are your peak after hours times?
  - When do you do the majority of your admissions? Day of the week? Time of the day?
  - Do you consider your on-call labor as part of your overall clinical labor pool?
  - Do you manage your patient care in shifts?
  - How do you pay for on-call visits or time?
  - Do social workers and counselors take any on-call? How do you reimburse them?

Labor

- Often, you can see a correlation between your labor spend and your CAHPS scores in areas such as:
  - Question 5 regarding weekend and evening response
  - Question 6 related to communicating schedules
  - Question 7 about getting help when needed
  - Question 30 regarding training related to physical support for the patient
  - Question 31 related to getting information about what to expect from the dying process

Mileage

- Efficient scheduling, patient grouping and accurate mileage counts help to keep this necessary cost at a minimum
- What do you do now to verify your staff members are being efficient in their mileage utilization?

DME

- What is required?
  - Hospices must provide drugs, supplies and **equipment** necessary for the palliation and management of the terminal illness (418.106)
  - Managing DME includes managing deliveries, pick ups and unused items
  - What opportunities for efficiencies exist in your office today in the ordering and management of DME? Which items do you think are ordered more than they should be?



DME

- Do we have an order for it?
- Does the patient need it for a hospice-related issue?
- Is it on the plan of care?
- Is it time-limited or will the patient need it from admission to discharge?
- Can the patient still benefit from the item?

Medical Supplies

- What is required?
  - Hospices must provide drugs, **supplies** and equipment necessary for the palliation and management of the terminal illness (418.106)
  - Supplies are medical supplies – these are items that Medicare would pay for normally in the course of care specific to the patient as they relate to the management of the patient's illness (covered as DME or Prosthetics)
  - Supplies are not:
    - Personal care items like shampoo and razors
    - Incontinence management products like briefs
    - Simple wound care items like band-aids and gauze

NOW, just WAIT…

Medical Supplies

- Medicare doesn't limit what you are able to provide to a patient – its definitions are the minimum requirements
- If you want to provide shampoo, razors, incontinence supplies, compression stockings and gloves **<u>you can</u>**
- Be aware of what your costs are in these categories, though. Consider the following:
  - What is necessary for good patient care practices?
  - What items did the patient have access to before hospice?
  - Are you supporting patients or your clinicians in the need to have these things?

Medical Supplies

- Patients in a Nursing Facility
  - Experiences vary widely – some facilities expect hospice to provide everything for patient care needs and others expect hospices to provide only certain items like briefs and mouth swabs
  - The relationship, the contracted agreement, and the state are the determining factors in how this is navigated
  - "Guard Rails":
    - Hospice is the professional manager of the patient's care and should determine what is covered for the patient and what is not
    - The facility is responsible to the payer of the room and board and its licensure regulator to ensure the patient has all necessary supplies for care and support of personal hygiene, wounds, and mobility

PHARMACY

- What is required?
  - Hospices must provide **drugs,** supplies and equipment necessary for the palliation and management of the terminal illness (418.106)
  - The hospice can set a formulary or other mechanism to manage the costs of medications as long as patients have **access** to appropriate medications for all conditions which are related to the terminal prognosis
  - The hospice is required to provide and pay for medications which relieve pain, reduce anxiety, manage nausea/ vomiting, and prevent or treat constipation as appropriate to the individual patient's needs *(Medicare Wage Index, FY 2015)*

PHARMACY

- What's NOT required:
  - Hospice is not required to pay for or provide a medication just because the patient/family wants it
  - Hospice is not required to pay for or provide medications which are no longer effective
  - Hospice is not required to pay for or provide medications which create a symptom burden or otherwise interfere with palliative care interventions
- Considerations:
  - What is the purpose of the medication?
  - Is it effective for its prescribed purpose?
  - Does it support a palliative vs curative approach to care?
  - It is burdensome (administration, frequency, etc.)?

PHARMACY

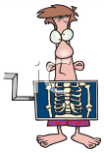
- Medications are a HUGE factor in perceptions of care
- CAHPS questions associated with medications are focused on whether the family member **understood** what the medications were and **what to expect** related to side effects

		HCF/DEYTA	Compassus
⊟	GETTING HELP WITH SYMPTOMS	75.3%	75.9%
16	Patient got as much help with pain as needed (Yes, definitely)	84.2%	85.8%
22	Patient received help for trouble breathing (Always)	81.9%	84.4%
25	Patient received help for constipation (Always)	72.0%	72.4%
27	Patient received help for anxiety or sadness (Always)	63.1%	61.0%
⊟	GETTING HOSPICE CARE TRAINING	75.5%	75.9%
18	Hospice team discussed side effects of pain medicine (Yes, definitely)	76.5%	75.7%
19	Provided training about side effects for pain medicines (Yes, definitely)	70.1%	69.6%
20	Provided training about if/when to give more pain medicine (Yes, definitely)	83.7%	86.7%
23	Provided training about how to help with breathing (Yes, definitely)	79.6%	81.5%
29	Provided training about what to do if restless or agitated (Yes, definitely)	67.7%	66.0%

Source: HCP/DEYTA for Compassus Jan 2018 – aggregate scores for all provider numbers vs national benchmarks for HCP/DEYTA

Purchased Services

- Do we have a contract?
- Did we get an order?
- Is it in the care plan?
- Does the patient need the service? Is it related to one of the reasons the patient is terminally ill?



Inspecting what you Expect

- Pharmacy reports
  - Utilization
  - High-cost outliers
  - What are the trends?
  - Does it look "right" – are you providing good medical care?
- Supplies invoices and reports
  - Utilization
  - High-cost outliers
  - Trends?
  - Stuff that shouldn't be there?
- DME invoices and reports
  - Utilization
  - High-cost outliers
  - Stuff that shouldn't be there?
- Financial review
  - Does your leadership review the financials together every month?
  - What about purchased services and labor reports?

Let's Practice…

- Scenario to work from
- Work in small groups of 3-5 people
- Your tasks:
  - Discuss the scenario provided and determine how you would propose to your leadership and your team some recommended changes in your approach to managing your care expenses.
  - Identify 2-3 CAHPS questions which might correlate to your desired outcome
  - Do you think there is any research or evidence to support your proposed change? How would you find this out?

Scenario

Each month, your leadership team reviews the financial reports and for the past 3 months, the costs for pharmacy and medical supplies have continued to rise. Your census has not been rising by the same ratio so it's clear that managing the expenses associated with these 2 items is necessary to balance all other costs for patient care. In addition, you've recently seen some disturbing trends in your CAHPS surveys related to communications. You suspect there is a relationship between the rising costs of medications and the downward trend in experience of care. Your leadership team has tasked you with coming up with ways to reduce the costs of medications and supplies.

Why this is important to the clinical manager

- No margin…no mission
  - Being a good steward of the financial resources ensures we can continue to reach patients every day
  - Demonstrating fiscal responsibility helps staff to understand their role in making their visits count
  - Efficiency and effectiveness are on a continuum – finding balance is the key to good patient care
  - Just because we can, doesn't mean we should – this goes for saying yes **and** saying no when unique situations arise. You need all the facts to make a good decision.