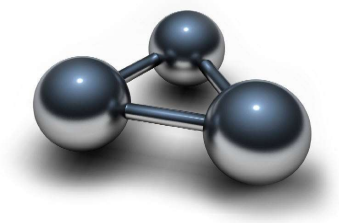
Inpatient Units

& the Model



Presented by
Andrew Reed, System Analyst, CPA
CEO & Chief Teaching Officer
Multi-View Incorporated

MVI Multi-View Incorporated SYSTEMS

The Model™ Balancing Purpose and Profit...

1

With this knowledge, you can…

Write your OWN TICKET in Hospiceland!

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2

3

How Perfect Visits Cure Virtually All Quality & Financial Woes!

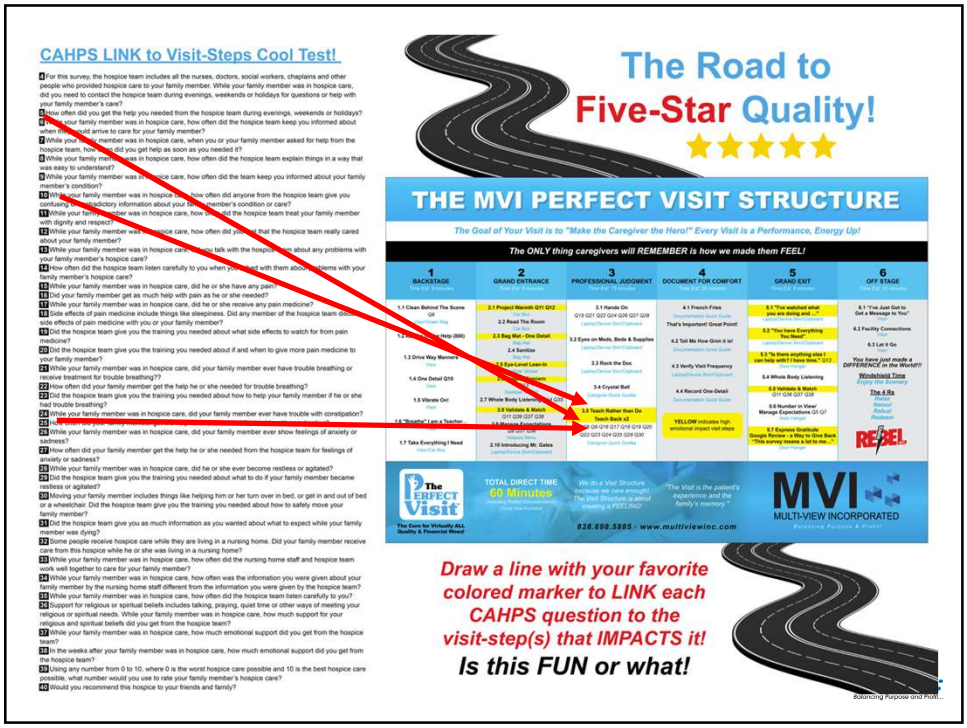
1. Patients/Families are Happy! Complaints are RARE.
2. Team sizes of Clinical Managers easily increase.
3. Billing goes out on time with little effort.
4. Less Compliance Staff are needed.
5. Marketers don't have to Lie…Quality is easy to sell in a broken healthcare world.
6. Census increases as a direct result of radically increased QUALITY!
7. Financials surge.
8. CAHPS scores surge.
9. Less Staff are needed and organizations can flatten.
10. You don't have to worry about a ZPIC (or similar) KILLING you off! You're tight!

The Model
Balancing Purpose and Profit...

4


MVI
MULTI-VIEW INCORPORATED
Magic
Implementing 94 Action Steps in 5-8 months that will Transform an Organization's Quality & Economics!
A Quality Program that transforms an organization into a coherent, fully-integrated "System of Care" where all parts work together, based on intense FOCUS on Quality accompanied by phenomenal Economics as a natural by-product.
Here what we implement!
Call/Email For Information!
828.698.5885
mvi@multiviewinc.com
FOCUS/ACTION ITEMS:
94 Action Steps
The PERFECT Visit
This is your most CERTAIN and FASTEST way to get Operations towards the 90th percentile!
The Model
Balancing Purpose and Profit...

5


CAHPS LINK to Visit-Steps Cool Test!
The Road to Five-Star Quality!
THE MVI PERFECT VISIT STRUCTURE
The Goal of Your Visit is to "Make the Caregiver the Hero!" Every Visit is a Performance, Energy Up!
The ONLY thing caregivers will REMEMBER is how we made them FEEL!
Draw a line with your favorite colored marker to LINK each CAHPS question to the visit-step(s) that IMPACTS it!
Is this FUN or what!
MVI
MULTI-VIEW INCORPORATED

6

FOCUS! Action Items!

People Development/Education

1. Operational Manual – Use the Extraordinary Clinical Leader as the basis.
2. 3 Questions at IDTs
3. Gratitude/Attitude Book
4. Patient Chair
5. Patient Chair Bands (for Flexible Training Situations and Marketing)
6. Perfect Visit Structure
7. Perfect Visit Video – Using the Modular Method
8. Perfect Visit Audio (extracted from Perfect Visit Video) Use the SAME!
9. Visit-Step IRMs
10. Perfect Visit PowerPoint
11. Narrated Perfect Visit PowerPoint
12. Pre-Recorded Visit Scenario – Basic
13. Pre-Recorded Visit Scenario – Caregiver and Patient
14. Pre-Recorded Visit Scenario – Reluctant Caregiver
15. Pre-Recorded Visit Scenario – Service Failure
16. Pre-Recorded Visit Scenario – Visit from Hell
17. Negative Example of Each Visit-Step
18. Test #1 - Perfect Visit – Why/Meaning Test
19. Test #2 - Timed 5-Minute Test
20. Test #3 – CAHPS Linkage to Visit-Steps Test
21. Manikins – Patient and Caregiver
22. Wall Drops – Kitchen/Living Room – Nursing Home
23. Lab Threshold
24. Lab Video Setup
25. Storing Videos Conventions
26. Standards Cards
27. Flashcards
28. Diagnosis Guides
29. Perfect Phone Pads
30. Pre-Recorded Phone Scenarios
31. Phone Test
32. Perfect Phone Audio Explanation/MP3
33. Look Book – with Meaning of the Colors and teaching Body Language
34. WOW! Training Programs for Nursing Homes and Facilities/Groups
35. Empowerment Programs – Links with Volunteer and Fundraising

The Model
Balancing Purpose and Profit...

7

FOCUS! Action Items!

Finance

36. Get Benchmarking going! For the intelligent direction of Energy and Resources based on precise information. Also, to help review/clean-up accounting and gain confidence in financials.
37. Set Profit Standard
38. Set NPR% Standards for each area and department.
39. Team/Location Report
40. Comprehensive Report
41. Establish Objective Monitoring Function
42. Compensation Structural and Methodology Work (See Compensation Manual)

Compliance/Quality

43. Perfect Documentation – COPD
44. Perfect Doc – CHF
45. Perfect Doc – Dementia
46. Perfect Doc – Cancer
47. Encapsulated/laminated Documentation Language Cheat Sheet
48. Non-Wounding Emails
49. Non-Standard Documentation Error Codes
50. Coach-Up Documentation Points
51. Documentation Audit Sampling Tracking
52. Payroll Report of Non-Standard Documentation Pay Period

IT/Website

53. Contact and give access to EMR to MVI – Get MagicViews and Payroll extract going
54. iPhone Recording Setup Conventions
55. Employee/Candidate Video Folder on Network
56. Teaching Video File Naming Convention
57. Accountability Video File Naming Convention
58. Extraordinary Employment Opportunities on Website
59. Steve Byrum – Hartman Value Profile
60. Website – Competency Test by Discipline with Written Narrative
61. Training Room Recording – Easy Setup for Audio – iPhone and where to store
62. Website use of Sequenced, Short Videos that "lead though" the process

HR

63. How to Sell the Compensation System
64. Standardize Phone Interview
65. Standardized Formal Interview Structure
66. Video Release Form
67. Accountability Contract
68. Offer Letter and Cool Box
69. Hiring Profiles for all Positions
70. 10/2 Cross-Training Tracking

The Model
Balancing Purpose and Profit...

8

FOCUS! Action Items!

Marketing

71. Perfect Marketing/Sales Call Visit Structure
72. Perfect Marketing Toolkit/ Marketing "Pitch Sheets/Resources
73. Perfect Marketing/Sales Call Video – Modular Method
74. Marketing IRMs (Visual Controls)
75. Perfect Marketing/Sales Call Audio
76. Perfect Marketing Call Scenarios
77. Perfect Emails
78. Perfect "Positive Jarring" Voice Messages for Gatekeeper BREAKTHROUGHS!
79. Rock the Doc Box and Letter
80. Nursing Home "Turf" Documentation book

Volunteers

81. WOW! Life-Changing Volunteer Training – with Accountability Contract
82. WOW! Training Events (Links with People Development)
83. Database to MATCH Volunteers to Patients and Functions
84. 2 Trained Volunteers for Each Church and Civic Group

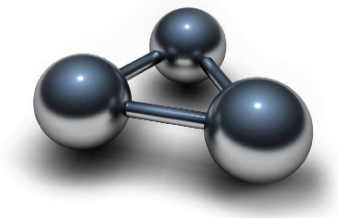
Bereavement

85. Certification in EMDR
86. Certification in IADC
87. Use of Hemi-Sync and other facilitation of Direct Experience
88. Training in how to elegantly "introduce" these Revolutionary Technologies and Methods

The Model
Balancing Purpose and Profit...

9

BASIS: Over 447 Hospice IPUs, not including IPUs we didn't help with during the planning & construction phase.



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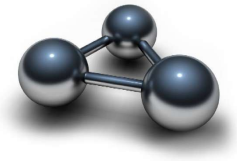
10

As you will see, if you can average a single additional patient a day annually as a result of the program, you will increase your bottom-line

from $150K to $225k.



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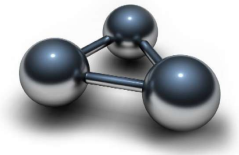
11

Regarding the Profitability of Hospice IPUs, the 90th Percentile has a profit of

10.35%

Of NPR. However, the "typical" IPU loses -18.85%.



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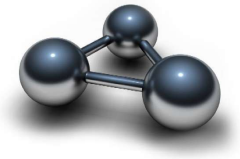
12

Suppose your Hospice's IPU loses -24% per year over 10 years...and that annual loss is $150,000... That's...

$1,500,000

that could have been used to pay people better or build reserves.



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13

Reality

IP Unit ~ Net Percentage of Revenue Comparison

Sunny Day Hospice | 2025 - YTD May

MVI Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data / Alerts	Variance of Median 10.00%	Median	10th Percentile	90th Percentile	MVI Model	Your Rank 20%	Count 334	Locations 759
Outpatient			0.17%	0.74%	0.01%	0.15%		45	199
Oxygen			0.61%	1.97%	0.17%	0.60%		100	254
Pagers			0.03%	0.15%	0.02%			5	8
Pharmacy			3.88%	6.71%	1.96%	3.50%		171	413
Therapies			0.29%	2.80%	0.02%	0.30%		86	262
Pass-Through Residual			0.04%	6.17%	-1.51%			46	168
Total			14.00%	22.76%	7.48%	12.00%		178	428
Total Direct Expense			88.03%	116.78%	63.46%	74.50%		183	440
Contribution Margin			**12.09%**	**-16.22%**	**36.54%**	**25.50%**		**182**	**439**
Indirect Expense			29.14%	56.67%	11.72%	18.00%		186	445
Net Segment Income			**-18.85%**	**-73.54%**	**10.35%**	**7.50%**		**184**	**441**

MVI Multi-View Incorporated

14

Reality: NPR

IP Unit ~ Net Percentage of Revenue Comparison

Sunny Day Hospice | 2025 - YTD May

MVI Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data	Variance of Median	Median	10th Percentile	90th Percentile	MVI Model	Your Rank	Count 334	Locations 759
Alerts		10.00%					20%		
Revenue									
Medicare			84.01%	57.93%	100.66%			179	437
Medicaid			5.06%	1.33%	11.78%			161	402
Commercial Benefit			7.78%	3.85%	20.06%			165	405
Commercial FFS			0.73%	0.73%	0.73%			1	1
Medicaid RB (own unit)			3.86%	0.03%	11.59%			12	25
Other RB (own unit)			7.24%	0.77%	48.56%			89	238
Physician Billing			5.11%	1.13%	10.10%			94	203
Self Pay			1.82%	0.33%	19.55%			114	306
Other Charity Rev			2.04%	0.27%	6.62%			68	183
Adjustments			-6.95%	-30.05%	-0.87%			163	407
Total	100.00%		100.00%	100.00%	100.00%	100.00%		188	447

MVI Multi-View Incorporated

15

Reality: NPR

IP Unit ~ Net Percentage of Revenue Comparison

Sunny Day Hospice | 2025 - YTD May

MVI Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data	Variance of Median	Median	10th Percentile	90th Percentile	MVI Model	Your Rank	Count 334	Locations 759
Alerts		10.00%					20%		
Direct Labor									
Nurses			46.35%	72.00%	34.59%	35.00%		181	438
HHA/CNA			15.96%	25.39%	8.96%	15.00%		171	420
SW			2.88%	5.28%	1.67%	3.00%		138	354
Spiritual Care			1.34%	3.01%	0.65%	1.00%		104	298
Physician/NP			4.78%	13.49%	0.21%	4.00%		138	311
On-Call			0.24%	1.40%	0.03%			32	110
Admissions			2.88%	9.07%	0.70%	2.50%		59	130
Bereavement			0.79%	2.10%	0.21%	1.00%		60	149
Volunteer			0.66%	1.98%	0.16%	1.00%		68	170
Call Center			0.80%	4.11%	0.11%			11	38
Total			74.74%	102.05%	53.78%	62.50%		184	441

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16

Reality: NPR

IP Unit ~ Net Percentage of Revenue Comparison
Sunny Day Hospice 2025 - YTD May

Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data	Variance of Median	Median	10th Percentile	90th Percentile	MVI Model	Your Rank	Count 334	Locations 759
Alerts		10.00%					20%		
Direct Patient-Related Expenses									
Ambulance			1.49%	4.09%	0.20%	1.00%		154	399
Bio Hazardous			0.15%	0.57%	0.04%	0.15%		88	214
Crisis Care			0.11%	0.42%	0.01%	0.20%		6	17
Dietary			0.34%	2.87%	0.01%	0.50%		44	77
DME			0.53%	1.75%	0.07%	0.45%		139	332
ER			0.05%	0.65%	0.02%			17	97
Food			2.02%	7.21%	0.50%	2.00%		164	385
Imaging			0.04%	0.20%	0.01%	0.05%		58	204
Lab			0.05%	0.34%	0.01%	0.05%		82	269
Linen			0.97%	2.51%	0.11%	1.00%		129	351
Medical Supplies			2.07%	3.50%	1.08%	1.75%		176	434
Mileage			0.12%	0.44%	0.02%	0.10%		127	348
Mobile Phone			0.10%	0.44%	0.02%	0.10%		81	238
Other			0.20%	0.59%	0.02%	0.10%		101	238
Outpatient			0.17%	0.74%	0.01%	0.15%		45	199
Oxygen			0.61%	1.97%	0.17%	0.60%		100	254
Pagers			[illegible]	0.15%	0.02%			5	8
Pharmacy			3.88%	6.71%	1.96%	3.50%		171	413
Therapies			0.29%	2.80%	0.02%	0.30%		86	262
Pass-Through Residual			0.04%	6.17%	-1.51%			46	168
Total			14.00%	22.76%	7.48%	12.00%		178	428
Total Direct Expense			88.03%	116.78%	63.46%	74.50%		183	440

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17

Reality: Patient-Day

IP Unit ~ Patient-Day Comparison
Sunny Day Hospice 2025 - YTD May

Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data	Variance of Median	Median	10th Percentile	90th Percentile	MVI Model	Your Rank	Count 334	Locations 759
Alerts		$ 10.00					20%		
Direct Labor									
Nurses			$ 332.22	$ 490.24	$ 203.61			181	438
HHA/CNA			108.81	173.42	52.95			171	420
SW			20.60	41.80	10.70			138	354
Spiritual Care			10.58	22.76	4.12			104	298
Physician/NP			32.63	107.15	1.42			137	310
On-Call			1.24	14.70	0.05			36	121
Admissions			21.94	61.72	4.72			59	130
Bereavement			5.17	15.80	1.72			61	159
Volunteer			4.65	14.56	1.14			68	170
Call Center			5.18	20.66	0.64			11	38
Total			$ 520.42	$ 718.35	$ 315.98			183	440
Direct Patient-Related Expenses									
Ambulance			$ 9.54	$ 28.73	$ 1.40			154	399
Bio Hazardous			1.10	4.21	0.27			88	214
Crisis Care			0.70	2.64	(0.32)			7	20
Dietary			1.57	17.23	0.03			50	88
DME			3.27	12.18	0.56			139	332
ER			0.39	4.41	0.08			18	98
Food			14.06	52.10	2.94			163	384
Imaging			0.28	1.44	0.07			61	207
Lab			0.26	1.71	0.02			97	307
Linen			7.18	17.82	0.91			128	350
Medical Supplies			14.07	26.42	6.82			174	432
Mileage			0.81	2.92	0.09			134	361
Mobile Phone			0.65	2.73	0.12			83	240
Other			1.12	4.61	0.10			103	247
Outpatient			0.87	6.64	0.04			48	205
Oxygen			4.58	12.80	1.30			101	255
Pagers			0.15	3.05	0.01			6	9
Pharmacy			24.65	53.01	12.44			171	413
Therapies			1.70	20.43	0.10			87	264
Pass-Through Residual			0.14	36.39	(8.51)			50	179
Total			$ 98.41	$ 180.20	$ 38.43			177	427
Total Direct Expense			$ 612.21	$ 866.13	$ 382.68			182	439

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18

To be an

Extraordinary Clinical Leader

1. Learn how to **INSPIRE** others…by **Endearing** the People You Lead to Embrace the **Profound**…
2. Learn how to **FOCUS** and Self-Regulate. This is Self-Control.
3. Work on your People/**Teaching Skills** and increasing your consciousness/ energy/atmosphere… This will make you extremely attractive and will inspire others. Work at your Spirituality, which is beyond measurement! This will help shape a non-critical and truly helpful attitude towards Life and others.
4. Know the **Perfect Visit with Perfect Documentation**... COLD!
5. Learn how to teach using *System7* to make knowledge deficits impossible.
6. Understand the **"Awakened/Liberated " State of Self-Ownership/Accountability** on a DEEP level. And BE able to EFFECTIVELY TEACH the TOPIC!
7. Know National Benchmarking metrics of the *norms of quality and cost* for professional perspective so that you know REALITY. NPR percentages, Median Caseloads, Visit Durations, Profit Margins, CAHPS, etc.
8. Teach the "Best Known Patterns" continually…
9. Increase your **Energy of CONFIDENCE** through study and successful practice under stress conditions or overcoming resistance/fear.

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IDT Question #1

What are You?

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20

IDT Question #2

What do you see yourself as?

21

IDT Question #3

What day is it?

Followed by a "Call Out"
- Looking for Accountability

22

Who are You?
Who am I?

The important question is
"what" are you?

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23

Evolution or De-Evolution?

MVI

24

Receiving the State *Malcolm Baldrige* Quality Award

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25

The Model has "transformed" slow, bureaucratic and low-trust cultures into award-winning, high-trust, "Best Places to Work" with single digit turn-over!

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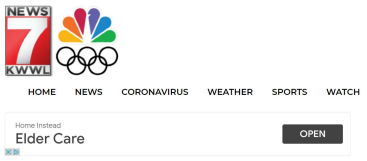
26

National Gallup Exceptional Workplace Award

Cedar Valley Hospice wins 2nd National **Gallup** Exceptional Workplace **Award**. For the second year in a row, we have been **awarded** the **Gallup** Exceptional Workplace **Award**. This **award** is **Gallup's** premier recognition for engaged workplace cultures, presented only to organizations that meet rigorous standards of excellence.

https://www.cvhospice.org › Gallup

Cedar Valley Hospice wins 2nd National Gallup Exceptional ...



Cedar Valley Hospice wins national Gallup award second year in a row

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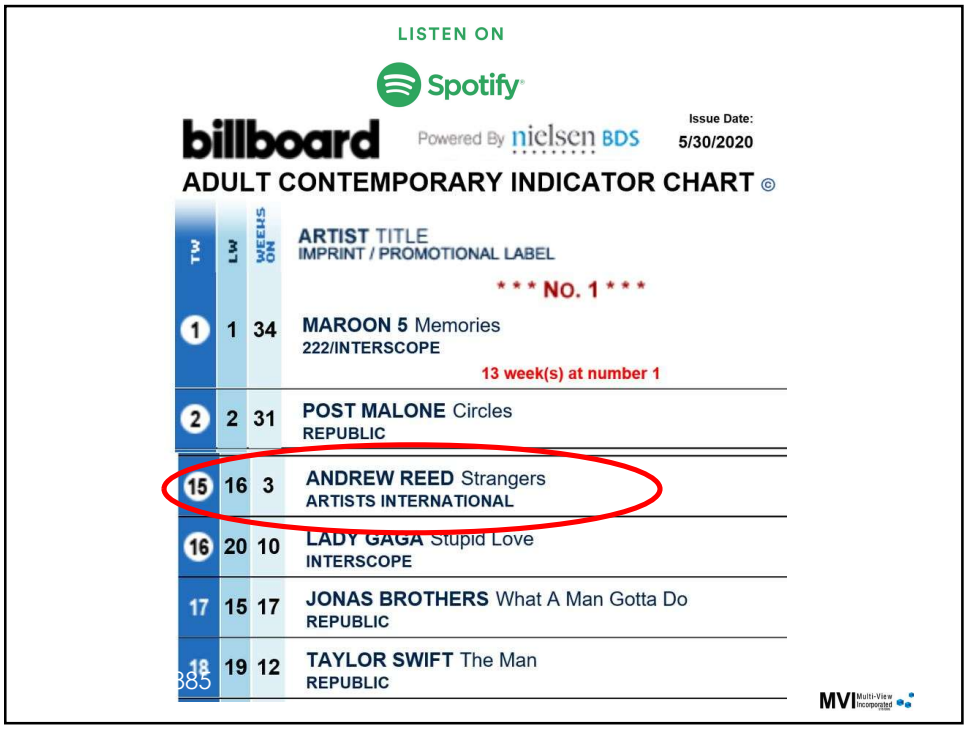
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Powered By nielsen BDS
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5/30/2020
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*** NO. 1 ***
1 1 34 MAROON 5 Memories
222/INTERSCOPE
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2 2 31 POST MALONE Circles
REPUBLIC
15 16 3 ANDREW REED Strangers
ARTISTS INTERNATIONAL
16 20 10 LADY GAGA Stupid Love
INTERSCOPE
17 15 17 JONAS BROTHERS What A Man Gotta Do
REPUBLIC
19 12 TAYLOR SWIFT The Man
REPUBLIC
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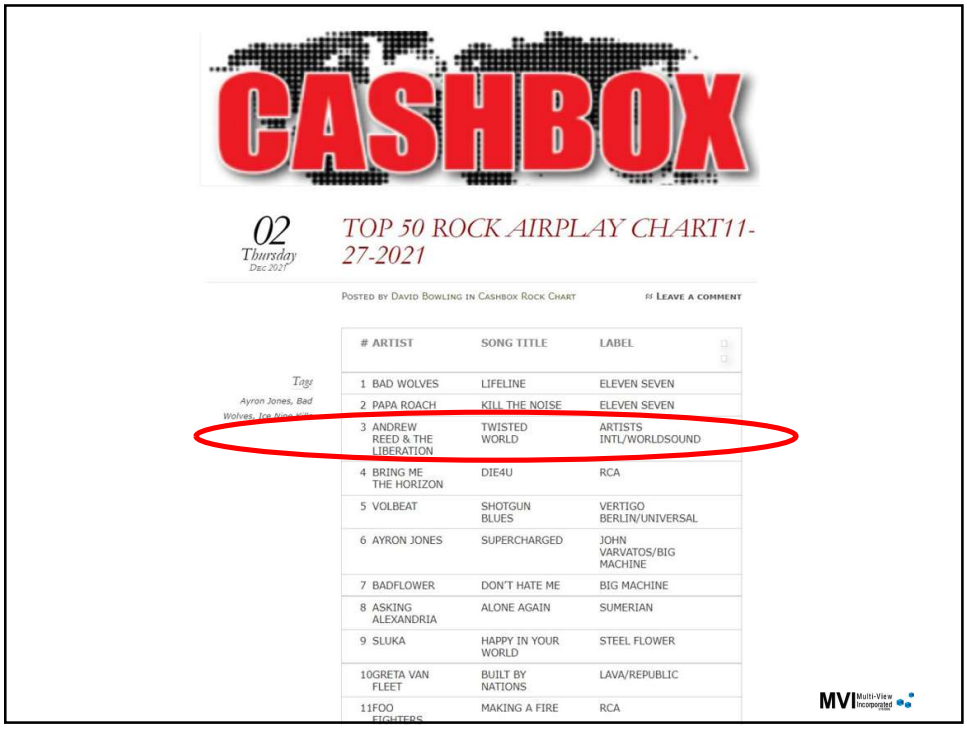
29


CASHBOX
02 Thursday Dec 2021
TOP 50 ROCK AIRPLAY CHART11-27-2021
Posted by David Bowling in Cashbox Rock Chart
Leave a comment
ARTIST SONG TITLE LABEL
1 BAD WOLVES LIFELINE ELEVEN SEVEN
2 PAPA ROACH KILL THE NOISE ELEVEN SEVEN
3 ANDREW REED & THE LIBERATION TWISTED WORLD ARTISTS INTL/WORLDSOUND
4 BRING ME THE HORIZON DIE4U RCA
5 VOLBEAT SHOTGUN BLUES VERTIGO BERLIN/UNIVERSAL
6 AYRON JONES SUPERCHARGED JOHN VARVATOS/BIG MACHINE
7 BADFLOWER DON'T HATE ME BIG MACHINE
8 ASKING ALEXANDRIA ALONE AGAIN SUMERIAN
9 SLUKA HAPPY IN YOUR WORLD STEEL FLOWER
10 GRETA VAN FLEET BUILT BY NATIONS LAVA/REPUBLIC
11 FOO FIGHTERS MAKING A FIRE RCA
MVI

30

Professional Perspective

LISTEN ON Spotify

NEW MUSIC WEEKLY

HOT 100

LWP	TWP	Artist - Song Title (Label)
1	1	**Weeknd** - Blinding Lights (Republic/UMG)
3	2	**Harry Styles** - Adore You (Erskine/Columbia)
2	3	**Justin Bieber w/Quavo** - Intentions (RBMG/Def Jam/UMG)
5	4	**Andrew Reed** - Strangers (Artists International)
4	5	~~Doja Cat - Say So (Kemosabe/RCA)~~
6	6	Dua Lipa - Don't Start Now (Warner Music)
11	7	**Lady Gaga & Ariana Grande** - Rain On Me (Interscope)
9	8	**Ariana Grande & Justin Bieber** - Stuck With You (Def Jam/UMG)
7	9	Lady Gaga - Stupid Love (Interscope)
10	10	**Dua Lipa** - Break My Heart (Warner Music)
8	11	Camila Cabello w/DaBaby - My Oh My (Syco/Epic)
12	12	**Megan Thee Stallion** - Savage (300 Entertainment)
17	13	**JP Saxe w/Julia Michaels** - If The World Was Ending (Arista/Sony)

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31

INDIE MUSIC

SINGLES CHART

Compiled by STS, the radio industry's leading radio airplay chart data system, of independently released singles of the week, based o

LWP	TWP	Artist - Song Title (Label)
1	1	**Andrew Reed** - Strangers (Artists International) **10 Weeks**
2	2	**Megan Thee Stallion** - Savage (300 Entertainment)
3	3	**December Rose** - When We Were Young (Indie)
5	4	**Rami 411** - Dream (Indie)
4	5	Black Pontiac - November State Of Mind (Appreciated Music)
6	6	**Jerry Cherry** - Miracle (Sweeter)
8	7	**Trevor Daniel** - Falling (Alamo)
9	8	**Linards Zarins** - I Miss You (Spinnup)
11	9	Garrett Young - Do You Hear My Cries (West Coast Collective)
14	10	**Emmanuelle Sasson** - Away From Me (Indie)
13	11	**Rachel Farris** - Light Me Up (Indie)

If you are inclined, Follow and Listen on **Spotify**…
Good Karma!

LISTEN ON Spotify

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32

Professional Perspective

DRT GLOBAL TOP 50 ADULT CONTEMPORARY AIRPLAY CHART
04-07-2018

#	ARTIST	SONG TITLE	LABEL
1	ED SHEERAN	PERFECT	ATLANTIC UK
2	P!NK	BEAUTIFUL TRAUMA	RCA
3	IMAGINE DRAGONS	WHATEVER IT TAKES	KIDINAKORNER/INTERSCOPE
4	PORTUGAL. THE MAN	FEEL IT STILL	ATLANTIC
5	P!NK	WHAT ABOUT US	RCA
6	ED SHEERAN	SHAPE OF YOU	ATLANTIC UK
7	CHARLIE PUTH	HOW LONG	ARTIST PARTNER/ATLANTIC
8	IMAGINE DRAGONS	THUNDER	KIDINAKORNER/INTERSCOPE
9	DUA LIPA	NEW RULES	WARNER BROTHERS
10	MAX	LIGHTS DOWN LOW	RED/SONY
11	ALICE MERTON	NO ROOTS	MOM & POP/RED
12	MAROON 5	WAIT	222/INTERSCOPE
13	JUSTIN TIMBERLAKE	SAY SOMETHING (FEAT. CHRIS STAPLETON)	RCA
14	CAMILA CABELLO	NEVER BE THE SAME	SYCO/EPIC
15	ANDREW REED	IF ALL THE WORLD WERE RIGHT	ARTISTS INTERNATIONAL
16	SHAWN MENDES	IN MY BLOOD	ISLAND/REPUBLIC
17	CAMILA CABELLO	HAVANA (FEAT. YOUNG THUG)	SYCO/EPIC
18	CHARLIE PUTH	ATTENTION	ARTIST PARTNER/ATLANTIC
19	ZEDD & MAREN MORRIS & GREY	THE MIDDLE	INTERSCOPE

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Issue Date: 7/7/2018

MAINSTREAM TOP 40 INDICATOR CHART ©

TW	LW	WEEKS ON	ARTIST TITLE / IMPRINT / PROMOTIONAL LABEL	PLAYS TW	PLAYS +/-	AUDIENCE MILLIONS	AUDIENCE RANK
			*** NO. 1 ***				
1	1	17	**BAZZI** Mine IAMCOSMIC/ATLANTIC 3 week(s) at number 1	4282	-43	4.463	1
2	2	16	**POST MALONE FEAT. TY DOLLA $IGN** Psycho REPUBLIC	4061	-1	4.339	2
3	4	10	**ARIANA GRANDE** No Tears Left To Cry REPUBLIC	3862	+87	4.009	6
4	6	18	**MARSHMELLO & ANNE-MARIE** Friends JOYTIME COLLECTIVE/ASYLUM/WARNER BROS.	3664	+131	4.198	4
5	3	26	**CAMILA CABELLO** Never Be The Same SYCO/EPIC	3512	-317	4.216	3
6	5	21	**ZEDD, MAREN MORRIS & GREY** The Middle COLUMBIA NASHVILLE-INTERSCOPE	3490	-157	4.078	5
7	7	13	**SHAWN MENDES** In My Blood ISLAND/REPUBLIC	3407	-99	3.723	7
8	8	15	**TAYLOR SWIFT** Delicate BIG MACHINE	3176	+41	3.417	8
29	25	14	**LOGIC & MARSHMELLO** Everyday VISIONARY/DEF JAM				
30	30	3	**BTS** Fake Love BIGHIT ENTERTAINMENT/COLUMBIA				
31	31	6	**ANDREW REED** If All The World Were Right ARTISTS INTERNATIONAL				
			◄ NEW ►				
32	–	1	**JENNIFER LOPEZ FEAT. CARDI B & DJ KHALED** Dinero				

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What are You?

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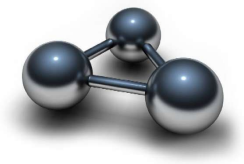
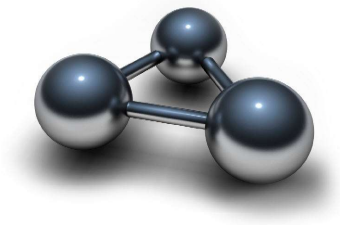
You will organize your IPU around the Feeling!



36

With each interaction we are…

Creating the Experience or Feeling



A system of care that starts with the **meticulous** creation of the patient/family experience and gracefully engineers all supportive structures to make sure that the feeling is created for every patient, every time…a world of **non-exception**.

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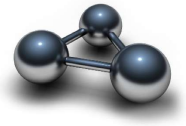
A Hospice doing the **Model** has

considered every aspect of the care experience and cares enough

to create that experience for every patient, every time, every patient, every time, every, every patient, every time…



38

A Hospice doing the **Model** has considered **every**

word and phrase

smell

image

our look, uniform

activity

from the viewpoint of

"How does it make a person feel?"

39

Can we Simplify the Business of Hospice to
"We are here to simply make people feel better!"
And organize everything else around that?

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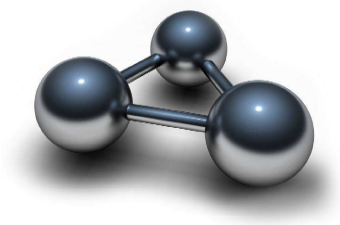
What is the Model?



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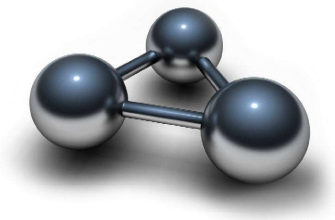
Best Definition of the Model:

The Creation[1] of a High-Quality[2], Predictable[3] Experience[4]



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Steps to Implement the Model

1. MVI Financials Make it EASY for Managers to FOCUS and precisely direct Energy[1] & Resources[2]
2. Benchmark To Develop Professional Management Perspective
3. Create Your Model/Standards Clear, Impressive & Sustainable
4. Focus on Perfect Phones, Perfect Visits & Revolutionary Bereavement
5. SuperPay! Align Compensation System (Auto-Accountability) with Model/Standards
6. Evolve an World-Class People Development System
7. Create a Life-Changing Experience & Volunteer Focus

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Where to Start to Get Things MOVING Quickly!

Because MVI is DEEP…with hundreds of tools, reports, training materials…sometimes people experience the feeling of OVERWHELM! And the question, *"Where do I Start?"* To make it simple, here is a good 3-Step plan! Which you will continue to improve, at your own pace, over time!

Where to Start?

To Standardize and Create World-Class Quality & a Coherent, Completely Integrated Organization.

First

Get Financial Reporting & Benchmarking Setup.
Why? So you can *precisely* determine *exactly* where to go to work and apply Best Known Practices!

Also First

FOCUS on Perfect Visits with Perfect Documentation.
Why? Virtually ALL of an organization's woes can be cured, Quality & Economic, with this *single* move!

Evolve

EVOLVE your Compensation System with a few elegant moves to Sure-Up Accountability!
Why? Without Accountability, Standards become "suggestions." Lack of Accountability is the root of the failure of most organizations and serious initiatives. The Compensation System is the *easiest* way to increase Accountability and REWARD the Talented and Productive! As well as remove those that destroy Happy Cultures! Let the "system" do the Accountability for you!

The Model

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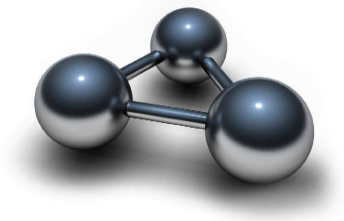
Less done extraordinarily well is vastly better than more done sloppily.



Big Model Concept #2

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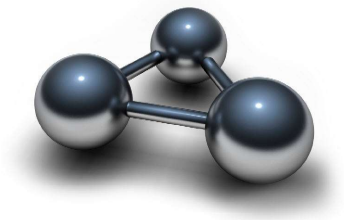
All working policies and procedures must be able to be memorized or recalled in order to be operationalized.



Big Model Concept #3

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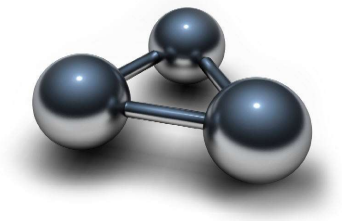
It is impossible for an organization (IPU) to become extraordinary without an extraordinary People Development System.



Big Model Concept #4

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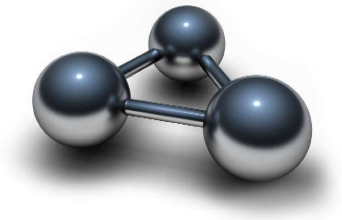
There is incredible value in high-quality

Predictability!



Big Model Concept #4

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The Variability of Care Problem in Hospiceland

There are tremendous differences in the quality of care provided by different Hospices as well as individual clinicians within Hospices.

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Variability of Care/Quality

- **RN A**
  - Creates an excellent patient/family experience
- **RN B**
  - Creates an average patient/family experience
- **Hospice Aide A**
  - Creates an OK patient/family experience
- **Hospice Aide B**
  - Creates a horrible patient/family experience

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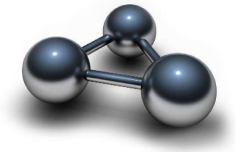
You have to see it...

Before you can Build it!



If you can't see it,
you can't build it...

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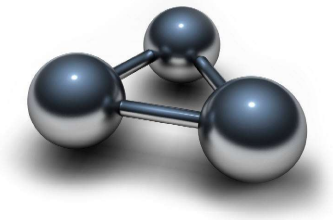
You Were Hired with an Assumption...



What was that Assumption?

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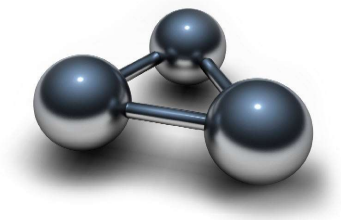
What is Management?



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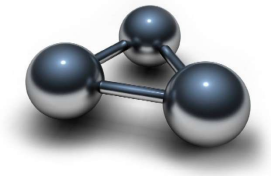
It is the direction of energy[1] and resources[2] towards the fulfillment of the mission or purpose.



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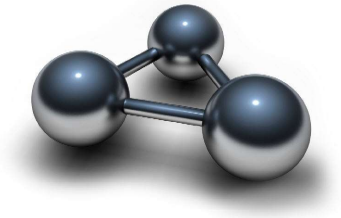
The Essence of Management is Self-Control!



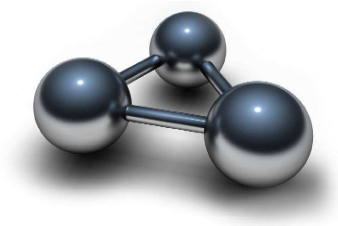
55

As you will see, if you can average a single additional patient a day annually as a result of the program, you will increase your bottom-line

from $150K to $225k.

56

Self-Control comes from Confidence and Confidence comes from Practice.



A person without confidence cannot have Self-Control, especially under stress conditions as a person will revert to the lowest level of his or her understanding in this state. This is why we use *System7*.

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Gaining Professional Perspective

The Profit Reality In Hospice

Our current reimbursement is
more than enough
to fund World-Class Hospice operations. This is evidenced by the lack of interest in understanding costs sufficiently to become true managed care organizations, professionals at mix and risk management.

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The Profit Reality In Hospice

The profitability of a well-run Hospice can be astounding without sacrificing quality. In fact, both can be raised to world-class standards (the 90th percentile) with deliberate focus. The profit reality in Hospice is that there are Hospices that provide award-winning quality and have profits of 35% of NPR (Net Patient Revenue). I have personally helped create the proprietary Models for many such entities. Of course, this will translate into "doing" things that only outliers and the minority of Hospices do. This takes overcoming the fears with associated such actions.

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How can a NFP Hospice NOT make Money?

- A typical everyday Hospice can have a **13%** operational margin from Hospice Homecare.
- Community Support - People actually write checks NFP Hospices!
- An NFP doesn't pay out **40%** of its profits in taxes!
- Some NFPs have an easier time recruiting Volunteer labor.

For-Profit Hospices work at a huge financial disadvantage.

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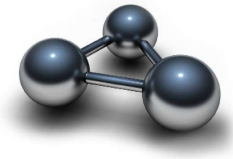
Regarding the Profitability of Hospice IPUs, the 90th Percentile has a profit of

10.35%

Of NPR. However, the "typical" IPU loses -18.85%.



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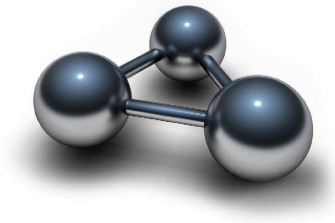
Outliers



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The Value of Humility

A spirit and attitude of Humility and Openness allows a person to consider alternative views and beliefs. Pride and fear shut a person off from new learning. We have to "let go," at least temporarily, of what we perceive we know to make "space" for alternative ways to look at things! This comes from the domain of **Integrity**.

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Understanding the Nature of Best Known Practices & Human Behavior

The 3 Phases of Best Known Practices:

1. Ridicule
2. Contempt
3. Acceptance

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Why do people often have a hard time implementing Model Practices?

These are not uncommon to virtually all Best Known Practices from use of penicillin to the idea that the earth is not flat or that washing hands decreases infections… All revolutionary ideas…

1. **Unfamiliarity** – Humans gravitate to the familiar and comfortable. We are habit-creatures…and new habits or thinking takes effort, and often courage.
2. **Lack of Confidence/Belief in the Practices** – Implementers lack the experience of seeing the practice work and the results. MVI is not theory-based or academic…but pragmatic – "what has worked"… We have direct or observed experience which gives us incredible confidence in the practices espoused. Adopters often must trust until they gain the first-hand experience and see the results in CAHPS scores, in turnover %s, and the financials.
3. **For CEOs, Fear of Public Humiliation** – This is one of the greatest fears of humans. Being an Outlier takes guts… People are not usually treated well when they deviate from the Herd…even if they do well!

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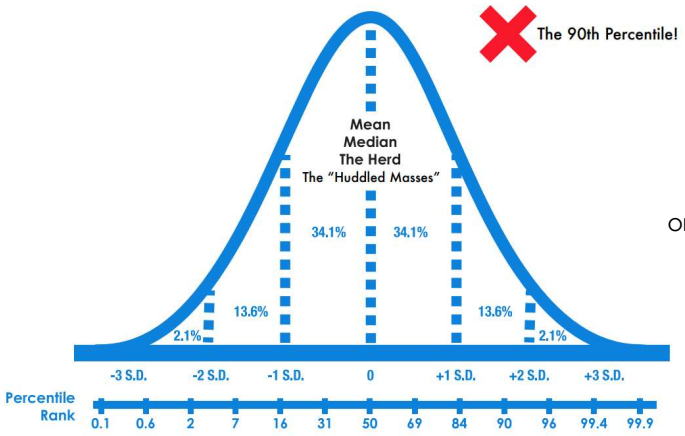
Normally Distributed Bell Curve



Elevated Consciousness of Integrity

100% of the organizations in the 90th percentile long-term:

1) Use unique/powerful methods of People Development.

2) Are highly "spiritual" organizations.

3) Have unique and different compensation practices that DO the ACCOUNTABILITY as most humans won't…

The Model Balancing Purpose and Profit…

66

Take Aways of the 90th Percentile

- Directional Correctness –
  - 1) Teaching –Teaching Accountability
  - 2) Spirituality – Teaching Accountability
  - 3) Comp Systems – TEACHING Accountability
- Accurate Thinking – No "Fantasies" about Life
- Taking Accountability for Your Organization
  - Ability to Attract & Retain Clinicians
  - Economics
  - Quality
  - "We don't have time"
  - Without Benchmarking, you are operating pretty much blind… Your internal budget doesn't mean "squat" to the outside world…

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What we will discover about the adoption of Best Known Practices or the Model is that it is as much about

"De-Programing"

people from their prior ideas as it is adding new thought defaults/ patterns.

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Focus on the 90th Percentile

We are **NOT** very interested in what the majority (the huddled masses) are doing. You can call up the Hospice next door and find this type of practice information. To become highly profitable based on extraordinary quality, you will have to become an "Outlier" and do things that typical Hospices are ignorant of or are afraid to do. It is a lonely but highly satisfying road.

NEVER focus on the mediocre majority!

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The Bell-Curve…

is always with us…

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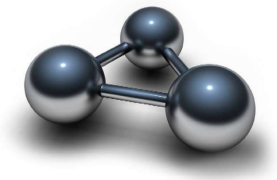
The BIG Moves of the Outliers that will TRANSFORM the Performance of Your IPU



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As we cover these **8** points, ask yourself if you are really doing them?

This "brute realism" is the beginning of your *Breakthrough*!

It is the beginning of

Personal Power.

(Accountability/Liberation/Awakening)

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The BIG Moves of the Outliers in IPUs

1 Tie the Financial Performance of the IPU Directly to the Compensation of the IPU Manager

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If an IPU Manager is uneasy about this, it is telling of his or her confidence in his or her abilities and perhaps in the organization as well. A Top IPU Manager would say:

"I've been waiting for this opportunity! Bring it on!"

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Clinical IPU Leader Pay Contribution Margin

Sunny Day Hospice - Compensation Structure
SUPERPAY!
Version 22.0

[redacted] 1 % of NPR = $ 3,931

Example Area	Actual Performance	NPR% Model	Difference	Frequency
Clinical Team A				
1) Position Pay (Base plus Standards Pay)				Per Pay Period
2) Individual Manager Pay Based on "beating" Contribution Margin				Per Pay Period
Controllable Costs	42%	45%	-3%	
Contribution Margin	**58%**	**55%**		Per Moth

3% = $ 11,792

split
50%
50%

$ 5,896 (to SDH company)

$ 5,896 (to Clinical Leader)

Managers need to be rewarded if we believe that Management is key

75

Clinical Pay - Hospice Inpatient Unit (IPU)

RN Example - This can be applied to most all clinical disciplines.

Weekly Average Census			5	6	7	8	9	10	11	12	13	14
			Percentages of Position Pay									
Base	Semi Monthly	Pay Period	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%
40,000.00	24	1,666.67	-	166.67	333.33	500.00	666.67	833.33	1,000.00	1,166.67	1,333.33	1,500.00
Individual Pay			-	4,000.00	8,000.00	12,000.00	16,000.00	20,000.00	24,000.00	28,000.00	32,000.00	36,000.00
Position Pay			40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00
Total Compensation			40,000.00	44,000.00	48,000.00	52,000.00	56,000.00	60,000.00	64,000.00	68,000.00	72,000.00	76,000.00

* Note: If performance or behavior is non-standard,the Standards Pay Bonus (10%) is not given.
** Note: IDT and other care coordination activities are included.

This is a slightly lower amount than is currently being paid.

This is the "magic" number which is 1 above breakeven.

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The BIG Moves of the Outliers in IPUs

2 Learn Your IPU's "Magic Number"

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Know how your costs behave at your IPU!

What is the financial IMPACT of 1 additional GIP patient?

78

Working with the IPU Planning Tool

- The GOAL is to work with the Pro Forma and NPR tabs **(RED tabs)**
- However, all other tabs link back to these tabs. We will work in this sequence.
  - # of Beds, Square Footage
  - Revenue
  - Staffing
  - Patient-Related
  - Operational

You will then alter the tool to understand how cost behave at your IPU and form your IPU Model.

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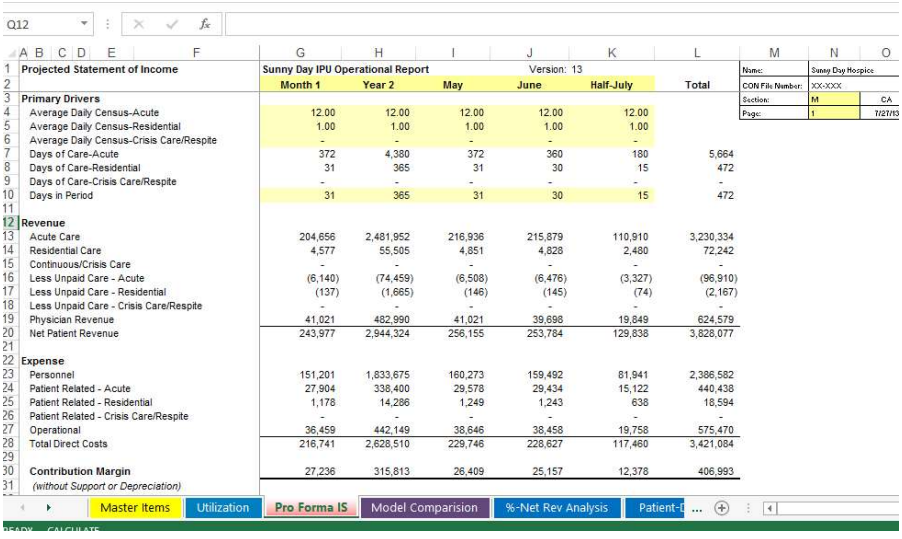

Projected Statement of Income	Sunny Day IPU Operational Report			Version: 13		
	Month 1	Year 2	May	June	Half-July	Total
Primary Drivers						
Average Daily Census-Acute	12.00	12.00	12.00	12.00	12.00	
Average Daily Census-Residential	1.00	1.00	1.00	1.00	1.00	
Average Daily Census-Crisis Care/Respite	-	-	-	-	-	
Days of Care-Acute	372	4,380	372	360	180	5,664
Days of Care-Residential	31	365	31	30	15	472
Days of Care-Crisis Care/Respite	-	-	-	-	-	-
Days in Period	31	365	31	30	15	472
Revenue						
Acute Care	204,656	2,481,952	216,936	215,879	110,910	3,230,334
Residential Care	4,577	55,505	4,851	4,828	2,480	72,242
Continuous/Crisis Care	-	-	-	-	-	-
Less Unpaid Care - Acute	(6,140)	(74,459)	(6,508)	(6,476)	(3,327)	(96,910)
Less Unpaid Care - Residential	(137)	(1,665)	(146)	(145)	(74)	(2,167)
Less Unpaid Care - Crisis Care/Respite	-	-	-	-	-	-
Physician Revenue	41,021	482,990	41,021	39,698	19,849	624,579
Net Patient Revenue	243,977	2,944,324	256,155	253,784	129,838	3,828,077
Expense						
Personnel	151,201	1,833,675	160,273	159,492	81,941	2,386,582
Patient Related - Acute	27,904	338,400	29,578	29,434	15,122	440,438
Patient Related - Residential	1,178	14,286	1,249	1,243	638	18,594
Patient Related - Crisis Care/Respite	-	-	-	-	-	-
Operational	36,459	442,149	38,646	38,458	19,758	575,470
Total Direct Costs	216,741	2,628,510	229,746	228,627	117,460	3,421,084
Contribution Margin	27,236	315,813	26,409	25,157	12,378	406,993
(without Support or Depreciation)						

Master Items | Utilization | Pro Forma IS | Model Comparision | %-Net Rev Analysis | Patient-D

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The BIG Moves of the Outliers in IPUs

3 **Provide the IPU Manager with the "Sweeping Powers" to Bring Patients into the Unit**

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"Sweeping Powers"

describes the *Authority* the IPU Leader is given to "command" GIP patients into the IPU. This Authority normally comes from the backing of the CEO.

82

Provide Incentives for Homecare Clinicians to Refer Patients

83

An excellent way to provide an incentive for Homecare clinicians to refer patients to the IPU is to allow referred patients to continue to be "counted" in the clinician's *Number of Patients/Visits* as well as in the IPU census. That is, the patient is counted on both censuses at the same time.

84

This could be an extra $75 or $250 per pay period for the referring clinician for

EACH

IPU GIP Patient.

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Hospice RN

	Multiple Factor	Base Rate		Standards Portion		Base + Standards	Number	Totals	Annualized	
# of Patients Visited	1	$ 40	+	$ 60	=	$ 100	15	1,500	360	36,000
Attitude/Standards Bonus		$ 20					15	300	360	7,200
Meetings	1	$ 40	+	$ 60	=	$ 100	1	100	24	2,400
On-Call - Weekday		$ -	+		=	$ -	-	-	-	-
On-Call - Weekend		$ -	+		=	$ -	-	-	-	-
Case MGMT Pay		$ 20.00					87	1,733	2,080	41,600
Sub-Total								3,633		87,200
Standards Bonus		0%						-		-
Attitude Bonus		$ -					-	-		-
Total		# Pt. Visited		FTEs				3,633		87,200
Number of FTEs		15		3.33				12,111		290,667
Percentage of NPR								0.4%		8.9%
Benefits								2,664		63,947
Percentage of NPR with Benefits								0.5%		10.9%

The Model

86

The BIG Moves of the Outliers in IPUs

4 You are Training the Community By Virtue of the Patients You Admit…And Scar Referral Sources with the Ones you Don't

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87

Pain is remembered more than good feelings.

Emotion is the foundation of all memory…and PAIN registers more powerfully in a person's memory than pleasant feelings.

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88

kid gloves

noun

gloves made of fine kid leather.

- used in reference to careful and delicate treatment of a person or situation.
  modifier noun: **kid-glove**; noun: **kid-glove**
  "the star is getting kid-glove treatment"

89

You want you MOST SKILLFUL PERSON at communicating BAD NEWS doing the communication of a Non-Admit to the IPU.

90

The BIG Moves of the Outliers in IPUs

5 Make Sure Your Physicians are Not Blockers, but Facilitate IPU GIP Occupancy

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91

Remove and replace any Physician that is overly conservative in their paradigm of what a Hospice GIP patient looks like or is overly controlling to the point of slowing down admissions.

Get a Physician with an "Expanded Paradigm" in place!

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92

Normally Physicians in an IPU can pay for themselves. This is one of the few places in Hospice where the Physician visit ideas breakeven or even make a bit of money. I recommend a pure, flexible per-visit approach. If you make a visit, you get paid. If you don't… then…

With a 14-15 bed IPU, you will normally need 1.5 Physicians. If an IPU has 14-15 beds, each patient should be visited "nearly" every day by a doc or an NP. The rounding can be done in 2/3 of a day if full. At approximately $110 per visit, the revenue well exceeds the Physician's cost at $1,500 in billings per day. If the Physicians are not salaried, but are flex, then this becomes even easier.

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93

Physician in an IPU - Per-Visit

			Minimum				
Weekly Visits			1 visit PP	50	56	70	75
	Rate	100.00					
	Semi	Pay	Minimum		Compensation		
Base	Monthly	Period					
-	24	-		5,000.00	5,600.00	7,000.00	7,500.00
Individual Pay				120,000.00	134,400.00	168,000.00	180,000.00
Position Pay				-	-	-	-
Total Compensation				120,000.00	134,400.00	168,000.00	180,000.00

* Note: If performance or behavior is non-standard,the Standards Pay Bonus (10%) is not given.
** Note: IDT and other care coordination activities are included.

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94

Link Physician Compensation to Collections and NOT Visits

95

The BIG Moves of the Outliers in IPUs

6 Build Confidence in IPU Documentation

96

Increasing the utilization of a Hospice IPU GIP is directly linked with increasing the confidence in IPU documentation.

97

The BIG Moves of the Outliers in IPUs

7 Tie IPU Staff Compensation to Unit GIP Occupancy

98

Clinical Pay - Hospice Inpatient Unit (IPU)

RN Example - This can be applied to most all clinical disciplines.

Weekly Average Census			5	6	7	8	9	10	11	12	13	14
			Percentages of Position Pay									
Base	Semi Monthly	Pay Period	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%
40,000.00	24	1,666.67	-	166.67	333.33	500.00	666.67	833.33	1,000.00	1,166.67	1,333.33	1,500.00
Individual Pay			-	4,000.00	8,000.00	12,000.00	16,000.00	20,000.00	24,000.00	28,000.00	32,000.00	36,000.00
Position Pay			40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00	40,000.00
Total Compensation			40,000.00	44,000.00	48,000.00	52,000.00	56,000.00	60,000.00	64,000.00	68,000.00	72,000.00	76,000.00

* Note: If performance or behavior is non-standard,the Standards Pay Bonus (5%) is not given.
** Note: IDT and other care coordination activities are included.

This is a slightly lower amount than is currently being paid.

This is the "magic" number which is 1 above

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99

If IPU staff are not paid using this “type” of method, when the IPU is full or operating at a high level of occupancy, they will complain that they are “overwhelmed.”

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The BIG Moves of the Outliers in IPUs

8 Understand the How to Take Care of Your IPU People

101

70%

of an employee's development[1], morale[2] & retention[3] will come from the immediate Manager!

Whoa!!!

102

The Immediate Manager is the #1 Factor in the Retention of Talent!

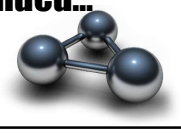
103

Breakthrough Paradigm

The Quality you want in your Leaders is that of being

INSPIRING!

It has ENERGY! Motivates Others!
Gives others insight into their potential(s).
It "Gives" and is a "Gift" as it can't be commanded…



104

We are in the healing profession…

People do not want so much for someone to tell them how to live a great life… Rather, they want to see a person that actually IS it.

Be *Inspiring!*

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105

To be INSPIRING

Do AMAZING Things!

Live Exceptionally Well!

Be Inspiring!

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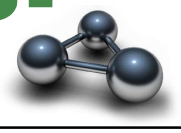


106

To truly "BE" *INSPIRING*... Perhaps there are at least 3 characteristics you want in Leaders

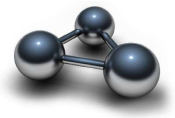
Intelligence

Energy

Integrity

Self-Control

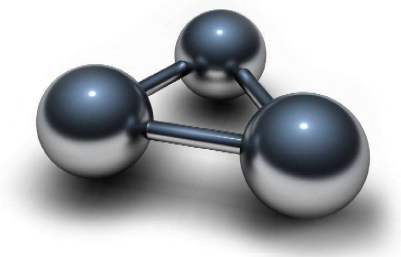
MVI FOCUS



107

Taking Care of Your People!

Most problems in an organization come from NOT taking care of its people...



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108

What is the Cost of NOT Taking Care of Your People?

1. Turnover of Talent
2. Inability to Attract Talent
3. Continual Waste
4. Loss of Reputation/Quality
5. Inability to Grow
6. Continual Frustration

109

How to Take Care of our People?

1. Provide a Electric, Transformational, Life-Changing Work Experience
2. Pay Great! Better than other employment options!
3. The removal of "Energy Sucks"
4. Eliminate 8-5 "normal" work hours for Clinicians
5. Simplify your EMR!
6. Structure "Enough" time for people to recharge!
7. Make Phone and Visit work EASY to do 100% of your Standards!
8. Help your people "believe" they are working with an elite, World-Class organization. Show "How to" or plan and sequence, and DO IT!
9. Provide employees Standards.
10. Remove the need for Clinical Managers to:
    1. Monitor Documentation
    2. Monitor Productivity
    3. Do Annual Evaluations
11. Have few meetings, maybe 2 a week.
12. Use "massive" amounts of Volunteer labor! Why not!

110

The 1st Duty of the IPU Manager

111

The 1st Duty of all Managers, including an IPU Manager is the responsibility to train the people they lead.

This is the ONLY way excellence can be replicated and multiplied…

112

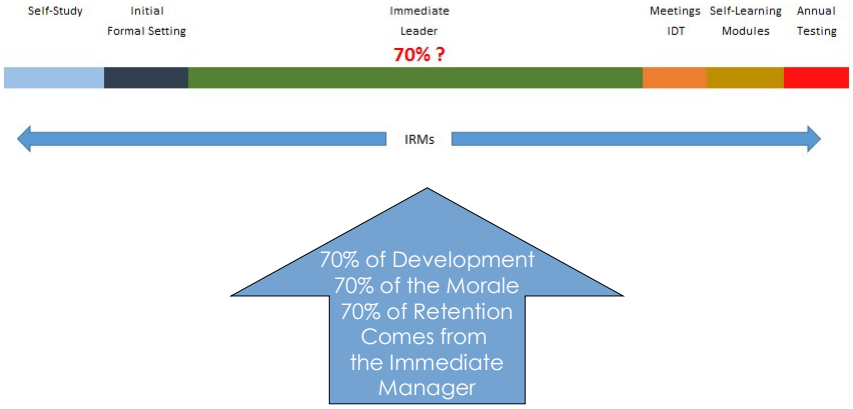
Why is this so important?

113

It is a complete fantasy to think an organization can be extraordinary without an extraordinary People Development System because the mission is only accomplished through people.

114

Where Does Learning Take Place in Our Organization?



115

Therefore, the 1st Duty of all Managers or managers is the responsibility to train the people they lead.

This is the ONLY way excellence can be replicated and multiplied…

116

The Truth about Quality

A Hospice can have no more or less quality than the quality of its People Development System.

It is a **COMPLETE FANTASY** to think otherwise.

So what is the quality of your People Development System?
Is it Extraordinary or something less?

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117

People can't give what they don't have.

You can't be what you are not.

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118

Not only can your People not give what they don't have.

YOU can't give what you don't have!

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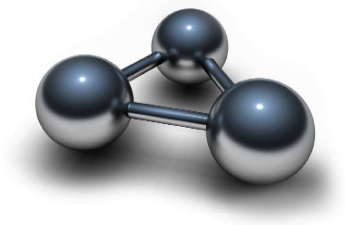
119

Where/How People Learn?

- _____ % from Self-Study
- _____ % from Initial Formal Education
- _____ % from the Immediate Manager
- _____ % from Informal means
- _____ % from IDT
- _____ % Annual Testing
- _____ % Audio Reinforcement
- _____ % IRM Tools

120

The Foundation of Memory & Recall



How to people remember things?

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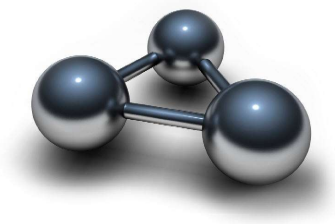
121

According to scientific findings, **ALL** thoughts are stored in the memory's filing system based upon the associated **feelings**. They are filed according to **feeling and tone**, not fact...



Gray-LaViolette, 1982

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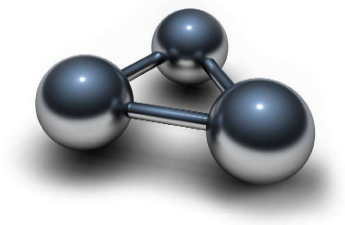
122

We are

Feelings

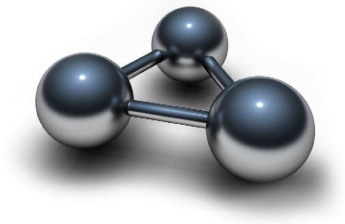


We are essentially "sensations" and "consciousness"…this is really all we know…

123

Learn to teach to the

feeling …



124

Confidence

Unconfident people provide unconfident care.

To the degree that people BELIEVE in the system and their individual abilities to succeed within the system, is the degree of high-quality care will be provided. Our People Development Methods must instill confidence on unprecedented levels…

Confidence is an end-product of our People Development efforts.

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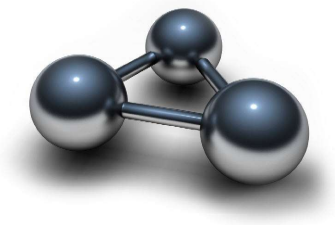
125

Confidence is a Feeling!



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126

Gaining Professional Perspective

Hospice Reimbursement is MORE THAN ENOUGH to fund a World-Class Hospice Experience. The evidence of this is overwhelming.

127

Gaining Professional Perspective

The Most Profitable Hospices are happening NOW!

Not in the "good ol' days!" Superior management practices have far and away outpaced any mandates, rate cuts or other environmental factors.

128

Gaining Professional Perspective

Destroying Hospice Myths

"Small Hospices can't make it?"

WHO is saying this? They obviously are either ignorant of the FACTS or their motives may not be integrous. The fact is that Hospices in the ADC range of 50 have a median profit of 15%! Then comes the question, "Why is this so?"

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129

Destroying Hospice Myths

Farm less ground

Well!

With all this talk about "scale" people are missing that you can increase profits with less volume managed well.

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130

Never merge or do "deals" with entities or groups of Hospices for the purpose of reducing Indirect Costs unless they are already have Indirect Costs of

31% or less!!!

YOU may be their "plan" for reducing their Indirect Costs!

IF they knew how to do low Indirect Costs, they'd already be doing it!!! being "paid" to manage…

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131

Community Support?

"Fundraising and Community Support provide the least return for the most effort."

Quote from one of most profitable CEO in Hospice history

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132

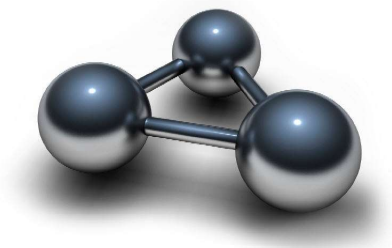
Community Support?

"Andrew, ignore Community Support and Fundraising. They don't exist for you. Learn to operate a Hospice without a dime from the community. I refuse to operate this Hospice on the kindness of others to bail out sloppy operations."

Deborah Dailey, Hospice CEO Legend

133

Our Training Commitment



Questions? 828-698-5885

134

Our Training Commitment: You will be trained in the habits of performing your job to 100% of the standards, 100% of the time, on a day-to-day basis, and at 100% census volume. We will never put you in situation where you can't succeed. You will always know if the standards of your job have been met. You have the power to correct any process or activity that deviates from the standards.

135

BAD IDEA: When you train people, you should expect them to make mistakes. In fact, new staff need to make mistakes in order to learn . . .

If this is the case, your Standards are not high enough.

136

Our Training Commitment: You will be trained in the habits of performing your job to 100% of the standards, 100% of the time and at 100% census volume. We will never put you in situation where you can't succeed. You will always know if the standards of your job have been met. You have the power to correct any process or activity that deviates from the standards.

137

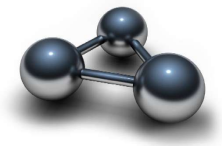
The 3 Elements in the Creation of Habits

Every habit you have, good or bad, follows a similar 3–step pattern.

- **Cue/Trigger/Reminder** (the trigger that initiates the behavior)
- **Routine/Action** (the behavior itself; the action you take)
- **Reward** (the benefit you gain from doing the behavior)

138

How long does it take ot create a Habit? Habits can be formed as soon as cause is linked to effect with a personal benefit!



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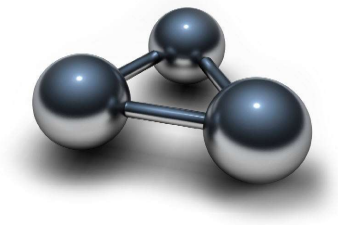
139

All working policies and procedures must be able to be memorized or recalled in order to be operationalized.



Big Model Concept #3

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140

Out of sight, out of mind = not done...

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141

IRMs™

Image Recall Mechanisms

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142

Steps to Create IRMs™

Image Recall Mechanisms

1. Define What (Habit Creation: Action)
2. Explain Why (Habit Creation: Reward)
3. Attach a Visual Image (Habit Creation: Cue/Trigger)
4. Attach a Word or Phrase (Habit Creation: Cue/Trigger)

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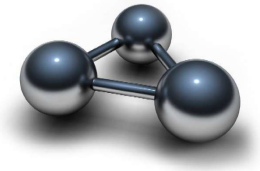
143

We will attach an IRM to every component of the Visit, Phone Interaction & other work where Predictability is critical.



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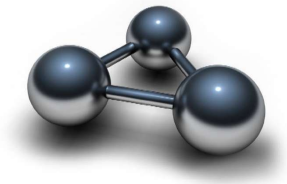
We will strategically place IRMs in the patient/family environment to cue Habits !



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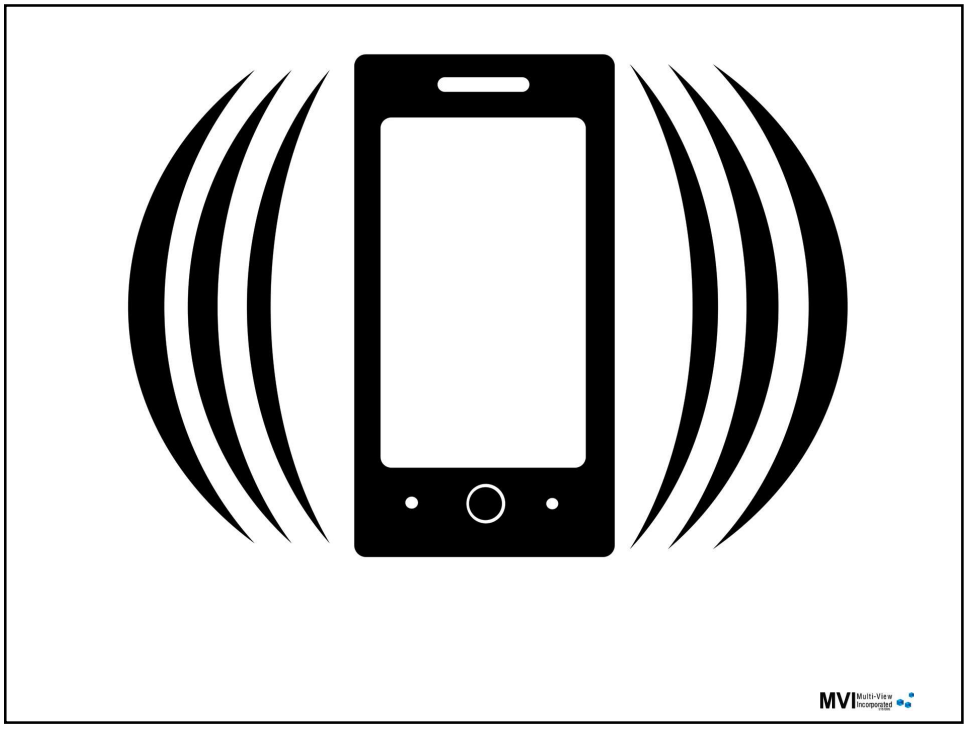
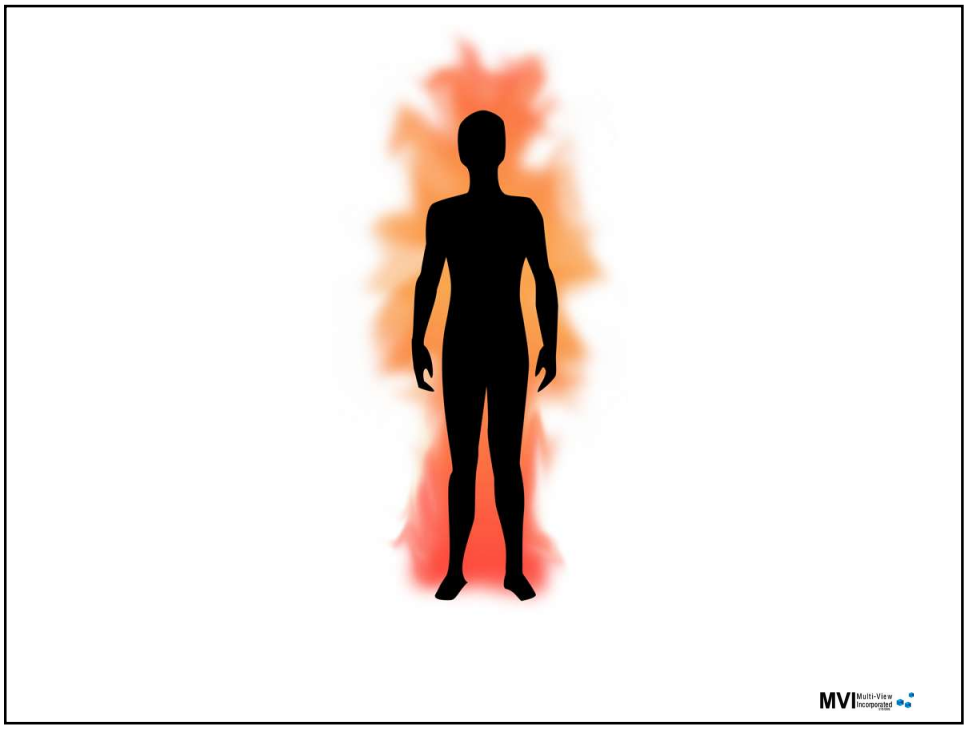
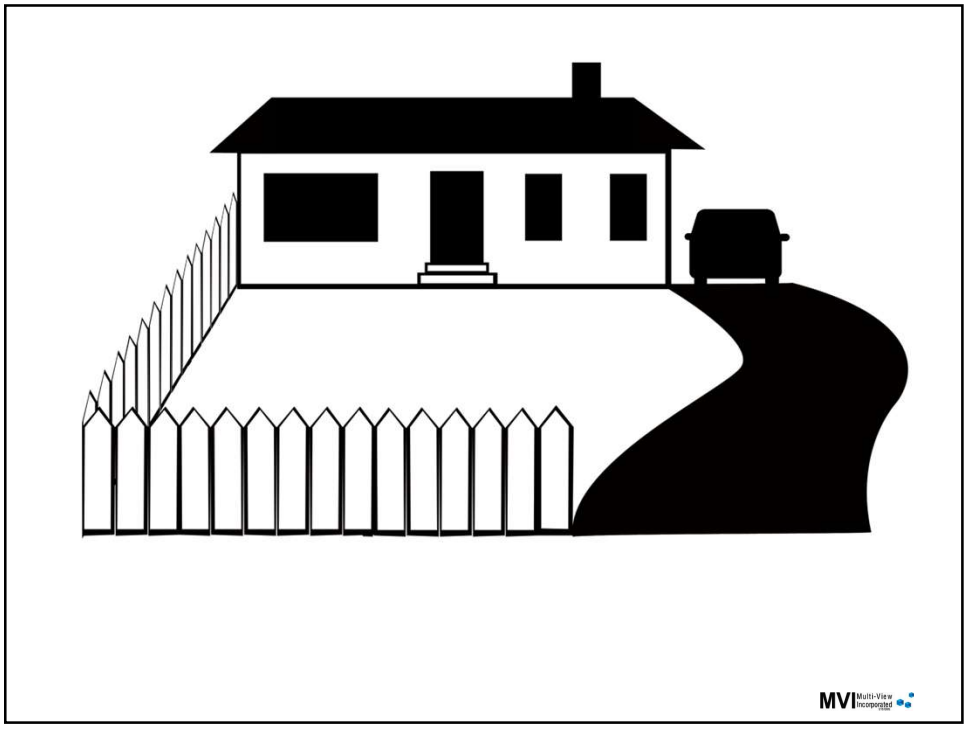
147



148



149



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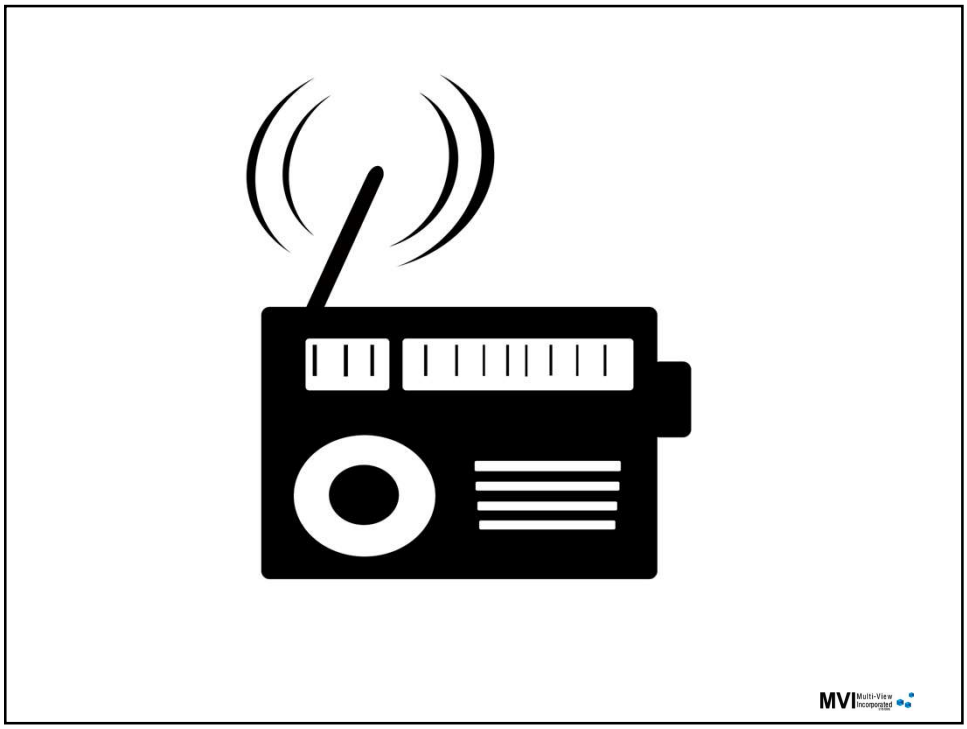

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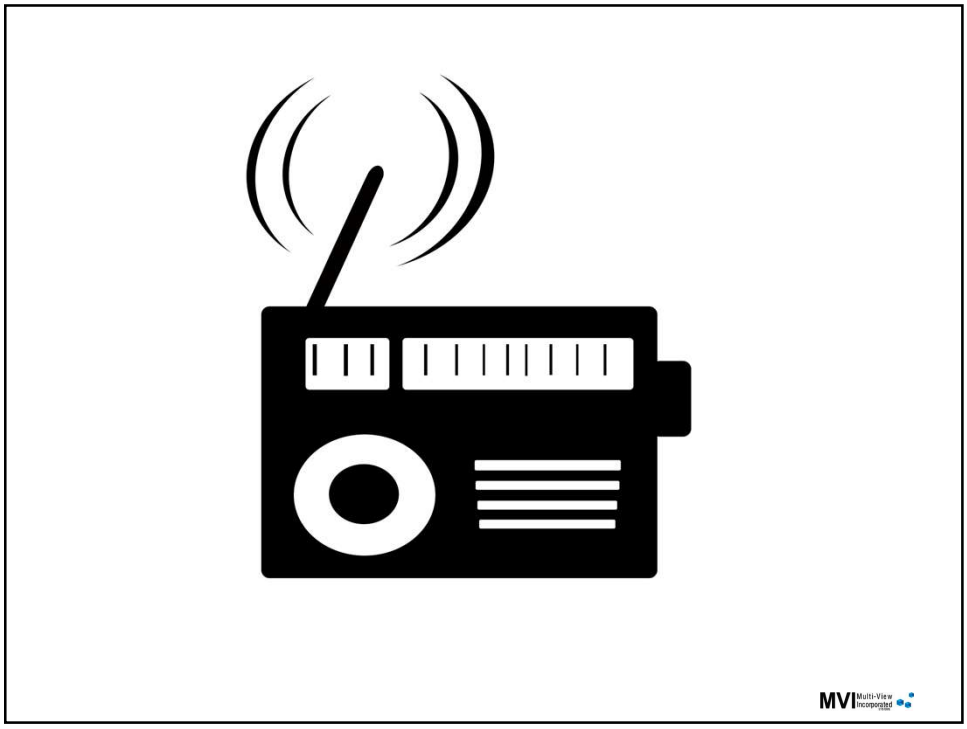
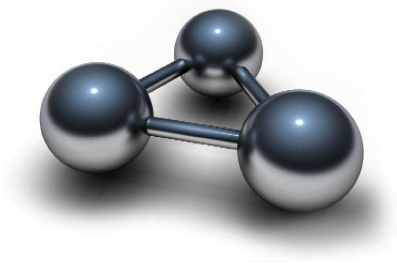


152

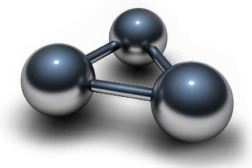
Accountability & Standards



153

When an organization DOES NOT get the results it wants to the Model, it can usually be traced to one thing,

Lack of Accountability!



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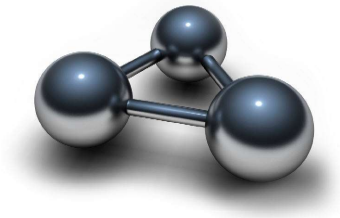
Creating a Culture of

Accountability



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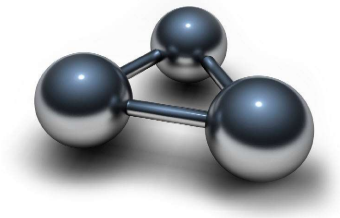
Accountability

must be Taught!



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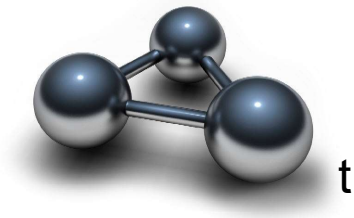
Accountability

is Spiritual!



In fact, it is Accountability and being Accountable that gives **MEANING** to our work and lives…

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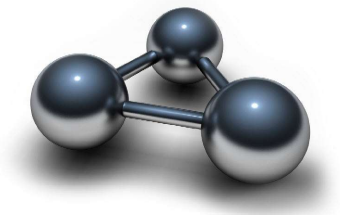
Accountability

is taking "complete ownership of your Life" and EVERY RESULT in it rather than blaming anyone else or circumstances…



158

Developing Professional Managers

All Managers on Video Teach (1-7) :

1. Memorize The Training Commitment
2. Memorize *System7*
3. Learn to use Master Teaching Methods
4. Teach the Standards
   - What is a Standard! Why 100%? Two Categories, 3 Attributes, 3 Things to Implement
   - Why Pain? Accountability & Responsibility, Spirituality
5. Teach the Visit
6. Teach Phone Skills
7. Demonstrate command of the *norms of quality & cost* via Benchmarking

---

8. Provide a Written Plan to the CEO how the area will remain at or below the Model NPR% with 10% fluctuations of census.
9. Sign an Accountability Contract

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Accountability

Starts with a deep commitment to quality and valuing what you do. It is about "caring enough" that no person is more important than the common purpose.

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Accountability

If you are unwilling to "put blood on the floor" you have no business in a Managership/Management position as the ability to fire a person is a prerequisite to Management.

People have to know you "mean what you say" and that you "stand for something."

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Accountability

You have to care less about being liked and care more about being quality and effective.

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Our Training Commitment: You will be trained in the habits of performing your job to 100% of the Standards, 100% on a day-to-day basis and at 100% census volume. We will never put you in situation where you can't succeed. You will always know if the Standards of your job have been met. You have the power to correct any process or activity that deviates from the Standards.

163

Our Training Commitment: You will be trained in the habits of performing your job to 100% of the Standards, 100% on a day-to-day basis and at 100% census volume. We will never put you in situation where you can't succeed. You will always know if the Standards of your job have been met. You have the power to correct any process or activity that deviates from the Standards.

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A Culture of

Accountability

starts with

Standards!

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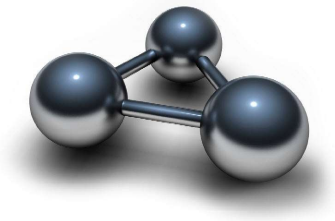
Standards

are the basis of all

People Development & Accountability Systems.



In fact, Standards are the ONLY thing you will teach…

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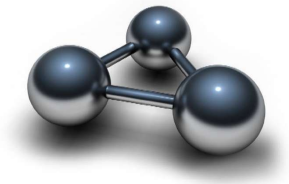
There can be NO meaningful discussion of Accountability w/o clear Standards!



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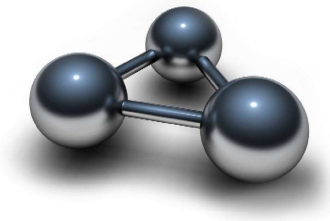
What is a Standard?



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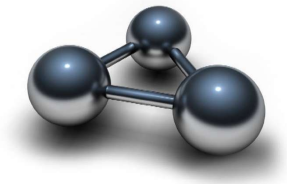
A Standard is NOT a goal! It is a norm. It is an everyday activity or result.



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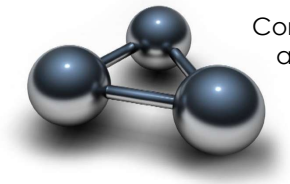
100% is the only acceptable Standard! Why?

If Standards are not Standards, call them suggestions…



Compound a 10% knowledge deficit by 100 employees and your screw-up factor is exponentially multiplied.

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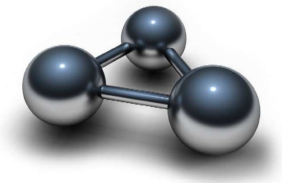
Standards

are NOT optional!



All testing is done to Pass/Fail…
Anything less will create knowledge deficits…

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BAD IDEA: When you train people, you should expect them to make mistakes. In fact, new staff need to make mistakes in order to learn . . .

If this is the case, your Standards are not high enough…

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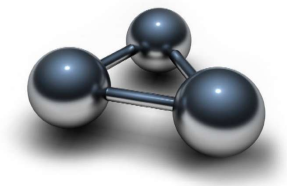
The Two Categories of Standards

- Behavioral
  - Less or non-measurable
- Performance
  - Includes the numeric denomination



The most important things in Life are BEYOND measurement…

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Only 5 Behavioral Standards !

1. Perfect Phone Interactions.
2. Dress in SD apparel.
3. Perfect Visits with Perfect Documentation.
4. Time to Meet, Ass in the Seat! – Eight58, Eleven17, Transformation Four29
5. Report all service failures (gifts) to the CEO/Chief Teaching Officer. Remedy before the Sun sets.

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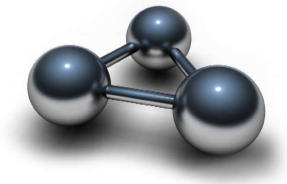
If there is no "pain" attached to non-standard behavior or performance, your system is weak...



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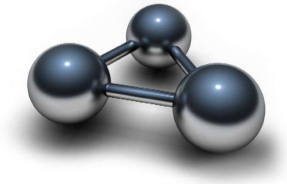
If your Accountability system is based on the "personal inspection of work," your system is weak...



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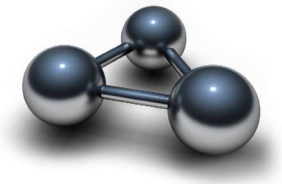
An organization uses the same Accountability methods for Quality as well as Financials!

It is delusional to think otherwise. Therefore, how well you manage financials is indicative of how well you manage quality.



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Standards Standards Standards

The 3 Attributes of Great Standards

- **Clear** – Everybody understands our Standards.
- **Impressive** – They are motivational. We take pride in our Standards.
- **Sustainable** – Our Standards do not burn people out. They are doable within our system of care. Our Standards rarely change. All routine work is done in an 8-hour day. Overtime is EVIL!

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Standards Standards Standards

- "I can do that!" is what you want.
- "I want to do that!" is what you want.
- "I can win in this System!"
- "I know at any time, whether I am "in" or "out" of our Standards." – Self-Control
- "I know at any time, whether anyone else is "in" or "out" of our Standards." – Self-Control
- We want an world of "non-exception."

179

"I Can Win!!!" That is what you want!

Hospice HomeCare	Caseloads		Visit Duration	Weekly Visits	
Category	Minimum	Excellent	Average*	Minimum	Excellent
Nursing					
Aides					
SW					
Spiritual Care					
Physicians					
Admissions					

Gap must be perceived as "achievable" with modestly increased effort

Hospice Nursing Home/ALF	Caseloads		Visit Duration	Weekly Visits	
Category	Minimum	Excellent	Average*	Minimum	Excellent
Nursing					
Aides					
SW					
Spiritual Care					
Physicians					
Admissions					

180

High Standards

attract and help retain Top Talent!

The Talented don't want to work with the Mediocre.

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Standards tied to Accountability enable you to create a

"World of Non-Exception,"

which saves time, stress & money. There simply is not a great need for many meetings as things aren't breaking and new issues are minimal.

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This
World of Non-Exception
makes Managing
so, so, so much
Easier!

183

Only 30% of the Visit is prescriptive! The remaining

70%

is up to the clinician's professional judgment!

184

The importance of Professional Judgment…

185

The 3 Things You Need to DO with Standards to Fuse them with Accountability

1. Clearly Define each Standard.
2. Teach each Standard by *System7.*
3. Attach Uniform Accountability to each Standard.

Your Accountability must be uniform.
"Billy Bob can't have his own system!"

186

Seven Step Training Method

System 7 - Teaching Well

1. Issue Self-Study Module
2. Tell – The Why & How
3. Show - Visual
4. Test - Evaluate Learning
5. Practice - Demonstrate
6. Evaluate Practice - Test
7. Certify/Annual Recertification

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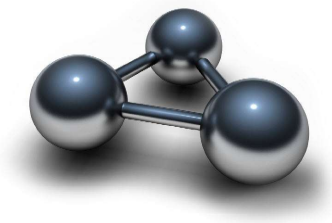
By using System7 you

remove the excuse,

"I didn't know that..."



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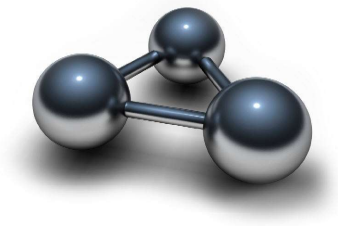
In System 7,

"Where does the emotion come into the teaching?"



189

Accountability Tools/Methods

- Self-Control (where anyone has the power to correct anything that deviates from our Standards)
- Compensation
- Videos of all Employees and Candidates
- The Personal Inspection of Work - Lead from the Front
- No committees (It is hard to "fire" a committee)
- All Disciplines Report to a Single Team Manager
- Peer Reviews
- Focus Board at Meetings
- The "Jar" – Cash in the Can!
- Lock the Door
- Accountability Contracts
- Weekly Update from Managers
- Incident Reports/Essay
- Public Posting of Scores/Results
- Reports with Individual's Names Denoted for All Areas

NOTE: Counseling is not an effective method of Accountability.
However, it is often necessary in conjunction with other Accountability Methods

190

Compliance – Audit Sheet

Audit to an 90% Confidence Interval over a 3, 6, 9 or 12 Month Period (depending upon # of Employees)

	NAME	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type
	Pay Period	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12
1	Doe, Jane	3/19 A											
2	Smith, Sally												
3	Brown, Robert			4/16 B									
4	Dally, Dilley												
5	Nice, Jill												
7	Bob, Billy						5/21 C	6/2 C	6/18 A				

A = Use of non-organizational language
B = Signatures not timely/not signed
C = HHA Supervision 14 days
D=Visit not adhering to the POC
E= Other

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Sunny Day Hospice - Comprehensive Model Report *(An F9 Report)*

Period: **March YTD**

Area	Leader	Direct Labor	Model	Patient Related	Model	Contribution Margin	Model	Traceable Indirect	Model
Team 1	Sue Brown	30.2%	30.0%	23.5%	22.0%	46.3%	48.0%	4.6%	3.0%
Team 2	Jill Lental	33.9%	30.0%	28.3%	22.0%	37.8%	48.0%	2.4%	3.0%
Team 3	Sam Jones	28.7%	30.0%	19.6%	22.0%	51.7%	48.0%	2.8%	3.2%
	Average	30.9%	30.0%	23.8%	22.0%	45.3%	48.0%	3.3%	3.1%

Centralized Direct		Labor	Model			Other	Model	Total	Model
Admissions	Chris Davis	4.2%	2.5%			2.5%	0.3%	6.7%	2.8%
On-Call	Jane Swift	2.2%	2.5%			2.5%	0.3%	4.7%	2.8%
Bereavement	Kim Black	0.7%	1.0%			1.0%	0.1%	1.7%	1.1%
Volunteer	Val Tiff	1.0%	1.0%			1.0%	0.1%	2.0%	1.1%
	Total	8.1%	7.0%			7.0%	0.7%	15.1%	7.7%

Indirect Areas		Labor	Model			Other	Model	Total	Model
Administration	Linda White	4.6%	3.0%			0.1%	0.3%	4.7%	3.3%
Medical Admin	Cracker Jack	8.1%	5.0%			0.2%	0.5%	8.3%	5.5%
Medical Director	Larry Reid	2.0%	1.5%			0.4%	0.2%	2.4%	1.7%
Finance	Captain Crunch	2.3%	2.5%			0.1%	0.3%	2.4%	2.8%
HR	Nancy Harpo	0.8%	1.0%			0.1%	0.1%	0.9%	1.1%
IT	Sid Vicous	1.3%	1.0%			0.2%	0.1%	1.5%	1.1%
Medical Records	Cheryl Green	0.9%	1.2%			0.1%	0.1%	1.0%	1.3%
QI/QA	Lin Marko	1.0%	1.0%			0.2%	0.1%	1.2%	1.1%
Education	Alto Sand	1.1%	1.0%			0.2%	0.1%	1.3%	1.1%
	Total	22.1%	17.2%			1.6%	1.7%	23.7%	18.9%
Other Operational	Linda White	4.1%	4.0%					4.1%	4.0%
Facility-Related	Linda White	4.3%	4.5%					4.3%	4.5%
	Total	8.4%	8.5%					8.4%	8.5%
	Total Indirect	30.5%	25.7%					32.1%	27.4%

	Total	Model
Total Expenses	**95.7%**	**86.2%**
Profit	**4.3%**	**13.8%**

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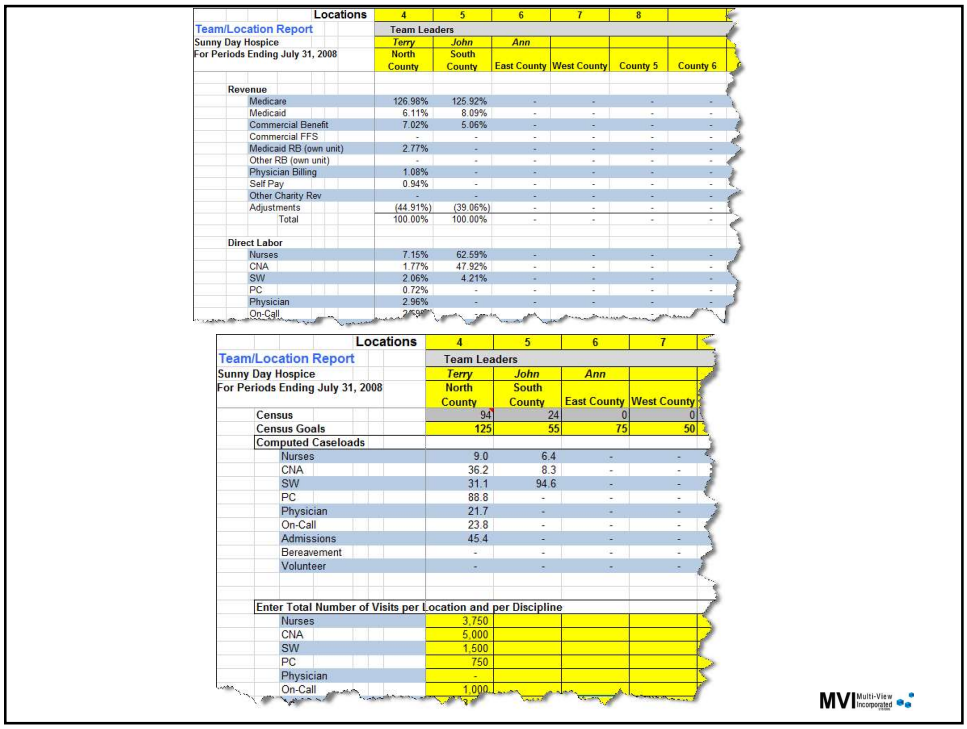

Locations	4	5	6	7	8	
Team/Location Report	Team Leaders					
Sunny Day Hospice	*Terry*	*John*	*Ann*			
For Periods Ending July 31, 2008	North County	South County	East County	West County	County 5	County 6
Revenue						
Medicare	126.98%	125.92%	-	-	-	-
Medicaid	6.11%	8.09%	-	-	-	-
Commercial Benefit	7.02%	5.06%	-	-	-	-
Commercial FFS	-	-	-	-	-	-
Medicaid RB (own unit)	2.77%	-	-	-	-	-
Other RB (own unit)		-	-	-	-	-
Physician Billing	1.08%	-	-	-	-	-
Self Pay	0.94%	-	-	-	-	-
Other Charity Rev	-	-	-	-	-	-
Adjustments	(44.91%)	(39.06%)	-	-	-	-
Total	100.00%	100.00%	-	-	-	-
Direct Labor						
Nurses	7.15%	62.59%	-	-	-	-
CNA	1.77%	47.92%	-	-	-	-
SW	2.06%	4.21%	-	-	-	-
PC	0.72%	-	-	-	-	-
Physician	2.96%	-	-	-	-	-
On-Call	2.58%					

Locations	4	5	6	7	
Team/Location Report	Team Leaders				
Sunny Day Hospice	*Terry*	*John*	*Ann*		
For Periods Ending July 31, 2008	North County	South County	East County	West County	
Census	94	24	0	0	
Census Goals	125	55	75	50	
Computed Caseloads					
Nurses	9.0	6.4	-	-	
CNA	36.2	8.3	-	-	
SW	31.1	94.6	-	-	
PC	88.8	-	-	-	
Physician	21.7	-	-	-	
On-Call	23.8	-	-	-	
Admissions	45.4	-	-	-	
Bereavement	-	-	-	-	
Volunteer	-	-	-	-	
Enter Total Number of Visits per Location and per Discipline					
Nurses	3,750				
CNA	5,000				
SW	1,500				
PC	750				
Physician	-				
On-Call	1,000				

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To get results in the real-world, most of it will come down to the CEO's and Manager's ability to teach

Accountability

without losing talented people.

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Unless a CEO is willing to "Do Accountability" – applying directives, even getting rid of those that aren't achieving the RESULTS you want, there is really little hope for an organization...

Most Hospices die today, not due to any other factor except Weenie-ish Leadership..."

Accountability

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Accountability

The Topic of Personal Transformation and Empowerment

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accountability noun

ac·count·abil·i·ty | \ ə-ˌkau̇n-tə-ˈbi-lə-tē \

Definition of *accountability*

: the quality or state of being accountable

especially : an obligation or willingness to accept responsibility or to account for one's actions

// public officials lacking *accountability*

Accountability is owning one's life without blaming others or circumstances.

Because of the importance of this topic, a simple definition, known verbatim, is needed by the organization.

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You want to get yourself[1] and your people[2] beyond victimhood, blame & excuse…

Victimhood and blame are not very empowering…

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The Model Balancing Purpose and Profit...

198

The Skill of the Manager is that of "doing" Accountability without losing Talent.

This involves having a compelling Vision, gaining respect, creating trust and having a supportive/transformative relationship where you can Teach Accountability effectively. This will cure so many problems.

199

Really, one might say, that the ability to

Teach Accountability Effectively

WILL be the determinate of success or failure or mediocrity.

This means having a **DEEP** understanding of Accountability beyond a pedestrian level.

200

A DEEP Understanding of Accountability

- If a "victim" world-view exists, a person will blame and point fingers at others and circumstances. Little progress will be accomplished. It is a weak energy state.
- When acceptance is learned "This is where I am…and I have something to do with it – and only God and I can really change my life." Then one can say, "What can I do?" This is the beginning of personal power and advancement.
- As one matures and learns not to fight the idea of Accountability, one begins to see it as helpful and that it actually gives one's life meaning. Meaning is created… A sense of fulfillment comes and a sense of healthy organizational pride from being part of a group or group effort. You lose the feeling of Separateness.
- Complaints and bad attitudes become less and less… People self-regulate with little need for supervision.

201

Payoffs from a Deep Understanding of Accountability

- If everyone would "own" their performance and do it to the Standards of the organization, most complaints from employees would go away. This frees up time and Energy!
- Accountability causes employees to grow-up and be mature professionals. Excuses become rare.
- An Accountable employee needs little supervision or management. Accountability translates to Self-Control or Self-Regulation.
- The Accountable employee has confidence in themselves and their work.
- An Accountable employee finds him or herself in a promotable position, thus filling the pipeline of Managers needed to grow.
- Retention of Talent – Mature, productive and trustworthy employees tend to stay with companies that are mature, productive and are trustworthy a long time as the alternative employment options do not cultivate such qualities.

202

Teaching Accountability Effectively

1. Create a Standardized Definition of Accountability.
2. Accountability needs to Hired For in a Hiring Profile as well as Cultivated Culturally.
   - We want people that **want** to grow Spiritually.
3. The Ongoing Cultivation of Accountability:
   - ❑ *The 3 Questions with a Call-Out on "What day is it?"*
   - ❑ *System7*!!!
   - ❑ Preemptive Teaching using Manager Scenarios in Front of Clinicians – to show the "Child" vs the "Mature/Awakened" Person
   - ❑ Special Programs and "High Calibration" Teachers – Who ALL DEEPLY understand the Value of Accountability.

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The Model Balancing Purpose and Profit...

203

The Steps

1. For Accountability to be possible, Standards must be created. I use Benchmarking and normally set the Standards a bit higher than the median or 50th percentile. This knowledge of the *norms of quality & cost,* through benchmarking, gives me professional perspective with which to make sound professional judgments.
2. I dig into MVI practices (Best Known Patterns at that time), into EACH major data-point topic where the benchmarked result is not what I want. Then I prioritize in light of:
   a) How much result can we get?
   b) Will it be difficult or easy to implement the practice?
3. I look, *with my most pragmatic eyes*, at my Managers… Can they create an electric work atmosphere and achieve the Standards? I give people only a month or 2 to impress me. I expect <u>them</u> to find the practices.
4. I "Ride the P&L" and the Key Metrics until I get what I want…100% of the Standards done on a day-to-day basis. No other outcome is acceptable. The numbers lead my month-to-month management. REPEAT, REPEAT, REPEAT, REPEAT…

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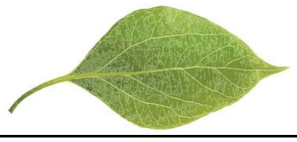
Money is obviously important…and needed to fulfill the **MISSION** of Hospice…

We need to be GREAT at it! The financials are perhaps the best way to manage…Quality & Economics….They will lead one throughout an organization and TELL you where to go to work…

Money is a fantastic teaching tool… The Nazarene used money in approximately 1/3 of the parables…



205

Productivity is OVERRATED…

It is more important to establish

"Sustainable High Standards."

Standards that give at least *double digit* profits & quality at either 1 or 2 in your market.

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Key Points in Creating Standards

- Set most of your Standards based on Benchmarking with most all of your Model NPR%s "slightly" better than the median.
  - This will result in a cumulative 12-14% profit without a great deal of work at any single person's part.
- One of the **BIGGEST** mistakes a Hospice can make is setting LOW profit Standards whether FP or NFP. One is setting themselves up for heartache and failure long-term. The point is, why waste money needlessly when a superior product & service can be provide for less?
- All work done within an 8-hour day without overtime.
- For clinical Standards, I take my highest performing clinicians and back the performance down approximately 20%.

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Only 5 Behavioral Standards !

1. Perfect Phone Interactions.
2. Dress in SD apparel.
3. Perfect Visits with Perfect Documentation.
4. Time to Meet, Ass in the Seat! – Eight58, Eleven17, Transformation Four29
5. Report all service failures (gifts) to the CEO/Chief Teaching Officer. Remedy before the Sun sets.

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Making Management EASIER!

The Compensation System is the ONLY known means to remove the need for Managers to:

1. Monitor Documentation
2. Monitor Productivity
3. Do Annual Reviews
4. Need to Fire People

These are REMOVED from the Clinical Manager's job description to free up time to do the *1st Duty*...to Teach and Coach as all employee's learn to self-regulate to the organizational Standards.

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Documentation Example

1. Documentation Standards are defined.
2. Self-Learning Modules with a short test are created.
3. Documentation is taught strictly to *System7*.
4. QI/Compliance audits charts to a 90-95% statistical confidence interval. The job of making sure documentation is to Standard is REMOVED from Clinical Manager duties.
5. If any material defect in a chart is identified (variance from Standards), QI/Compliance sends an email with a Self-Learning Module link to the person and notifies the Clinical Manager as well.
6. The clinician fixes the issue, if possible, and completes the Self-Learning Module within 1 day.
7. In addition, any performance pay as well as Standards Bonus is not received. Normally this is 5% for 2 weeks.

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Incident Reports with Essays

This is a relatively easy method of accountability to implement and it is effective. Using documentation as an example, an RN fails to documents a visit to the Hospice's Standards. Upon detection (by Compliance or other), the RN must come into the office, that day, and fill out an Incident Report, sign it and complete an essay explaining how his or her lack of documentation impacted the team. You will get pushback on this initially. You will also get REAL insight into the behaviors of your team members. Some essays will be filled with excuses as to why they didn't document to standard. These are the weenies. I think you have to question whether they are fit to represent your Hospice. Other clinicians will take responsibility, which is exactly what you want! "I did it, I fess up. It won't happen again." You want people to take responsibility for their actions and to be grownups. This method of accountability can be applied to many, many things.

211

How does an organization take the "Punitive Feel" out of Accountability?

212

By attaching

Spiritual Principles/Values

to each Standard and then teaching them well.

But this is not so easy…as Spirituality comes from the CEO's and each Manager's personal enlightenment…

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The CEO is the Gatekeeper of the Standards

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People Develop has 4 Processes

- People Attraction Process
- People Selection Process
- People Development Process
- People Retention Process

The word "Talent" is a more powerful description than "People."

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Training Sequence Example

Step	What	Who	How
	People Attraction Process		
	1) Great Compensation 2) Inspirational/Spiritual Atmosphere	HR	Educational Events Advertising/Internet Word of Mouth Public Speaking
	People Selection Process		
A	Screening - Education Regarding Sunny Day's Vision, Values and Ideologies	CLO/HR	Link in Website
B	Screening - Technical Competencies	CLO/HR	Link in Website
C	Screening - Cultural Fit based on Values/Judgment Hartman Value Profile/ Steve Byrum Method Will Brown (423) 505-2580 willbrown@smith.com	CLO/HR	Link in Website
D	Phone Call to Determine Initial Impressions and Competency	2 People including HR	Standard Set of Questions 1) (2-5 seconds) 2) 1-2 Characteristics
E	Formal Interview	HR & applicable leaders	Ask standard set of questions
	People Development Process		
1	Introduce Self-Learning Modules	CLO	Web Learning
2	Sell Vision, Values & Ideologies	CEO	1) Live Presentation 2) Props 3) Demonstrate
3	Overview of the "Sunny Day" Model -Why and How the Model was Created -Set Yourself in the Patient Seat -Meticulous Attention to Details of the Experience/Feeling -Model Portals for Your Input -Our Measurements and Why they Matter -Meeting Formats	CLO Chief Learning Officer	1) Live Presentation 2) Props 3) Demonstrate 4) Exam
4	Teach the Sunny Day Phone Interaction	Phone Talent	Use similar methods as shown in Step 2
5	Teach the Sunny Visit Structure	Lead Visit Talent	Use similar methods as shown in Step 2
6	Teach the Business of Hospice	Lead Financial Talent	Use similar methods as shown in Step 2
7	Computer Curricula – Communications, Network	Lead Visit Talent	Use similar methods as shown in Step 2
8	Basic Documentation (for Everyone!)	Lead Visit Talent	Use similar methods as shown in Step 2
9	Demonstration in Synthetic Space	Lead Visit Talent	Demonstration of Competence in a Synthetic Space
10	Discipline Breakouts	Area Leader	
	People Retention Process		
1	1st Duty of the Clinical Leader	CLO	1/3 of the Clinical Leader's job is developing its people
2	Life-Skill Programs and Formal Personal Development Programs	CLO	Semi-monthly, non-mandatory meetings that teach life-skills and spiritual values
3	1) Great Compensation 2) Inspirational/Spiritual Atmosphere	Everyone!	The way we live and work every day!

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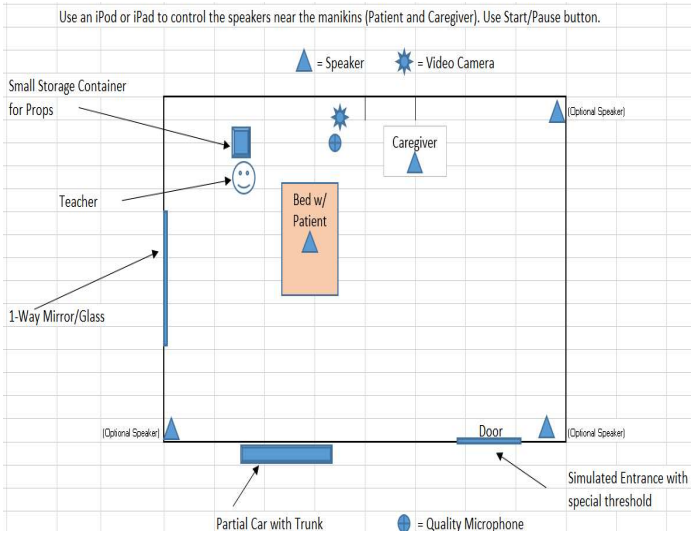
Wanted: Superstar clinical talent for a world-class healthcare organization where every aspect of the care experience is considered. People that are successful within our system of care aspire to provide the highest quality experience to all and love learning as well as teaching. Our cultural environment is a balance of purposeful and spiritually-rich work with excellent rewards based on providing extraordinary value. Please apply through our website. www.sunnydayway.com.

No phone calls please.

217

The Synthetic Lab



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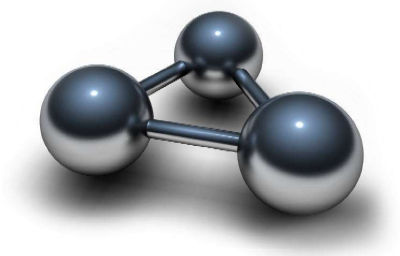
The Business of Hospice



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Questions? 828-698-3685

221

No Budgets!

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222

The Definition of Net Patient Revenue

Net Patient Revenue – Revenue earned for the provision of services to patients from sources such as Medicare, Medicaid, Commercial Insurance and Private Pay. It is less contractual allowances and bad debt. It does NOT include pass-through income such as: Nursing Home Room & Board, Contracted IP, Contracted Respite or Consulting Physician Services. It also DOES NOT include Community Support or Fundraising. It is very important that you have a clear understanding of this term because most comparison data is based on a percentage of Net Patient Revenue.

223

NPR = Net Patient Revenue

224

Calculating Percentage of Net Patient Revenue (NPR)

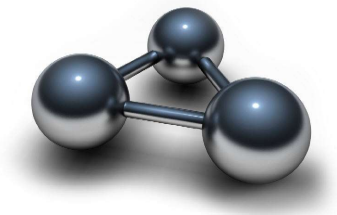
Example: Medication Costs for a Month

$25,000 ÷ $300,000 = 8.3%

All financial elements can be denominated as a Percentage of Net Patient-Revenue.

225

Benchmarking is absolutely necessary to be a True Professional Hospice Manager!



226

So what if you are hitting your own marks in a vacuum?

~ Jack Welsh

Benchmarking links you to the external world…

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Benchmarking

is the means by which an individual moves from the ranks of an amateur to the ranks of the

Professional

within a relatively short period of time.

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228

If a Hospice doesn't benchmark, the person or organization lacks the

intelligence

to really be a force in a competitive environment.

Get rid of the person that blocks or resists benchmarking…

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Why use the Percentage of Net Patient Revenue Approach rather than Patient-Days?

- Comparison - %s are comparable with other Hospice programs to help us gain perspective (Pros vs Amateurs)
- The Model - Is better suited for the creation of "the model". Percentages are "scaleable", meaning they can be used by any size of Hospice.
- Easy to Understand - People "get" percentages.

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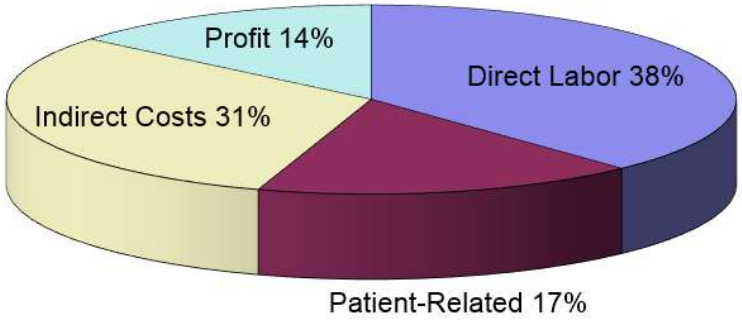
Model Based on NPR Percentages



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Understanding Hospice Measurements, Key Concepts & Definitions

- **Net Patient Revenue** – Revenue earned for the provision of services to patients from sources such as Medicare, Medicaid, Commercial Insurance and Private Pay. It is less contractual allowances and bad debt. It does NOT include pass-through income such as: Nursing Home Room & Board, Contracted IP, Contracted Respite or Consulting Physician Services. It also DOES NOT include Community Support or Fundraising. It is very important that you have a clear understanding of this term because most comparison data is based on a percentage of Net Patient Revenue.
- **Direct Labor** - Labor expense that is directly involved with the provision of care such as RNs, LPNs, CNAs, SWs, Chaplains and visiting physicians. It does NOT include supervisors or Managers even if they perform occasional visits. Bereavement, Volunteer, Triage, Admissions and On-Call areas are also considered Direct Labor. The staff of these areas provides direct care. All other labor costs are considered Indirect Labor.
- **Patient-Related Costs** – Costs such as Medications, Medical Supplies, Therapies, DME, etc. Sometimes they are referred to as Ancillary Costs. Other Patient-Related costs are: Ambulance, Bio-Hazardous Waste, Clinical Mobile Phones, Clinical Pagers, Lab, Outpatient, Mileage, etc.

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Understanding Hospice Measurements, Key Concepts & Definitions

- **Indirect Costs** – Are all costs other than Direct Labor and Patient-Related costs. There are also 3 sub-categories of Indirect Costs:
  - **Indirect Labor** – All labor that is NOT Direct Labor: the CEO, CFO, Clinical Managers, Medical Director, QI, Education, Medical Records, HR, Finance, IT, Housekeeping, Maintenance, etc.
  - **Facility-Related** – Costs related to your building or structure from which your organization coordinates or provides services. It includes: Rent, Utilities, Building Maintenance, Building Depreciation, Property Taxes, Building Loan Interest, etc.
  - **Operating Expense** – This category of Indirect Costs includes all costs that are not Facility-Related or Indirect Labor. These costs would include: Answering Service, Bank Service Changes, Audit Costs, Office Supplies, Printing, Postage, Telephone, Marketing Supplies, Continuing Education, Dues & Subscriptions, Computer Support, Computer Expense, etc.
- **Contribution Margin** – Contribution Margin is computed by subtracting Direct Expenses from Direct Revenue. The amount a team or business unit is "contributing" to Indirect Costs and Profit. It is the segment's Direct Revenue less Direct or Traceable expenses. A Hospice homecare team needs to be providing a 45% Contribution.

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Contribution Margin

The amount your area is internally "contributing" to cover Indirect Costs and provide for profit.

Example: Team C for a month

Patient Revenue	$100,000
Less: Direct Labor	$38,000 (38%)
Less: Patient-Related	$17,000 (17%)
Contribution Margin =	$45,000 (45%)

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Understanding Hospice Measurements, Key Concepts & Definitions

- **Patient Days** = ADC multiplied by the number of days in the period. OR the aggregate number of days patients were on Hospice services for a period of time.
- **ADC or Average Daily Census** = Total patient days in a period/number of period days.
- **FTE or Full-Time Equivalent** = Working hours in a period/the number of FTE hours. Normally, the number of annual hours used to compute an FTE is 2080. On a monthly basis, the average is 173 hours.
- **Average Length of Stay (Terminated Patients)** = Total patient-days for terminated patients/The number of terminated patients.
- **Median Length of Stay (Living Patients**) - This measurement has importance when CAP is a factor. It provides a truer picture of the overall mix of patients. It is NOT in the Standard reporting of most patient management systems. The best way to obtain this measurement is via an export of a list of your current patients on census with each patient's respective SOC (Start-of-Care) date into Excel. Subtract the current date (today) from the SOC date in a separate column. Then use Excel's =Median(cell range) formula to calculate your Median LOS.
- **Average Visits Per Patient, Per Week** = Total number of visits during a week by clinician divided by the number of patients served by the clinician.

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Understanding Hospice Measurements, Key Concepts & Definitions

- **Number of Visits Per Week** – This is the count of the number of visits per clinician per week (see the chart for Standards).
- **Number of Admissions Per Week** – This is the count of the number of admissions per Marketing FTE per week.
- **Number of Visits by Discipline per 8-Hour Day** = Total number of visits/(Total time worked/8).
- **Visit-Hours by Discipline per 8-Hour Day** = Total number of visit-hours/(Total time worked/8).
- **Computed Caseloads** = ADC/(Salaries/Average Hourly Rate/FTE Hours)
- **Days in Accounts Receivable** = Accounts Receivable/Annual Revenue X 365 or Period Days/AR Turnover Rate which is Net Patient Revenue divided by Patient Accounts Receivable.
- **Facility Mix** = Total number of patients in nursing homes and assisted living communities/Total number of Hospice patients.
- **Patient Mix over 365 Days** = Number of patients that have been on Hospice service for more than a year/Total number of patients.
- **Death Service Percentage** = Total Program Deaths/Total Deaths in Service Area. This is the true indicator of Hospice penetration.

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Productivity Measures

Number of Visits or Number of Visit-Hours

Total Time Worked ÷ 8

237

Computed Caseload

ADC

Total Salaries for a Discipline ÷
Average Hourly Rate ÷ FTE Hours

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Understanding Hospice Measurements, Key Concepts & Definitions

- **Admission/Inquiry Percentage** = Total Number of Admissions/Total Number of Inquiries.
- **Same Day Visit Percentage** = Total number of admission or informational visits in a day/Total number of Inquiries in that same day.
- **Pass-Through** - A Pass-Through is where the Hospice bills on behalf of another entity that cannot bill for itself, due to government regulations. The Hospice then reimburses the contracted entity (hospital, nursing home, consulting physician) based on the contract between them. There are 4 major types of Pass-Throughs. :
  - Nursing Home Room & Board
  - General Inpatient in Contracted Hospitals
  - Consulting Physician Services.
  - Respite Care in Contracted Facilities
- **Development Return Ratio** = Total revenue from Community Support and Fundraising/Total expense for the Development Function.

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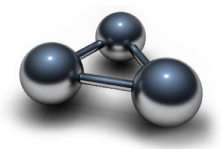
The Manager's Job is to manage the area's NPR%s at or below the Model.

To be frank, if you can't do this, we don't need you as a Manager.



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Key Measurements

	Measurement	Median	Model	Excellent
a.	Average Length of Stay (Terminated)	69	90	??
b.	Median Length of Stay (Living)		140	<165
c.	Days in Accounts Receivable	45	45	42
d.	Facility Mix	23%	35%	50%
e.	Patient Mix over 365 Days		10%	<30%
f.	Death Service Percentage	36%	40%	50%
g.	Admission/Inquiry Percentage	65%	75%	85%
h.	Same Day Visit Percentage			80%
i.	Development Ratio	3:1	4:1	6:1

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Hospice Homecare Costs

	Cost Category	Median	Model	90th
a.	Total Direct Labor	43.1%	38%	31.8%
b.	Total Patient-Related	16.4%	15%	11.4%
c.	Contribution Margin	41.3%	47%	52.1%*
d.	Total Indirect Costs	36.7%	34%	25.3%*
e.	Indirect: Salary Costs	23.2%	22%	15.9%
f.	Indirect: Operational Costs	8.8%	8%	5.3%
g.	Indirect: Facility-Related	3.8%	4%	1.5%
h.	Net Operational Income	4.5%	13%	26.8%*
	Direct Labor *(Benefits included, 22%)*			
i.	Nursing	18.1%	14%	12.74%
j.	Aides	5.6%	7%	3.72%
k.	SW	4.1%	4%	2.75%
l.	Spiritual Care	2.1%	2%	1.10%
m.	Physician (Net)	2.6%	2%	.52%
n.	On-Call	3.9%	3%	0.99%
o.	Admissions	3.9%	3%	1.21%
p.	Bereavement	1.3%	1%	.45%
q.	Volunteer	.9%	2%	.47%
r.	Call Center/Triage	1.7%	2%**	.45%
	Direct Labor Subtotal	43.1*	38.00%	31.76%*
	Primary Patient-Related Items			
s.	Medical Supplies	1.8%	1.5%	.89%
t.	Therapies & Outpatient	.4%	.5% to 3%	.04%
u.	DME	4.0%	4.0%	2.91%
v.	Imaging & Diagnostics	1.3%	.1%	.01%
w.	Ambulance	.4%	.4%	.07%
x.	Pharmacy	4.8%	4.5%	3.10%
y.	Lab	.07%	.1%	.1%
z.	Mileage	2.3%	2.25%	1.28%
	Pass-Throughs & Other	.7%	.3%	-1.47%
	Patient-Related Subtotal	16.4%*	15%	11.44%*

** - Each benchmark median is an independent data point as well as totals. Therefore, the total rarely equals the sum of the data points as it is difficult to be in the 90th percentile in all categories. Some numbers may be rounded for ease of memorization.*

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Indirect Costs

	Indirect Salaries *(Total Organization)*	Median	Model	90th
a.	Administrative Salaries **	5.9%	3.50%	2.42%
b.	Clinical Management Salaries **	5.3%	4.75%	2.01%
c.	Compliance/QAPI	1.5%	1.25%	.57%
d.	Education	.9%	2.00%	.22%
e.	Finance Salaries	2.6%	2.25%	1.11%
f.	HR	1.2%	1.00%	.43%
g.	Marketing Salaries	2.8%	3.75%	.81%
h.	Medical Director	1.9%	2.00%	.38%
i.	Medical Records Salaries	.90%	1.00%	.31%
j.	IT Salaries	1.3%	1.25%	.41%
k.	Other	.8%	0%	.06%
	Indirect Salaries Subtotal	23.2%*	22.00%	15.93%*
	Indirect Operational *(Total Organization)*			
l.	Computer Expenses	1.4%	1.00%	.22%
m.	Continuing Education+	.2%	.30%	.05%
n.	Dues, Licenses & Subscriptions	.6%	.40%	.14%
o.	Insurance	.6%	.60%	.21%
p.	Office Supplies	.3%	.2%	.09%
q.	Postage/Mailings/Printing	.3%	.25%	.05%
r.	Telephone	.8%	.90%	.16%
s.	Marketing	.8%	1%	.18%
	Indirect Operational Subtotal	8.8%*	8.00%	5.29%*

** - Each benchmark median is an independent data point as well as totals. Therefore, the total rarely equals the sum of the data points as it is difficult to be in the 90th percentile in all categories. Some numbers may be rounded for ease of memorization.*

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Hospice Inpatient Units

	Cost Category	Median	Model	90th
a.	Total Direct Labor *(includes all unit staff)*	75.1%	62.50%	54.62%
b.	Total Patient-Related	14.1%	12.00%	7.89%
c.	Contribution Margin	11.93%	25.50%	32.81%
d.	Indirect Costs *(includes some allocated costs)*	33.08%	18.00%	10.68%
	Segment Net Income	-23.68%*	7.50%	7.84%*
	Direct Labor *(Benefits included, 22%)*			
e.	Nursing	48.4%	35%	34.09%
f.	Aide	15.9%	15%	8.57%
g.	SW	3.1%	3.0%	1.74%
h.	Manager/Charge Nurse *(RN preferred w/ IPU 15 bed or <)*		6.5%	
i.	Ward Clerks		5%	
j.	Physician (NET) *(should pay for themselves through billings)*		1%	
k.	Grounds and Maintenance *(may be part of Indirect.)*		2.5%	
	Total		**68%**	
	Patient-Related			
l.	Ambulance	1.4%	1.00%	.21%
	Biohazardous	.15%	.15%	.03%
m.	Dietary	.51%	.20%	.03%
n.	DME	.47%	.45%	.10%
o.	Food *(includes labor)*	2.11%	2.00%	.55%
p.	Imaging	.04%	.05%	.02%
q.	Lab	.06%	.05%	.01%
r.	Linen	.99%	1.00%	.28%
s.	Medical Supplies	2.12%	1.75%	1.21%
t.	Mileage	.12%	.10%	.03%
u.	Mobile Phone	.11%	.10%	.02%
	Other	.18%	.10%	.02%
v.	Outpatient	.15%	.15%	.01%
w.	Oxygen	.62%	.60%	.18%
x.	Pharmacy	3.94%	3.50%	1.93%
y.	Therapies	.28%	.30%	.03%
z.	Subtotal	14.11%*	12.00%*	7.89%*

** - Each benchmark median is an independent data point as well as totals. Therefore, the total rarely equals the sum of the data points as it is difficult to be in the 90th percentile in all categories. Some numbers may be rounded for ease of memorization.*

244

12-14%

This is our recommendation for a typical Hospice's Homecare(including Nursing Homes/ALFs) Net Income goal at present, with a sold **10%** being the Net Income goal when ALL programs (IP Unit, Palliative Care, Community Bereavement, Peds) are combined.
This is WITHOUT community support.

245

Reserves: How much?

6-9 Months

This is our recommendation for a typical Hospice. A Hospice should have 6-9 months of operating costs.

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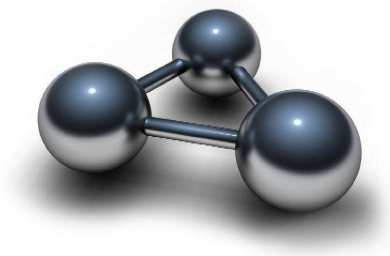
CAP Calculations

- Aggregate
  - MCR Admissions X CAP Rate
  - Example: 200 X 19,000 = $3,800,000
- Inpatient
  - Less than 20% of MCR Patient-Days can be at the GIP Level of Care
  - Example: If MCR Patient-Days total 20,000 in a year, then only 4,000 days can be at the GIP Level of Care

247

Benchmarking



Questions? 626-698-3885

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Benchmarking – External References

Benchmarks are absolutely necessary to move from the ranks of *amateur* Manager to the ranks of the Hospice *professional*. Our movement is overflowing with people masquerading as Hospice professional Managers. This is evidenced by poor financial performance. **HOW** can a Manager be a professional without quite precise financial knowledge of the industry (movement)? This continually evolving knowledge should be recitable from memory. If it isn't, it isn't deep enough…

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Behind Every Line is a Practice

I use financial benchmarking as a road map. Each line represents an area of focus and there is a best known practice for each.

In the MVI world, ***cost follows function***. This means that all traceable costs for a function are grouped in each line. Examples: Admissions would include the admissions RN and any supporting staff for the admission function. If a CFO wants an assistant, the assistance is charged to the Finance area, not Administration.

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If measurements are flawed….

MEaRSURE

anyway!!!!!

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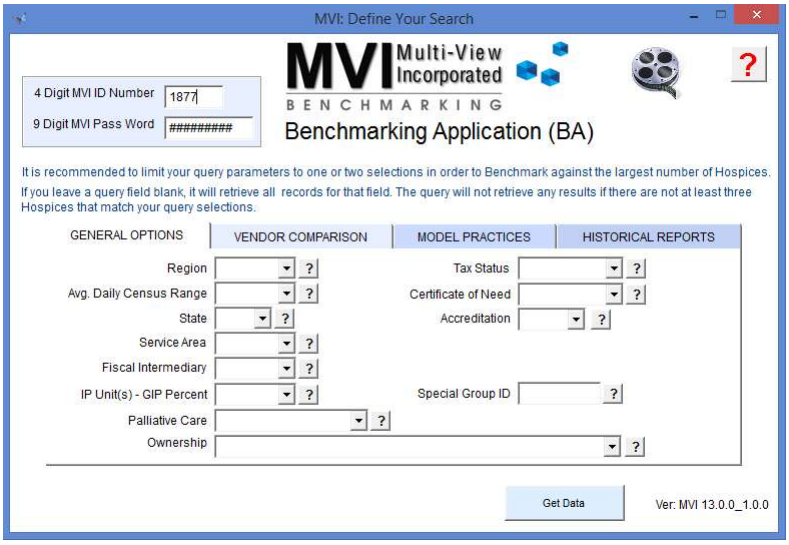

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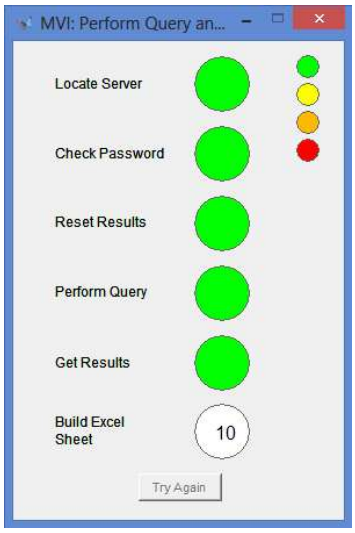

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Reality

IP Unit ~ Net Percentage of Revenue Comparison

Sunny Day Hospice | **2025 - YTD May**

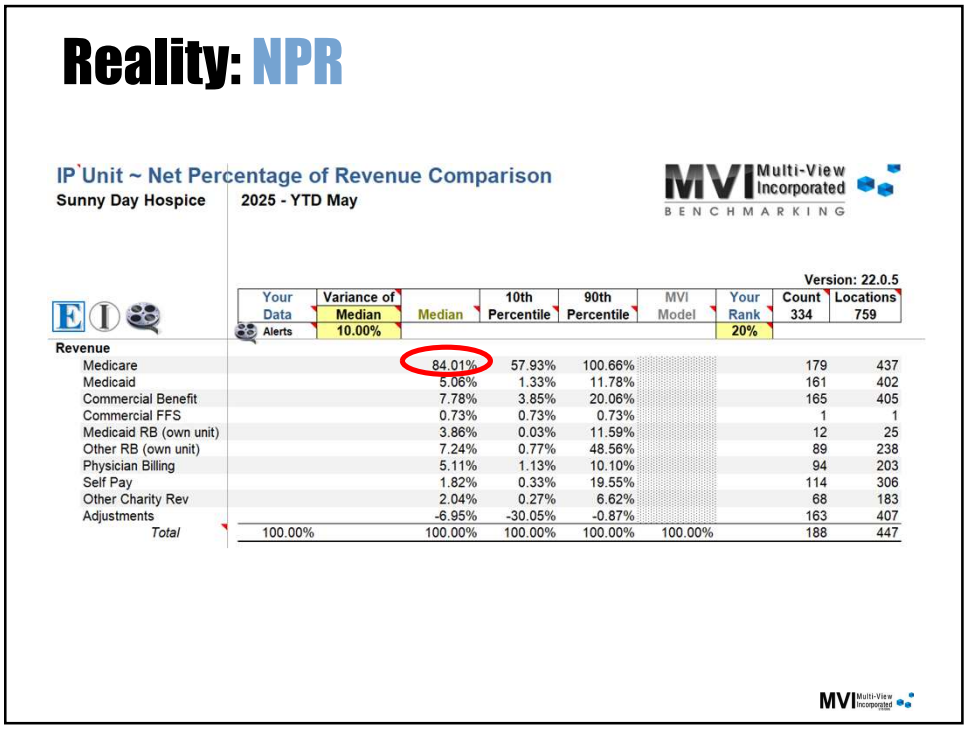
MVI Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data / Alerts	Variance of Median 10.00%	Median	10th Percentile	90th Percentile	MVI Model	Your Rank 20%	Count 334	Locations 759
Outpatient			0.17%	0.74%	0.01%	0.15%		45	199
Oxygen			0.61%	1.97%	0.17%	0.60%		100	254
Pagers			0.03%	0.15%	0.02%			5	8
Pharmacy			3.88%	6.71%	1.96%	3.50%		171	413
Therapies			0.29%	2.80%	0.02%	0.30%		86	262
Pass-Through Residual			0.04%	6.17%	-1.51%			46	168
Total			14.00%	22.76%	7.48%	12.00%		178	428
Total Direct Expense			88.03%	116.78%	63.46%	74.50%		183	440
Contribution Margin			**12.09%**	**-16.22%**	**36.54%**	**25.50%**		**182**	**439**
Indirect Expense			29.14%	56.67%	11.72%	18.00%		186	445
Net Segment Income			**-18.85%**	**-73.54%**	**10.35%**	**7.50%**		**184**	**441**

254

Reality: NPR



IP Unit ~ Net Percentage of Revenue Comparison

Sunny Day Hospice | 2025 - YTD May

MVI Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data / Alerts	Variance of Median 10.00%	Median	10th Percentile	90th Percentile	MVI Model	Your Rank 20%	Count 334	Locations 759
Revenue									
Medicare			84.01%	57.93%	100.66%			179	437
Medicaid			5.06%	1.33%	11.78%			161	402
Commercial Benefit			7.78%	3.85%	20.06%			165	405
Commercial FFS			0.73%	0.73%	0.73%			1	1
Medicaid RB (own unit)			3.86%	0.03%	11.59%			12	25
Other RB (own unit)			7.24%	0.77%	48.56%			89	238
Physician Billing			5.11%	1.13%	10.10%			94	203
Self Pay			1.82%	0.33%	19.55%			114	306
Other Charity Rev			2.04%	0.27%	6.62%			68	183
Adjustments			-6.95%	-30.05%	-0.87%			163	407
Total		100.00%	100.00%	100.00%	100.00%	100.00%		188	447

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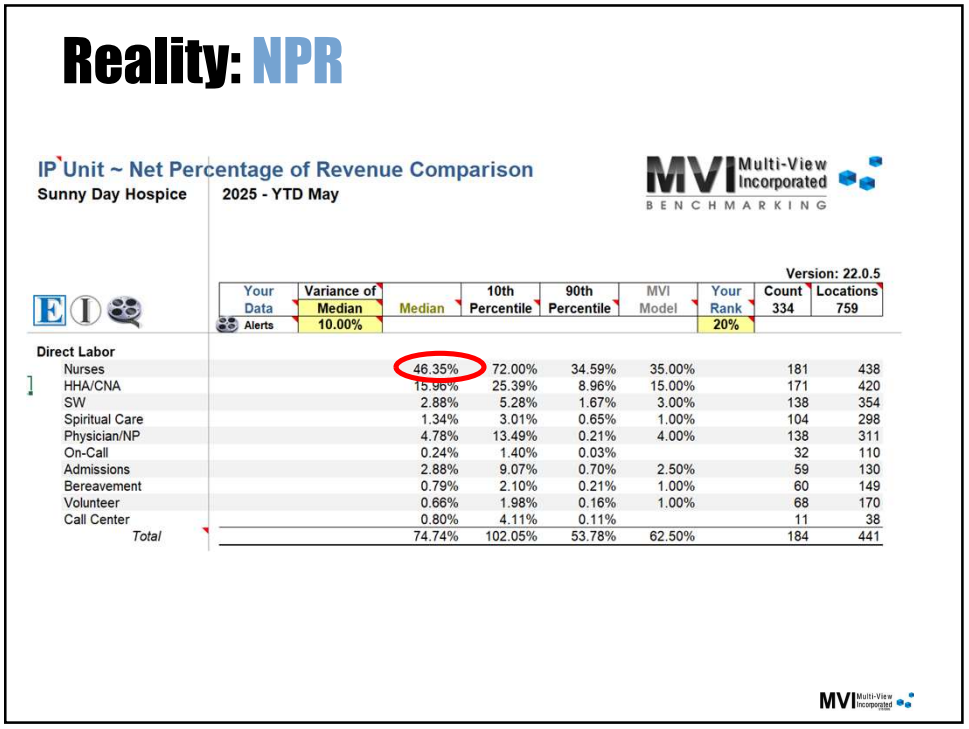
Reality: NPR



IP Unit ~ Net Percentage of Revenue Comparison

Sunny Day Hospice | 2025 - YTD May

MVI Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data / Alerts	Variance of Median 10.00%	Median	10th Percentile	90th Percentile	MVI Model	Your Rank 20%	Count 334	Locations 759
Direct Labor									
Nurses			46.35%	72.00%	34.59%	35.00%		181	438
HHA/CNA			15.96%	25.39%	8.96%	15.00%		171	420
SW			2.88%	5.28%	1.67%	3.00%		138	354
Spiritual Care			1.34%	3.01%	0.65%	1.00%		104	298
Physician/NP			4.78%	13.49%	0.21%	4.00%		138	311
On-Call			0.24%	1.40%	0.03%			32	110
Admissions			2.88%	9.07%	0.70%	2.50%		59	130
Bereavement			0.79%	2.10%	0.21%	1.00%		60	149
Volunteer			0.66%	1.98%	0.16%	1.00%		68	170
Call Center			0.80%	4.11%	0.11%			11	38
Total			74.74%	102.05%	53.78%	62.50%		184	441

MVI Multi-View Incorporated

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Reality: NPR

IP Unit ~ Net Percentage of Revenue Comparison
Sunny Day Hospice 2025 - YTD May

Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data	Variance of Median	Median	10th Percentile	90th Percentile	MVI Model	Your Rank	Count 334	Locations 759
Alerts		10.00%					20%		
Direct Patient-Related Expenses									
Ambulance			1.49%	4.09%	0.20%	1.00%		154	399
Bio Hazardous			0.15%	0.57%	0.04%	0.15%		88	214
Crisis Care			0.11%	0.42%	0.01%	0.20%		6	17
Dietary			0.34%	2.87%	0.01%	0.50%		44	77
DME			0.53%	1.75%	0.07%	0.45%		139	332
ER			0.05%	0.65%	0.02%			17	97
Food			2.02%	7.21%	0.50%	2.00%		164	385
Imaging			0.04%	0.20%	0.01%	0.05%		58	204
Lab			0.05%	0.34%	0.01%	0.05%		82	269
Linen			0.97%	2.51%	0.11%	1.00%		129	351
Medical Supplies			2.07%	3.50%	1.08%	1.75%		176	434
Mileage			0.12%	0.44%	0.02%	0.10%		127	348
Mobile Phone			0.10%	0.44%	0.02%	0.10%		81	238
Other			0.20%	0.59%	0.02%	0.10%		101	238
Outpatient			0.17%	0.74%	0.01%	0.15%		45	199
Oxygen			0.61%	1.97%	0.17%	0.60%		100	254
Pagers			[illegible]	0.15%	0.02%			5	8
Pharmacy			3.88%	6.71%	1.96%	3.50%		171	413
Therapies			0.29%	2.80%	0.02%	0.30%		86	262
Pass-Through Residual			0.04%	6.17%	-1.51%			46	168
Total			14.00%	22.76%	7.48%	12.00%		178	428
Total Direct Expense			88.03%	116.78%	63.46%	74.50%		183	440

MVI Multi-View Incorporated

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Reality: Patient-Day

IP Unit ~ Patient-Day Comparison
Sunny Day Hospice 2025 - YTD May

Multi-View Incorporated BENCHMARKING

Version: 22.0.5

	Your Data	Variance of Median	Median	10th Percentile	90th Percentile	MVI Model	Your Rank	Count 334	Locations 759
Alerts		$ 10.00					20%		
Direct Labor									
Nurses			$ 332.22	$ 490.24	$ 203.61			181	438
HHA/CNA			108.81	173.42	52.95			171	420
SW			20.60	41.80	10.70			138	354
Spiritual Care			10.58	22.76	4.12			104	298
Physician/NP			32.63	107.15	1.42			137	310
On-Call			1.24	14.70	0.05			36	121
Admissions			21.94	61.72	4.72			59	130
Bereavement			5.17	15.80	1.72			61	159
Volunteer			4.65	14.56	1.14			68	170
Call Center			5.18	20.66	0.64			11	38
Total			$ 520.42	$ 718.35	$ 315.98			183	440
Direct Patient-Related Expenses									
Ambulance			$ 9.54	$ 28.73	$ 1.40			154	399
Bio Hazardous			1.10	4.21	0.27			88	214
Crisis Care			0.70	2.64	(0.32)			7	20
Dietary			1.57	17.23	0.03			50	88
DME			3.27	12.18	0.56			139	332
ER			0.39	4.41	0.08			18	98
Food			14.06	52.10	2.94			163	384
Imaging			0.28	1.44	0.07			61	207
Lab			0.26	1.71	0.02			97	307
Linen			7.18	17.82	0.91			128	350
Medical Supplies			14.07	26.42	6.82			174	432
Mileage			0.81	2.92	0.09			134	361
Mobile Phone			0.65	2.73	0.12			83	240
Other			1.12	4.61	0.10			103	247
Outpatient			0.87	6.64	0.04			48	205
Oxygen			4.58	12.80	1.30			101	255
Pagers			0.15	3.05	0.01			6	9
Pharmacy			24.65	53.01	12.44			171	413
Therapies			1.70	20.43	0.10			87	264
Pass-Through Residual			0.14	36.39	(8.51)			50	179
Total			$ 98.41	$ 180.20	$ 38.43			177	427
Total Direct Expense			$ 612.21	$ 866.13	$ 382.68			182	439

MVI Multi-View Incorporated

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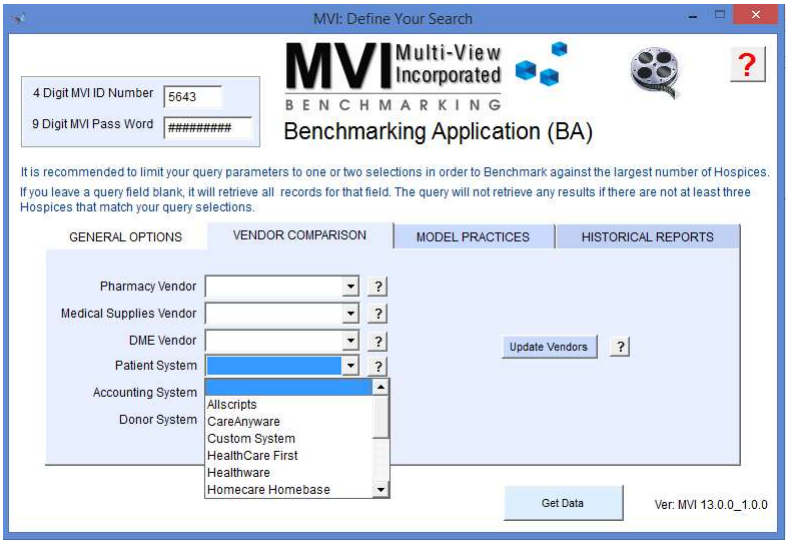
Vendor Selection – Critical to the Value Chain



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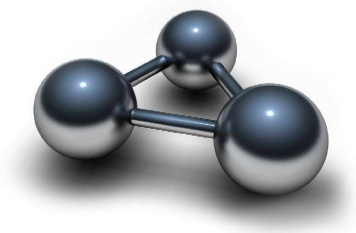
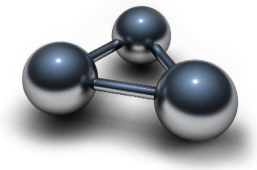
IPU Practices



260

Self Evaluation

You must be willing and able to "get real" with yourself in order to advance…like an AA meeting.



MVI Multi-View Incorporated SYSTEMS

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IPU Practices

1. **Design/Location of the IP Unit.**
2. **The Manager of the IP Unit is the <u>Primary Factor</u> in making a Hospice IP Unit Successful.**
3. **Physician Practices**
4. **The IPU Manager is given "Sweeping Powers" to "bring patients" into the IPU from Hospice Homecare.**
5. **The IPU Manager is Has Skin in the Game.**

MVI

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IPU Practices

6. Manage on a Contribution Margin basis.
7. All IPU Staff's Compensation Increases or Decreases with Census Changes.
8. Propensity Reports
9. Speed Up Physician Rounding
10. Market it as a "Specialty Unit."
11. A Well-Managed IP Unit makes Money.
12. Units allow a Hospice serve a new class of patient.

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IPU Practices

13. The Over Looked Value of IP Units on the Hospice Aggregate CAP.
14. The Magic Number.
15. There is ALWAYS Room at the Inn! NEVER NO!
16. The "Zone" is to manage the IPU between the Magic Number and capacity. This is a type of "self-regulation."
17. An Occupancy Protocol should be Automatically used when the IPU Census Nears the Magic Number.

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IPU Practices

18. Use the MVI F9 IPU-Continuous Care Planning & Management Tool to Manage Your Unit on an On-Going Basis.
19. Averaging ONE Patient above the breakeven or to the Magic Number translates to $150,000 to $225,000 profit.
20. The On-Going Cultivation of Referral Sources. ***The IPU Manager is a marketer!!!!!!***
21. Feasibility Studies?
22. Will Other Hospices Contract with your IPU for GIP care?

265

IPU Practices

23. "Build it and They Will Come?"
24. Ideal Size of Units - 7 Bed Pods
25. Use Professionals
26. Build something that is marked by Excellence!
27. If the Design of the Unit is too Large, then staff it with People that want to Walk…
28. Make your IPU an Outrageously Attractive Place to Work.
29. On-Stage, Off-Stage.
30. Food Services - 65% of IPU Patients Don't Eat (substantially).

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IPU Practices

31. Staffing Model
32. 12-Hour Shifts
33. Some IPUs are staffed 100% with Flex positions.
34. Don't have a Dedicated Spiritual Care or Volunteer Coordinators at the IPU.
35. With smaller units, the IPU Manager should be an RN.
36. NEVER use Contracted staff for your IPU.
37. PRN or Flex Staff must be Trained and Held to the Same Standards as Regular Staff. *Do not pay a premium for PRN staff.*

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IPU Practices

38. Markers Need to Play a Role in Keeping the IPU filled.
39. The CEO or COO should move their office to IPU if the IPU is losing money.
40. Mix of Patients (Inpatient vs. Residential).
41. Keep Residential Bed Utilization at LESS than 10%.
42. Residential Patients cost nearly the same as GIP Patients, UNLESS they are in a completely separate facility.

268

IPU Practices

43. Start the Discharge Process on the Day of Admission.
44. The Profile of the IPU SW needs to be TOUGH and FAST.
45. Educate your Homecare Staff about the Unit.
46. Sell the IPU internally.
47. Utilize existing facilities.
48. Contributions Usually Increase.
49. How to pay for your unit?
50. Task Lists are used to Systematize the Maintenance and Upkeep of the IPU.

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IPU Practices

51. Billing Options?
52. Run Continuous Care in your IPU if the state has limited your GIP Beds.
53. An IPU is only as Good as its Weakest Vendor.
54. "Patients are Sicker Today" – They need more IVs.
55. IPU Staff should have Uniforms.
56. Documentation – Before coming to the IPU, During the Stay and upon Discharge or Death.
57. In Benchmarking, pay attention to the 90th percentile.
58. Respite Care – Use it sparingly.

270

IPU Practices

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271

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272

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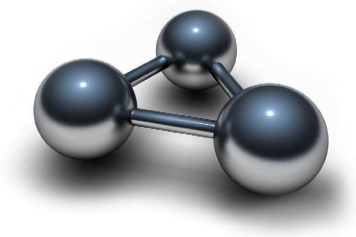
IPU Reports



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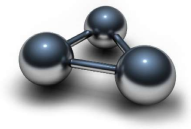
Don't just take the CFO budget as what you manage to! Use your **Tool**!



MVI Multi-View Incorporated

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Inpatient Unit Management Report

Team:
Period: For the Period Ending March 31, 2008
Year: 2008

	Period Actual	Period NPR%	YTD Actual	YTD NPR%	Model NPR% Standard	NPR% Variance Period from Standard	NPR% Variance YTD from Standard
Manager/Charge RN	-	0.00%	-	0.00%	6.50%	6.50%	6.50%
Ward Clerks	67,875.89	56.85%	197,205.20	58.13%	3.50%	-53.35%	-54.63%
Nurses	35,098.67	29.40%	102,830.72	30.31%	33.00%	3.60%	2.69%
Hospice Aide	27,135.76	22.73%	77,838.65	22.94%	15.00%	-7.73%	-7.94%
SW	-	0.00%	-	0.00%	2.50%	2.50%	2.50%
Spiritual Care	1,304.37	1.09%	3,772.32	1.11%	1.00%	-0.09%	-0.11%
Physician	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Nurse Practitioner	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
On-Call	5,115.84	4.29%	14,648.86	4.32%	1.00%	-3.29%	-3.32%
Admissions	2,432.12	2.04%	6,056.94	1.79%	1.00%	-1.04%	-0.79%
Bereavement	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Volunteer	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Other/Maintenance	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Total	138,962.64	1.16	402,352.70	1.19	68.50%	-47.90%	-50.10%

F9 Parameters

Location	Dept/Disc	Na
3	C0	40
3		40
3	61,62	40
3	65	40
3	66	40
4	67	40
	6M	58
	6N	
4	63,64	40
4	I?	40
4	B?	40
4	V0	40
4	6F,6G	40

Controls | HomeCare to IPU Allocation | Benefits | IPU Management Report

MVI Multi-View Incorporated

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Inpatient Unit Management Report

Team:
Period: For the Period Ending March 31, 2008
Year: 2008

	Period Actual	Period NPR%	YTD Actual	YTD NPR%	Model NPR% Standard	NPR% Variance Period from Standard	NPR% Variance YTD from Standard
Revenue							
Medicare	111,300.00	93.23%	319,200.00	94.09%	80.00%	-13.23%	-14.09%
Medicaid	4,200.00	3.52%	9,800.00	2.89%	5.00%	1.48%	2.11%
Commercial Benefit	7,000.00	5.86%	19,600.00	5.78%	8.00%	2.14%	2.22%
Commercial FFS	-	0.00%	-	0.00%	5.00%	5.00%	5.00%
Medicaid RB (own unit)	-	0.00%	-	0.00%	3.00%	3.00%	3.00%
Other RB (own unit)	-	0.00%	-	0.00%	6.00%	6.00%	6.00%
Physician Billing	-	0.00%	-	0.00%	6.00%	6.00%	6.00%
Self Pay	-	0.00%	-	0.00%	2.00%	2.00%	2.00%
Other Charity Rev	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Adjustments	(3,114.07)	-2.61%	(9,342.60)	-2.75%	-10.00%	-7.39%	-7.25%
Total	119,385.93	100.00%	339,257.40	100.00%	106.00%	6.00%	6.00%
						Desirable NonDesirable	Desirable NonDesirable
IPU Labor							
Manager/Charge RN	-	0.00%	-	0.00%	6.50%	6.50%	6.50%
Ward Clerks	67,875.89	56.85%	197,205.20	58.13%	3.50%	-53.35%	-54.63%
Nurses	35,098.67	29.40%	102,830.72	30.31%	33.00%	3.60%	2.69%
Hospice Aide	27,135.76	22.73%	77,838.66	22.94%	15.00%	-7.73%	-7.94%
SW	-	0.00%	-	0.00%	2.50%	2.50%	2.50%
Spiritual Care	1,304.37	1.09%	3,772.32	1.11%	1.00%	-0.09%	-0.11%
Physician	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Nurse Practitioner	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
On-Call	5,115.84	4.29%	14,648.86	4.32%	1.00%	-3.29%	-3.32%
Admissions	2,432.12	2.04%	6,056.94	1.79%	1.00%	-1.04%	-0.79%
Bereavement	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Volunteer	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Other Maintenance	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Total	138,962.64	1.16	402,352.70	1.19	66.50%	-47.90%	-50.10%

MVI Multi-View Incorporated

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Inpatient Unit Management Report

Team:
Period: For the Period Ending March 31, 2008
Year: 2008

	Period Actual	Period NPR%	YTD Actual	YTD NPR%	Model NPR%	NPR% Variance Period from	NPR% Variance YTD from
						Desirable NonDesirable	Desirable NonDesirable
Direct Patient Related Expenses							
Ambulance	135.00	0.11%	506.30	0.15%	1.00%	0.89%	0.85%
Bio Hazardous	-	0.00%	-	0.00%	0.10%	0.10%	0.10%
Dietary	62.96	0.05%	164.90	0.05%	0.08%	0.03%	0.03%
DME	490.34	0.41%	1,307.56	0.39%	0.40%	-0.01%	0.01%
ER	1,284.46	1.08%	3,636.14	1.07%	0.00%	-1.08%	-1.07%
Food	1,219.37	1.02%	4,030.81	1.19%	1.75%	0.73%	0.56%
Imaging	-	0.00%	-	0.00%	0.10%	0.10%	0.10%
Lab	8.50	0.01%	8.50	0.00%	0.10%	0.09%	0.10%
Linen	569.89	0.48%	1,816.80	0.54%	1.00%	0.52%	0.46%
Medical Supplies	1,284.46	1.08%	3,636.14	1.07%	2.00%	0.92%	0.93%
Mileage	-	0.00%	-	0.00%	0.12%	0.12%	0.12%
Mobile Phone	-	0.00%	-	0.00%	0.07%	0.07%	0.07%
Other	-	0.00%	-	0.00%	0.00%	0.00%	0.00%
Outpatient	-	0.00%	-	0.00%	0.15%	0.15%	0.15%
Oxygen	-	0.00%	-	0.00%	0.48%	0.48%	0.48%
Field Device (Pagers)	-	0.00%	-	0.00%	0.00%	0.00%	0.00%
Pharmacy	-	0.00%	-	0.00%	4.00%	4.00%	4.00%
Therapies	71.99	0.06%	1,945.14	0.57%	0.50%	0.44%	-0.07%
Pass-Through Residual	-	0.00%	-	0.00%	0.00%	0.00%	0.00%
Total	5,126.97	4.29%	17,052.29	5.03%	12.00%	7.71%	6.97%
Total Direct Expense	144,089.61	120.69%	419,404.99	123.62%	80.50%	-40.19%	-43.12%
Contribution Margin	(24,703.68)	-20.69%	(80,147.59)	-23.62%	25.50%	46.19%	49.12%
Statistics							
ADC	-		-		10.0	10.00	10.00
g/p	-		-		8.0	8.00	8.00
Residential	-		-		1.0	1.00	1.00
gc	-		-		1.0	1.00	1.00
Respite	-		-		-	0.00	0.00
ALOS	-		-		8.0	8.00	8.00
Number of Patient Days	-		-		0.1	0.07	0.07
g/p	-		-		0.1	0.07	0.07
Residential	-		-		0.1	0.07	0.07
gc	-		-		0.1	0.07	0.07
Respite	-		-		0.1	0.07	0.07
% of Occupancy	-		-		0.4	0.07	0.07

MVI Multi-View Incorporated

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Inpatient Unit Management Report

Team:
Period: **For the Period Ending March 31, 2008**
Year: **2008**

	Period Actual	Period NPR%	YTD Actual	YTD NPR%	Model NPR% Standard	NPR% Variance Period from Standard	NPR% Variance YTD from Standard
Manager/Charge RN	-	0.00%	-	0.00%	6.50%	6.50%	6.50%
Ward Clerks	67,875.89	56.85%	197,205.20	58.13%	3.50%	-53.35%	-54.63%
Nurses	35,098.67	29.40%	102,830.72	30.31%	33.00%	3.60%	2.69%
Hospice Aide	27,135.76	22.73%	77,838.65	22.94%	15.00%	-7.73%	-7.94%
SW	-	0.00%	-	0.00%	2.50%	2.50%	2.50%
Spiritual Care	1,304.37	1.09%	3,772.32	1.11%	1.00%	-0.09%	-0.11%
Physician	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Nurse Practitioner	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
On-Call	5,115.84	4.29%	14,648.86	4.32%	1.00%	-3.29%	-3.32%
Admissions	2,432.12	2.04%	6,056.94	1.79%	1.00%	-1.04%	-0.79%
Bereavement	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Volunteer	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Other/Maintenance	-	0.00%	-	0.00%	1.00%	1.00%	1.00%
Total	138,962.64	1.16	402,352.70	1.19	68.50%	-47.90%	-50.10%

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Inpatient Unit Management Report

Team:
Period: **For the Period Ending March 31, 2008**
Year: **2008**

	Period Actual	Period NPR%	YTD Actual	YTD NPR%	Model NPR% Standard	NPR% Variance Period from Standard	NPR% Variance YTD from Standard
Statistics							
ADC	-		-		10.0	10.00	10.00
GIP	-		-		8.0	8.00	8.00
Residential	-		-		1.0	1.00	1.00
CC	-		-		1.0	1.00	1.00
Respite	-		-		-	0.00	0.00
ALOS	-		-		8.0	8.00	8.00
Number of Patient Days	-		-		0.1	0.07	0.07
GIP	-		-		0.1	0.07	0.07
Residential	-		-		0.1	0.07	0.07
CC	-		-		0.1	0.07	0.07
Respite	-		-		0.1	0.07	0.07
% of Occupancy	-		-		0.1	0.07	0.07

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Working with the IPU Planning Tool

- The GOAL is to work with the Pro Forma and NPR tabs **(RED tabs)**
- However, all other tabs link back to these tabs. We will work in this sequence.
  - # of Beds, Square Footage
  - Revenue
  - Staffing
  - Patient-Related
  - Operational

You will then alter the tool to understand how cost behave at your IPU and form your IPU Model.

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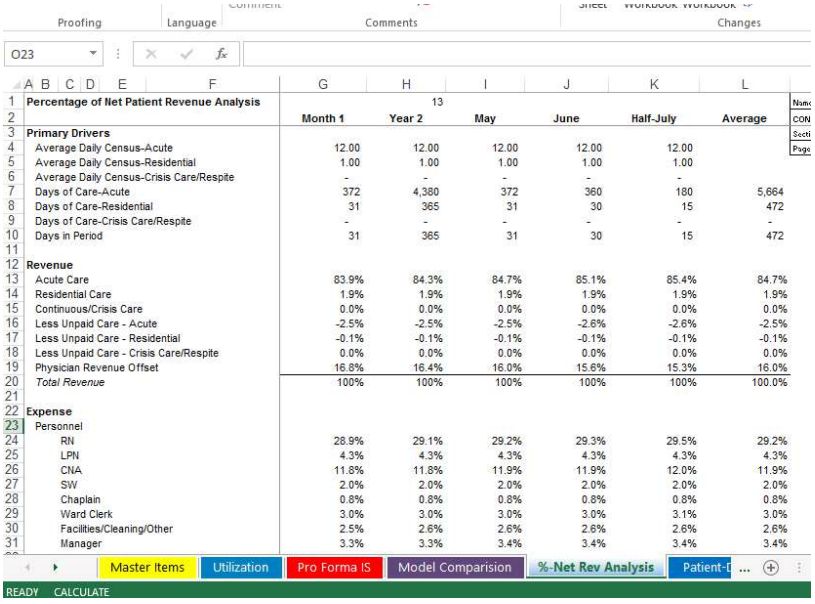

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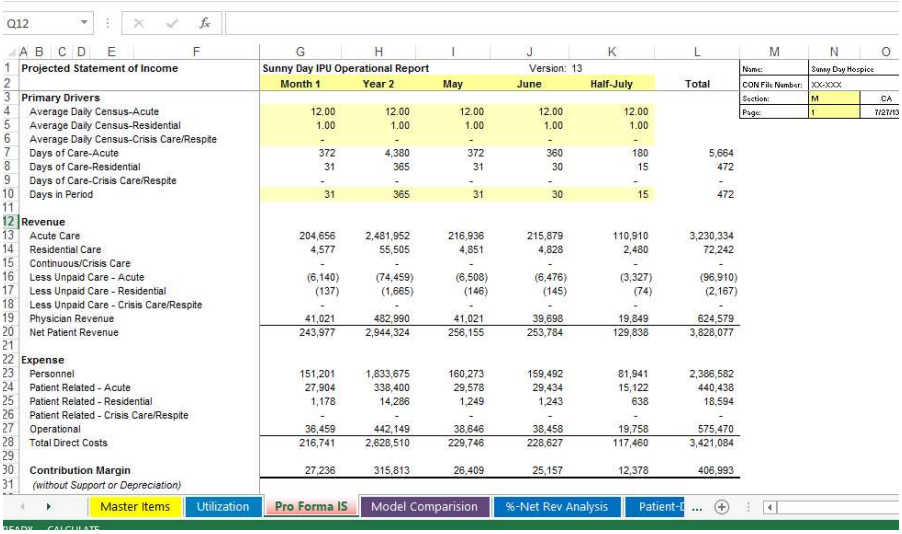

Projected Statement of Income	Sunny Day IPU Operational Report			Version: 13		
	Month 1	Year 2	May	June	Half-July	Total
Primary Drivers						
Average Daily Census-Acute	12.00	12.00	12.00	12.00	12.00	
Average Daily Census-Residential	1.00	1.00	1.00	1.00	1.00	
Average Daily Census-Crisis Care/Respite	-	-	-	-	-	
Days of Care-Acute	372	4,380	372	360	180	5,664
Days of Care-Residential	31	365	31	30	15	472
Days of Care-Crisis Care/Respite	-	-	-	-	-	-
Days in Period	31	365	31	30	15	472
Revenue						
Acute Care	204,656	2,481,952	216,936	215,879	110,910	3,230,334
Residential Care	4,577	55,505	4,851	4,828	2,480	72,242
Continuous/Crisis Care	-	-	-	-	-	-
Less Unpaid Care - Acute	(6,140)	(74,459)	(6,508)	(6,476)	(3,327)	(96,910)
Less Unpaid Care - Residential	(137)	(1,665)	(146)	(145)	(74)	(2,167)
Less Unpaid Care - Crisis Care/Respite	-	-	-	-	-	-
Physician Revenue	41,021	482,990	41,021	39,698	19,849	624,579
Net Patient Revenue	243,977	2,944,324	256,155	253,784	129,838	3,828,077
Expense						
Personnel	151,201	1,833,675	160,273	159,492	81,941	2,386,582
Patient Related - Acute	27,904	338,400	29,578	29,434	15,122	440,438
Patient Related - Residential	1,178	14,286	1,249	1,243	638	18,594
Patient Related - Crisis Care/Respite	-	-	-	-	-	-
Operational	36,459	442,149	38,646	38,458	19,758	575,470
Total Direct Costs	216,741	2,628,510	229,746	228,627	117,460	3,421,084
Contribution Margin	27,236	315,813	26,409	25,157	12,378	406,993
(without Support or Depreciation)						

Name:	Sunny Day Hospice	
CON File Number:	XX-XXX	
Section:	M	CA
Page:	1	7/27/13

Master Items | Utilization | Pro Forma IS | Model Comparision | %-Net Rev Analysis | Patient-D ...

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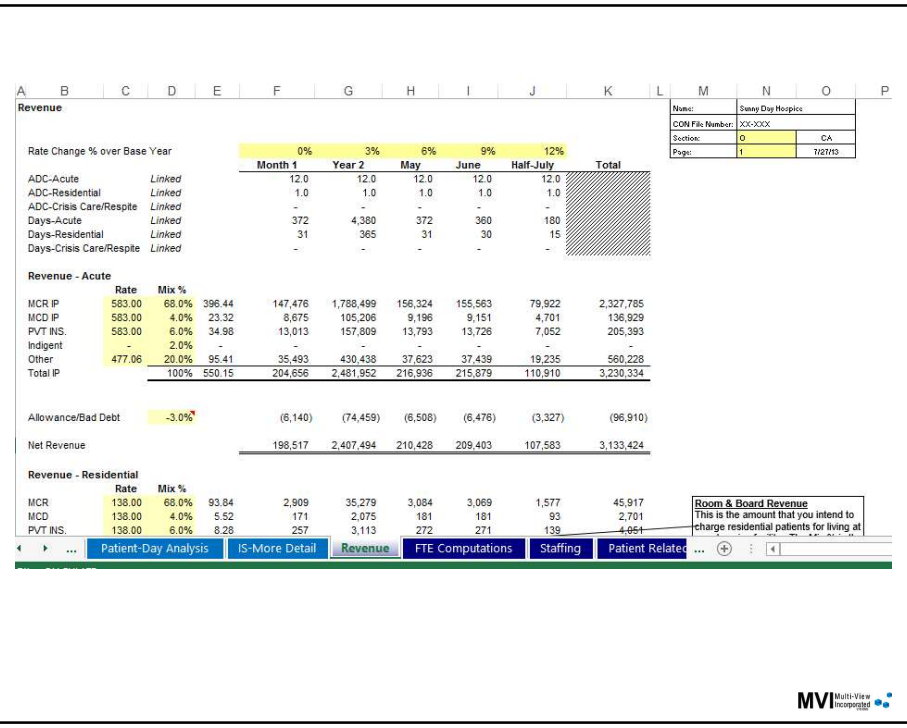

Revenue

Rate Change % over Base Year				0%	3%	6%	9%	12%	
				Month 1	Year 2	May	June	Half-July	Total
ADC-Acute	*Linked*			12.0	12.0	12.0	12.0	12.0	
ADC-Residential	*Linked*			1.0	1.0	1.0	1.0	1.0	
ADC-Crisis Care/Respite	*Linked*			-	-	-	-	-	
Days-Acute	*Linked*			372	4,380	372	360	180	
Days-Residential	*Linked*			31	365	31	30	15	
Days-Crisis Care/Respite	*Linked*			-	-	-	-	-	
Revenue - Acute									
	Rate	Mix %							
MCR IP	583.00	68.0%	396.44	147,476	1,788,499	156,324	155,563	79,922	2,327,785
MCD IP	583.00	4.0%	23.32	8,675	105,206	9,196	9,151	4,701	136,929
PVT INS.	583.00	6.0%	34.98	13,013	157,809	13,793	13,726	7,052	205,393
Indigent	-	2.0%	-	-	-	-	-	-	-
Other	477.06	20.0%	95.41	35,493	430,438	37,623	37,439	19,235	560,228
Total IP		100%	550.15	204,656	2,481,952	216,936	215,879	110,910	3,230,334
Allowance/Bad Debt		-3.0%		(6,140)	(74,459)	(6,508)	(6,476)	(3,327)	(96,910)
Net Revenue				198,517	2,407,494	210,428	209,403	107,583	3,133,424
Revenue - Residential									
	Rate	Mix %							
MCR	138.00	68.0%	93.84	2,909	35,279	3,084	3,069	1,577	45,917
MCD	138.00	4.0%	5.52	171	2,075	181	181	93	2,701
PVT INS.	138.00	6.0%	8.28	257	3,113	272	271	139	4,051

Name:	Sunny Day Hospice	
CON File Number:	XX-XXX	
Section:	O	CA
Page:	1	7/27/13

Room & Board Revenue
This is the amount that you intend to charge residential patients for living at

... Patient-Day Analysis | IS-More Detail | Revenue | FTE Computations | Staffing | Patient Related ...

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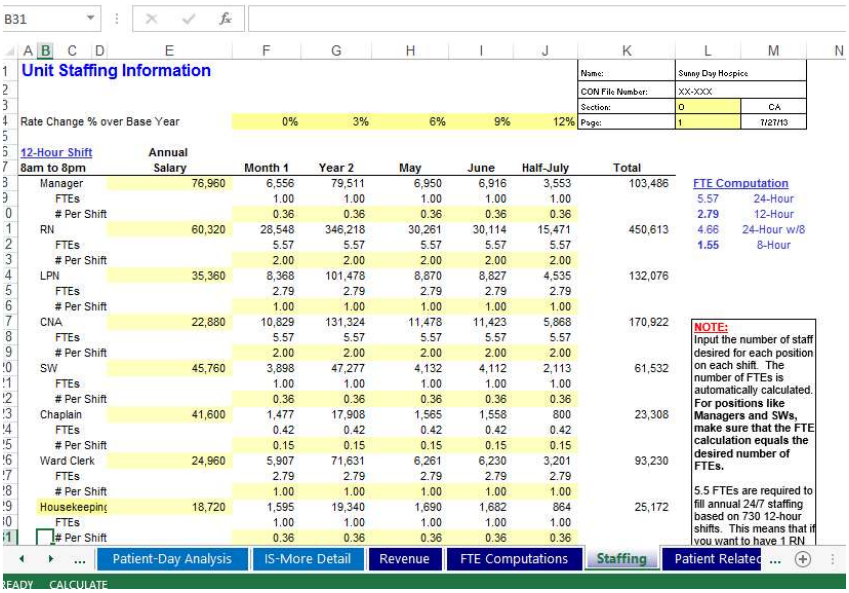

Unit Staffing Information

Name:	Sunny Day Hospice									
CON File Number:	XX-XXX									
Section:	O	CA								
Page:	1	7/27/13								

Rate Change % over Base Year: 0% | 3% | 6% | 9% | 12%

12-Hour Shift 8am to 8pm	Annual Salary	Month 1	Year 2	May	June	Half-July	Total
Manager	76,960	6,556	79,511	6,950	6,916	3,553	103,486
FTEs		1.00	1.00	1.00	1.00	1.00	
# Per Shift		0.36	0.36	0.36	0.36	0.36	
RN	60,320	28,548	346,218	30,261	30,114	15,471	450,613
FTEs		5.57	5.57	5.57	5.57	5.57	
# Per Shift		2.00	2.00	2.00	2.00	2.00	
LPN	35,360	8,368	101,478	8,870	8,827	4,535	132,076
FTEs		2.79	2.79	2.79	2.79	2.79	
# Per Shift		1.00	1.00	1.00	1.00	1.00	
CNA	22,880	10,829	131,324	11,478	11,423	5,868	170,922
FTEs		5.57	5.57	5.57	5.57	5.57	
# Per Shift		2.00	2.00	2.00	2.00	2.00	
SW	45,760	3,898	47,277	4,132	4,112	2,113	61,532
FTEs		1.00	1.00	1.00	1.00	1.00	
# Per Shift		0.36	0.36	0.36	0.36	0.36	
Chaplain	41,600	1,477	17,908	1,565	1,558	800	23,308
FTEs		0.42	0.42	0.42	0.42	0.42	
# Per Shift		0.15	0.15	0.15	0.15	0.15	
Ward Clerk	24,960	5,907	71,631	6,261	6,230	3,201	93,230
FTEs		2.79	2.79	2.79	2.79	2.79	
# Per Shift		1.00	1.00	1.00	1.00	1.00	
Housekeeping	18,720	1,595	19,340	1,690	1,682	864	25,172
FTEs		1.00	1.00	1.00	1.00	1.00	
# Per Shift		0.36	0.36	0.36	0.36	0.36	

FTE Computation

5.57	24-Hour
2.79	12-Hour
4.66	24-Hour w/8
1.55	8-Hour

NOTE:
Input the number of staff desired for each position on each shift. The number of FTEs is automatically calculated. **For positions like Managers and SWs, make sure that the FTE calculation equals the desired number of FTEs.**

5.5 FTEs are required to fill annual 24/7 staffing based on 730 12-hour shifts. This means that if you want to have 1 RN

Patient-Day Analysis | IS-More Detail | Revenue | FTE Computations | Staffing | Patient Related

READY CALCULATE

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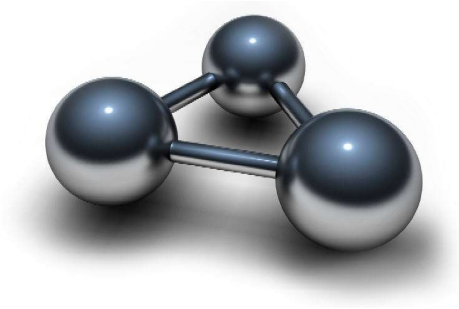
Compensation Design



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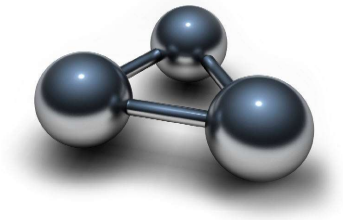
Why?

Performance Pay



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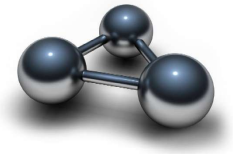
Because it WORKS!



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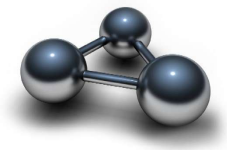
People **behave** the way they are **paid**.

And we **ALL** get paid… in every situation…



Even the Volunteer gets paid…

The Model
Balancing Purpose and Profit...

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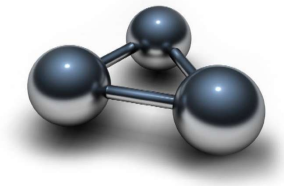
Compensation is your **#1 Tool** to shape behavior.



What is the Payoff?

The Model
Balancing Purpose and Profit...

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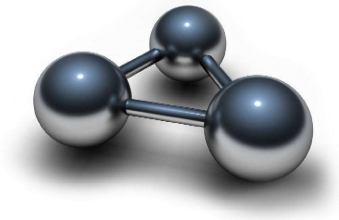
MasterPractice

Compensation

is perhaps your most effective teaching tool.



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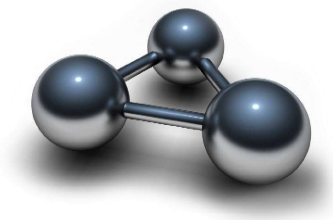
Getting Past the Fear Barrier

& the Importance of the Rollout



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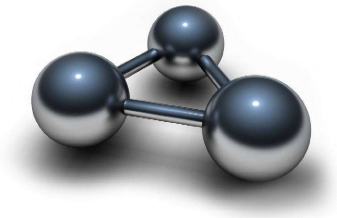
The Phantom

"Everyone will quit!"



No they won't… This is a "phantom fear." We have NEVER EVER seen a large or even small scale exodus of people…even poor employees don't quit as you'd like them to!

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Phantom Fears…

- Everyone will quit… If it's done even half-way intelligently, they won't. And if some people do quit, are they really the players you want on your team anyway? If they don't have the confidence to bet on their own performance, do you really want them?
- We will lose good people…
- Staff will dislike me…
- It will change the organization's values into a corrupt and un-noble business.
- People will be motivated by money and not by the mission anymore.
- Once we change the Compensation System,

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The Model

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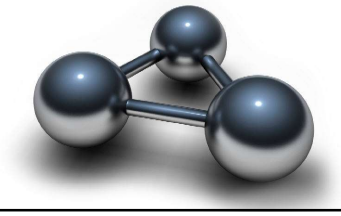
Getting Past the Business Prevention Units



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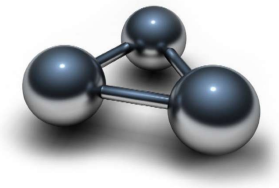
We are not paying you to do the care! We are paying you to Teach caregivers how to provide the care!



The Model

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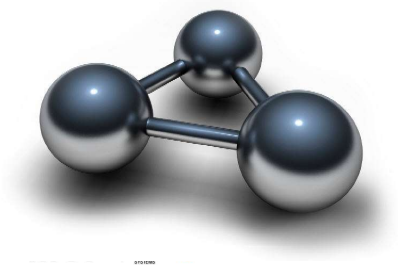
Money is NOT the biggest form of compensation…. but it is surely important.



People would prefer to be paid what they believe they are worth. To say that money is not important is ignorant as it impacts so many areas of our lives. Where we live, how we live, our educational opportunities, our healthcare, our dreams and on and on… The paycheck matters!

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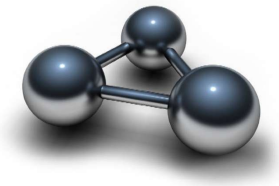
We want Confident People….

People that are willing to bet on themselves and the company…



Confident people provide Confident Care…

The Model
Balancing Purpose and Profit...

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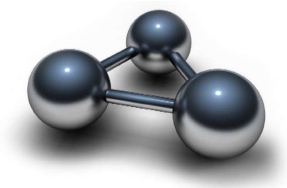
We want to be the best paying system around!

We want to attract and retain the most talented, caring and productive people in our area.



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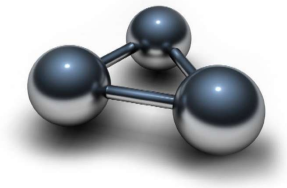
We want a fair system!

That rewards the hardworking and productive…



The Model
Balancing Purpose and Profit...

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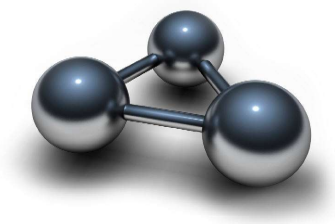
Create a
Life-Style
for your People!



- No 8-5 Work Hours for Clinical staff
- Set Your Own Pay
- Spiritually Rich Work Atmosphere
- Incredible Opportunities for Personal Growth
- Becoming a Master Teacher
- Total Positivity!

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SuperPay! (Brand your Comp System!)

1. Low Base Pay – Salary, Hourly or Per Visit
   - 30-60% is STRONGEST, but it can be 100% or 90-95% of current pay UNLESS comp is excessive
2. Individual Pay with Standards Portion - Based on "Productivity Unit" – Result - "Just Doing Your Job" including a "Standards" Portion of "Productivity Unit" or %

The most important element!

3. Attitude/Team Accountability Pay- 20%
4. Clinical Leader/Manager Pay (Based on Savings/Beat the Cost Percentages) Monthly

Every paycheck essentially becomes a "report card" telling the person how well they are doing with little effort, especially from the Manager. This creates a culture of "self-regulation."

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The Model

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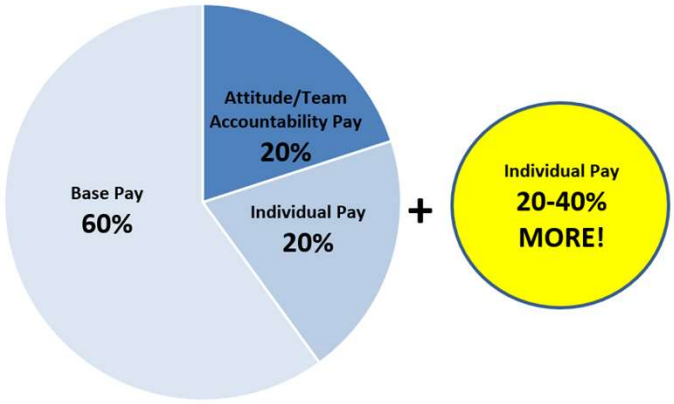
3 Main Categories of Pay

SuperPay! Enpowerment Pay!
Liberation Pay!



Creating these "categories" of Pay provide an organization incredible flexibility, levers and options!

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3 Main Categories of Pay

1. **Base Pay** is what they can count on every pay period.
   - Why? It creates a FEELING of certainty and people like that.
2. **Attitude/Team Accountability Pay** is based on how their peer group rates them regarding Attitude and team performance (critical for a Happy/Productivity work environment).
   - Why? To retain talented people, a Happy and Productive work environment must be created. Even with incredible pay, you will lose talented people if the culture is sick.
3. **Individual Pay** to reward the employee for productivity. It is something they can directly control.
   - Why? This creates personal Accountability and GROWTH as forces people to have to OWN their work and results.

The Model

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SuperPay/Empowerment Pay - RN

Hospice RN

	Multiple Factor	Base Rate		Standards Portion		Base + Standards	Number	Totals	Annualized		%	
Individual Pay - Unique # of Patients Visited	1	$ 40	+	$ 60	=	$ 100	12	1,200	288	28,800	36%	
Admission/Info Visit		$ -					-	-	-	-	0%	
spare	0	$ -	+	$ -	=	$ -	-	-	-	-	0%	
Compassion Pay - Last 7 Days	1	$ 20	+	$ 30	=	$ 50	10	200	240	4,800	6%	
On-Call - Weekend		$ -	+		=	$ -	-	-	-	-	0%	
Attitude/Team Accountability Pay		$ 7.00					87	607	2,080	14,560	18%	
Base Pay - Case MGMT Pay		$ 15.00					87	1,300	2,080	31,200	39%	
Sub-Total								3,307		79,360	100%	
Optional: Standards Bonus as a %		0%						-		-	0%	
spare		$ -					-	-		-	0%	Per Hour Equivalence
Total		# Pt. Visited		FTEs				3,307		79,360	100%	$ 38.15
Number of FTEs		12		8.33				27,556		661,333		
Percentage of NPR								0.4%		10.4%		
Benefits								6,062		145,493		
Percentage of NPR with Benefits								0.5%		12.6%		

Per Hour Equivalence

$ 38.15

3 Main Categories with Standards Portion for Accountability/Quality.

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SuperPay/Empowerment Pay - CNA

Hospice Aide

	Multiple Factor	Base Rate		Standards Portion		Base + Standards	Number	Totals	Annualized		%
Individal Pay - Number of Visits	1	$ 10	+	$ 10	=	$ 20	20	400	480	9,600	29%
spare visit type											0%
spare visit type											0%
Attitude/Team Accountability Pay		$ 4					20	80	480	1,920	6%
Meetings	1	$ 10	+	$ 10	=	$ 20	1	10	24	240	1%
On-Call - Weekday		$ -	+		=	$ -	-	-	-	-	0%
On-Call - Weekend		$ -	+		=	$ -	-	-	-	-	0%
											0%
Base Pay - Case MGMT Pay		$ 10.00					87	867	2,080	20,800	64%
Sub-Total								1,357		32,560	100%
Optional: Standards Bonus as a %		0%						-		-	0%
spare		$ -					-	-		-	0%
Total		# Pt. Visited		FTEs				1,357		32,560	100%
Number of FTEs		20		0.00				-		-	
Percentage of NPR								0.0%		0.0%	
Benefits								-		-	
Percentage of NPR with Benefits								0.0%		0.0%	

Per Hour Equivalence $ 15.65

Per Hour Equivalence

$ 15.65

3 Main Categories with Standards Portion for Accountability/Quality.

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Examples of the Flexibility of the use of Attitude/Team Accountability Pay

- **"Avoidable Waste" Pay Type** - It is interesting to note that by simply "adding" a Pay Type, without using it or rarely using it, WILL IMPACT human behavior! The establishment of an "Avoidable Waste" Pay Type is such a thing!

The Avoidable Waste Pay Type can be added to all positions on the Org Chart. It can and should be displayed on every pay stub to reinforce its message and meaning. The Avoidable Waste Pay Type establishes a set portion or method of pay where an employee's compensation can be reduced IF poor or foolish purchase decisions or resource use are unnecessarily and are "egregiously" wasted.

- **Complaints/Service Failures** is another pay type that can be applied. The rule could be that receiving an avoidable "complaint" would wipe out all of a person's Attitude/ Team Accountability Pay for a pay period.

The Model

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A Big Deal...

Objective Monitoring

- **Objective Monitoring -** The monitoring and enforcement of organizational Standards and Performance is one of the most difficult things to do. We are all humans with Feelings…and most of us don't like to be perceived as the "bad person" or the one that "rats" on transgressors. We just don't like it! People will avoid associating with us…won't look you in the eye when you walk down the hall…it's a drag! OK! This is a Human Reality we have to face with a meaningful Compensation System. There are a few ways of handling it: based on how their peer group rates them regarding Attitude and team performance (critical for a Happy/Productivity work environment).
  - OPTIONS:
    - Outsource to Objective External Entity
    - Designate a "Tough Minded" Person within your organization
    - Rotate Monitoring

The Model

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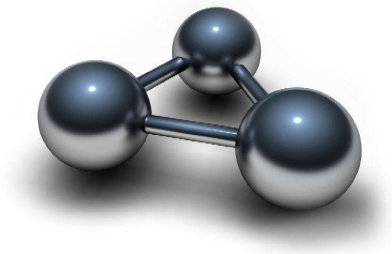
What about

Quawlity?



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The Same Measures Can be Used for So Many Clinical Positions

Quality Measures for Clinical Positions

Version 22.0

Use as few as possible!

Choose only one if possible!

Position	Quality Measures (1) Documentation	(2) Productivity	(3) Quality
Clinical - Direct Labor			
RN	1) Documentation to Standard	2) # of Patients Visited and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
LPN	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Aide	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
SW	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Spiritual Care	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Admissions RN	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Advanced Practice Nurse	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
On-Call RN	1) Documentation to Standard	2) # of Visits or Chart Audits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Occupational Therapist	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Physical Therapist	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Speech Therapist	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Physician/NP	1) Documentation to Standard	2) # of Patients Visited or Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Homemaker	1) Documentation to Standard	2) # of Visits and 100% to POC	3) No Complaints/Gifts, Avg Pain Scores
Inpatient Unit			
RN	1) Documentation to Standard	2) Unit GIP Census	3) No Complaints/Gifts, Avg Pain Scores
LPN	1) Documentation to Standard	2) Unit GIP Census	3) No Complaints/Gifts, Avg Pain Scores
Aide	1) Documentation to Standard	2) Unit GIP Census	3) No Complaints/Gifts, Avg Pain Scores
Charge Nurse	1) Documentation to Standard	2) Unit GIP Census	3) No Complaints/Gifts, Avg Pain Scores

MVI Suggestion in RED

IF YOU CAN ONLY MONITOR DOCUMENTATION AND PRODUCTIVITY EASILY, THEN JUST USE THOSE!

MVI suggests RNs use Number of Patients Visited Per Pay Period and to 100% of the POC.

Simply running a Plan of Care (POC) report for compliance is really sufficient when the Number of Patient Visited is being used too!

The Model

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The Role of the Compliance Area

Compliance – Audit Sheet - Audit to at least a 90% Confidence Interval

	NAME	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type	Email Date/ Error Type
	Pay Period	Period 1	Period 2	Period 3	Period 4	Period 5	Period 6	Period 7	Period 8	Period 9	Period 10	Period 11	Period 12
	Blue Team - Smith												
1.	Doe, Jane	3/19 A											
2.	Smith, Sally												
3.	Brown, Robert			4/16 B									
4.	Dally, Dilley												
5.	Nice, Jill												
7.	Bob, Billy						5/21 C	6/2 C	6/18 A				

A = Use of non-organizational language
B = Signatures not timely/not signed
C = Other

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Where Do You Get the Time to Teach & do Ride-Alongs?

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Making Management EASIER!

The Compensation System is the ONLY known means to remove the need for Managers to:

1. Monitor Documentation
2. Monitor Productivity
3. Do Annual Reviews
4. Need to Fire People

These are REMOVED from the Clinical Manager's job description to **free up time** to do the *1st Duty*...to Teach and Coach as all employee's learn to self-regulate to the organizational Standards.

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The "system" does the heavy lifting for the Managers and removes many of the negative aspects of management.

The Compensation System brings great relief and makes management radically EASIER!

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Documentation Example

1. Documentation Standards are defined.
2. Self-Learning Modules with a short test are created.
3. Documentation is taught strictly to *System7*.
4. QI/Compliance audits charts to a 90-95% statistical confidence interval. The job of making sure documentation is to Standard is REMOVED from Clinical Manager duties.
5. If any material defect in a chart is identified (variance from Standards), QI/Compliance sends an email with a Self-Learning Module link to the person and notifies the Clinical Manager as well.
6. The clinician fixes the issue, if possible, and completes the Self-Learning Module within 1 day.
7. In addition, any performance pay as well as Standards Bonus is not received. Normally this is 5% for 2 weeks.

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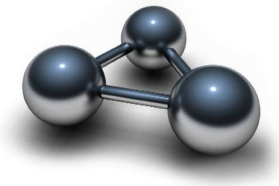
Who do

Indirect and Support Staff

"live to serve?"



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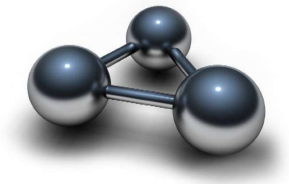
Clinical Leaders!



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Indirect and Support Areas Live to Serve the Clinical Managers!

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This Creates a Service Culture at all Levels of the Organization

Indirect Labor - A simple and effective system that fosters a "Culture of Service".

Administration	If 2 Negative Codes are received, 5% of Attitude/Performance Pay removed. If more than 2, 10%.
Clinical Management	If 2 Negative Codes are received, 5% of Attitude/Performance Pay removed. If more than 2, 10%.
Finance	If 2 Negative Codes are received, 5% of Attitude/Performance Pay removed. If more than 2, 10%.
HR	If 2 Negative Codes are received, 5% of Attitude/Performance Pay removed. If more than 2, 10%.
IT	If 2 Negative Codes are received, 5% of Attitude/Performance Pay removed. If more than 2, 10%.
Marketing	If 2 Negative Codes are received, 5% of Attitude/Performance Pay removed. If more than 2, 10%.
Education	If 2 Negative Codes are received, 5% of Attitude/Performance Pay removed. If more than 2, 10%.
Compliance/PI	If 2 Negative Codes are received, 5% of Attitude/Performance Pay removed. If more than 2, 10%.

Each Pay Period, Clinical Leaders can register a Standard Growth/Negative Code if they experience serious dissatisfaction with an Indirect/Supporting area.
Do the same monthly for each Indirect area.
If a Indirect or Support area gets less than a 7 average score, the entire department's 10% Standards Pay is removed for one pay cycle.

Growth Codes	
Helpful Feedback to GROW!	
A	Poor **Attitude**
P	Non-**Performance**/Poor Follow-Through
C	Poor **Communication**
Q	Poor **Quality** of Work/Errors
M	Late to **Meeting**(s)
L	**Late** to Work
G	Customer Complaint/**Gift**
E	**Exessive** Time-Out - Abuse of Work Latitude
+	Outstanding Job Performance
	The system "resets" NEW every Pay Period…a NEW/FRESH Start each time!

All Indirect functions also must have at least one person crossed trained in each function and allow the person to work in that capacity for 2 non-concurrent months of the year. Costs are not allocated from their normal position.

If a position or function is outsourced, that cost still remains with the Indirect Area and is including in the NPR% calculation.

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This Indirect "10/2 Cross Training" Achieves 4 Important Things!

All Indirect functions also must have at least one person crossed trained in each function and allow the person to work in that capacity for 2 non-concurrent months of the year. Costs are not allocated from their normal position.

- 1) Redundancy of Function
- 2) Documentation of Process
- 3) Supports Teaching Paradigm
- 4) Disrupts the Fraud Triangle

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It is up to Indirect Departmental Managers to determine a few specific weekly/monthly measures for their people, which are far fewer in number.

Indirect Positions - These should already be in job descriptions.

CEO/Executive Director	Chief Education Officer! A walking billboard of Vision and Confidence. Scored by Quality, Profitability and Growth.
Executive Assistant	Based on the assessment of the CEO (1) ability to anticipate (2) communication skills (3) Scores from Management team.
Chief Clinical Officer/Primary Clinical Manager	Based on Overall Quality, Profitability and Scores from Clinical Managers and Management Team
COO	Based on Overall Quality, Profitability and Scores from Clinical Managers and Management Team
CFO	Overall Satisfaction Scores of Clinical Managers and Management Team
Staff Accountant	Satisfaction Level of Clinical Managers & CFO
Billing Supervisor	Days in AR-Quality of Billing Function
Biller	Days in AR - Adjusted for ADRs
Accounts Payable	Days in Payables
Payroll Clerk	Accuracy of Payroll-# of Reported Errors Errors in Payroll impact morale
Data Entry Position	# of Errors
Chief Medical Officer	(1) Documentation, including 180 Recerts, (2) Education & Outreach contacts, (3) Calls to Patients and (4) Visits
Medical Director	(1) Documentation, including 180 Recerts, (2) Education & Outreach contacts, (3) Calls to Patients and (4) Visits
Clinical Team Manager/PCC	Based on Documentation, Live Patient Scores and Confidence Scores
Quality Improvement Manager (VP, Director)	Same as Education or People Development
Quality Improvement Staff	Scores from Audits
Compliance Officer	# of Deficiencies, Independent Review of Compliance
Director of Education (VP, Manager)	Level of Confidence of Staff via Mental and Synthetic Testing
Staff Educator	Level of Confidence of Staff via Mental and Synthetic Testing
Bereavement Manager (VP, Director, Supervis	Overall Level of Confidence of Staff - Appreciation Scores 1-10
Bereavement Staff	Appreciation Scores 1-10, Contact with All Bereaved on a predictable and eff With our innovative methods, often grief is vastly minimized
Volunteer Coordinator Manager (VP, Director, S	Overall Number of Patient-Care Volunteer Hours and All Volunteer Hours
Volunteer Coordinator	Number of Patient-Care Volunteer Hours and All Volunteer Hours
Marketing Manager (VP, Director)	Overall Number of Admissions
Marketers	Number of Admissions
HR Manager (VP, Director)	Satisfaction Level of Clinical Managers and ALL other areas
HR Staff	Satisfaction Level of Clinical Managers and ALL other areas
IT Manager (VP, Director)	Satisfaction Level of Clinical Managers and ALL other areas

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All Quality comes from the Quality of your

People

***Be** rather than to **Seem**…*

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MVI Multi-View Incorporated SYSTEMS

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