2013 Final Rule

- Update hospice payment rates for FY 2014 by 1.8%
  - BNAF for FY 2010 reduced the budget by 10% as the first year of a 7-year phase-out of the BNAF, to be followed by an additional Adjustment 5 percent per year reduction in the BNAF in each of the next 6 years.
  - BNAF (Budget Neutrality Adjustment Factor) will be reduced by an additional 15% for a total reduction of 70%
  - Total BNAF phase-out will be complete by FY 2016.
2013 Final Rule
Diagnosis Coding

- More specific diagnoses required
  - Claims must include all relative diagnoses contributing to terminal illness
  - Can no longer use "Adult Failure To Thrive" or "Debility" as a primary diagnosis.
  - Claims with "Adult Failure To Thrive" or "Debility" as a primary diagnosis after October 1, 2014 will be returned to the provider
  - Medical Director must use the "most contributory diagnosis to the condition as primary".

Hospice Information Set (HIS) 2014

- Effective July 1, 2014
  - Hospices will be required to complete and submit an HIS document at admission and discharge
- 7 NQF Endorsed Items Will Be Calculated by HIS
  - NQF#1617 – Patients who are treated with an opioid and given a bowel regimen
  - NQF#1634 – Pain screening
  - NQF#1637 – Pain assessment
  - NQF#1638 – Dyspnea treatment
  - NQF#1639 – Dyspnea screening
  - NQF#1641 – Treatment preferences
  - NQF#1647 - Beliefs/Values addressed (if desired)
- 2% reduction in APU for FY 2016 for failure to report
**Hospice Information Set (HIS) 2014**

- The Hospice Information Set (HIS)
  - Is NOT a patient assessment like the OASIS in home care
  - Will NOT replace the initial patient assessment
  - Will provide a standardized data collection set
  - Must be submitted on ALL hospice patients regardless of payer source
  - Hospice will be penalized if even one patient HIS is not submitted
  - CMS to provide HIS software free of charge
    - Beta software ready May, 2014
    - Final version ready July, 2014

**Hospice Medicare Payment Changes**

CMS’ is studying changes to the current flat rate “per day” methodology that would maintain budget neutrality with expenditures

- “U” shaped model that compensates for heavier concentration of services at the onset and the end of the LOS and reduces the daily payment rate in the middle
- Tiered approach based upon length of service
Hospice Medicare Payment Changes

- Abt Associates U shaped tiered model based upon the patient’s LOS
  - Days 1-5
  - Days 6-10
  - Days 11-30
  - Days 31+
  - Last 7 days with and without visiting services
  - *Length of stay 5 days or less*

Hospice Medicare Payment Changes

- Proposed new Medicare Cost Report will provide more detailed cost data by Level of Care.
  - Requires new General Ledger accounts
  - New Financial Statement Format
- Anticipate further payment changes as the data is collected and analyzed
Operational & Profitability Goals
2014 and Beyond

- Increase Revenues by Increasing Referrals
- Increase Clinical Staff Case Capacity by Increasing Productivity and Efficiency
- Achieve Optimum FEHC (and HIS) Scores with continuity and consistency of care
- Manage and Control the Cost per Visit by Discipline
- Manage and Provide the Proper Utilization of Services and cost per LOS

*Will your Agency’s Culture Fit These Goals?*

The Clinical Model

- Continuity and consistency of care indicates a Primary Care Case Manager RN for each patient
  - Performs the admission and weekday follow-up visits
  - Case manages and coordinates all other disciplines
  - Full-time staff and five days per week!
- Integrate initial Social Work visit with RN’s patient admission
  - More accurate picture of patient/family dynamics and needs
  - Takes over patient sign-up responsibilities from RN
The Clinical Model

- Eliminate supply closets in favor of a patient specific delivery vendor
  - Every office visit equals a patient visit!
- Eliminate unnecessary daily “stops” into the office!

Incentive Based Compensation

The Change from Managing Productivity To Real-time Clinical Case Management

- Controls the Cost per Visit and the Cost per LOS
- Eliminates management of staff visits per day
- Eliminates the search for clinicians to:
  - Cover visits
  - Admit patients
- Reduces and eliminates delinquent documentation
- Improves team chemistry
- Improves communication between the Supervisor and the Clinical Case Manager in the field
Value Clinicians

- Identify and Align Performance Incentives
- Ask Clinicians what they think!
- Educate first!
- Put your money where it will have the most effect...

Clinicians and Finance...
Work WITH your People!

- How much effort is required for your clinical staff spend:
  - In the field making visits?
  - Documenting and conferencing with other disciplines and the physician?
  - Point of Care technology?
  - Traveling
  - Participating in IDGs?
  - At staff meetings?
**Financial Impact of Clinical Operations**

- Differences in the type of visits effect per visit costs:
  - Admission
  - Follow-up
  - Crisis
  - Death
  - Telephone Follow-up

  How the stage of the terminal illness effects the length of a visit and the documentation requirements!

  Visit frequency factors and specific standards of practice effect productivity, efficiency and costs per visit and LOS!

---

**Provide the Right Tools**

**“Point of Care”**

- Clinician laptops should have Wireless feature and “Air cards” to facilitate remote syncing to system
  - Access by all disciplines to most recent documentation
  - Email and team communications
  - Transmission of patient Admission information
  - Provide power cords for laptops to car power source

- Facilitates Clinical Case Conferencing
  - Clinician and supervisor (team leader) referring to same patient records

- All RNs and Social Workers should have “smart phones”

- Provides complete up to date patient records for oncall

- Ordering non-routine medical supplies directly from vendor
Compensate Fairly
Incentive Based

Pure Incentives (Per Visit Rates -- Exempt) – Field Clinicians

- Visit Rates
  - Structured by Type and Weight of Visit, including Telephone Follow-up Visits and Meetings
- Case Management Fee for Cases Managed in a 4 week period (Calendar Month) – RNs Only!
- Paid Days Off Based Upon Average Daily Earnings initially for the Previous 12 weeks (Quarter), then 24 weeks (2 Quarters)
- Compensation Floor at 80% of Average Projected Earnings, if Advantageous
- Implementation test period(s) – staff compensated under current method with bonus payment(s) for positive differences under the new plan

---

Compensate Fairly
Incentive Based

Pure Incentives (Per Visit Rates -- Exempt) – Field Clinicians

- Visit Productivity Incentive, at $X.00 per visit for exceeding Threshold in a 12 week (Calendar Quarter) period
- Cases Managed, Layered up to 3% of Quarterly Earnings, Based Upon Threshold of Cases Managed in a 12 Week (Calendar Quarter) period
- FEHC scores, Layered up to 3% of Quarterly Earnings, Based Upon Threshold of Targeted Outcome Achievement in a 12 Week (Calendar Quarter) period
  - Hospice CAHPS results when in effect
Compensate Fairly
Incentive Based

Incentives – Clinical Supervisors (Team Leaders, etc.)

- Bonus Incentives of Visit Productivity, Cases Managed and FEHC achieved that mirror those for their staff
- Additional Incentives for team achievements could include thresholds for:
  - Timeliness of submitted documentation
  - FEHC results (Hospice CAHPS when in effect)
  - HIS results when effective

Questions Often Asked

- Recommended Clinical Model:
  - Primary Nurse – Care Management

- Productivity and Case Capacity
  - RNs: minimum 20 visits (hands on) / week
    14-15 patient Average Daily Census
  - MSWs & BSWs: minimum 20 visits (hands on) / week
    25-30 patient Average Daily Census
Questions Often Asked

**Visit weighting – RN**

- Admission 1.90
- Follow-up 1.00
- Crisis 1.30
- Death 1.30
- Telephone Follow-up 0.25
- Inservice/Preceptorship Conference 1.00
- Staff Meeting 1.50
- IDGT Meeting 1.50

### Questions Often Asked

(Visit Weight – Time Equivalents)

<table>
<thead>
<tr>
<th>Visits per Day</th>
<th>Follow-up</th>
<th>Admission</th>
<th>Crisis/Death</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visit Value</td>
<td>1.00</td>
<td>1.90</td>
<td>1.30</td>
</tr>
<tr>
<td>4.00</td>
<td>120 minutes 2 hr 00 min</td>
<td>228.0 minutes 3 hrs 48 min</td>
<td>156.0 minutes 2 hrs 36 min</td>
</tr>
<tr>
<td>4.25</td>
<td>112.9 minutes 1 hr 53 min</td>
<td>214.5 minutes 3 hr 34 min</td>
<td>146.7 minutes 2 hr 27 min</td>
</tr>
<tr>
<td>4.50</td>
<td>106.7 minutes 1 hr 47 min</td>
<td>202.7 minutes 3 hr 23 min</td>
<td>138.7 minutes 2 hr 19 min</td>
</tr>
<tr>
<td>4.75</td>
<td>102.1 minutes 1 hr 42 min</td>
<td>194.0 minutes 3 hr 14 min</td>
<td>132.7 minutes 2 hr 13 min</td>
</tr>
<tr>
<td>5.00</td>
<td>96 minutes 1 hr 36 min</td>
<td>182.4 minutes 3 hr 02 min</td>
<td>124.8 minutes 2 hr 05 min</td>
</tr>
</tbody>
</table>

All times include hands-on, documentation, travel, conference and case management time.
Goals of Aligned Incentives

“Provide the right amount of care efficiently and effectively to achieve anticipated or desired patient & financial outcomes”
Overview of Faith Hospice

- Not for profit subsidiary of Holland Home, a faith based CCRC
- Holland Home affiliates also offer skilled home health, private duty, skilled nursing facility, assisted living, independent living, and other options
- Faith Hospice was founded in 1995
- Located in Western Michigan
- Faith Hospice offers hospice services in the community as well as in our free standing hospice residence

Faith Hospice Statistics

- Hospice average daily census is 175
- 1400 deaths per year (300 of these in hospice residence)
- 50 community based hospice staff
- Service area covers 6 counties
- Average length of stay 42 days
Faith Hospice Statistics

<table>
<thead>
<tr>
<th>Days on Service</th>
<th>Faith Hospice</th>
<th>State SHP Reference</th>
<th>National SHP Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>39.9%</td>
<td>42.6%</td>
<td>35.8%</td>
</tr>
<tr>
<td>8-14</td>
<td>14.1%</td>
<td>13.1%</td>
<td>12.9%</td>
</tr>
<tr>
<td>15-29</td>
<td>14.3%</td>
<td>11.8%</td>
<td>13.0%</td>
</tr>
<tr>
<td>30-59</td>
<td>13.2%</td>
<td>10.3%</td>
<td>11.8%</td>
</tr>
<tr>
<td>60-89</td>
<td>6.1%</td>
<td>5.9%</td>
<td>6.9%</td>
</tr>
<tr>
<td>90-179</td>
<td>7.3%</td>
<td>7.5%</td>
<td>9.1%</td>
</tr>
<tr>
<td>180+</td>
<td>5.1%</td>
<td>8.7%</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

History

- Home health incentive compensation model implemented by sister company - Home Care of Holland Home in 2011
  - Visits per patient episode increased 11%
  - Census rose 15%
  - Field clinicians are more efficient and thus are earning more on average
  - Total cost per visit dropped 12%
  - Management tool to incentivize desired behaviors
  - Profitability increased additional 300.00%
History

- Our hospice was challenged by similar clinical model problems, but hospice work is completely different than home health

- Identified need for a hospice-specific incentive compensation model

Our Goals for a Hospice Incentive Compensation Model

- Higher patient and family satisfaction: more visits per patient, better staff consistency (schedule)
- Exceptional clinical quality: management oversight of clinical performance, documentation, clinical performance indicators
- Clinical staff incentives: Staff rewarded based on performance and patient/family satisfaction, with potential to increase earnings
Our Goals for a Hospice Incentive Compensation Model

- Wage expenses will track patient census
- Wage expenses will be at least budget neutral
- Evolving goal: the new model will align with hospice payment models currently under consideration by CMS- example Abt Associates U shaped tiered model
  - Days 1-5
  - Days 6-10
  - Days 11-30
  - Days 31+
  - Last 7 days with and without visiting services
  - Length of stay 5 days or less

Faith Hospice Pre-Design

1) Clinical Operations review:
   - We needed to make many operational changes to prepare for the incentive compensation model
2) Implement recommendations:
   - Realign management structure to meet expectations of the model
   - Admission Nurse model change to Primary Case Management model
   - Patient home delivered supplies
   - More documentation at point of care
   - Maximize technology
   - IDT efficiencies
**Faith Hospice Design**

3) Compensation analysis visit:
   - Selected staff who represented a range of staff abilities and territory characteristics to meet with consultant

4) Model design:
   - Analysis of current staff visit patterns
   - Analysis of non-visit activity
   - Creation of financially sustainable model

5) Introduction of custom model to clinical staff
   - Staff reaction

---

**Faith Hospice Testing and Adaptation**

6) Side by Side Testing
   - 16 weeks
   - Field clinicians begin to adapt practice patterns
   - Management learns that we must change also (office contribution to decreased productivity)
   - Field staff and management input into model

7) Model adjustment
   - Not only is hospice different from home health, but hospices are also different from one another
   - After hours nurse model (7 days on, 7 days off)
Faith Hospice
Implementation and Evaluation

8) Final Implementation
9) Bonuses
   – Difference checks during the test period
   – 12 week bonuses
   – % of staff receiving bonuses increases over time
10) Evaluation and continued adaptation

Bonus Tracking: Faith Hospice

Your solution will be software specific
Our background database tracks hands on visits and clinical points by pay period
Our database also tracks caseload daily
Quantitative bonuses are calculated automatically
Family Evaluation of Hospice Care (FEHC) survey results- Clinician Scorecard
Similarities to our Home Health Incentive Comp Model

- Weighted visit payments based on effort normally required
- Activity payments for non-visit work
- Case load payment for case managers
- 12 week incentive bonuses for productivity, case load, patient/family satisfaction

Differences from our Home Health Incentive Comp Model

Hospice
- Applies to Registered Nurses and Medical Social Workers
- Afterhours nursing staff are salaried, after hours social workers are on the incentive compensation model
- Visits are often longer and more complex

Home Health
- Applies to Registered Nurses, Physical Therapists, Occupational Therapists
- Afterhours nursing staff are on the incentive compensation model
- Visits may be shorter and more focused
### Differences from our Home Health Incentive Comp Model

<table>
<thead>
<tr>
<th>Hospice</th>
<th>Home Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Nursing visits per day: 4</td>
<td>• Nursing visits per day: 5</td>
</tr>
<tr>
<td>• Nursing points per day: 5.25</td>
<td>• Nursing points per day: 6.25</td>
</tr>
<tr>
<td>• Visit types or weights vary: admission with or without sign on, crisis, death, bereavement</td>
<td>• Visit types or weights vary: resumption of care, recertification, therapy re-evaluation</td>
</tr>
<tr>
<td>• Bonus types and thresholds vary: visits, case load, FEHC</td>
<td>• Bonus types and thresholds vary: visits, case load, HHCAHPS and HHCompare</td>
</tr>
</tbody>
</table>

### Our Early Results

- Patients/families are more satisfied (FEHC survey results are higher and significantly above State and National references since the change to Primary Case Management)
- RN Case Manager
  - Average hands on visits per day increased 12%
  - Average clinical points per day increased 11%
- Social worker
  - Average hands on visits per day increased 30%
  - Average clinical points per day increased 28%
Our Results

- RN staffing – FTEs: 10.3 to 7.40
- Average visits/day: 3.58 to 4.38
- Average visit weights/day: 3.86 to 5.72
- Average cases managed – 4 weeks: 16.6 to 22.0
- Compensation cost/visit:
  - RNs: 26.62% reduction, $99.59 to $73.08
  - MSWs: 10.56% reduction, $74.62 to $66.74
- % of Clinicians Receiving a Bonus:

<table>
<thead>
<tr>
<th>Case Management</th>
<th>Visit Productivity</th>
</tr>
</thead>
<tbody>
<tr>
<td>- RNs 66%</td>
<td>44%</td>
</tr>
<tr>
<td>- MSWs N/A</td>
<td>83%</td>
</tr>
</tbody>
</table>

Our Results

FEHC SCORES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>G1. Rating care patient received under hospice (% excellent)</td>
<td>78%</td>
<td>70%</td>
<td>67%</td>
<td>122.58%</td>
</tr>
<tr>
<td>1. Provide Coordination of Care</td>
<td>92%</td>
<td>92%</td>
<td>90%</td>
<td>109.09%</td>
</tr>
<tr>
<td>DOMAIN PERFORMANCE (NHPCO COMPOSITES)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Attend to Family needs</td>
<td>96%</td>
<td>93%</td>
<td>93%</td>
<td>85.71%</td>
</tr>
<tr>
<td>3. Provide information about Symptoms</td>
<td>91%</td>
<td>93%</td>
<td>92%</td>
<td>47.06%</td>
</tr>
<tr>
<td>4. Inform &amp; Communicate about patient</td>
<td>86%</td>
<td>83%</td>
<td>81%</td>
<td>111.54%</td>
</tr>
<tr>
<td>DOMAIN PERFORMANCE (SHP COMPOSITES)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Symptom Responses – Appropriate Level</td>
<td>97%</td>
<td>94%</td>
<td>94%</td>
<td>80.00%</td>
</tr>
<tr>
<td>6. Patient Treatment</td>
<td>93%</td>
<td>88%</td>
<td>78%</td>
<td>72.34%</td>
</tr>
<tr>
<td>7. Family Instruction/Confidence</td>
<td>83%</td>
<td>79%</td>
<td>78%</td>
<td>54.05%</td>
</tr>
<tr>
<td>8. General Staff Evaluation</td>
<td>82%</td>
<td>79%</td>
<td>76%</td>
<td>31.11%</td>
</tr>
</tbody>
</table>
Other Findings

- Attrition, retention and recruitment
- Field clinicians do not realize how much they vary from each other in their clinical practice. The model levels these differences.
  - Managers needed to coach some nurses and social workers to increase patient contacts (visits and phone calls) and improve efficiency
  - Other clinicians, who exceeded expectations prior to compensation model implementation, needed coaching to avoid overwork and burnout

Advice for those contemplating an incentive compensation model:

- Check your motives: patient, family, and staff satisfaction; quality of care reasons
- Don’t use your home health model for hospice
- Ensure the management team is on board
- Involve physicians. Their support is key!
- Be prepared for some turnover
- Be willing to adapt your clinical model and your non-visit activity expectations of field staff
Advice for those contemplating an incentive compensation model:

- Be ready to prepare comparative pay period reports by individual before the start of the side by side period
- Share results as timely as possible with management team and field staff
- Schedule one on one meetings with field clinicians
- Understand there will be triangulation amongst staff
- Identify and encourage champions among field clinicians

Advice for those contemplating an incentive compensation model:

- Ensure Finance, Human Resources and Information Services staff are involved from the beginning and ready for implementation
- Pay the difference, during the test period!
- Successful implementation takes significant time and effort on the part of both field and management staff
- We believe the hospice incentive compensation model will be good for patients, families and staff; and position us for coming changes
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