Hospice Industry Realities: The Inevitable Need for Change

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Objective

Provide an overview of the hospice Industry and discuss the leadership strategies and, changes needed for the near future.

National and State Demographics

- Hospice Expenditures
- Hospice Growth
- Patient Demographics

Value-Driven Initiatives

- Regulatory Updates: CAHPS, HEART, HIS, OIG

Workforce

- Current and Future Status
- Potential for Telehealth

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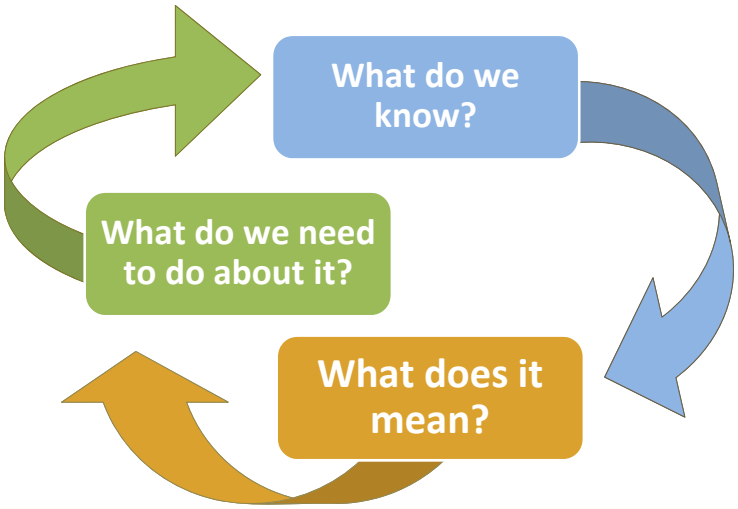
Strategic Management Model



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Hospice Expenditures

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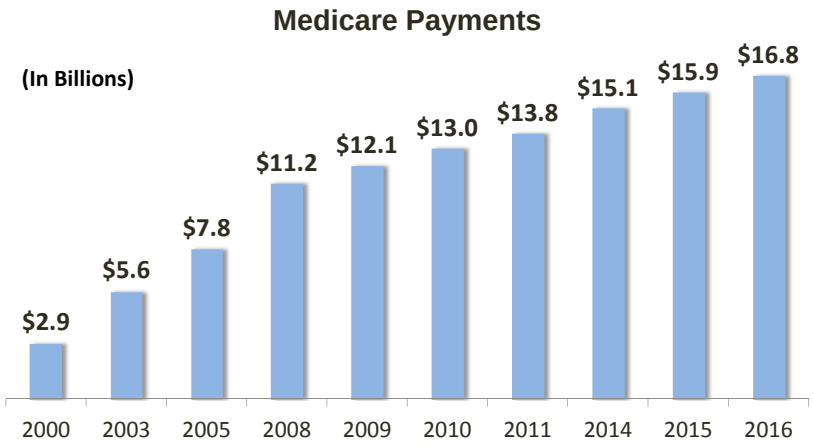
Hospice Spending



Source: CMS/OIS/HCIS, June 2006. MedPAC, A Data Book: Health care spending and the Medicare program, March 2012, June 2017, March 2018

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Hospice Spending

We estimate that aggregate payments to hospices in FY 2018 will **increase by $180 million**, or 1.0 percent, compared to payments in FY 2017.

Source: Federal Register. Vol. 82, No. 149. Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. Final; Rule. 42 CFR Part 418. August 4, 2017.

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Hospice Spending

	2002	2011	2012	2013	2014	2015
Percent of hospices exceeding annual payment cap	2.6%	9.8%	11.0%	10.7%	12.2%	12.3%
Avg payments over the cap per hospice exceeding the cap (in thousands)	$470	$424	$510	$460	$370	$320
Payments over the cap as a percent of overall Medicare hospice spending	0.6%	1.1%	1.4%	1.3%	1.2%	1.0%

Source: MedPAC, Report to Congress. March 15, 2018.

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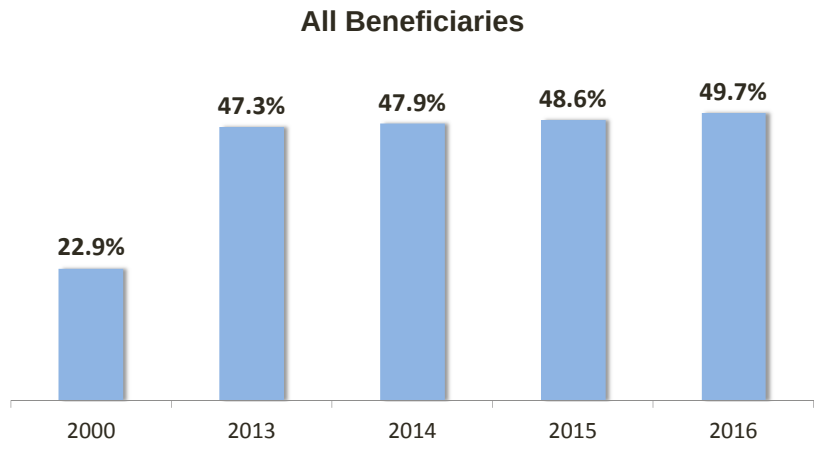
Percent of Medicare Decedents Who Used Hospice



Source: CMS/OIS/HCIS, June 2006. MedPAC, A Data Book: Health care spending and the Medicare program, March 2012, June 2017, March 2018

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Hospice Medicare Margins

	2008	2011	2012	2013	2014	2015
All	5.3%	8.7%	10.0%	8.5%	8.2%	10.0%
For profit	10.2	14.7	15.4	14.7	14.6	16.4
Nonprofit	0.5	2.3	3.6	0.9	-0.7	0.1

	2008	2011	2012	2013	2014	2015
Below cap	5.7	8.9	10.3	8.6	8.4	10.0
Above cap	1.2	4.1	5.2	7.0	6.0	9.9
Above cap (including cap overpayments)	19.1	18.4	21.3	20.1	18.8	21.4

Source: MedPAC, A Data Book: Health care spending and the Medicare program, June 2017. Report to Congress. March 15, 2018.

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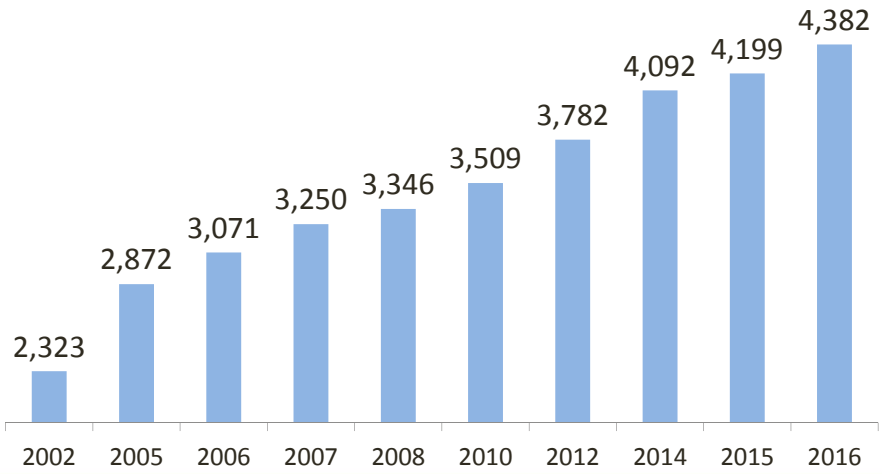
Growth of Medicare-Certified Hospices



Source: MedPAC. Report to the Congress: Medicare Payment Policy. March 2018 and Fazzi analysis of Medicare claims data.

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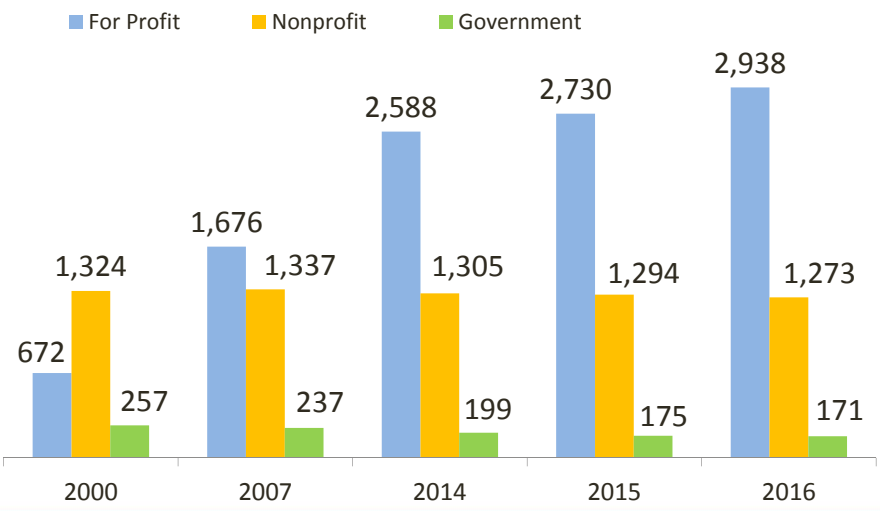
Growth of Medicare-Certified Hospices



Source: MedPAC. Report to the Congress: Medicare Payment Policy. March 2018 and Fazzi analysis of Medicare claims data.

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Kentucky Hospices

- In 2003, CMS reported 27 hospice providers in Kentucky.
- In 2015, Medicare's Provider of Services file reported 24 hospice providers, and 23 providers in 2017. (A total of 32 were reported and 9 had termination dates.) Hospice Compare provides data on 32 hospices.
- Kentucky.gov Medicaid Provider Directory reported 23 hospice providers.

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Hospices by Medicare Payment

Medicare Payment	% of Agencies National	% of Agencies Kentucky
Blank	4.3	4.2
<$500K	18.1	8.3
$500K–$2M	32.6	29.2
$2M–$5M	24.9	25.0
$5M–$10M	12.4	20.8
$10M–$20M	5.2	4.2
$20M+	2.4	8.3

Source: Fazzi analysis of Medicare 2016 claims

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Demography is Destiny

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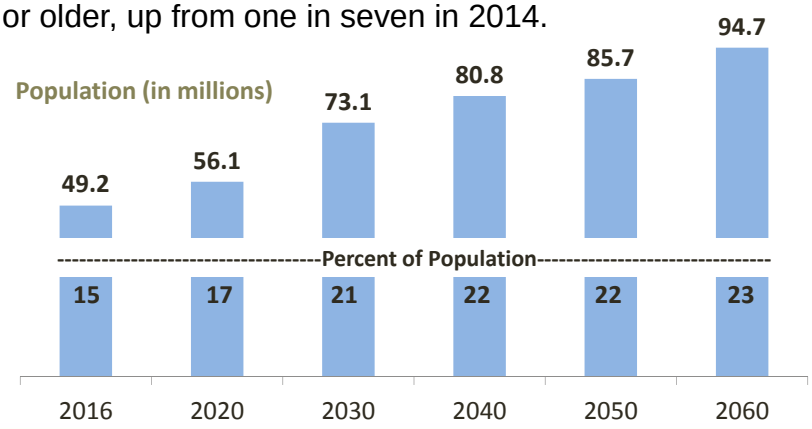
Population Projections Age 65 and Older

By the 2030 Census all baby boomers will have reached age 65 or older (this will actually occur in 2029). In that year, one-in-five Americans would be 65 or older, up from one in seven in 2014.



Source: U.S. Census Bureau, 2017 National Population Projections. Projections of the Older Adult Population: 2020 to 2060.

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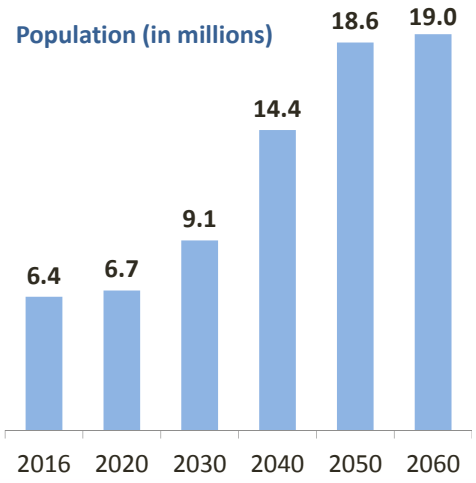
Population Projections Age 85 and Older

The number of people 85 years and older is expected to nearly double by 2035 (from 6.4 million to 11.8 million) and nearly triple by 2060 (to 19 million people).

The country will also add one-half million centenarians over the same period.



Source: U.S. Census Bureau, 2017 National Population Projections. Population by Age Group: Projections 2020 to 2060.

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Why the Health System Must Focus on People with Chronic Diseases

- They are hospitalized more;
- They visit the emergency room more;
- They are more costly than the average person of their age;
- They represent a high proportion of home health patients;
- They have the highest risk of being institutionalized

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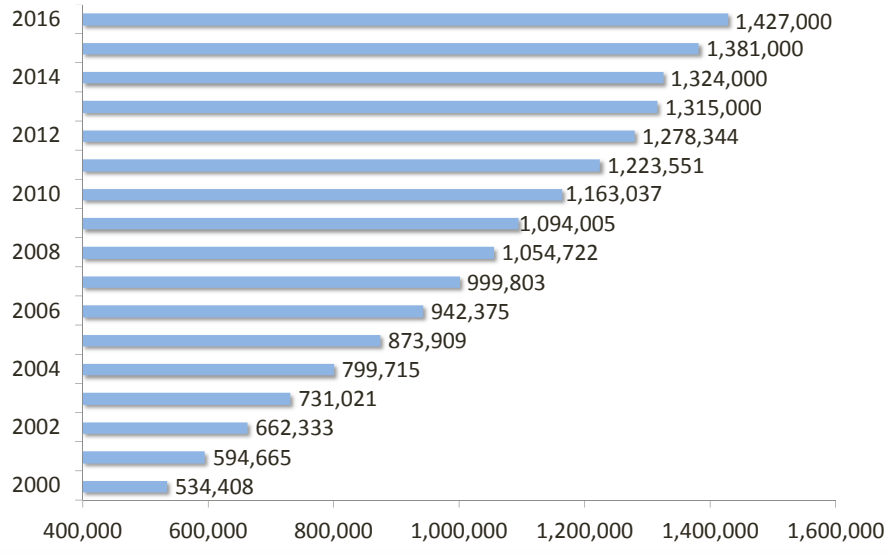
Medicare Hospice Patients



Source: Medicare & Medicaid Research Review, 2013 Statistical Supplement and CMS/OIS/Medicare Data Extract System. Table 8.1 and MedPAC:. Report to the Congress: Medicare Payment Policy. March 2017.

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Medicare Enrollment

	Kentucky	National
% Eligible for Medicaid	**26.45%**	19.89%
% of Beneficiaries Using HH	8.99%	9.20%
% of Beneficiaries Using Hospice	2.08%	2.68%
Hospital Readmission Rate	**18.87%**	17.93%
Emergency Department Visits per 1,000 Beneficiaries	**785**	661

Source: CMS, State and County Level Demographic, Cost, Utilization, and Quality Data, 2015

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Kentucky Medicare Demographics

	Kentucky	National
% of beneficiaries using hospice	2.08%	2.68%
Hospice covered stays per 1,000 beneficiaries	21	28
Hospice covered days per 1,000 beneficiaries	1,049	1,839
Hospice per capita standardized Medicare costs	$187.36	$308.80
Hospice per user standardized Medicare costs	$9,018.89	$11,538.46

Source: CMS Medicare Geographic Variation File. State and County Level Demographic, Cost, Utilization, and Quality Data. State_County_2015

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Kentucky Hospice

	Hospital or HHA-based	Nonprofit	Proprietary
Days / Patient	42.4	48.7	61.1
Days / Discharge	47.2	54.9	70.9
Payment / Patient	$6,853	$8,106	$10,120
Payment / Day	$162	$167	$166
% Live Discharges	8.7%	9.9%	12.0%
% of Total Patients	17.2%	77.9%	5.4%

Source: Fazzi analysis of 2016 Medicare claims data.

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Chronic Care Management

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Chronic Conditions Prevalence Fee-for-Service Beneficiaries

	Kentucky Prevalence (%)	National Prevalence (%)
Alzheimer's Disease/Dementia	9.4	9.9
Arthritis	33.2	30.0
Asthma	10.2	8.2
Atrial Fibrillation	7.9	8.1
COPD	16.7	11.2
Cancer	6.8	7.8
Chronic Kidney Disease	18.5	18.1
Diabetes	28.6	26.5

Source: Centers for Medicare & Medicaid. County Table Chronic Conditions Prevalence by Age 2015.

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Chronic Conditions Prevalence Fee-for-Service Beneficiaries

	Kentucky Prevalence (%)	National Prevalence (%)
HIV/AIDS	0.2	0.4
Heart Failure	15.0	13.5
Hyperlipidemia	46.5	44.6
Hypertension	59.7	55.0
Ischemic Heart Disease	29.1	26.5
Osteoporosis	5.0	6.0
Stroke	3.7	4.0

Source: Centers for Medicare & Medicaid. County Table Chronic Conditions Prevalence by Age 2015.

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Medicare Beneficiary Characteristics by Neighboring States, 2015 Medicare File

Area	MA Participation Rate	% Eligible for Medicaid	% Using PAC: HH	HH Episodes per 1,000 Beneficiaries	% Using Hospice	Hospice Covered Stays per 1,000 Beneficiaries
Illinois	26.13 %	15.21 %	10.25 %	211	2.55 %	26
Indiana	25.71 %	20.39 %	7.12 %	126	2.81 %	29
Kentucky	28.41 %	26.45 %	8.99 %	174	2.08 %	21
Missouri	30.98 %	18.75 %	7.87 %	122	2.91 %	30
Ohio	44.80 %	18.01 %	8.98 %	163	3.06 %	32
Tennessee	37.46 %	20.03 %	9.13 %	192	2.51 %	26
Virginia	21.93 %	12.05 %	8.68 %	144	2.31 %	24
West Virginia	28.68 %	27.42 %	7.41 %	132	2.29 %	24

File. State and County Level Demographic, Cost, Utilization, and Quality Data. State_County_2015

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Medicare Beneficiary Characteristics by HRR, 2015 Medicare File

Area	MA Participation Rate	% Eligible for Medicaid	% Using PAC: HH	HH Episodes per 1,000 Beneficiaries	% Using Hospice	Hospice Covered Stays per 1,000 Beneficiaries
Covington	39.55 %	17.29 %	9.64 %	164	3.01 %	31
Lexington	29.13 %	33.20 %	8.37 %	174	2.11 %	22
Louisville	27.01 %	22.14 %	9.66 %	178	2.06 %	21
Owensboro	22.35 %	23.07 %	7.46 %	133	2.10 %	22
Paducah	22.39 %	21.91 %	8.38 %	145	1.88 %	19

File. State and County Level Demographic, Cost, Utilization, and Quality Data. State_County_2015

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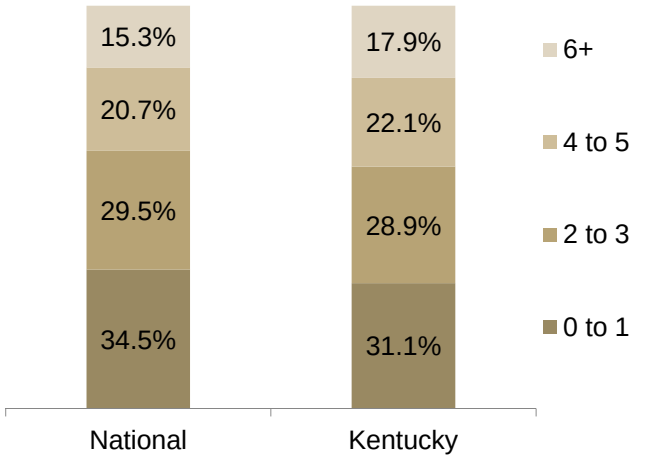
Chronic Conditions Prevalence



Source: CMS Chronic Conditions 2015

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Chronic Conditions Prevalence Fee-for-Service Beneficiaries

	National Prevalence (%)	Kentucky Prevalence (%)
Alzheimer's / Dementia	9.95	9.37
Arthritis	30.02	33.19
Asthma	8.17	10.18
Atrial Fibrillation	8.09	7.85
COPD	11.20	16.70
Cancer	7.83	6.82
Chronic Kidney Disease	18.12	18.48
Diabetes	26.55	28.65
Heart Failure	13.46	14.96
Hypertension	54.99	59.66
Heart Disease	26.46	29.11
Stroke	3.97	3.70

Source: Centers for Medicare & Medicaid. Comparison of Geographic Areas by Chronic Conditions, 2015.

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KY Top 10 Hospice Diagnoses

ICD-10 Code	Diagnosis	% KY Patients	% US Patients
G30.9	Alzheimer's disease, unspecified	7.47%	11.18%
J44.9	Chronic obstructive pulmonary disease, unspecified	5.54%	5.19%
G31.1	Senile degeneration of brain, not elsewhere classified	5.00%	4.04%
C34.90	Malignant neoplasm of unspecified part of unspecified bronchus or lung	3.85%	3.82%
I50.9	Heart failure, unspecified	3.21%	5.58%
G30.1	Alzheimer's disease with late onset	2.38%	2.27%
I51.9	Heart disease, unspecified	2.19%	1.44%
J44.1	Chronic obstructive pulmonary disease with (acute) exacerbation	2.17%	2.30%
I63.9	Cerebral infarction, unspecified	2.11%	1.41%
N18.6	End stage renal disease	1.93%	1.53%

Source: Fazzi analysis of Medicare claims 2016

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Leading Causes of Death

Cause of Death	% of Total Deaths	Rate KY	% of Total Deaths	Rate U.S.
All causes	100.0	1,052.3	100.0	844.0
Cancer	22.1	233.0	22.0	185.4
Diseases of heart	21.6	227.7	23.4	197.2
Chronic lower respiratory diseases	7.2	75.3	5.7	48.2
Accidents	6.4	66.9	5.4	45.6
Cerebrovascular disease	4.4	46.3	5.2	43.7
Alzheimer's disease	3.6	38.3	4.1	34.4
Diabetes	3.1	32.9	2.9	24.7
Nephritis, Nephrosis	2.1	22.6	1.8	15.5
Influenza and pneumonia	2.1	21.9	2.1	17.8
Septicemia	1.9	19.7	1.5	12.7

Source: Centers for Disease Control and Prevention. LCWK9. Deaths, percent of total deaths, and death rates for the 15 leading causes of death: United States and each State, 2015

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Mortality: Age-Adjusted Death Rate by Neighboring States

	Age-Adjusted Death Rate per 100,000 Population
National	729.9
Illinois	726.1
Indiana	829.5
Kentucky	**910.3**
Missouri	810.6
Ohio	816.6
Tennessee	882.5
Virginia	721.3
West Virginia	932.0

Source: CDC. Health, United States, 2016. Table 16.

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Live Hospice Discharges

State	Total Discharges	% Live Discharges	% Discharges Expired
Total	1,208,128	17%	83%
Illinois	44,078	10%	90%
Indiana	27,477	15%	85%
Kentucky	**16,260**	**10%**	**90%**
Missouri	26,889	16%	84%
Ohio	57,153	13%	87%
Tennessee	26,104	14%	86%
Virginia	25,465	16%	84%
West Virginia	8,519	13%	87%

Source: Fazzi Analysis of Medicare 2016 Hospice Claims

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Reimbursement and Regulations

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Hot Off the Press

- CMS Issues Proposed FY2019 Hospice Payment and Quality Reporting Rule
- Projects Update of 1.8 percent
- Will Eliminate Public Reporting of 7 HIS Measures
- Proposed Hospice Wage Updates:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/Hospice/Hospice-Regulations-and-Notices-Items/CMS-1692-P.html?DLPage=1&DLEntries=10&DLSort=3&DLSortDir=descending

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Reimbursement

PROPOSED HOSPICE PAYMENT UPDATE: PERCENTAGE/PAYMENT RATES

Under existing law the hospice update percentage for FY2019 is calculated using the proposed hospital market basket update of 2.9 percent and reducing it by Affordable Care Act (ACA)-enacted adjustments (a productivity adjustment estimated at 0.8 percentage point and an additional 0.3 percentage point reduction specific to hospice providers).

Taking these factors into consideration, the estimated hospice payment update for FY2019 is 1.8 percent

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Following are CMS' proposed base payment rates for FY2019. Please note that the SIA rate is the hourly CHC rate, estimated at $41.62 in FY2019).

Code	Description	FY2019 Proposed Payment Rates
651	RHC (Routine Home Care) Tier 1 (days 1 – 60)	$196.25
651	RHC Tier 2 (days 61+)	$154.21
652	CHC (Continuous Home Care) (full rate=24 hours of care) ($41.62 hourly rate)	$998.77
655	IRC (Inpatient Respite)	$176.01
656	GIP (General Inpatient)	$758.07

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Impact to Hospices for FY 2018

East South Central: Alabama, Kentucky, Mississippi, Tennessee

	Number of Providers	Updated wage data (%)	FY 2018 total change (%)
All hospices	4,355	0.0	1.0
Urban hospices	3,381	0.0	1.0
Rural hospices	974	0.1	1.1
Urban hospices: East South Central	159	0.0	1.0
Rural hospices: East South Central	124	-0.1	0.9
Non-profit ownership	1,059	0.0	1.0
For profit ownership	2,735	0.1	1.1

Source: Federal Register. Vol. 82, No. 149. Medicare Program; FY 2018 Hospice Wage Index and Payment Rate Update and Hospice Quality Reporting Requirements. Final; Rule. 42 CFR Part 418. August 4, 2017.

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Hospice Cap

The hospice aggregate Cap amount for 2019 will be **$29,205.44**, which represents the 2018 rate of $28,689.04 updated by the FY2019 payment update percentage of 1.8 percent.

In conjunction with the hospice Cap changes over recent years, CMS is also proposing a technical correction to the regulations to reflect alignment of the Cap year with the federal fiscal year (the 12 month period ending September 30).

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Be Prepared to Defend Your Claims

- Evaluate your Pepper Reports carefully.
- Dig into your revenue cycle and find sticking points/areas of risk.
- Work, proactively, to provide operational supports needed for workflow efficacy.

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Regulatory Burden - Reduction

- Sequential billing stays for now…
- CMS indicates that beginning October 1, 2018, providers will have the option to report aggregate DME (pump and infusion drug information) and drug charges on claims.
- This change will potentially reduce the number of line items required to be billed on hospice claims by approximately 21.5 million in the aggregate. CMS released transmittal detailing these changes on April 26. CMS indicates it will continue to consider whether future regulatory or sub-regulatory changes are warranted to reduce unnecessary burdens.

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Physician Assistants

- **PHYSICIAN ASSISTANTS AS ATTENDING PHYSICIANS**
- As previously reported, the Bipartisan Budget Act of 2018 authorizes physician assistants (PAs) to serve as a hospice patient's designated attending physician. Effective January, 2019.
- The rule proposes revisions to hospice regulations to reflect this change, and specifies that PA will be defined as: a "professional who has graduated from an accredited physician assistant educational program who performs such services as he or she is legally authorized to perform… in accordance with state law…and who meets the training, education, and experience requirements as the Secretary may prescribe."
- Under this change, Medicare will pay for services that are:
  - medically reasonable and necessary services that would normally be provided by a physician, and are paid at 85 percent of the fee schedule amount
  - provided by a PA to a patient who has selected the PA as their attending physician
  - Regardless of whether or not the PA is directly employed by the hospice
  - NOT related to the certification of terminal illness
  - PAs may not serve as hospice medical directors, may not lead a hospice interdisciplinary team, certify a beneficiary's terminal illness, or conduct the hospice face-to-face encounter.

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Medicare Hospice

- Summer 2017: Hospice Compare
- Ongoing: Hospice Evaluation & Assessment Reporting Tool (HEART)
- Future: HIS-based measures:
  - Potentially avoidable hospice care transitions
  - Access to levels of hospice care
  - Service Intensity Add-on Re-evaluation

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HIS Reporting

Updates to Public Display of HIS Measures: Currently seven "component" HIS measures are displayed on Hospice Compare.

CMS believes that the HIS Composite Measure provides for consumers "a more accessible measure for evaluating the quality of a hospice" and holds hospices to a higher standard because it requires that they perform all seven care processes for a patient admission.

Once the **HIS Composite Measures** is available for reporting on the Compare website, CMS is proposing to no longer directly display the seven component measures, although they will remain accessible to patients and others who are seeking additional detail on a hospice's quality of care.

This proposal would not change existing HIS data collection requirements and the seven component measures would still be reported on CASPER QM reports and HIS provider preview reports.

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HEART Instrument

Projected Project Timeline

- October 2017: Recruit hospices with varying characteristics (size, location, organizational features)
- January 2018: Train hospices for Pilot A data collection
- January 2018: Begin data collection (six weeks)
- February 2018: End data collection
- February/March 2018: Debriefing calls with all hospice pilot sites to collect qualitative data about their data collection and submission processes
- March 2018: RTI data analysis
- June 2018: Train hospices for Pilot B data collection
- July 2018: Begin data collection (eight weeks)
- August/September 2018: End data collection
- August/September 2018: Debriefing calls with all hospice pilot sites to collect qualitative data about their data collection and submission processes
- September 2018: RTI data analysis

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With HEART and HIS

- Don’t forget the horse which pulls the cart…

Assess competence at bedside, first, in assessment technique and data capture.

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Risk Management

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OIG Work Plan: Hospice

- Medicare Hospice Benefit Vulnerabilities and Recommendations for Improvement

  OIG will summarize OIG evaluations, audits, and investigative work on Medicare hospices and highlight key recommendations for protecting beneficiaries and improving the program.

- Review of Hospices' Compliance with Medicare Requirements

  OIG will review hospice medical records and billing documentation to determine whether Medicare payments for hospice services were made in accordance with Medicare requirements.

Source: Department of Health and Human Services. Office of Inspector General. OIG Work Plan 2017

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OIG Work Plan: Hospice

- Hospice Home Care – Frequency of Nurse On-Site Visits to Assess Quality of Care and Services

  OIG will determine whether registered nurses made required on-site visits to the homes of Medicare beneficiaries who were in hospice care.

Source: Department of Health and Human Services. Office of Inspector General. OIG Work Plan 2017

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Risks - Continued

- What is the HIS data telling the government with respect to the Service Intensity Add On
- What is the risk to your agency based on the outcomes you generate?
- What are the risks you have with respect to a growth market of need and challenging workforce realities?

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Workforce

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Kentucky Occupational Employment and Wage Estimates

Occupation	Employment	Employment per 1,000 jobs	Location Quotient	Annual Mean Wage
RNs	45,500	24.337	1.20	$59,810
LPNs & LVNs	10,520	5.626	1.12	$39,460
Nursing Assts.	23,930	12.799	1.25	$25,160
HHAs	2,540	1.356	0.23	$25,710

Source: Bureau of Labor Statistics. May 2016 . State Occupational Employment and Wage Estimates

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Kentucky Short Term Employment Projections

Occupation	Employment 2017	Employment 2019	% Change	Average Annual Openings
RNs	47,040	47,970	2.0	2,860
LPNs & LVNs	10,690	10,750	0.5	780
Nursing Assts.	24,590	24,930	1.4	2,930
HHAs	2,620	2,750	5.0	370

Source: Projections Central. State short-term occupational projections are developed in the labor market information sections of each State Employment Security Agency.

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Kentucky Long Term Employment Projections

Occupation	Employment 2024	KY % Change	U.S. % Change
RNs	61,130	35.6	16.0
LPNs & LVNs	8,910	27.3	16.3
Nursing Assts.	37,180	46.1	17.6
HHAs	6,620	59.4	38.1

Source: Projections Central. State long-term occupational projections are developed in the labor market information sections of each State Employment Security Agency.

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Kentucky 5 Year Projected Demand by Local Workforce Area, 2017-21

Area	Employed	Projected Job Openings	Average Wage
Northern Kentucky	3,615	878	$65,061
Kentuckiana Works	13,388	3,328	$64,738
Lincoln Trail	944	173	$60,711
Green River	1,816	434	$56,435
West Kentucky	4,107	693	$53,395
South Central	2,277	494	$59,796
Cumberlands	2,672	666	$56,737
Bluegrass	6,467	1,248	$61,079
TENCO	2,637	577	$54,099
EKCEP	3,680	634	$53,655

Source: KCEWS.ky.gov. Kentucky Future Skills. Accessed March 15, 2018.

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How Can We Manage Workforce?

Four Main Areas of Focus:

1. Address Culture
2. Address Preparation of Our Staff – Providing Them Tools to Meet Today's Expectations
3. Evaluate Best Practice Utilization Management – Where and How are You Using Your Resources?
4. Innovate!

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Culture - Be Intentional

1. Create specific organizational structures and strategies to create success
2. Use the strategies and measured results
3. Build practices and processes around the structure and strategy

Overall Focus: Intentionality: reaching specific goals and ensuring that it is completed in a timely and quality manner

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Process Accountability for Leaders

1.Clarify Expectations of Performance (KPBs).

2.Provide Skills/Tools to Meet Expectations.

3.Have a Method to Monitor Adherence to Process.

4. Hold People Accountable

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Build Culture of Excellence

- Leverage your commitment to the hospice philosophy and your mission.
  - Tie mission-alignment to your QAPI program and individual and team outcome improvement.
  - Align authority and responsibility optimally within your organizational structure.
  - Identify Key Performance Indicators (KPIs) as measures of success for each team/department within the organization.
  - Identify underlying Key Performance Behaviors (KPBs) for each KPI – distilling the processes and behaviors which will drive positive movement of the metric.
  - Use Metrics to monitor the impact of leadership choices

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Provide Staff the Tools to Meet the Expectations of Work

- By clearly defining the KPI and KPB relationships, you can better define what we need to train, supervise and create hardwired-performance accountability.
- Accountability = Advocacy
- First we need to understand what it is like to 'walk a mile in the shoes' of a field clinician, in today's hospice agencies….

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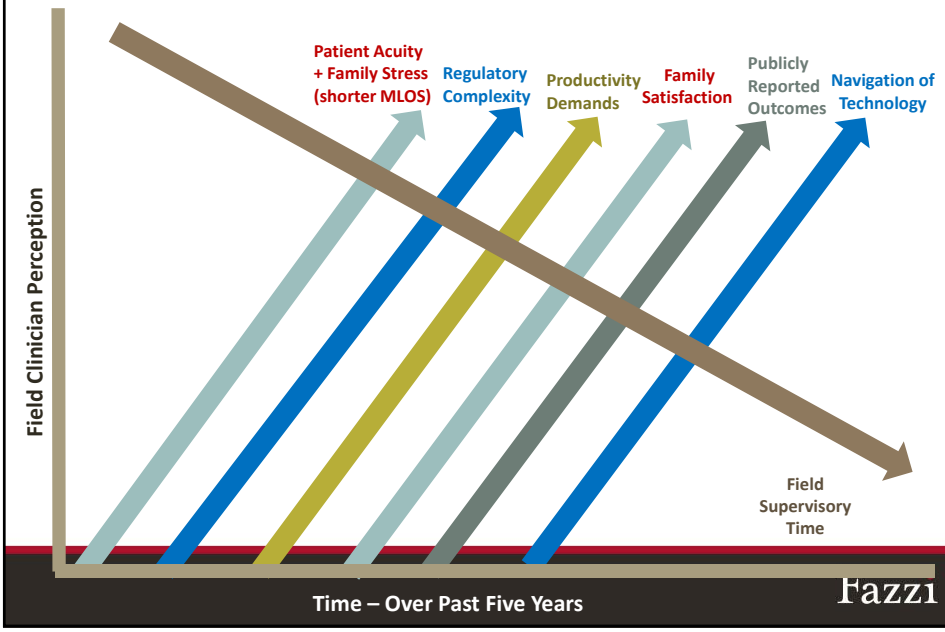
Walk A Mile In Their Shoes



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Software and Workflow – Think LEAN

- Gemba Walk – Go to Where the Work is Done
- Master Key Performance Behaviors, (such as a great assessment and capture of documentation using best practice), **at the point of care.**
- If we don't lead/support/monitor **there**, we will be perpetually stuck in reactive cycles.
- If your software inhibits your supervisory capacity, rethink the workflow and aligned roles and responsibilities.

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Behavior Gap Leads to Frustration

Bridging The Gap

Hardwiring Key Performance Behaviors to drive Key Performance Indicators

Build the Bridge Between Knowledge and Action

KPI'S ARE DRIVEN BY KEY PERFORMANCE BEHAVIORS

- **Identify the key behavioral behaviors (KPB's) to**
- **move the metrics (KPI's) to goals desired:**
  - **Individual Clinician**
  - **Team**
  - **Department**
  - **Organization**
  - **Leadership**
- **Form Follows Function! Does current structure work?**

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KPI'S HOSPICE - THERE IS BEAUTY IN SIMPLICITY: FOUR KPI'S

1. Timely, quality documentation – HIS, NOE, CTI

2. Productivity - visits/day and cases managed

3. Clinical competence – Palliation achieved within "X" hours of admission. Admit within 4 hours.

4. Family satisfaction - "likelihood to recommend" in top 20%, nationally

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KPI: TIMELY, QUALITY DOCUMENTATION

KPI – % of HIS COMPETENCE: Bedside (100%) and Document (>90%)

Note: Working toward competence, at the bedside, with POC documentation.

KPB's

- Performance Based HIS - competence at bedside
  - Front line manager assesses competence/*measured*.
- Knowledge Based HIS (documentation)
  - QAPI Coordinator tracking/trending % of accuracy/*measured*.
  - Outsource coding – focus on quality and risk-stratified care planning.

KPI - NOE within timeline

KPB - Scheduling, clinician documentation and workflow within defined cascade

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KPI: PRODUCTIVITY (V/DAY + CASELOAD)

Key Performance Behaviors:

1. **Predictive Staffing:** metric-driven, staff ahead of volume!
2. **Scheduling accountability-clinician:** adjust and synch at start and end of day, dynamic changes to scheduler as occur.
3. **Scheduling accountability – Intake and Scheduler** – stop slotting schedule unless time-sensitive. All RNs trained to admit.
4. **Point of care documentation** best-practice visit integration; scripting for patient satisfaction – supervised.
5. **Personal organization and time management**
6. **Geographically organized route**, optimizing capacity

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KPI: Clinical Effectiveness as Evidenced By:

KPI Hospice – Palliation achieved at "X" level within 48 hours of admission.

Admission within 4 hours standard goal.

KPB's:

- HIS assessment **competence; field and document.**
- Risk stratified, best practice care planning and utilization management.
- QAPI integration into standardized IDG meeting process – using teaching approach to incrementally 'stack skills', clinically.
- Evidence based best practice and risk stratification, taught in grand rounds format involving the IDT, prn. Provides ongoing learning for care planning.

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Best Practice Utilization Management

- How are you evaluating the use of your resources?
- Is every visit intentional and within a risk-stratified plan of care?
- Are there visits which are 'wasted', or which could have had needs met in a different way?

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Integration of IS Platforms AND Best Practice Field Supervision

"The first rule of any technology used in a business is that automation applied to an efficient operation will magnify the efficiency. The second is that automation applied to an inefficient operation will magnify the inefficiency." Bill Gates

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Align Software Workflow With Key Position Priorities

- Who is assigned to complete what IS Platform tasks within operational workflow/revenue cycle?
- Consider re-design of flow to optimize the impact of front line manager, supporting their ability to:
  - Guiding clear expectations of field base practice
  - Providing support, skills and tools to meet the expectations
  - Having a method to directly supervise and measure key performance behaviors, where the work is done
  - Hold staff accountable

Leadership - Actualized

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Dare to Innovate!

We must and we can….but first we have to embrace a different mindset.

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Dr. Michael Burcham – NHPCO April, 2018

"Too much focus on "what our organization does" and too little focus on the benefits we provide the customer makes us blind to an aging business model"…

Dr. Burcham noted musings heard around him at the meeting:

- Build the model around the consumer.
- Get out of our own way - we make enrollment really complex
- We must have data.
- We scare people - associated with "giving up…"
- We are afraid to venture outside the traditional Medicare model.
- For profit vs. Not-for-Profit - excuses.
- **Not enough human or capital resources to sustain our current model.**

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The Drivers of our Change

- **People**
- **Process**
- **Technology**

How are we harnessing what is already in our reach, while daring to move into new areas of practice?

First, grab the low hanging tech-fruit!

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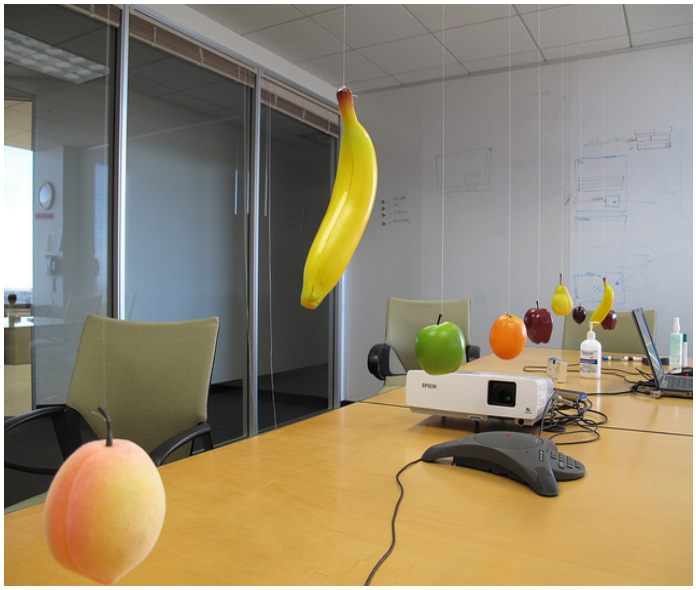

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Low Hanging Fruit

- **Data analytics and predictive staffing**
  - *Best-practice utilization management in line with SIA expectations and human need.*
  - *Metrics to predict volume needs, staffing ahead of revenue.*
- **Integrated remote monitoring/telehealth**
  - **On-call supports, palliation support**
- **GPS, navigation tools for schedule optimization**
  - *Accountable use of IS platform and scheduling - generally poor.*

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Low Hanging Fruit

- **Point Of Care documentation**
  - *Rarely fully trained, high contributor to burn-out and turnover. High impact to revenue cycle.*
- **Outsourced Services Increasing**
  - *On-call*
  - *Call center*
  - *Billing/coding/human resources/virtual coaching*
  - *Telemedicine – gaining ground through cross-state legislative push*

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Impact from Telehealth Program

	Decrease	No Change	Increase	Not Sure
Overall quality	0.7%	13.8%	74.9%	10.6%
Referrals	0.0%	51.5%	38.9%	9.6%
Visits per episode	36.4%	46.8%	7.7%	9.1%
Unplanned hospitalizations	62.6%	17.9%	8.0%	11.5%
Emergent care	50.9%	29.5%	7.3%	12.3%
Patient self care	2.4%	28.4%	59.5%	9.6%
Patient satisfaction	3.5%	22.4%	63.4%	10.8%
Agency costs	18.0%	35.9%	30.1%	16.0%

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Artificial Intelligence

"I call it *creative intelligence*; we are just starting to learn how smart it is; we need creativity to solve today's challenges."

Bern Terry, personal communication February, 2017
VP, Healthcare, VGo Robotic Telepresence
www.vgocom.com

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Machine Learning

- Processing massive amounts of data
- Learning, constantly, finding patterns of behavior and choices yielding optimal outcomes
- Add to the Internet of Things…

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Tele-Physicians and APNs

"Hello Doctor…
It is hard for me to get out of the house…"

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Innovation Needed to Cope and Compete

- Prediction of clinician shortages are real; optimizing our 'reach' compels further innovative method.
- Wide variation in tech adoption/integration a known factor.
- Differentiation through optimal adoption a choice!
- Enhanced connectivity with caregivers

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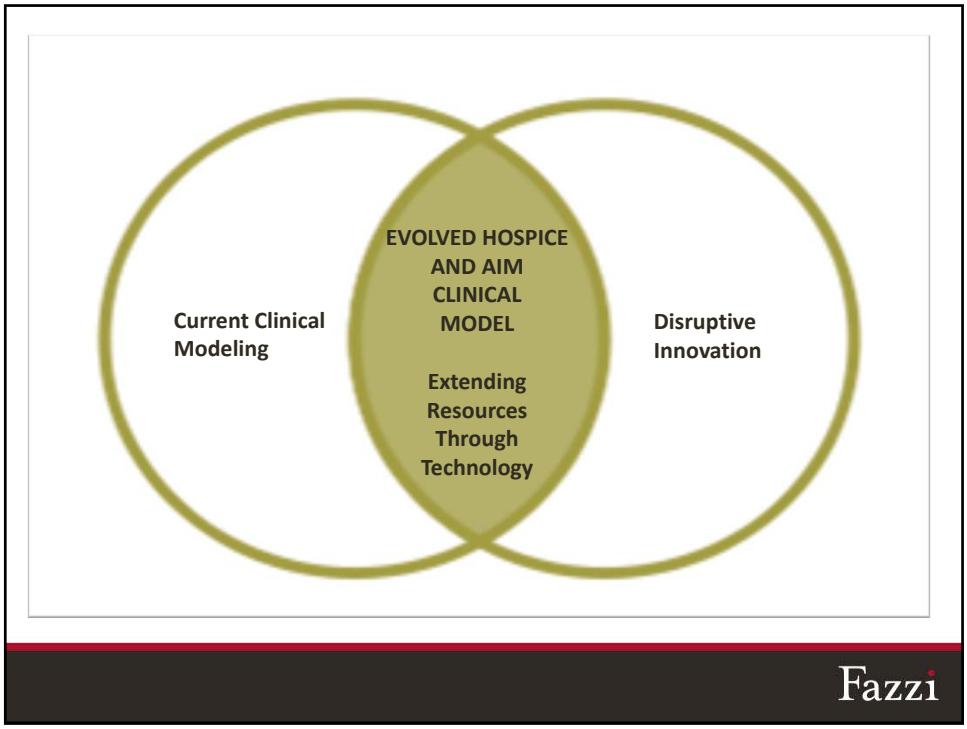
Current Clinical Modeling
EVOLVED HOSPICE AND AIM CLINICAL MODEL
Extending Resources Through Technology
Disruptive Innovation
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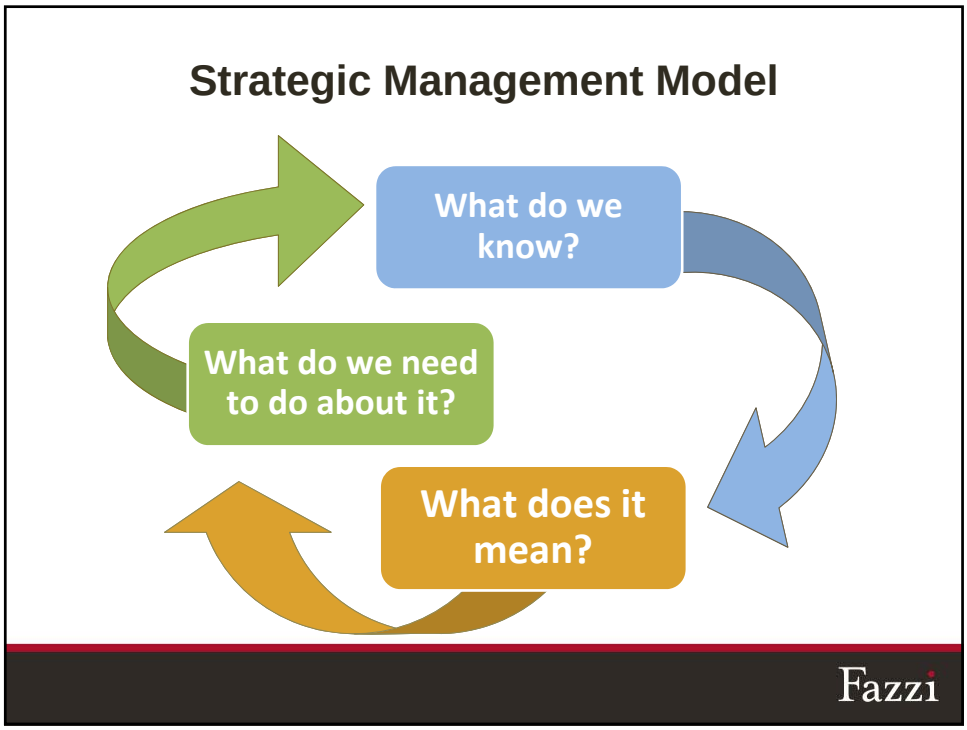
Strategic Management Model
What do we know?
What do we need to do about it?
What does it mean?
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As You Initiate Strategic Change Efforts, Remember the J Curve of Change

J

- Whenever you initiate change, it never goes exactly how you expect.
- There is often resistance and the belief by some that the change won't work.
- Like the letter J, the path may go down but it will go up.
- Having a clear vision and an unwavering commitment to your mission and core values will absolutely lead to success.

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So….How Will We Control and Plan Our Future?

The best way to predict the future is to create it.

Peter Drucker

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What questions do you have?

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