The Center to Advance Palliative Care

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Transformation Business Plan for 2013-2021

January 22, 2013

The Center to Advance Palliative Care is poised to catalyze systems change in the U.S. healthcare system by bringing the palliative care innovation fully to scale in the United States by the year 2020.

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Executive Summary

The Center to Advance Palliative Care (CAPC) is a national organization devoted to increasing access to quality palliative care for seriously ill persons and their families in the U.S. CAPC pursues its mission through three strategies – building awareness and demand across a range of audiences, influencing supportive policy, and providing tools and technical assistance to support new team establishment and sustainable program growth. CAPC has a track record of success in each domain.

CAPC has the opportunity to support the development of palliative care in community settings and to ensure that high quality services are accessible throughout the health care system, building upon strong relationships with more than 600 active hospital based palliative care programs and leaders. However, the current business model is inadequate to support building the capacity to meet demand for new services or to take on the new development necessary for a community settings' strategy.

This business plan summarizes the planned approach to the ***transformation of the business model*** for technical assistance – CAPC's core strategy for supporting the "bottom up" growth of palliative care programs. Concurrent with this transformation of operational functions, and enabled by it, CAPC will launch the ***community settings' initiative***.

Why now? Health care reform has stimulated tremendous interest in solutions that are high quality, patient centered, and proven to be cost effective. Proposed and emerging payment changes are pushing communities and health systems to work together to re-organize how and where care is delivered to manage costs better. Palliative care now has high visibility as a practical solution that can be implemented with little risk. Health system leaders and new community players are very interested in getting proven, efficient implementation support to ramp up their palliative care initiatives.

Why CAPC? We are the proven name brand for credible implementation support for palliative care. Our approach has a track record, and most program leaders in the field know us.

Why does CAPC need to change? We have delivered high value "free" content. To support the value proposition of a user membership model, we need to move our methods to the next level by creatively utilizing web opportunities to create relationships and effective learning environments, and to make good use of our content experts. We need a better "platform" for technical assistance. Investing in it now will enhance our capacity to scale up at a lower cost. This platform will also be very important to low cost broad outreach to community partners, who have even smaller budgets than hospitals and great difficulty finding ways to get staff training and collaborations.

Will they pay? We have the potential, through this conversion, to create new high value approaches that utilize web-based tools to the maximum, package implementation support and clinical content to make it reliable and easy for "turn key" implementation. Given the broad range of initiatives that are underway in health care, if we can package things well so that they are customized to meet the needs of health systems, hospitals, and community hospices, they will be willing to pay, and the proposed pricing ($8,000/yr/hospital) is reasonable when compared to other programmatic expenditures.

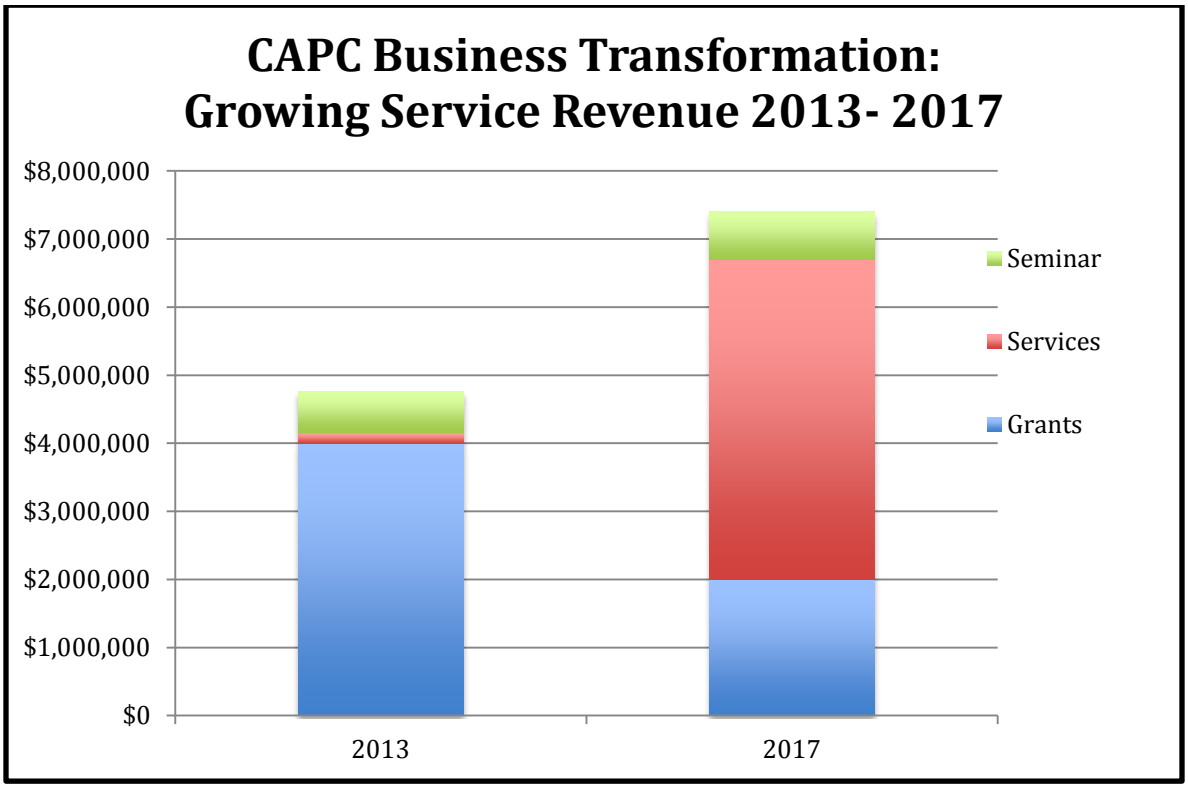
Our new tools and implementation packages will include targeted products that address "30 day readmission rates", Emergency Department utilization, and other high profile, high value concerns

of leaders. We will demonstrate that our approach is the best option to ensure that new and growing palliative care programs are providing high quality care through consistent practices that reflect evidence-based best practices, and with the efficiencies and effectiveness that will ensure optimal scope and scale within a health system or community.

What will we do? We will enlist outside experts to help us design the right web based platforms for our building blocks, and we are working with content experts to build out a broad range of products and services that can be rolled out as new value added, and within a firewall and available to members. We will continue to do the things that are essential to our success – continuing to work for supportive Policy reform, work with Payers, create an environment that supports research, and work to engage the public.

What do we need? In order to support the ***Transformation activities***, and maintain core operations while developing and then launching the membership strategy, we will need $9.1 million in support over a 36-month period. To launch the ***Community Settings' initiative***, which will combine an early stage change strategy with concurrent tool development to accelerate model innovation, we will need an additional $9.6 million (this includes funding through 2021). We are also requesting $1.9 million over the 36-month period to support ***policy outreach initiatives***, which will not be user funded but are very timely. The total funding request is $20.8 million.

Over the next two years we want to build out the changes and launch the membership model in 2015 for growth in 2016 and 2017. We expect to shift from a majority of funding from grants, to a majority of funding from operations in this period.



Proposal for CAPC Business Transformation

Background: The Center to Advance Palliative Care (CAPC) is a national organization devoted to increasing access to quality palliative care for seriously ill persons and their families in the U.S. Launched in 1999 as a National Program Office of the Robert Wood Johnson Foundation, located at The Mount Sinai School of Medicine in New York, and supported since 2006 by a consortium of foundations, CAPC has contributed to the rapid spread of palliative care teams in hospitals and other settings across the nation. Palliative care is a rapidly expanding new team-based medical specialty focused on improving quality of life for persons with serious illness and their families through relief of pain and other symptoms, communication about and support for person-centered goals, and continuity of care across stages of illness and settings of care. A growing body of evidence demonstrates that palliative care improves quality of care and quality of life, prolongs life in several studies, and, as an epiphenomenon of this better care, markedly reduces need for costly hospitalization. Because of its impact on the value equation, demand for palliative care services across the full continuum of care is rising. This proposal describes our plan for securing the funding necessary to scale access to palliative care for the seriously ill across all care settings.

CAPC pursues its mission through three strategies – building awareness and demand across a range of audiences, influencing supportive policy, and providing tools and technical assistance to support new team establishment and sustainable program growth. CAPC has a track record of success in each domain.

For the past twelve years CAPC has put significant energy into technical assistance for program building with a focus on settings where there was a clear business and quality case for palliative care- hospitals and hospices. As a result of this work and its success, CAPC now has a large and loyal constituency of health systems, hospitals, hospices, and their leaders and clinicians who turn to us for reliable technical assistance, support for key policy initiatives, and national leadership. Overall, 1,962 hospitals in the US currently report having a palliative care program[1] and more than 600 of these have accessed CAPC services within the past year.

CAPC is frequently asked to provide technical assistance and support to established teams, health systems, and community based organizations, and is constrained by capacity bottlenecks.

Problem Statement: The field of palliative care is growing rapidly and requires an increasing volume and complexity of technical assistance. Health care reform is stimulating shifts of funds and innovation away from hospitals and towards community care settings, improving the demand for palliative care models and rapid exchange of ideas in these new settings. CAPC is the "go to" organization for technical assistance but our current business model does not generate sufficient operating revenue from users to support the major expansion necessary. Our dependence on philanthropy is a constraint to scalability and reduces our ability to leverage the excellent momentum of the field.

CAPC currently generates $1.4 million in revenue from fees, but half of this is treated as a pass through to our 8 regionally distributed Palliative Care Leadership Centers, and the remainder is largely attributable to our annual seminar (618 attendees in 2012) and directly offset by expenses[2].

[1] 2012 AHA data (draft analysis, Dec. 2012)
[2] PCLC revenue at 100 sites/yr = $750k; CAPC seminar > $600k, $100k other products

All fees to date have been tied to specific services or events. In an effort to drive rapid uptake and dissemination, CAPC's intellectual property has been contributed without charge both to the field and to partner organizations with the ability to stimulate demand, awareness, quality, or payment for palliative care services.

The time is appropriate for CAPC to expand the funding strategy for technical assistance from a sole reliance on philanthropy to include support from user-funded fees. This strategy will 1) further align service design with constituent needs; 2) create a business model that is more scaleable (services can grow with user interest); and 3) build a platform that will be necessary to develop and disseminate the new "community setting" initiatives.

Successful transformation of the technical assistance platform to a fee and subscription-based model will allow future philanthropy to focus on the research and development necessary for new models for palliative care in community settings, pursuit of structural change through policy regulatory, payment initiatives, and expansion of public awareness and engagement.

Over the next five years, CAPC needs to concurrently 1) build the platform and enhanced tools that will support a membership fee based structure; 2) develop a Community Initiative to complement the strong success of the past decade in hospitals, and to build on the momentum created by health care reform; and 3) continue to pursue policy opportunities and consumer engagement strategies.

Proposed Strategy to launch membership fee structure

CAPC plans to transition the business model for our technical assistance from philanthropic support to self-sustaining operations through a user fee-based structure. CAPC's annual operating expenses net of current revenues for technical assistance activities are approximately $3 million. Our goal is to develop operating revenue to offset this and to do so with an operating model that will grow revenue matched to demand for new services. Accomplishing this will require increasing our expenses to build capacity, thus our goal for 2017 is to generate more than $4 million in operating revenues.

The most effective way for us to leverage our current brand, generate revenue, and support our mission is to introduce annual fees for hospitals, hospices, and health systems. This will provide the revenue base to expand support for innovation through technical assistance. Based on requests and queries from our constituents over the last 2 years, the increasing demand for comparative metrics, implementation support, and access to emerging best practices in the community setting is sufficient to support this conversion.

An annual fee structure (paid per hospital, hospice, or health system vs. per individual member or per service used) has various benefits to users and to CAPC, including simplicity (one decision and one payment), and flexibility (access granted to multiple users at each organization) and is consistent with the design and delivery of services requested by constituents. CAPC will include an individual member option to accommodate individuals who are not affiliated with larger organizations or who wish to belong as individuals, but the benefits will be structured to not undermine the attraction of organizational membership.

Successful introduction of an annual fee to our constituents will require that we launch attractive and new/enhanced products and services and that we leverage existing relationships for early success.

Sales Strategies to ensure that the initial launch is successful include:

- Approaching a small number of health systems already highly engaged with CAPC to be founding members of a health system roundtable with access to executive leaders & system tools
- Working through established philanthropy partners to introduce some first year fee matching support, similar to activity in NY through the Samuels Foundation and the NYS Health Foundation, – this will ease the transition and motivate early members
- Develop state strategies targeting 3-5 high profile states (and leveraging payers or funders) such as California and the California Healthcare Foundation
- Develop a strategy specifically for Catholic hospitals and Catholic Health Systems which represent a large proportion of total hospitals, some of the health systems most committed to palliative care, and with a national commitment to palliative care
- Develop specific support initiatives for Hospices who are already or plan to provide community based palliative care services.

Priorities for our product strategy include:

- Maintain and grow the personal relationships and access that people have with CAPC leaders and staff
- Increase peer-to-peer opportunities for engagement of front line staff and team leaders
- Provide on line tools utilize new web based options to reach a broader group of clinicians for generalist training
- Leverage web based options and redesigned products to have low unit costs and to be quickly scaleable
- Ongoing alignment with mission – our product priorities will support the broad, accessible, and high quality development of sustainable palliative care services across all care settings.

New products that will support the value proposition include:

- National Palliative Care roundtable for health systems
- Web based e-learning linked to clinical training for generalists and specialists
- Expanded national Registry with cohort profiling and "system" comparative reporting
- ACO integration and implementation guides for community based palliative care models
- Implementation and measurement tools to align palliative care efforts and readmissions initiatives
- Boot camp and mentoring service for palliative care team managers and leaders
- Expanded and restructured access to national experts through "virtual office hours"
- Expanded and more user-friendly implementation guides
- Recognition and Award strategies
- Focused topic "expedition series" with small group size of early adopter/innovators
- Discounts related to existing products such as audio-conferences or annual seminar

Organizational Strengths include brand recognition and credibility, nationally recognized leadership, consistent management within core operations, deep content expertise that can support product development, and the presence of basic operating infrastructure.

Over the past decade our focus has been on spread (adoption by new hospitals and health systems). For this reason, we have intentionally minimized financial barriers to participation in a new field with a vulnerable (cost avoidance) business case. **The spread goal has been successful; the majority of U.S. hospitals now report a palliative care program.** These programs are gaining in stature and impact and driving innovation, spread across regions and care settings, and building new leaders. As a result, our constituency's appetite for more technical assistance for the full range of care settings is growing.

People in the field look to us (awareness), and trust our advice (credibility). They have unmet needs (demand). Our challenge will be to deliver a fresh product strategy that stimulates decision making to pay an annual fee, converting loyal constituents into paying customers.

The ongoing work of executive leadership to expand awareness, build new community based models, and impact policy and payment will complement the technical assistance business strategy by bringing new content, new markets, and high visibility to CAPC affiliates.

Risks and Key Assumptions: Success in this business transformation will depend on: 1) Developing sufficient new value to stimulate purchase decisions >$8,000 by more than 300 hospitals, hospices, and health systems; 2) Building new products with very low costs for scalability; 3) Accomplishing the transition in 36 months; and 4) Maintaining core operations and developing new technical assistance for community settings, while learning new approaches to customer interfaces, information technology platforms, and operating within the realities of business constraints.

Proposed Strategy to Develop a Community Initiative in Palliative Care

With the momentum spurred by health care reform, there is an opportunity to significantly expand palliative care in the community. The Business Transformation proposal assumes that some of this expansion will come through the support of technical assistance to our core current constituency of hospitals and hospices**. The Transformation budget includes $9.6 million in additional funding for an initiative to more thoroughly develop community based palliative care**. CAPC will utilize the same approach that has worked for hospital-based models – stimulate awareness, drive policy and payment, work through partners, and support innovation and adoption with technical assistance.

Rationale: The imperative to expand palliative care into community settings

Our objective during the next eight years is to expand palliative care beyond the hospital setting to home and community, where most persons with serious and complex illness live and need help. Our Phase 1 activities for 2014-2017 launch this initiative, which will continue through 2021.

The crisis of value in U.S. health care is leading to a rapid transformation of American medicine away from fee-for-service and towards global budgets, capitation, payment for value, and other managed care models. The forces driving this transition include budget constriction, efforts to capitalize on shifting funding streams and workforce imbalances. Improved quality of care and alignment with patient and family choices is also a stated goal. The major engine of this change is coming from a diversity of experiments in the private sector. More than 75% of new ACOs and ACO-like integrated and managed care models are led by the private sector; Medicare Advantage, new

Managed Medicaid and Long Term Care entities, integrated provider-payer partnerships, and for-profit care management entities.

The field of palliative care is critical to the success and sustainability of these new initiatives because of its central focus on listening to the patient and the family and on developing and implementing an achievable and realistic care plan that is consistent with their goals and needs. Rapid integration of high quality palliative care models and clinical skill is key to protection of the best interests of patients and families during serious illness- they have the greatest need, they cost the most, and they are the primary targets for fundamental changes in access to care.

Hospital palliative care, proven to improve patient quality of life and survival, and reduce costs, has grown exponentially and is now available in more than two-thirds of U.S. hospitals, thanks to substantial investments in the Center to Advance Palliative Care from the private sector. While the availability of palliative care to *hospitalized* seriously ill patients represents a dramatic improvement in care delivery, this access does not readily extend to the places seriously ill patients live with their illness and wish to receive their care: home and community. Few community-based options for palliative care exist. This deficit is in part attributable to limited information about effective community-based models and the tools and technical assistance needed to develop viable programs as well as insufficient palliative care training and skills of community-based clinicians, and poorly aligned regulatory and financial incentives.

CAPC's plan to expand access to palliative care to the home, office, nursing home and assisted living settings- where seriously ill patients actually live and need care- occurs in the context of a health care system facing pressure to contain costs while protecting access to quality care for the sickest, (and therefore most expensive), patients. As a result, the time is right to shift CAPC's business model to enable us to expand palliative care capacity to community care settings in a scaleable and sustained manner. CAPC will leverage our experience as the nation's leading resource for palliative care development by transferring our successful hospital dissemination strategies to community settings.

More information about the Community Initiative is included in Appendix 1, and includes program mission, objectives, assumptions, initial strategies, a detailed budget, and longer term goals.

Funding Request: CAPC is seeking philanthropic support of $21 million to underwrite the transition period of thirty-six months (mid 2013-2017).

- $9.1 million for the 36-month conversion of the business model, including investment in start-up expenses, such as the development of clinical e-learning materials, migration to a learning management system, addition of key staff, new tool development and marketing launch.
- $9.6 million for the launch of the Consumer Initiative, including $3.6 million for initial outreach, engagement, and development of core tools, and $6 million to support the ramp up of this support through 2021 (a total of 8 years of support).
- $2.1 million for the ongoing and expanded work of Dr. Meier to build upon policy impact opportunities and continue outreach and consumer engagement.

A critical area of investment will be the identification of best practices, possibly outside of health care and non-profit organizations, for the building of virtual communities of professionals that supports rapid exchange of ideas, adoption of best practices, and adaptation to new environments. If CAPC can create this environment and support it with content, experts, facilitation, and a structured approach, then this transformation will be financially successful and accomplish our mission goals, while demonstrating a successful model for broad and truly scaleable technical assistance.

Detailed budget information is attached.

Revenue Goal: By 2017 CAPC will create a new annual revenue stream of $4 million+ through a combination of annual fees from health systems, hospitals and hospices. Enrollment of 40 health systems (10% of the total in the US) and 370 hospitals (less than 10% of total hospitals and less than 20% of hospitals with palliative care programs), and 50 hospices would achieve this level of revenue. From 2017 forward, participation and revenue will grow annually by at least 10%, to fund new and expanded services and stimulate growth in the field.

Timeline

- Jan – June 2013 - Identify funding for business transformation
- Jan – June 2013 initiate outreach to experts who can review the proposed strategy and business assumptions and supplement the business planning process
- ASAP identify & engage experts in design of virtual communities/ web based approaches to peer-to-peer exchange to advise on the E-learning strategy and the other platform design features that will support a flexible, scaleable, and high impact product strategy.
- March 2013 launch product development/conversion with long lead time, such as the E-learning content conversion
- June 2013- 2014 other product development, business conversions, physical space moves, as well as staff changes and additions.
- July 2014– formal announcement of new structure, features, and timetable, reinforced at the annual CAPC seminar in November 2014
- January 2014 initiate the Community Initiative, to continue over an 8 -year period, but to yield first stage of tools and technical support by 2017.
- January 2015 official enrollment kicks off with sustainable enrollment after 18-24 months.

Major Tasks or Milestones	**Jan 2013-June 2013**	**July 2013-June 2014**	**July 2014-June 2015**		**July 2015-June 2016**
			July-Dec	Jan -Jun	
Ongoing/Improved CAPC Operations	Throughout 3.5 year period				
Identification of Transformation Funding	6 months+				
Planning Input, ID of key Vendors, new Staff or consultants	6 - 12 months				
Design & Develop New Business Platform & Content	24 months				
Community Based Initiative – Phase 1 Development		Beginning of an 8 year initiative			
Pre-marketing			12 months		
Launch Membership Campaign January 2015				Launch Jan 2015; reach goals by Dec 2016 – 24 month ramp up	
Additional Funding Support Period		36 months of support to planning, development, & operations support during ramp-up			
Sustainable Enrollment Levels by July 2016 for FY 2017					*

Description of Palliative Care and CAPC's Organizational History

What is palliative care?

Palliative care is specialized medical care for people with serious illnesses. This type of care is focused on providing patients with relief from the symptoms, pain, and stress of a serious illness - whatever the diagnosis. The goal is to improve quality of life for both the patient and the family. Palliative care is provided by a team of doctors, nurses, and other specialists who work with a patient's other doctors to provide an extra layer of support. Palliative care is appropriate at any age and at any stage in a serious illness, and can be provided together with curative treatment

A growing literature demonstrates that palliative care services result in better clinical outcomes for patients and families, improved rates of survival, and, as an epiphenomenon of better care, leads to markedly reduced reliance on emergency services and hospitals. To promote access to high quality palliative care, CAPC is committed to the following vision and mission:

Vision of the Center to Advance Palliative Care:
All patients with serious illness and their families will have access to quality palliative care throughout the course of illness and across care settings.

Mission:
- To ensure that patients and families know to request palliative care.
- To ensure that health professionals have the knowledge and skills to provide palliative care.
- To ensure that hospitals and other healthcare organizations and practices are equipped to deliver and support quality palliative care services.

To achieve this mission CAPC:
- Develops and disseminates technical support to stimulate new program growth and to assure the long-term sustainability and quality of established teams.
- Engages in outreach to major national health care organizations, policy makers, payers, and educators to catalyze supportive payment policy, strengthen the workforce, and assure regulatory and accreditation incentives aimed at assuring access to quality palliative care.

CAPC has two primary roles in the U.S.: 1) Provision of tools and technical assistance to improve the care of seriously ill persons and their families by supporting adoption, expansion, and impact of palliative care programs in every health care setting; and 2) Promotion of policy change to improve the care of seriously ill persons and their families by defining and driving changes in the larger health care environment that improve access to palliative care services. These roles are related and synergistic.

Now in its 13th year, CAPC has developed abundant technical assistance resources. It has provided direct training and mentorship to more than 1,962 hospital palliative care teams across the country to help teams start, sustain, and grow palliative care programs to meet and exceed current national standards and guidelines. In addition, CAPC directly serves and trains thousands of healthcare professionals through its website, seminars, training sites, audio conferences, and publications.

- Core Tools and Technical Assistance Activities build competencies among clinical leaders to start and sustain successful palliative care programs that serve patient needs and are aligned

with their institution's strategic goals; focus on core operational quality elements that are integral to program success; and securing the right support for growth, quality and sustainability. Our technical assistance products and services include web-based tools, print products, national seminars, and intensive small group mentoring.

- Formalizing Activities involve intensive focus on bringing the palliative care innovation to scale through a range of policy levers. By this we mean encouraging and formalizing palliative care service delivery, quality and access through promotion of medical organizational partnerships, regulatory and accreditation criteria, professional certification, educational and training mandates, supportive delivery and payment models, and enhanced research funding. Through these and other avenues the goal is to legitimize and require palliative care as standard of practice for all persons with serious illness in the U.S. healthcare system.

CAPC Outcomes

Through these strategies CAPC has contributed to a near tripling in the number of hospitals providing palliative care in the U.S., from 658 programs in 2000, to 1,962 in 2011 (American Hospital Association 2012 report of 2011 FY data and CAPC's National Palliative Care Registry data.) We have accomplished this through application of standard business and social change principles to the diffusion of the palliative care innovation, including development of a strong financial and business case for palliative care, and investment in effective audience research and marketing to hospital executives, clinicians, patients and families, policy makers and payers. Our strategies include partnerships with organizations well positioned to advance the field (such as the American Hospital Association, The Joint Commission, IHI, and the American Cancer Society).

During this period the field of palliative care has received recognition as an official medical subspecialty (2006, American Board of Medical Specialties), The Joint Commission has added an advanced certification for palliative care programs (2011), the Commission of Cancer has required access to palliative care as a condition of accreditation of U.S. cancer centers, and palliative care has been included in national practice recommendations from the National Quality Forum (NQF), the American Society of Clinical Oncology (ASCO), and other leading organizations that influence clinical service design and delivery in health care.

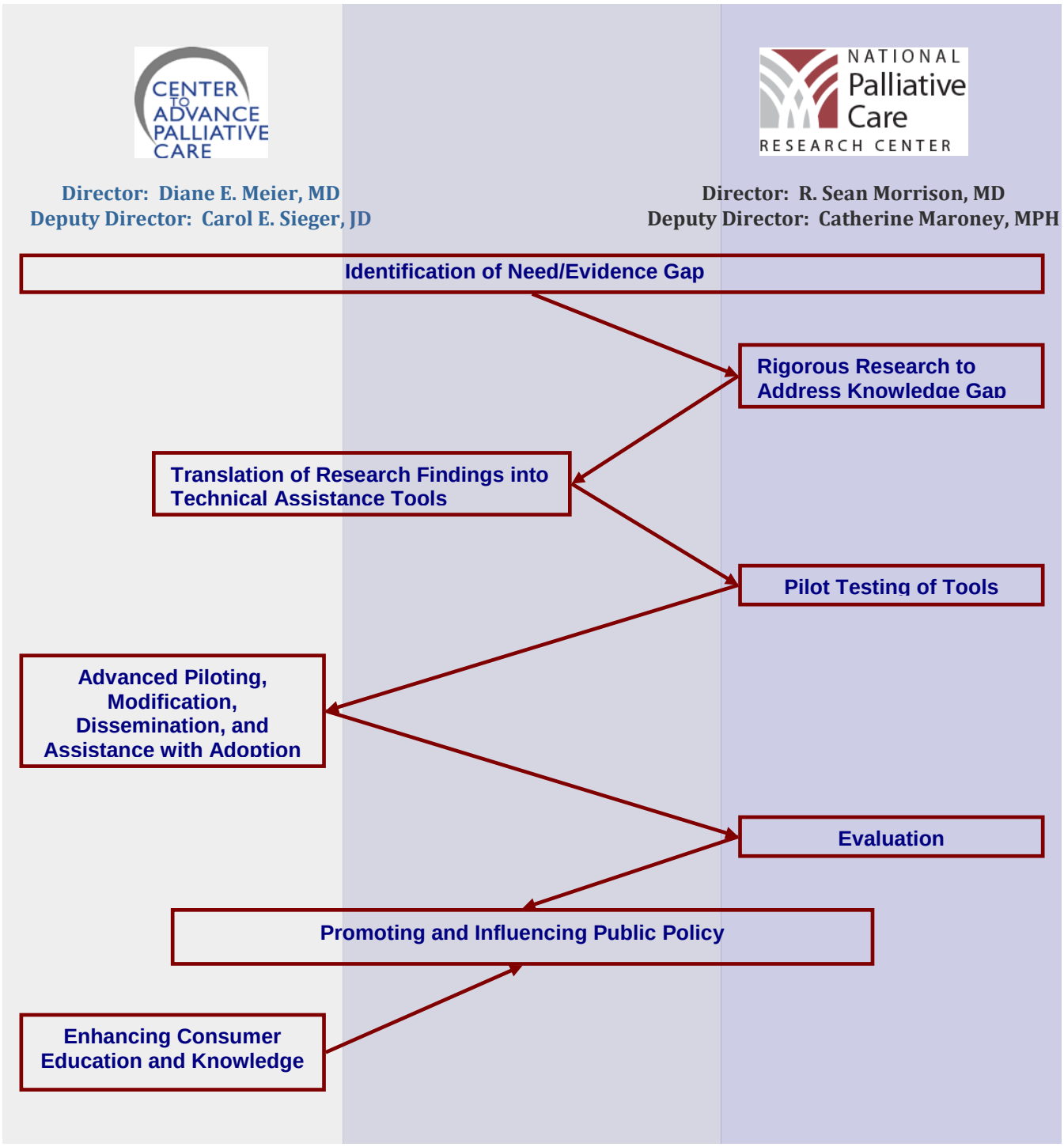
The executive leadership of CAPC, Diane E. Meier, MD http://www.capc.org/about-capc/diane-meier and NPCRC, R. Sean Morrison, MD http://www.mountsinai.org/profiles/rolfe-sean-morrison are highly respected, visible, and nationally recognized leaders with an array of awards recognizing their effectiveness as leaders of a social change initiative within healthcare. Both individuals have been involved with CAPC since inception and provide continuity and credibility.

Partner organization

The National Palliative Care Research Center (NPCRC) was established in 2008 (http://www.npcrc.org/about/about_show.htm?doc_id=386162) and promotes the shared mission of CAPC through establishing research priorities, developing researchers, and coordinating studies focused on the evidence base for palliative care clinical models. NPCRC and CAPC collaborate on projects such as the CAPC Registry (profiling comparative performance on

operational and quality metrics for palliative care programs) and in building the evidence base for excellence in care.

Illustration of Collaborative Work between CAPC and NPCRC



Industry and Market Analysis

CAPC's current market for annual fee-based services includes US Hospitals and Health Systems, US Hospices, and other organizations working with the health system and/or international organizations. The "most likely" early purchasers will be hospitals, health systems, and hospices with active palliative care programs.

For 2015-2017 our first enrollment will be current satisfied constituents - hospitals, systems, or hospices. This is a subset of the hospitals that report having a palliative care program and of the 500+ hospices that are major players in their markets. In each of the past 3 years more than 600 hospitals and hospices have accessed CAPC fee based services, and a larger number have participated in open access services such as using the website, downloading free tools, and participating in the CAPC forum. 500 hospitals went to the considerable effort of submitting detailed program data to the CAPC Registry in 2011, which is a strong indicator of a core of committed organizations that are looking to CAPC for benchmarking data and expert advice.

The following table shows the overall size of the hospital market with and without palliative care programs and also the distribution by health system status. Our target market is most likely to be the 1,525 hospitals with palliative care programs and with > 50 beds, and the 387 health systems in the US. We will continue to see the addition of programs and therefore have potential to support new programs, and increase market for our services.

Overview of US Hospitals (from AHA data 2012 Report)	**In Health Systems**	**Not in Health Systems**	**Total**
Hospitals with Palliative Care	606	1,356	1,962
Hospitals without Palliative Care	1,388	1,506	2,894
Total US Hospitals	1,994	2,862	4,856
US Hospitals with > 50 beds			2,404
Hospitals with > 50 beds, with palliative care programs			**1525**
% of hospitals with > 50 beds, with palliative care programs			63%
# of Health Systems in US			**387**

Many hospices participate in CAPC events and are actively engaged in market activities to provide palliative care services, either in the community or in partner hospitals. CAPC will be able to attract a subset of the overall hospice market. This table is a brief overview of the volume and characteristics of US Hospices. During the planning stage (2013-2015) CAPC will need to find

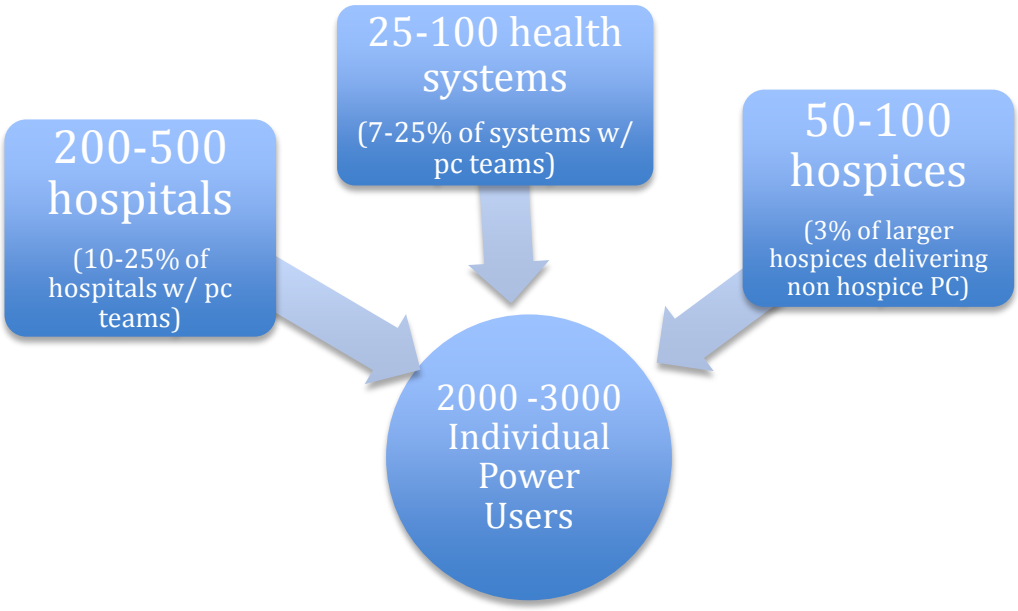
sources to stratify this data for the target group of larger hospices that are free standing and non-profit.

Overview of U.S. Hospice Data 2011 Facts from NHPCO[3]	**Volume (%)**	**Target Market & Capture Rate Goal**
Total US Hospices, 2010	5,150	
US Hospices with Average Daily Census >100	1,597 (31%)	2017 Goal for CAPC enrollment: **50** Hospices (3% of larger hospices) Longer term goal: **158** hospices, 10% of larger hospices
Free Standing Hospices (not part of health system or home health agency or SNF)	2,987 (58%)	
Non-profit Hospices as % of total:	1,854 (36%)	

[3] http://www.nhpco.org/files/public/statistics_research/2011_facts_figures.pdf accessed 01/05/13

Revenue Models for Business Transformation

Our business models assume that our new product structure will result in the following ranges of utilization by subscribers: 10-25% of hospitals reporting palliative care teams; 7-25% of health systems with current palliative care teams; and 3% of larger hospices already or interested in providing non hospice palliative care services. Our service delivery capabilities must provide high value and new products in a manner that can provide a high volume of services by keeping the variable cost low through design of infrastructure, systems, and support capabilities. The graphic below includes "power users" – these are the palliative care team program leaders and active coordinators who access CAPC services regularly. In addition, it is expected that each hospital or hospice may have a hundred or more individuals accessing e-learning tools each year.



The following table shows a plausible combination of Health Systems, Hospitals, and Hospices that achieves the revenue targets. *Each health system will have a number of hospital members, each of which will then get a discounted rate. Therefore this model shows an average of 4 hospitals per system at a 25% discount (160 hospitals), and 210 independent hospitals.*

Revenue Model Assumptions that Achieve Revenue Target of $4 million/yr in 2017		
	Rate/Site	Total $$
40 Systems	$25,000	$1,000,000
160 Hospitals from Systems (with discounted rate)	$6,000	$960,000
210 other Hospitals	$8,000	$1,680,000
50 hospices (or other community orgs)	$8,000	$400,000
12 other orgs	$5,000	$60,000
Total Revenue		**$4,000,000**

The next tables illustrate the range of possible revenues that might be generated under different pricing and volume assumptions. A key fact is that Health Systems that enroll will also receive discounted rates for their hospitals, and will likely encourage their hospitals to join to permit cross-system profiling and shared project work. Thus a relatively small number of active systems will drive a significant portion of revenue.

Our initial thinking, to be tested with experts, is that we would prefer participation of a small volume of systems representing many hospitals at a higher system level subscriber fee of approximately $25,000 (permitting delivery of more custom access and services) as opposed to a large volume of individual hospital subscribers, and that the hospital fee should be between $5000 and $10,000. We have modeled revenue at $8,000.

		Annual System Fee			
		$15,000	$20,000	$25,000	$30,000
Systems		**Annual Revenue (before service costs or discounts)**			
	20	$300,000	$400,000	$500,000	$600,000
	30	$450,000	$600,000	$750,000	$900,000
	40	$600,000	$800,000	$1,000,000	$1,200,000
	50	$750,000	$1,000,000	$1,250,000	$1,500,000
	60	$900,000	$1,200,000	$1,500,000	$1,800,000
	70	$1,050,000	$1,400,000	$1,750,000	$2,100,000
	80	$1,200,000	$1,600,000	$2,000,000	$2,400,000
	90	$1,350,000	$1,800,000	$2,250,000	$2,700,000
	100	$1,500,000	$2,000,000	$2,500,000	$3,000,000
		Annual Hospital Fee			
		$6,000	$7,000	$8,000	$9,000
Hospitals		**Annual Revenue (before service costs or discounts)**			
	100	$600,000	$700,000	$800,000	$900,000
	125	$750,000	$875,000	$1,000,000	$1,125,000
	150	$900,000	$1,050,000	$1,200,000	$1,350,000
	175	$1,050,000	$1,225,000	$1,400,000	$1,575,000
	200	$1,200,000	$1,400,000	$1,600,000	$1,800,000
	225	$1,350,000	$1,575,000	$1,800,000	$2,025,000
	250	$1,500,000	$1,750,000	$2,000,000	$2,250,000
	275	$1,650,000	$1,925,000	$2,200,000	$2,475,000
	300	$1,800,000	$2,100,000	$2,400,000	$2,700,000

Planned New Products and Services (to Support Business Model)

Product or Service	Overview & Rationale
National Palliative Care roundtable for health systems	Numerous health systems have system wide palliative care initiatives and are seeking advice, tools, and peer exchange re best practices to achieve consistent, high quality services. Health systems will have preferred access to consultants/experts and virtual content, and will have leadership access to D. Meier with emphasis on policy, payment, and consumer initiatives.
Prospective Patient Screening Criteria for Palliative Care Needs	Consider Kaiser algorithm, base on Consensus recommendations, and include Cancer Center Guidelines. Evidence based & easy to use automated criteria will simplify adoption.
Web based e-learning linked to clinical training for generalists and specialists	Full implementation of palliative care principles combined with systemic screening criteria will stimulate need for clinical skill building for nurses, social workers, generalist physicians, and other specialists. Presence of an on-line, current, and flexible learning platform will help build the field and also be high value added for participating organizations.
Expanded national Registry with cohort profiling and "system" comparative reporting	Currently more than 400 hospitals are submitting detailed data and CAPC has 3 years of results. The on-line data survey will be refined such that participating organizations can get customized comparisons and profiling for their system, or with similar cohorts. The data is targeted toward operational data, including staffing and productivity as well as penetration (% of patients served).
Easy-to-use communication tools based upon "Fast Facts" and other content sources	Good content exists, but many new palliative care professionals do not know they exist and are not using them. "Packaging" access into practical formats, such as an electronic newsletter that can be easily customized by a site will help them educate and market, at minimal effort.
ACO integration and implementation guides for community based palliative care models	Health systems, health plans, and ACOs are interested in rollout of palliative care in the community setting (nursing homes, primary care medical homes, specialty offices). A new suite of tools is needed and will be designed, pending funding.
Implementation and measurement tools to align palliative care efforts and	There are many pilots underway to design palliative care initiatives that directly impact readmission rates, mortality reporting, or resource use. Converting the results of these pilots into tools will we a priority in 2014.

Product or Service	Overview & Rationale
readmissions initiatives	
Boot camp and mentoring service for palliative care team managers and leaders	There are hundreds of new programs, and many more established programs have grown and added coordinator/manager/medical director roles. These leaders often have minimal management experience or training, and struggle with routine tasks & with leadership tasks. There is a demand for supporting them, and if also tied to "resource management" skills and best practices, this is attractive to senior leaders.
Expanded and restructured access to national experts through "virtual office hours"	Currently the CAPC leaders and consultants, and many of the other top leaders in the field are constantly doing "one-off" counseling and advising of others in the field. This is time-consuming, inefficient, and has no revenue base. By converting this ad hoc time into planned and schedulable time for small group calls on "frequently asked questions" this can be converted into high leverage, high value service that is accessible only for subscribing organizations.
Expanded and more user-friendly implementation guides	This is an ongoing effort and increasingly done on through the web. There are many opportunities to convert best practices that are emerging into new tools.
Recognition and Award strategies	Individuals, organizations, and systems like recognition. An award and recognition plan will be built around participation in Registry, implementation of recommended capabilities, generalist training, etc. Design TBD
Focused topic "expedition series" with small group size of early adopter/innovators	This will be a way to harness interest of early adopters in new content development, and adding value through well facilitated small team efforts.
Discounts related to existing products such as audio-conferences or annual seminar	Individual members will get discounted or free journal and possibly audio conference discounts. Hospital and system members will get more substantial discounts designed to stimulate system membership.
New program Support through small group on-line cohorts (similar to NICHE LTP)	We still have many new programs starting up. Many of them should eventually attend a Palliative Care Leadership Center. However, we want to have an on-line curriculum that mixes interactive work with independent learning and helps get programs off to a good start, and builds loyalty for membership.

Next Steps: Tasks & Priorities

In order to move forward, CAPC must concurrently manage several important domains in short timeframe:

1. Maintain current high quality operations at CAPC and move the office
2. Manage the transformation to a new business model
    a. Raise funding for the transformation effort
    b. Seek and engage outside experts who can advise/review/ or take on critical areas of the proposed plan
    c. Build new capabilities through redesign of staff roles and strategic hiring while coordinating major new product development initiatives
    d. Market and build interest in the new products and willingness to engage in the fee structure
3. Begin the Community Initiative by 2014 and pursue it concurrently, enlisting new experts.
4. Expand policy advising and outreach activities to take advantage of the critical window of opportunity at CMS, NQF, and other health care reform constituents.

<u>Top Priority areas for the Transformation work include:</u>

1. Pricing design and product strategy to ensure success in a timely fashion

2. Design a product strategy with low variable cost

3. Evaluation and design for the best customer management and communications plan – what are the processes, roles, and principles?

4. Learning Management System and E-learning platform and design plan – what are the best practices in delivering distance learning? How can we differentiate ourselves, leverage new content, and keep unit cost low?

5. Streamlined office functions and accounting functions / best way to simplify complex work at MSSM while adding products…Need to maintain high quality operations while designing and introducing change

6. New conceptual model of our virtual environment – web, forum, etc.

7. Identifying the interdependencies among these topics, and crafting a sequence that maximizes effective transition.

Summary

CAPC has a twelve-year track record for successful development, launch, dissemination, and support of technical assistance for a growing and vibrant palliative care field. Growing evidence of palliative care's impact on value in combination with external validation from The Joint Commission, the NQF and others, is driving robust interest from senior health care leaders and organizations in expanding and supporting palliative care clinical services across the full continuum of care.

Together these factors create a supportive environment for the design and launch of a new business model for technical assistance that will provide much needed financial support for both our core technical assistance operations and for broad and rapid engagement of the growing constituents in the field- clinicians, health care leaders, policy makers, and the public. Success will require new approaches, platforms, and ways of thinking that embrace the virtual web community and flexible web based instructional designs.

There remain irreducible uncertainties about exactly how this should be done, including how best to move quickly past the habits of our prior technical assistance work, how to design and price services; and how to shift the culture of the organization towards efficient and scaleable product platforms. Given our track record, stability of leadership, the rapidly increasing strength and reach of the field, as well as the ongoing and gracious support of many key philanthropic leaders, we believe that the time is now for us to take these actions. This plan captures our current thinking on the scope and scale of the planned endeavor.

We are hopeful that funding for the Business Transformation, the Community Initiative, and the Policy work will be forthcoming, so that we can undertake this work successfully.

Appendix 1: Community Settings Strategy Document

With the momentum spurred by health care reform, there is an opportunity to significantly expand palliative care in the community. The Business Transformation proposal assumes that some of this expansion will come through the support of technical assistance to our core current constituency of hospitals and hospices. The Transformation budget includes $9.6 million in additional funding for an initiative to more thoroughly develop community based palliative care. CAPC will utilize the same approach that has worked for hospital-based models – stimulate awareness, drive policy and payment, work through partners, and support innovation and adoption with technical assistance.

Community Palliative Care Engagement

1. Rationale: The imperative to expand palliative care into community settings
Our objective during the next eight years is to expand palliative care beyond the hospital setting to home and community, where most persons with serious and complex illness live and need help. Our Phase 1 activities for 2014-2017 launch this initiative.

The crisis of value in U.S. health care is leading to a rapid transformation of American medicine away from fee-for-service and towards global budgets, capitation, payment for value, and other managed care models. The forces driving this transition include budget constriction, efforts to capitalize on shifting funding streams and workforce imbalances. Improved quality of care and alignment with patient and family choices is also a stated goal. The major engine of this change is coming from a diversity of experiments in the private sector. More than 75% of new ACOs and ACO-like integrated and managed care models are led by the private sector; Medicare Advantage, new Managed Medicaid and Long Term Care entities, integrated provider-payer partnerships, and for-profit care management entities.

The field of palliative care is critical to the success and sustainability of these new initiatives because of its central focus on listening to the patient and the family and on developing and implementing an achievable and realistic care plan that is consistent with their goals and needs. Rapid integration of high quality palliative care models and clinical skill is key to protection of the best interests of patients and families during serious illness- they have the greatest need, they cost the most, and they are the primary targets for fundamental changes in access to care.

Hospital palliative care, proven to improve patient quality of life and survival, and reduce costs, has grown exponentially and is now available in more than two-thirds of U.S. hospitals, thanks to substantial investments in the Center to Advance Palliative Care from the private sector. While the availability of palliative care to *hospitalized* seriously ill patients represents a dramatic improvement in care delivery, this access does not readily extend to the places seriously ill patients live with their illness and wish to receive their care: home and community. Few community-based options for palliative care exist, a deficit attributable to limited information about effective community-based models and the tools and technical assistance needed to develop viable programs; insufficient palliative care training and skills of community-based clinicians; and poorly aligned regulatory and financial incentives.

CAPC's plan to expand access to palliative care to the home, office, nursing home and assisted living settings- where seriously ill patients actually live and need care- occurs in the context of a health care system facing pressure to contain costs while protecting access to quality care for the sickest,

(and therefore most expensive), patients. As a result, the time is right to shift CAPC's business model to enable us to expand palliative care capacity to community care settings in a scaleable and sustained manner. CAPC will leverage our experience as the nation's leading resource for palliative care development by transferring our successful hospital dissemination strategies to community settings.

2. Program Mission/Objectives/Key Assumptions

A. **Mission –**

- *All community health care settings/providers that provide care for seriously ill patients have the resources and training to provide state-of-the art palliative care clinical services.*
- *Community health care settings within geographic regions have linkages between palliative care resources so that provision of care is seamless across health care settings.*

B. Objectives

1. *Discover and promote models and linkages of community based palliative care*-CAPC will seek out and disseminate palliative care service delivery models beyond the hospital to community care settings (home, office, and long term care facilities); CAPC will also work to promote linkages across health care settings that have traditionally operated in silos (home care, long term care, clinic-based care).

2. *Provide access to resources and training for front-line community-based healthcare workforce* recognizing the central role of nurses, community health workers, and primary care providers, through provision of both clinical and leadership training to these audiences; CAPC will move beyond training on palliative care leadership and operational design to include and emphasize web-based and scaleable *clinical* training aimed at the clinician workforce.

3. *Promotion of standardization and quality for community palliative care*-CAPC will work with providers of scaleable community-based models of care to promote standardization of care process, data collection and training in an effort to improve quality of care.

4. *Advocate community-based palliative care*- CAPC, through its extensive reach to hospitals, funders, and policy leaders, can promote the integration of palliative care into the continuum of health care.

C. Key Assumptions

1. The current hospital-based palliative care "medical model" may not be appropriate for all community health care settings; CAPC will work to identify the most appropriate models that match the culture of care in different health care settings.
2. CAPC has an outstanding track record for development of technical assistance products that meet the hospital audience; CAPC recognizes that it has much work to do to learn how best to work in new settings (home care, long-term care, hospice, community ACO)
3. The fiscal, administrative, legal and regulatory barriers to palliative care in community health care settings are significant; CAPC will need to learn, partner and adapt to these barriers to seek optimal solutions.

3. Implementation Strategy

Our plan to improve community palliative care will mirror our prior success at driving rapid implementation of palliative care teams across the U.S., which is based on application of **6 foundational social change principles:**

A) Technical Assistance: Identification and packaging of best practices into transferable skill sets through a range of technical assistance products and platforms;

B) Partnerships: identification of strategic partnerships, both individuals and organizations, that can leverage small models of change into large-scale changes in the health care system;

C) Social Marketing: Sophisticated social marketing and messaging techniques that change behavior because they are based on and responsive to the concerns of our key audiences-patients, families, clinicians, administrators, payers, and policy-makers;

D) Business Case: Development of a compelling business case for palliative care delivery, now relevant in community settings as a direct result of health reform and value-based purchasing pressures forcing reduced reliance on hospitals; and

E) Training: Strengthening the skills, knowledge, and competencies of front-line clinicians through accessible peer-to-peer mentoring and intensive training opportunities;

F) Standardization/Quality: Assure the process of change is as simple and reproducible as possible to facilitate rapid uptake of change, at the same time measures are instituted to capture outcomes that drive quality improvement.

4. Benchmarks for Progress

The following benchmarks will indicate progress in community palliative care:

A. Major metropolitan engagement

2014 - Complete a thorough needs assessment to best define the needs, priorities, barriers and key individual, institutional and organization partners and competitors.
2016 - A minimum of 10 major US metropolitan areas (population > 100,000) are working towards comprehensive palliative care services (see definition below);
2018 - A minimum of 25 major US metropolitan areas (population > 100,000) are working towards comprehensive palliative care services.
2021 - A minimum of 50 major US metropolitan areas (population > 100,000) are working towards comprehensive palliative care services.

Definition: *Comprehensive Community Palliative Care Services* implies that palliative care services are available across the continuum of healthcare settings (hospital/clinic, home care, hospice, long-term care) within a definable geographic community. This may be demonstrated within a single health system (e.g. Kaiser-Denver) or via community providers working collaboratively to improve care (e.g. Minnesota Rural Palliative Care Initiative).

B. Use of CAPC Technical Assistance (TA) Materials. Annual tracking of use that indicates both geographic spread, and spread of use by health systems vs. individual health settings:

- ✓ Attendance at CAPC National Seminar
- ✓ Attendance at CAPC Audio-conferences
- ✓ Downloads of CAPC TA monographs promoting community palliative care

C. Use of Clinical Care educational courses. Annual tracking of the utilization of clinical course work by front-line health care providers in community care.

5. Time Line:

2013-2014	**Community needs assessment** - Identify/recruit national advisory consultants - Identify key national organizations - Identify early models of innovation in all health care settings -Identify learning needs of generalist clinicians in each health care setting - Identify potential collaborators/competitors - Seek out strategic partnership with hospice regarding community Palliative care initiatives - Identify/recruit specific workgroups for health care sites - Identify/recruit capc staff program leaders for community Engagement
2014-2015	- Develop new TA high priority products by health care setting, using IPAL work processes - Complete/write-up 4 site visits of exemplar programs - Develop community engagement workbook-"how-to" guide for community health care settings to build/share palliative care resources - Complete clinical education resource modules for generalist clinicians - Refine data collection system to measure project impact - Being work to define the business case for community palliative care - Identify 3-5 *Palliative Care Leadership Centers* for community palliative care, to provide direct instruction and mentoring to peer communities - Roll-out *Community Palliative Care Palliative Care Leadership Centers*; goal of 20 trainings per year - Develop linkages to CAPC *Community (Patient-Family) Engagement* strategy
2016-2017	- Continue to develop new TA materials as needed - Complete work on the business case for palliative care - Roll out marketing strategy for community palliative care including patient engagement.
2018-2021	- Refine, revise, adapt and promote all the initiatives developed to date; - Develop new collaborations and partnerships to further community palliative care

6. Community Setting Initiative Budget: 2014-2021

	Description	Comments, Timeline	Total/year	# Years	Total
Consultants	External experts for project work	3 people at $50k/yr	$150,000	4	$600,000
Contracted services	Marketing	$50k/yr contracted	$50,000	4	$200,000
Contracted services	E-learning, educational development	$50k/yr contracted	$50,000	4	$200,000
Marketing materials	Outreach and multi setting	Startup costs 2015 -2016	$75,000	1	$75,000
Travel budget	Consultants & collaborators, site visits	2014-2016	$30,000	3	$90,000
Convened meetings	Small groups -intense work	2015-2016	$40,000	2	$80,000
Outreach	Sponsorships, booths, attendance at relevant conferences	2015-2017	$50,000	3	$150,000
Tool Development	Survey instrument for community - to be part of Registry	2015 or 2016	$100,000	1	$100,000
Data Costs	Industry data acquisition & contracted analysis	2014 or 2015	$75,000	1	$75,000
Contingency	Misc. expenses related to initiative				$150,000
Total of non personnel costs					**$1,720,000**
Personnel Costs (from summary budget & personnel budget) for 4 years (2014-2017)					**$1,551,603**
Total Costs for Community Initiative before indirects					**$3,271,603**
Indirects from MSSM at 10%					**$327,160**
Total Costs for Community Initiative including indirects - first 4 years					**$3,598,763**
Estimated Costs for Additional 4 years to achieve 8 year goals at $1.5 million/yr including indirect expenses					$6,000,000
Total Costs for 8 Year Community Initiative					**$9,598,763**

Appendix 2: CAPC Budget for 2013-2017 and Community initiative through 2021

REVENUES	FY 2014	FY 2015	FY 2016	FY 2017	Totals FY 2014 -FY 2017
Revenue from Grants	$2,066,118	$500,000	$0	$0	$2,566,118
Indirect Expenses (MSSM)	(206,612)	(50,000)	0	0	(256,612)
Net Revenue from Grants (as of 1/2013)	1,859,506	450,000	0	0	2,309,506
Revenue from operations					
Annual Seminar	650,000	650,000	650,000	750,000	2,700,000
Other revenue	200,000	100,000	220,000	406,238	926,238
New services & annual membership fees	0	500,000	1,750,000	4,100,000	6,350,000
Operating Revenue before indirects	850,000	1,250,000	2,620,000	5,256,238	9,976,238
Indirect Expenses (MSSM)	(127,500)	(187,500)	(393,000)	(788,436)	(1,496,436)
Net Revenue from operations	722,500	1,062,500	2,227,000	4,467,802	8,479,802
Total Revenue - Grants + Operations (net of indirect expenses)	2,582,006	1,512,500	2,227,000	4,467,802	10,789,308
EXPENSES					
Baseline 2013 Operations & Technical Assistance Personnel costs (including benefits at 29%)	1,149,710	1,184,201	1,219,727	1,256,319	4,809,957
Additional Personnel Costs - new roles or revised jobs for technical assistance	604,690	622,831	641,516	660,761	2,529,799
Subtotal for Operations & Tech Staff, including new	1,754,400	1,807,032	1,861,243	1,917,080	7,339,755
Policy & Outreach Personnel Costs including benefits	457,950	471,689	485,839	500,414	1,915,892
Community Settings Initiative	370,875	382,001	393,461	405,265	1,551,603
Personnel Costs including benefits	2,583,225	2,660,722	2,740,543	2,822,760	10,807,250

REVENUES	FY 2014	FY 2015	FY 2016	FY 2017	Totals FY 2014 -FY 2017
Consultants & core content experts	550,000	550,000	400,000	400,000	1,900,000
Subtotal Personnel and Consultants	3,133,225	3,210,722	3,140,543	3,222,760	12,707,250
Other expenses (not including transformation investments)					
Subtotal -Other expenses	**1,197,369**	**1,021,290**	**1,045,929**	**1,071,307**	**4,335,896**
Rent, utilities, & building maintenance - Occupancy Exp	200,000	206,000	212,180	218,545	836,725
Seminar expenses	552,500	552,500	552,500	550,000	2,207,500
Total Expenses	**5,083,094**	**4,990,512**	**4,951,153**	**5,062,612**	**20,087,371**
Net Income or Loss	**(2,501,088)**	**(3,478,012)**	**(2,724,153)**	**(594,810)**	**(9,298,063)**
Non-Staff Business Transformation Expenses - 2014-2017 (excluding indirect charges)	(1,251,000)	(1,251,000)	(834,000)	(834,000)	(4,170,000)
Staff & Non-Staff Business Transformation Expenses	(3,752,088)	(4,729,012)	(3,558,153)	(1,428,810)	(13,468,063)
Indirect Expenses (MSSM)	(375,209)	(472,901)	(355,815)	(142,881)	(1,346,806)
Cumulative Funding Needed (including Community Initiative for 4 years & ongoing Policy work)					(14,814,869)
Additional Funding Needed for 2018-2021 for the Community Initiative (8 year initiative)					(6,000,000)
Total Funding Requested for Business Transformation, Community Initiative & ongoing Policy work					(20,814,869)
TOTAL: Community Initiative (Personnel, other expenses, and indirects)- 8 years					(9,598,763)
TOTAL: Business Transformation to Membership Fee Supported Operations (excluding Community Initiative & Policy)					(9,108,625)
TOTAL: Policy and Outreach (this is for a regular annual budget, excluding special projects or consumer campaigns)					(2,107,481)

Appendix 3: Budget Narrative – FY 2013-FY 2021 Budgets

The line item budget includes CAPC operations, including additional staff expenses anticipated for the Transformation work., and including investment in a new initiative to bring palliative care to the Community Setting over an 8-year period. There are detailed worksheets on personnel, other transformation expenses, revenue modeling, and the Community initiative.

Notes:

1. The majority of revenue for FY 2013 is from grants/foundations. FY 2014 reflects some carry-over from FY 2013 commitments plus new commitments for FY 2014, as does FY 2015. There are no commitments yet for FY 2016. MSSM assesses an average 10% fee for indirect expenses on all grant revenue.

   This budget includes costs for activities for which additional grant funding will be sought, however, these funds are not yet included in the revenue budget.

2. Annual seminar revenue is reported in "revenue" and expenses are reported separately as the last item before "total expenses". The current seminar was an improvement over prior years and was approximately a breakeven event. We plan to raise rates and therefore revenue in FY 2014 (fall 2013 seminar) increases the revenue prediction. However, as we will introduce the membership fee structure, it will include a seminar discount for participating hospitals, thus decreasing or damping revenue projections in outer years. Non-members will be able to attend, but at a higher rate, but may be less than 50% of attendees. The overall assumption is that the seminar will be planned for a breakeven.

3. Other revenue is a rough placeholder. FY 2013 reflects budget. Actual may be $20k higher. FY 2014 assumes some increase in either volume, or rates (particularly of audio-conferences). However, for FY 2015 forward a significant proportion of audio-conference participants will be covered under the fee structure, and therefore will incur some expense without revenue. The assumptions in this line assume that some other revenue begins to be generated through other services, such as E-learning or Expeditions, but the assumptions are conservative given uncertainty re costs, volume, or offsets with annual fee structure.

   If the annual fee structure is lower or takes off slower, then "other revenue" can and should increase to cover some of the gap with more fee based services. However, it is very unlikely to be able to close the gap as a full substitute.

4. New services and annual fee – this reflects the introduction of the annual fee structure in FY 2015 (announced in mid 2014, first enrollments in Jan 2015), with a start up year of participation followed by a more full participation in FY 2017. These projections

assume FY 2017 participation of 40 health systems at $25k, and 370 hospitals at $8000 (or $6000 for health system members), as well as 50 hospices and a small number of other organizations. Individual membership is reflected, but accounts for small dollars. Achieving these levels of membership within 2.5 years of launch will require successful development of high visibility, high value new products and services.

5. Personnel expenses for "operations and technical assistance" include current level of staff, even if roles and people change, with a 3% cost of living annual adjustment.

6. New positions show 1 to 2 new positions ASAP (partial year expense) in FY 2013 to try and jumpstart some of the new skills needed, like an E-learning Director, and then show other positions added in FY 2014 and maintained. More detail is provided on the "personnel" tab of the workbook. This budget shows one way in which the appropriate skills and capacity might be assembled. It is deliberately generic and not tied to specific individuals or positions that currently exist, although there is overlap. During the early transformation work, and with support from outside experts, the proposed structure and positions should be evaluated and refined.

7. Policy and Outreach Personnel costs includes 50% of the Executive Director, the current Policy Assistant, and new support for grant writing, as well as expanded support for research projects and a full administrative fte. The general intent is that CAPC will continue to seek outside philanthropic support for new initiatives and policy and outreach, vs. limiting activity to what can be covered through the fee structure.

8. Consultants and core content experts: Currently this group does significant work as virtual employees and leadership representatives of the organization. The efforts during the transformation will expand. However, if the staffing proposed in the new positions is implemented successfully, this budget line should shrink in 2016-2017. There will continue to be a need for contracted content experts and project leaders in the field, but the deployment of these funds may change over time. Ideally more of this expense in the future can be included in product specific expenses and tied to the service-pricing model. Additional consulting dollars are also included in the "transformation" budget and in the "community initiative". These will be for technical experts and targeted content experts.

9. Service contracts currently include the web maintenance contract and other key vendors. During the 2014 period it is critical to look at all infrastructure and service expenses for opportunities to reduce annual cost using newer platforms or technology. The office will be moved in 2013, which will provide a good impetus to re-evaluation.

10. The Consumer outreach project in FY 2013 and FY 2014 is tied to a specific grant and is a placeholder for expected outside contracts to accomplish the goals of the grant. The grant revenue is included in revenue.

11. Honorarium net of seminar: The cost of seminar honorarium should be reported under seminar expenses. This includes payments for faculty for audio-conferences and other ad hoc events.

12. "New expenses related to expanded services" is a placeholder for the unknown. An additional contingency is built into the specific Transformation budget. Other new expenses should be built into the pricing models for new services so that the net revenue is shown in new revenue. This is the method used in the "oper rev" tab of the excel workbook.

13. Rent and Occupancy Expenses: CAPC is planning a space move by summer 2013. The expected cost based on current negotiations is approximately 40% lower than current costs for more and better space. Thus the rent expense for outer years is reduced. The Transformation budget includes $150k for one-time relocation expenses.

14. Seminar expenses are assumed at breakeven or with a small contribution after reducing revenue for the 15% factor for indirect expenses from MSSM. Since membership will include seminar discounts, membership dues are the higher leverage revenue source vs. the seminar.

15. Summary items: the summary of net income or loss shows results after including new revenue from service fees but before any additional grant revenue. Various subtotals are shown to help understand the relative weight of the business transformation, of the community initiative, and of policy and outreach initiatives. Clearly CAPC does not plan to operate with an unfunded deficit, but the grant revenue lines only include current commitments.

Appendix 4: CAPC Budget for Transformation Expenses 2013-2021

This budget includes one time investments in contracted services, consultants, system improvements, and marketing to prepare for the infrastructure and build the platform for e-services, build capacity, and launch a fee-based structure for technical assistance. It also includes expenses for the Community initiative.

DESCRIPTION	VENDOR	BUDGET	COMMENTS
Business Planning Consultants & Strategic Advisors/Experts	TBD	$300,000	External advice re structure, strategy, pricing, and re e-platform design for technical assistance/social change initiative. Consider corporate structure options and staffing plans. Also consider advisors for consumer component or "crowd sourcing" options to expand access and impact.
E-Learning Instructional Design for Clinical courses	TBD	$300,000	10 modules @ $25k each per DW; $50k additional startup expenses
E-Learning licensing or fees for use of existing materials		$200,000	It is unclear whether licensing fees will be needed, but this is a placeholder for some funding to ensure access to good existing curriculum.
Learning Management System (LMS)		$50,000	Platform setup
Community Palliative Care - Investment in New Models, Relationships, and Tools through Consultants, Contracts, and participation in outreach	Various	$1,720,000	This effort is a start up Phase 1 initiative that is critical to overall goal of accessible high quality palliative care throughout continuum. It will benefit from new platform for CAPC services and will contribute participating organizations and value to members. Additional costs are in personnel budget.
Registry - Conversion of Inpatient Survey (500 hospitals in 2011)	DatStat?	$150,000	Convert to new platform; develop capacity for custom reports; host data collection; launch 2013 Registry;
Registry - Development of Outpatient Benchmarking Survey	DatStat?	$75,000	2013-2014 new content
Registry - Workforce/Subscriber Benchmarking Surveys	DatStat?	$75,000	2014-2015 new content
Content Experts to be contracted for Outpatient & Workforce Survey Development	TBD from field	$150,000	Contracted project managers for survey development to convene field leaders, ID important questions, and plan out survey content. DatStat then converts into a scaleable survey and database. Budget may include convening and travel.

DESCRIPTION	VENDOR	BUDGET	COMMENTS
Customer Relationship Database Development + Conversion	SalesForce?	$150,000	Select customer management system and design related functions to support new business; convert existing data into new system, including outreach & data verification & data cleanup; development of new processes for data collection and for data management.
Website Conceptual Design & Development		$200,000	Website needs to support efficient peer-to-peer exchange, allow user posting of tools, synchronous and asynchronous learning, and have a public section and capacity to offer tiered access to members.
Marketing and Roll Out		$300,000	We will need to equip our constituents with materials to support budget request and decision making within their institutions, and will need to promote this within key national organizations.
Office space relocation costs		$200,000	CAPC is moving their offices to get more and more flexible space at a significantly lower annual cost (40% less, at least $100k less per year) but will have one time expenses associated with relocation
Contingency for Unknown		$300,000	Success will depend on best choices re scaleable e-platforms, good design and implementation, and excellent rollout.
Transition Budget - Outside Expenses before Indirects		**$4,170,000**	**This excludes support for new staff and for ongoing operations during conversion; these are included in personnel budget & summary budget and spread over 4 years, 2014-2017.**
Indirect Expenses -MSSM @ 10%		$417,000	Assumes that funding comes from grant revenue.
Transition Budget - Outside Expenses including indirects		**$4,587,000**	**This excludes support for new staff ; see personnel budget for these expenses**

Appendix 5: Proposed Staffing for Transformation

This budget replaces the existing CAPC staff budget for $1.4 million and approximately 10 staff + leadership. It is assumed that a core of current staff will remain, there will be planned turnover, and there will be some new hires. This budget is used for staffing estimates for FY 2014 forward with some early hiring late in FY 2013.

Job Description	Reports to…	Key Roles	% FTE	Benefits	Total 1 year
TECHNICAL ASSISTANCE PORTFOLIO				29.0%	
Executive Director		External relationships, policy, outreach, fundraising, and setting priorities for operations; portion of fte below in policy section.	50%	$29,000	$129,000
Deputy Director or COO	Director	Planning & managing business lines, outreach, OFFICE management, funder interface and reports	100%	$43,500	$193,500
CFO	COO	Finance, Planning, Support to Svc Lines, Contracts, Process redesign to reduce cost	100%	$34,800	$154,800
Bookkeeper	CFO	accounting functions	100%	$15,950	$70,950
Knowledge Manager	COO	Master of virtual info design & leverage, Manager/team leader of staff, works wt Social Media vendor, web vendor, & Sales Force; Innovation Leader	100%	$34,800	$154,800
E-Learning Instructional Design Director	Knowledge Manager	Leads E-learning initiative and manage vendors, consultants, & products.	100%	$31,900	$141,900
Applied Research/Data Manager	COO	Designs new products, manages Registry, coordinates applied research with and for constituents and with NPCRC	100%	$26,100	$116,100
Data Analyst	Knowledge Manager	tech support, report design, custom reporting; harvesting data for Sales and Outreach Manager	100%	$17,400	$77,400
Project Manager	Knowledge Manager	Audio, Store, Annual Membership Campaign	100%	$21,750	$96,750
Project Manager	Knowledge Manager	Expedition Series, National Roundtable, Interns	100%	$21,750	$96,750
Marketing/Communications Coordinator	COO	marketing, communications, outreach, media	100%	$23,200	$103,200
Sales & Outreach Manager	COO	Develop & implement sales and service plans for fee structure; manage the customer database	100%	$20,300	$90,300

Job Description	Reports to…	Key Roles	% FTE	Benefits	Total 1 year
Website Coordinator	COO	Manage vendors, carry out design for managers, implement improvements and maintain site.	100%	$26,100	$116,100
Admin Asst / clerk	Knowledge Manager	clerical + bookkeeping + general support	100%	$13,050	$58,050
Admin Asst/clerk	COO	clerical + bookkeeping + general support	100%	$13,050	$58,050
Event Coordinator	COO	Seminar, other mtgs, vendor relationships, sponsorship	100%	$21,750	$96,750
		Operations - Totals	**15.50**		**$1,754,400**
POLICY AND STRATEGIC CHANGE INITIATIVES					
Director	self	Outreach, Policy, Fundraising, System Roundtable	50%	$29,000	$129,000
Research Support	Director	Partial fte in MSSM research for data projects	50%	$14,500	$64,500
Policy Assistant	Director	TBD by Director	100%	$23,200	$103,200
Grant Writer	Director	Assist Director	100%	$23,200	$103,200
Admin Asst	Director	To support Director, Policy Asst, and System Roundtable	100%	$13,050	$58,050
		Policy and strategy totals	**4.00**		**$457,950**
COMMUNITY SETTINGS PHASE I INITIATIVE					
Manager of Community Palliative Care Initiative	Director	Leadership outreach, vision, & management of initiative	100%	$37,700	$167,700
Community Initiative Project Managers (1.5 ftes)	Manager of Community Initiative	Organize, facilitate, and support various workgroups to achieve engagement and new product creation.	150%	$32,625	$145,125
Admin Asst / clerk	Manager of Community Initiative	general support & management of outreach contacts; development of sales leads	100%	$13,050	$58,050
		Community Settings Phase 1 totals	**3.5**		**$370,875**
TOTALS - ALL ACTIVITIES			**23.00**		**$2,583,225**

Appendix 6: Leadership Biography

Dr. Diane E. Meier is Director of the Center to Advance Palliative Care (CAPC), a national organization devoted to increasing the number and quality of palliative care programs in the United States. Under her leadership the number of palliative care programs in U.S. hospitals has more than tripled in the last 10 years. She is also Vice-chair for Public Policy and Professor of Geriatrics and Palliative Medicine, and Gaisman Professor of Medical Ethics at the Mount Sinai School of Medicine in New York City. In 2009-2010, she was a Health and Aging Policy Fellow in Washington, DC.

Dr. Meier was recognized in 2010 by HealthLeaders as one of 20 Americans who make health care better. She is the recipient of a MacArthur Foundation 'genius award' Fellowship in 2008. Other recognition includes the Open Society Institute Faculty Scholar's Award of the Project on Death in America, the Alexander Richman Commemorative Award for Humanism in Medicine, the Founders Award of the National Hospice and Palliative Care Organization 2007, AARP's 50th Anniversary Social Impact Award 2008, Gold Humanism Honor Society National Honoree 2008, Castle Connelly's Physician of the Year Award 2009, the American Academy of Hospice and Palliative Medicine Lifetime Achievement Award in 2009, an Honorary Doctorate of Science from Oberlin College in 2010, and the American Cancer Society's 2012 Medal of Honor. She is currently Principal Investigator of an NIH-NCI-funded five-year multisite study on the outcomes of hospital palliative care services in cancer patients.

Dr. Meier has over 200 publications in major peer-reviewed medical journals, including the *New England Journal of Medicine* and the *Journal of the American Medical Association*. She authored *Palliative Care: Transforming the Care of Serious Illness* (Jossey Bass, 2010), edited the first textbook on geriatric palliative care, as well as four editions of *Geriatric Medicine*, and has contributed to more than 20 books on the subject of geriatrics and palliative care.
Diane E. Meier received her BA from Oberlin College and her MD from Northwestern University Medical School. She completed her residency and fellowship training at Oregon Health Sciences University in Portland. She has been on the faculty of the Department of Geriatrics and Palliative Medicine and the Department of Medicine at Mount Sinai since 1983.

Appendix 7: List of Current CAPC Staff, Roles, & Consultants

CAPC's staff is comprised of the Director (Diane E. Meier, MD), the Deputy Director (Carol E. Sieger, JD) and 9 other full time equivalents.

Director - Diane E. Meier, MD, F.A.C.P. (see prior section)

Deputy Director - Carol E. Sieger, JD is responsible for coordinating all operational, financial and managerial aspects of CAPC. Previously, Ms. Sieger was the Director of Legal Affairs at Partnership for Caring, a national nonprofit consumer advocacy organization. Prior to her work at Partnership for Caring, Ms. Sieger was a practicing elder law attorney focusing on estate, health care and Medicaid planning. Ms. Sieger received her law degree from Hofstra University School of Law and is a member of the New York State Bar.

Communications Coordinator: Manages CAPC's communication campaigns, clinician and consumer website, and marketing outreach around CAPC seminars, products and events. Activities include coordinating activity with the consumer press including web, print, television and radio.

Director of Research: Responsible for managing all activities related to CAPC research and data collection including ensuring the quality of data and the web-based data collection systems, ensuring adherence to IRB rules and regulations, and identifying, designing and managing research.

Policy Analyst: Provides policy and analytic support to CAPC's efforts to facilitate greater access to palliative care through public policy education. Monitors federal and state legislative activities, develops activities to educate policy professionals, coordinates policy activities with other national organizations and writes nonpartisan policy statements and reports.

Finance Manager: Responsible for grants management and financial accounts reporting, and coordinating activity with Mount Sinai's finance department.

Project Manager: Responsible for managing the Palliative Care Leadership Center program, audio-conferences, e-learning and the CAPCconnect networking forum.

Events Manager: Responsible for managing CAPC's national seminars, trade shows across the country, and small business meetings.

Bookkeeper: Monitors and processes all of CAPC's expenses and provides monthly reconciliation reports on spending to the budget director. She works closely with Mount Sinai's purchasing and accounts payable department.

Store Manager/Web Editor/Administrative Assistant: Manages all e-commerce sales activity handles light website editing, provides the back-end support for the CAPC audio-conferences, provides general clerical support, monitors CAPC email, and updates database entries.

Administrative Assistants (2 FTEs)

Mount Sinai Director of Finance/Accounting (.2 fte): Director is responsible for Mount Sinai accounting and preparation of official financial reports.

Consultants

CAPC has used key national leaders as consultants throughout the thirteen years. These individuals participate in CAPC planning, develop new products and lead content development projects, and partner with executive leadership. The consultants are viewed as "CAPC" by constituents, and extend the "virtual leadership" core of CAPC.

Financial and Business Planning Consultant
Lynn Hill Spragens, MBA's work includes synthesis of financial and clinical objectives through business plan development, operations overview and redesign projects, business system evaluations, and professional staff development. She has provided support to CAPC since 2000 and is the lead on business case development for palliative care. Ms. Spragens has a Masters in Business Administration from the University of North Carolina and an undergraduate degree with honors from Duke University. She began her career as the business manager of a division of Duke University. She has also served as a member of the Duke University Board of Trustees. She was an Investment Advisor in the financial services industry before beginning her career in health care administration with nine years at Kaiser Permanente.

Education and Content Design Consultant
David Weissman, MD, FACP is a Professor Emeritus, and founder of the Medical College of Wisconsin's Palliative Care Center. He is board certified in medical oncology, hospice and palliative medicine. In 1991 he began one of the first academic palliative care programs in the United States. In 2003, the Medical College of Wisconsin's Palliative Care Program was designated as one of six United States Palliative Care Leadership Centers. He was the director of EPERC (End-of-Life Palliative Education Resource Center) and was the founding editor of the Journal of Palliative Medicine. Dr. Weissman is the lead on all educational and training initiatives at CAPC.

Hospice Liaison Consultant
Amber B. Jones, MEd' practice focuses on hospice, health policy, planning and management. She was the Chairperson on the National Hospice Work Group and serves on the National Association of Social Work Foundation Board of Directors. She is past president and chief executive officer of the Hospice and Palliative Care Association of New York State. She was a member of the Core Task Force of the National Access and Values for Care at the End of Life Project, and the Advisory Committee for the Palliative Care Project for Friends and Relatives of Institutionalized Aging. Ms. Jones maintains collaborative relationships between CAPC and the nation's leading hospice and palliative care organizations.

Hospital Leadership and Liaison Consultant
James A. Block, MD is president of J.A. Block Health Associates, a consulting firm working with the Emily Davie and Joseph S. Kornfeld Foundation, the Commonwealth Foundation and The Robert Wood Johnson Foundation, among others. He is the former President and Chief Executive Officer of Johns Hopkins Health System and the Johns Hopkins Hospital. He was President and Chief Executive Officer of University Hospitals of Cleveland, Case Western Reserve University and President of Rochester Area Hospital Corporation. Dr. Block provides crucial networking and relationship-building liaison with mainstream health care organizations in the U.S.

Appendix 8: CAPC Product Timeline – Historical Products

Product	Format	Need	Launch Year
CAPC National Seminar-Level 1	Conference	Basic information on palliative care program design for hospitals wishing to start a program.	1999
CAPC Collected Tools/Resources	Web-based tools	Tools and resources collected from "early adopter" programs so that new programs do not need to "reinvent the wheel"	2000
CAPC Audio Conferences	Audio conference	Brief topical presentations on aspects of program development/design	2001
Guide to Starting a Palliative Care Program	Book	Comprehensive written instructions for new program development.	2004
Palliative Care Leadership Centers	1:1 mentoring	Direct instruction from peers along with mentoring in program design and start-up	2004
CAPC Report Card	On-line state ranking	Benchmarking state activity in palliative care program development	2006, 2011
CAPC National Seminar-Level 1/2	Conference	The Level 1 CAPC seminar was expanded to meet the needs of both established programs and hospitals wishing to learn how to start a palliative care program	2008
CAPC National Registry	On-line registry	Collect/analyze data on program operational features for benchmarking	2008
CAPC Connect Forum	On-line Bulletin Board	Provide a forum for program leaders to ask/get answers to specific questions and share information among all programs	2007
CAPC Campus On-Line	E-Learning courses	Provide asynchronous learning opportunities for new or existing programs seeking operational information on palliative care programs	2009
CAPC Top Tools	Book	Provide a single collection of the most useful tools for new or established programs	2010
CAPC Consensus Standards	Peer reviewed consensus journal publications	Standardize key elements of program design and metrics for palliative care programs	2008-2011
IPAL-ICU	Web tools	Methods/resources to integrate palliative care into intensive care	2010
IPAL-ED	Web tools	Methods/resources to integrate palliative care into emergency medicine	2011
Joint Commission Tools	Tools, needs assessments, guides	Information and tools to assist programs achieve Joint Commission Advanced Palliative Care Certification	2011
IPAL-OP	Web tools	Methods/resources to integrate palliative care into outpatient care	2012

Appendix 9: New Product Example

Using CAPC E-Learning Products for Improving Generalist-Level Palliative Care Guide for the Chief Medical Officer to Introduce Broad Skill Building

1. The Case for Palliative Care Training

Hospitals have a major interest in ensuring that all clinicians providing care for seriously ill patients have the requisite attitudes, knowledge and skills in primary palliative care so that:

a) care is truly patient (person) centered, with a strong focus on ensuring comfort, timely communication and efficient discharge planning;
b) the quality of care meets/exceeds national standards (Joint Commission, NQF, Commission on Cancer);
c) readmissions and hospital mortality are minimized through timely goal setting and discharge planning;
d) hospital resources are used most efficiently (ICU beds, ED rooms);
e) moral distress among hospital staff is minimized.

Palliative Care services provided by specialists (Board Certified in Hospice and Palliative Medicine) have been demonstrated to provide the model for best practice patient-centered care--but specialist resources are finite and cannot hope to meet all the needs of seriously ill patients and their families. Generalist-level palliative care (aka primary palliative care) encompasses the attitudes, knowledge and skills that all clinicians who care for seriously ill patients must have in order to provide competent and compassionate care. Generalist palliative care training has only been provided in medical school and residency programs for the past 10 years and even then, the depth of education at medical schools and residencies is highly variable--it should be acknowledged that most physician staff will have had limited palliative care training.

CAPC e-learning courses for physicians[1] are designed to provide a core level of knowledge in palliative care (generalist level) for physicians who are not-board certified in Hospice and Palliative Medicine, yet who are in specialties with a large percentage of patients with one or more serious illnesses. These include but are not limited to:

- Emergency Medicine
- Geriatrics
- Hospitalists
- Intensive Care Unit physicians—all specialties
- Neurology
- Nephrology
- Oncology (Medical, radiation, GYN, neurological and surgical)
- Cardiology and Pulmonary
- Trauma and Transplant surgeons

2. Course Content

The CAPC Course catalog contains XX courses; course has the following features:

- ✓ Pre-course self-assessment

- ✓ Course content
- ✓ Post-test with CME (0.5-1.0 per course)
- ✓ Palliative Care *Fast Facts and Concepts*
- ✓ Links to supplementary material
- ✓ *Practice-change* worksheet

3. Using the Courses

To realize the greatest potential gains in terms of improved person-centered care, the following are recommended guidelines for use of the CAPC E-Learning courses.

1. Stratify physicians in your setting by their specialty and specific practice into: *Frequent vs. Infrequent* contact with serious illness. (see list above)

2. Require completion of 6 courses, (~ 4.0 hours CME), as part of the credentialing process for new physicians, to your hospital:

    - Self-assessment of attitudes
    - Clarifying diagnosis and prognosis
    - DNR orders
    - Discussing care goals
    - Negotiating conflict
    - Use of Artificial hydration/nutrition

3. For physicians already credentialed, begin the process of requiring the same six courses prior to their next re-credentialing period.

4. Once physicians have completed the core six courses, then for each subsequent re-credentialing period, require an additional four courses of the physician's choosing.

5. To receive "credit" for course completion, physicians must complete the:
    a. The course post-test (required for CME).
    b. The *Practice Change worksheet*—these should be turned in to the medical staff/credentialing office upon completion.

Appendix 10: Collaborator and Competitor Organizational Inventory

CAPC has invested consistently in building senior level relationships with numerous national organizations. Some of these organizations also utilize CAPC tools and may be viewed as collaborators or competitors for health care organizational dollars. Some of these organizations are important to our individual constituents within the palliative care field (such as the American Academy of Hospice and Palliative Medicine). Others are important to our institutional constituents, around which our product strategy is designed. This includes organizations like IHI or NHPCO. Decisions to participate in the proposed fee based structure will be influenced by the tradeoffs or synergy with other organizations and their costs.

Organization	Purpose	Fees	Collaborator	Competitor
American Academy of Hospice and Palliative Medicine (AAHPM)	Provides education and clinical practice standards, foster research, facilitate personal and professional development of its members, and by public policy advocacy.		X	
American Cancer Society (ACS)	A nationwide, community-based voluntary health organization dedicated to eliminating cancer as a major health problem; Provides information; funds and conduct research; offers support programs; addresses advocacy and policy issues.	No fee for most services		
American Geriatrics Society (AGS)	Membership association of geriatrics health care professionals, research scientists, and individuals dedicated to improving the health, independence and quality of life of all older people; provides guidelines and recommendation, and education through an annual meeting.	Membership fee; various rates	X	
American Hospital Association (AHA)	Leads, represents and serves hospitals, health systems and other related organizations that are accountable to the community and committed to health improvement. Provides conferences & webinars	Membership fee based on type and size of organization	X	
AHA's HPOE (Hospitals in Pursuit of Excellence)	A division of AHA that works to accelerate performance improvements in hospitals by providing education, toolkits,	Prices vary by product or service	X	

Organization	Purpose	Fees	Collaborator	Competitor
	resources and national projects / initiatives.			
Association of Professional Chaplains (APC)	Interfaith professional pastoral care association of providers of pastoral care ; standards, advocacy & education (annual conference & webinars)	Membership fee: $105/ individual; $1000-$5000 /corporate Webinar: $55-$95	X	
End of Life / Palliative Education Resource Center (EPERC)	Advancing end of life care via an online community of scholars, providing training materials and resources	No fee	X	
HMS Center for Palliative Care (Harvard)	Fostering leadership and supporting outstanding educational programs in palliative care. Various offerings follow:		X	X
HMS Center for Palliative Care (Harvard)	*HMS's Program in Palliative Care Education and Practice (PCEP)*: Two-part intensive learning includes two seven-day1sessions and a 6-month interim to work on an individual project and contribute to weekly email discussions.	$6600	X	Program developme nt and clinical training
HMS Center for Palliative Care (Harvard)	*HMS's Practical Aspects of Palliative Care: Integrating Palliative Care into Clinical Practice (PAPC)*: Two-and-one-half-day course offers physicians and other clinicians information and skills to provide specialist-level palliative care in a variety of practice settings.	$650 - $800	X	X: clinical training
HMS Center for Palliative Care (Harvard)	*HMS's Palliative Care for Hospitalists and Intensivists (PCFHI):* Two-and-one-half-day course for hospitalists and intensivists	$650 - $800	X	X: clinical training
HMS Center for Palliative Care (Harvard)	*Art & Science of Palliative Nursing (ASPN:)*Two day course for generalist & advanced practice nurses	Tuition TBD	X	X: clinical training

Organization	Purpose	Fees	Collaborator	Competitor
HealthCare Chaplaincy	National organization that collaborates with major academic medical centers and other professional organizations to integrate spiritual care within health care. Provides professional chaplaincy services, professional education and research.	Fees of various amounts for contracted chaplain services & TA	X	
Hospice and Palliative Nurses Association (HPNA)	Exchanges information, experiences, and ideas to promote understanding of the specialties of hospice and palliative nursing and to study and promote hospice and palliative nursing research. Provides education through conferences and online offerings.	Various fees for educational services	X	X: clinical training (eLearning)
Institute for Health Care Improvement (IHI)	Works to accelerate improvement by building the will for change, cultivating promising concepts for improving patient care, and helping health care systems put those ideas into action.	Expedition $750; Passport (bundled educational offerings): approx. $5000/yr	X	
National Association of Social Workers (NASW)	Membership organization works to enhance the professional growth and development of its members, to create and maintain professional standards, and to advance sound social policies	Membership fees: $125-$190; online courses and webinars at various prices	X	
National Hospice and Palliative Care Organization (NHPCO)	Nonprofit membership organization representing hospice and palliative care programs and professionals	Prices vary for eLearning and webinars; approximately $95/module	X	X: clinical training (eLearning , Inc. Pediatrics)
The Advisory Board	Prominent national organization with 3,000+ hospital subscribers; sponsors excellent monographs and small meetings and audio conferences. Has targeted interest groups. CAPC has collaborated with them for several monographs and audio-conferences.	More than $50,000 per institution with additional fees for subgroups	X	x

Organization	Purpose	Fees	Collaborator	Competitor
The National Palliative Care Research Center (NPCRC)	Stimulating, developing, and funding research directed at improving care for seriously ill patients and their families	No fee	X	
Nurses Improving Care for Healthsystem Elders (NICHE)	Provide principles and tools to stimulate a change in the culture of healthcare facilities to achieve patient-centered care for older adults; engages hospitals and their affiliates in achieving and sustaining the NICHE designation	Annual fee: $4700	X	
Palliative Care McGill	Interdisciplinary network of clinicians, educators, researchers, allied-health professionals, volunteers and support staff who work together across five teaching hospitals to provide top-quality palliative care, education, and research.	$175 full day educational session	X	X: clinical training
Social Work in Hospice and Palliative Care Network (SWHPN)	Network of social work organizations and leaders who seek to further the field of end-of-life and hospice/palliative care.	Membership fee $95/individual	X	

Appendix 11: CAPC's Education Strategy for New Products

1. Needs Assessment

To advance the strategy of improving palliative care across the continuum of health care, CAPC has identified a key deficiency in health professional palliative care education not currently met by any single vendor or professional organization. In particular, there is no single source for clinical care content for all health professionals at a palliative care *generalist* level:

- ✓ Hospital, Long-term Care and Home Care nurses
- ✓ Generalist physicians (not palliative are specialist physicians)
- ✓ Social workers and chaplains working across the health care continuum

Through a needs assessment process, CAPC has identified that the single most needed education platform to reach the widest population is a robust E-Learning system. To this end, we have identified the following features needed to support high-quality e learning:

A) A Learning Management System (LMS) to organize and deliver e learning courses to the end users in hospitals, nursing homes, home care and other non-hospital venues.
B) Course development methodology to take existing clinical content and format into optimal e-learning course.
C) Course content that best reflects the needs of generalist clinicians.

A) LMS Desired Specification

Single-point E-learning platform to provide modular, CME/CEU credit courses, in primary palliative care. The specifications of LMS vendors include:

- Asynchronous and synchronous training availability
- Ability to include text, PowerPoint, video; downloading files and we blinking
- Post-course testing will be required along with automatic completion certificates and CME/CEU delivery;
- Reporting system for user institutions to access and track usage and integrate into Human Resource system for staff course completion tracking;
- Content must be SCORM compliant
- Mobile device interface (e.g. IPAD)
- Extremely easy and intuitive user interface
- Automated password recovery
- Individual Reports
- Authoring capabilities

CAPC has completed initial informational meetings with four prominent LMS Vendors who are well connected to the health care market:

- SumTotal Systems
- Inquisiqr3
- NetLearning
- Health Stream

CAPC will issue a forma Request for Proposals to finalize the LMS vendor.

B) Course Development

Courses will be 30-60 minutes in length, with an intermediate level of e learning course design sophistication. Course content will likely include migration of already available open-access courses along with new course development.
For new course development, CAPC is planning to use on-line course instructional design specialists to develop high quality courses that maximize user interactivity and adult learning principles. A mature course catalog by year 3 will contain ~25-30 courses. Conservative anticipated user volume is:

Year 1: 200 hospitals x 25 staff x 5 courses/year = 25,000 individual courses
Year 2: 300 hospitals x 25 staff x 5 courses/year = 27,500 "

CAPC is interviewing various course development vendors to select the optimal match for our needs.

C) Course Content

CAPC has done an extensive needs assessment of existing palliative care e-learning course materials along with delivery systems and user interfaces. Discussions are in process with ELNEC about content sharing for nursing content. EPEC-O is an excellent open-access content platform for developing a generalist physician curriculum. New content will need development for social work and chaplain e-learning content as there are no available products.

Next Steps

- Develop RFP for selecting a LMS
- Continue interviewing course content development vendors
- Convene national advisory board to assist CAPC in course content/design oversight;
- Finalize job descriptions for CAPC staff necessary to manage LMS system and serve as user interface with users