

Inpatient Units & the Model

WORKBOOK 13:



14th Edition

- *Designing the Perfect Hospice – Workbook 0*
- *CEO Preparation for the Model – Workbook 1*
- *Vision & Values – Workbook 2*
- *The Basics of Creating Your Model – Workbook 3*
- *Alignment of Systems – Workbook 4*
- *Proprietary Model Workshop – Workbook 5*
- *Model Curriculum for Customization – All Staff - Workbook 6*
- *Model Curriculum for Customization – The Extraordinary Clinical Manager - Workbook 7*
- *Model Curriculum for Customization – Board of Directors - Workbook 8*
- *People Development & the Model – Workbook 9*
- *The CEO Retreat – Workbook 10*
- *The CFO Program – Workbook 11*
- *Marketing & the Model Program – Workbook 12*
- *Inpatient Units & the Model – Workbook 13*
- *Compensation & the Model – Workbook 14*
- *The Attraction and Retention of Talent – Workbook 15*
- *The Deep Retreat – Workbook 16*
- *Revolutionizing the Volunteer Program – Workbook 17*





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Program Objective

The objective of this program is to equip Hospice Inpatient Unit and Continuous Care managers with the mindset and industry knowledge to be effective at their respective organizations. Participants will:

- Gain Perspective on current Hospice IPU financial results.
- Learn the Primary Factors of Hospice IPU success.
- Discover the best-known practices regarding IPU profitability.
- Breakout: Working with Your Data to develop a Model specifically for your IPU operations.

Recommended CPE Credit Hours: 8

In accordance with the Standards of the National Registry of CPE Sponsor, CPE credits have been granted based on a 50-minute hour.

Prerequisites

Participants should have a basic understanding of accounting and Excel.

Course Level

Intermediate.

Field of Study

Management - Hospice Management

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Program Description

Hospice Inpatient Unit financial losses are epidemic...and it is getting worse. This program will convey the best-known practices to-date regarding the management of Hospice IPUs so that they can be financially viable based on our work with 250+ IPUs. This program also has direct application to Continuous Care programs. Bring a laptop with Microsoft Excel, your Benchmarking reports and cost information regarding your Hospice's current IPU operations. This is a 1½ day program with participants having the option to stay the additional half-day to further refine their work with MVI staff.

Program Materials

Program materials include a comprehensive manual with an in-depth table of contents and index for quick reference, as well as an Inpatient & Continuous Care Planning and Management Tool and the Inpatient Management Report. Exams are provided upon arrival. Program evaluation forms are contained in the back of the manual.



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Breakout: Participants will work with the Inpatient–Continuous Care Planning and Management Tool, using the data they brought to fully understand how costs behave in their specific Hospice IPU, as it varies greatly with each unit. Participants will develop Standards and know exactly what is required to run a profitable IPU in terms of the business model. We are not engineering this for breakeven, but rather a profit.



If You Find an Error in the Manual...

With MVI, the latest Best Known Practices are adopted as soon as they are 1) identified and can be 2) systematized. Our materials are constantly being updated to improve care and management as FAST as practical. Therefore, you may find spelling or grammar errors even with proofing happening! The point is to get the “meaning or essence” of the material. The least talented people are critical of small oversights and often miss the true significance of an idea or practice because of a “speck” on the windshield. If you find an error, let us know but understand that we value SPEED of implementation over perfection when developing people. This is the same Best Known Practice we recommend for your organization with internal materials when developing your people.

Testing

There is a reason that schools, universities, and other educational institutions test students. Testing works! It provides the individual and others an indication of our level of understanding. As we will learn from this program, if something is important, it should be measured. This applies to everyone participating in this program, the people coming to work at your Hospice, and the people that are already working at your Hospice. Here are a few points to keep in mind about the testing:

- Participants will have 4 opportunities to pass the exam. You have 2 exam periods each day. The following is the normal schedule. Occasionally this will be altered due to facility and other factors.

Test Period	Day	Begin Time	End Time
1	Day 1	4:00pm	4:30pm
2	Day 2	8:00am	8:30am
3	Day 2	11:30am	12:00pm

We will not endlessly grade till you pass. We will grade the multiple choice portion ONCE during each testing period so that you can get an idea of how well you are doing. It will be graded at the end of each testing period as well.

- The calculation portion of the exam will only be graded at the end of each testing period.
- Passing the exam does not necessarily mean that you have passed the program. Attitude, perceived understanding of the material and ethics (cheating) will play large roles in the determination of whether or not an individual passes the program.



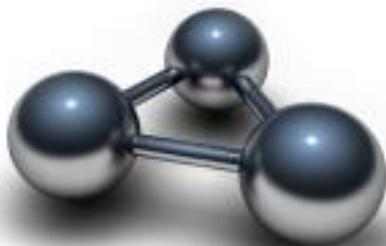
What are you?



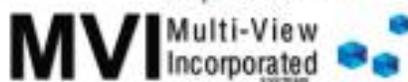
0 Prelude – The Model Overview

With each interaction we are...

Creating the Experience or Feeling



The system of care starts with the meticulous creation of the patient/family experience and gracefully engineers supportive structures that give rise to ultra-high confidence levels in team members regarding the predictability of the experience.



Can we simplify what we do in Hospice to:

“We are here to help people FEEL better and orchestrate everything around this end”??”



The Model is the creation of a high-quality, predictable experience.

This is the definition of the Model I would recommend that you use. If you want to embellish, say, “The Model is the creation of a high-quality, predictable experience... that is financially balanced.” Below is the formal definition of the Model. Both of these definitions need to be explored.

The Model is the intentional design of a Hospice culture that simultaneously balances purpose and financial realities to create a sustainable World-Class experience.

The focus on the Model is the intentional creation of **long-term structures** to augment/create operational platforms. These structures, if well planned and executed, should be able to last for decades into the future as “structures of adaptation” are built into the platform so that the organization can change as needed or desired, whether due to internal, external or a combination of these forces. This deliberate incorporation of “flexibility” is critical. Without such flexibility, a Model is virtually outdated on the first day of implementation.

The Model is NOT a Management program. Though it is recognized that Management is a key ingredient, perhaps the most important aspect of building a great organization, it is also recognized that it takes concrete, time/space structures to truly create a “devastatingly” effective entity.



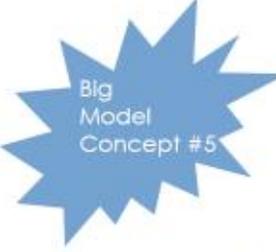
It is impossible for an organization to become extraordinary without extraordinary People Development processes.



Big Model Concept #4



There is incredible value in high-quality
Predictability!



Big Model Concept #5



Predictability leads to repeat business... and Hospice is a repeat business.



1 Introduction

You Were Hired With an Assumption

When you were hired as the Manager of the Inpatient Unit, it was assumed you knew how to run a successful business segment in terms of effectiveness and profitability. With FP Hospices, this is *normally* understood. With NFP organizations, this might not be explicitly expressed. However, any Manager of any area will be displaced if financial losses threaten the organization. In addition, many Hospice Managers and Boards of Directors are confused about the idea of profitability. They often think that NFP means that operational profit is not a good thing and that the organization should spend nearly everything towards the mission. This type of thinking needs to be eradicated.

IPU Managers need to have a deep-rooted certainty about the absolute NEED for profits and proportionally large financial reserves. Profitability is essential to organizational sustainability and capacity.

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.



What is Profitability Really?

What is profitability really? We probably all have our own take on it and view it a bit differently. However, most people would see profitability as essentially advancement. It is moving forward, in a positive direction. It is about where the negative is less than the positive or where the incomings are more than the outgoings.

Definitions of profitability are:

- making money
- producing good or helpful results or effects

I think that if you are alive, you are moving forward, period. Time moves forward and we along with it. We are in the process of change constantly (even if we are temporarily behaving badly, the bad example teaches). However, much of our discussion in this program is about profitability in the financial realm.

prof-it

/ˈpräfɪt/

noun

- A financial gain, the difference between the amount earned and the amount spent in buying, operating, or producing something.

verb

- To obtain a financial advantage or benefit



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 and overcoming the fears with associated such actions.

A world-class Hospice has world-class financial results (14% margins and upward). An extraordinarily, well-managed enterprise is highly profitable as well as highly effective. Right or wrong, the world measures and recognizes success in financial terms. It is an undeniable FACT that money equates to capacity and sustainability for a business organization. Therefore, why not make your Hospice highly profitable when it is readily doable and the Hospice herd is SO slow? Take advantage of the opportunity and the excellent business climate.

Why should a NFP Hospice be highly profitable?

- A typical NFP can make 14%+ from Hospice operations.
- An NFP receives community support in terms of cash inflows.
- An NFP usually receives large amounts of free labor in the form of volunteers.
- An NFP doesn't have to pay taxes. Normally a FP pays 40% of its profits in taxes!

How can we NOT make money with all these factors?

The Profit Reality In Hospice

However, currently there is an overall despair or negativity in the hospice movement regarding census and financial performance. This disposition is unnecessary.

Profitability in hospice is a choice. Profitability is largely an internally driven result and is, to a much lesser extent, a result of external forces.

Being “highly” profitable will require behaviors that are markedly “different” than the vast majority of hospices. Therefore, you can't call around and find out the best known practices, because they don't know...





The Profitability of IPU: The 90th Percentile is 14.13% PROFIT!

The 90th percentile in terms of IPU profitability is 14.13% as a percentage of NPR (Net Patient Revenue). However, the typical IPU loses -24.37%! This median percentage used to be -11%, but has increased DRAMATICALLY over the last few years. Based on our work with over 250 IPU's, it is our opinion that most Hospice units are NOT managed particularly well. The fact that they are often staffed ABOVE ICU levels gives us some perspective for comparison. However, the fact that this loss has increased so dramatically over the past few years provides some indication that the external world is changing and it is probably not due to IPU management's worsening. With this said, profitability has more to do with us (internal) than out there (the external world).

The fact that some Hospice IPU's are making money means that profitability is possible. We believe it is not only possible, but that it will happen for IPU's that make the decision to operate IPU's differently. The question is, "what are these Hospices are doing?" (Which we will address as we proceed in this program).

The New IPU Medicare Reimbursement

Practice changes and the 35% GIP and 155% Respite rate increases changed the MVI IPU Model a bit!

- **IPU Profit NPR% is 8%.** Most Hospice IPU's should EASILY be able to do this. If not, then add a few elements to your compensation system for clinicians and the IPU Manager. That will solve it!

PREDICTION: We expect that most Hospice IPU Managers will spend the increased revenue rather than product the 8% surplus. Why? It is just easier to spend more when more is available. Plus, most Hospices don't have strong Accountability to keep the increased revenue in the bag! Also, there will be a lot more FP IPU's popping up because of these increases in GIP and Respite!



2 Outliers

The Profit Outlier

By being highly profitable, you will, by definition, be in the minority. Since money is highly emotional, it will cause you some degree of isolation. Traveling with the minority is a fairly lonely road. However, it is an exciting one as well!

I had to come to grips long ago with the reality that most of the practices that MVI identifies and provides will be ignored and will only be implemented by a few organizations. Some MVI practices are almost universal at this point in time such as Pass-Throughs, the methods of treating Pass-Throughs, Crisis Care, the use of NPR, the fundamental presentation of Hospice financial statements, etc. However, the vast majority of our recommended practices are “interesting reading” and are only seriously considered when crisis looms.

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, you will have to become an “outlier” and do things that typical hospices are ignorant of or are afraid of doing. It is a lonely but highly satisfying road.

Don't focus on the mediocre majority.



The Heck with the Middle! Become an OUTLIER!

Are you an outlier? Though this term can carry a negative connotation in the reimbursement and regulatory worlds, here we are viewing it positively. It is an interesting topic to contemplate. Secretly, most individuals seek differentiation and want to be recognized, at least according to Maslow and his Hierarchy of Needs. Or we could cite Viktor Frankl in that we all seek meaning and purpose in our lives and would like to accomplish something noble and good. If your organization is not actively becoming an outlier, then I would venture to say that you have an unattractive organization and that it will never be able to attract and retain highly talented people. Thus, the organization will never become world-class (*see the section, How to Build a Team*). Becoming an outlier is not about being different for the sake of being different, though this is a perfectly fine justification in my mind. Rather, it is about pushing limits to see how far you can advance. You can also become an outlier by sitting around the bus stop when everyone else has left!

All organizations that are doing the Model or have done a Model Workshop have a goal of becoming an outlier, bar none. One subtle but important shift in thinking is that you must choose to be an outlier as an individual before the organization can become an outlier as the organization is shaped by the behaviors of individuals within the enterprise. This especially applies to the CEO. Outlier organizations are usually led by obsessed and possessed people that are willing to focus uncommon levels of intention towards the fulfillment of a vision or result. They can be crass, tough-driving individuals or they can be highly evolved, soft-spoken spiritual people. However, they are always demanding and are relentless in their pursuits, even if they are completely calm and serene in the process. They usually have high energy levels, great capacities for imagination and have a sense of urgency. To put the urgency characteristic bluntly, outliers change the world...often at a pace that leaves the huddled masses in the dust.

Are you an outlier? It is fairly easy to tell if you're an outlier or not. Look at your numbers. By virtue of your position on a normally distributed bell curve and by definition, an outlier lives in the extremities. Are your numbers radically different from the majority? In the MVI Benchmarking Application (BA) are you around the 90th or 10th percentiles in the areas of your intention? When you go to networking meetings, do you find that the conversations tend to revolve around the same old topics that you have already refined to extraordinary levels? Do people scratch their heads when they see your operations and go "WOW!"? Do referrals sources, ACOs and patients/families comment on the extreme quality and consistency of your meticulously designed care experience and comment that it is UNLIKE anything they have ever seen in healthcare? You can also tell if you're an outlier by your level of discomfort from pushing outside the norms and measures of central tendency. An outlier organization subjects itself – willingly - to the discomfort and stress of venturing into unfamiliar and uncharted territory.



Where are your opportunities to become an outlier? Most innovation opportunities lie in everyday tasks. They are hidden in mundane work. The innovations that make an organization an outlier come from within as well as from the outside. The key is to be able to recognize an innovation when it is observed AND have a system of incorporating it into practice. This insight is not common or else everyone would be doing it. Can you specifically identify language or a practice that could be used during clinical visits that would decrease On-Call by 50%? Can you get great ideas from John Deere, Apple, Ritz Carlton and Disney or even from horridly run organizations so you know what to do as well as what NOT to do? Also, in the external innovation category, note that some outlier Hospices are EXTREMELY CAREFUL in their selection of conferences and educational events for their staff. Why? It is because they do not want to contaminate their cultures. They are not hiding or are ignorant of the outside world. Rather, they pay close attention to the movement and its trends while being protective of their productive cultures that they have worked hard to create and nurture.

In a competitive Hospice world, the outlier has an enormous competitive advantage. Most Hospices are slow moving freighters that take 30 miles to make a turn. It often takes *years* for an innovation to become commonplace. A good example is charting at the point-of-care. How many Hospices still struggle with this situation even though some Hospices have mastered it? If we don't know how to do this, we simply have not been paying attention. This overall glacial speed makes for easy pickings!

It takes guts to be an outlier. It takes confidence to venture into deeper waters. In addition, there is a price for being an outlier. The outlier finds itself alone or with only a few others. Through the course of becoming an outlier, the organization will find itself lost, confused and frustrated at times with occasional failed undertakings. The outlier will be mocked and ridiculed by the huddled masses. However, the wins of the outlier are often big and the talent (people) of the organization is inspired as it leads the "industry" back to a "movement." The outlier will look back one fine day and realize that it is now far removed from the pack. You find the "industry's" conversations bland and strangely bizarre. But such retrospection is short-lived as the organization's intention is again focused on making the intangible tangible. The thrill of progress outweighs the pain and discomfort of being an outlier...and you would not trade it for conformity and the divine feeling of self-actualization as a distinct organizational personality. Do you walk in familiar, well worn, comfortable paths? That's fine if you want to remain in the middle. However, know that you can choose where you want to be on the bell curve!



3 The BIG Moves of the Outliers that WILL Transform the Performance of an IPU

There are many things an organization can do to improve the performance of a Hospice IPU. We will cover many of these in a subsequent chapter. However, the moves listed below are a few that will have the greatest impact. Most have to do with Accountability and methods to increase it through the use of incentives. ALL OF THE NATURAL WORLD OPERATES BASED ON INCENTIVES. Most all initiatives and attempts to increase performance will either succeed or not based on Accountability or ownership of results.

As we cover these 8 points, ask yourself if you are really doing them with complete honesty. This acceptance of reality and owning the current performance is the starting point of all great transformations.



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

You want to bring the IPU Manager as close to revenue as possible. This is direct Accountability. If the IPU is winning, the IPU Manager is winning! If the IPU is not doing well, the IPU Manager is not doing well in the compensation department. It is almost as simple as that. You want to create natural incentives that will cause a person to really engage and own performance. Money is emotional. Therefore, it is one of the most effective teaching tools in the modern world. An IPU Manager with well-aligned incentives will automatically begin to think in creative ways to make the IPU a success. Tying compensation to performance is one of the most effective ways to find out if a person has CONFIDENCE. Confidence in their own abilities as well as confidence in the organization. Confident people do not mind being compensated based on performance because they BELIEVE in their own power and abilities. Unconfident people have trouble with it and want to distance themselves from responsibility for the results of the IPU rather than owning the results. Confident and growing people seek opportunities to fully utilize their abilities.

We recommend that an IPU Manager receive a modest base salary (Base Pay), have 5-10% of their pay as Standards Pay (or Standards Bonus) and receive 25% of the savings from beating the Net Patient-Revenue (NPR) percentage Standard each month. If the IPU Profit Standard or Cost Standard is not met, then the IPU Manager's Standards Bonus is not given. This results in the IPU Manager receiving 90-95% of their normal compensation without the bonus as there is nothing to bonus out. However, as the Profit or Cost Standard is not set too tight and is highly achievable, the competent IPU Manager is set up to WIN each month and can have monthly bonuses ranging from \$500 to \$5,000 depending on performance.

This move takes some guts! The success of a Hospice IPU gets "real" quickly. And that is exactly what you want!

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!”



2) Learn Your IPU's "Magic Number"

The Magic Number in an IPU is 1 patient above breakeven. The Magic Number is NOT breakeven. Averaging 1 patient above breakeven annually equates to approximately \$175,000 profit! Therefore, if an IPU is going to be profitable or lose far less money than a typical Hospice IPU, the target or Magic Number must be known.

Many CFOs don't even know this number. Therefore, sometimes the IPU Manager must determine it. In nearly all cases, MVI recommends that the IPU Manager learn how costs behave in their particular IPU firsthand from the use of the ***IPU Management and Planning Tool***. This time-tested tool has been used with over 176 Hospice construction processes and hundreds of other IPU's entrenched in existing facilities like Nursing Homes and Hospitals. It is used for planning IPU's and is also used for on-going management. **It provides the IPU Manager the ability to easily do "What-If" analysis so he or she can Model the anticipated results and develop better ways of managing BEFORE the actual changes are made!** From a completely pragmatic rationale, the math or numbers HAVE TO work before it will work in reality. Some IPU Managers have stumbled across things that work without such precise knowledge, but with deeper retroactive analysis, the practices result in the math.

Each Hospice IPU's costs behave differently from any other. This is due to many factors including IPU design, location and other things. Therefore, use of **the *IPU Management and Planning Tool* is needed to determine cost behavior at each IPU**. Using this tool, an IPU Manager should want to know:

- "What is the cost of various staffing options?"
- "What difference will 1 additional GIP patient make?"
- "How many Residential patients can I have without running below the Magic Number?"
- "What would be the impact if we close a wing?"
- "What would happen if we use a particular vendor?"

The tool can show the IPU Manager the financial impact with great precision. And it can be used to compare current monthly performance to the IPU Manager's model! The ***IPU Management and Planning Tool*** is an F9 template meaning that MVI designed it to be used with the most powerful financial reports writer in the world, **F9**. There is no manual entry to pull in your monthly or YTD actual amounts or statistics. With the press of a button (once the tool is mapped to your Accounting System), your monthly and YTD actuals will appear and you can compare actual performance with your IPU Model.

Know how your costs behave at your IPU!



3) Provide the IPU Manager with the “Sweeping Powers” to Bring Patients into the Unit

“Sweeping Powers” is a phrase we use to describe the authority of an IPU Manager to bring patients from Homecare to the IPU. We also call this the “Gas Pedal,” as it is used to regulate the IPU census to the Magic Number! An IPU Manager should be given the authority to review the EMR (usually with the help of a few specialized queries or reports) to find patients that could benefit from the IPU.

Many times Homecare clinicians are resistant to sending patients to the IPU as they see it as failure to take care of the patient in the home or other setting. This resistance mindset must be trained out of such clinicians. Other times, the Homecare clinicians might resist sending patients to the IPU because they perceive it as a pain in the rear to get a patient into the IPU! So IPU admission processes need to be streamlined and made EASY!!! A walk-through of the process from the Homecare clinician’s viewpoint should be done and if it seems awkward or burdensome, the process should be simplified. Sometimes this will mean that the IPU staff need to take on more of the work of admitting patients. In this case, incentives need to be put in place for IPU staff. The easiest way to do this is with incentives in the form of compensation.

In addition, natural incentives need to be put into place so that Homecare clinicians benefit directly when their patients are admitted to the IPU.

Provide Incentives for Homecare Clinicians to Refer Patients

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* as well as in the IPU census. That is, the patient is counted on both censuses at the same time. We have constructed RN, SW and PC compensation around the *Number of Patients* as a performance metric. If clinicians are able to count referred patients to the IPU as part of their “census” it causes clinicians to refer more as most of the care at that point will be performed by IPU staff. This translates to less work and expenditure of Energy by the clinician and the ability to have a higher *Number of Patients*. If Homecare clinicians are receiving an extra \$50, \$75 or \$100 for each additional patient above or equal to Excellent level, having 1 or 2 patients in the IPU is a great deal financially! In addition, IPU staff are paid more when the IPU census is high.

See the Compensation section of this manual for more on practices to create these incentives.



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

You are training the community by virtue of the patients you admit...and SCAR referral sources with the ones you don't... This a rather strong statement and it happens whether you are conscious of it or not. This concept applies to Hospice Homecare as well as Hospice IPU's. Here is the reality of the human condition:

Pain is remembered more than good feelings.

When a physician refers a patient they feel is dying and in need of Hospice or IPU care and the Hospice or IPU does not admit the patient, the physician is disappointed. He or she might have a 40-year history with the patient and know things or observe behavior that a one-visit Hospice RN or Physician doesn't as there are so many factors involved with the decline and death of any human being. Most of the time, the Hospice owes it to the Physician that is willing to certify the patient to admit the patient and use the certification process as it was intended.

The Physician in this case is disappointed. This is Emotional. The disappointment is remembered.

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

That Physician may try to refer another patient if they are resilient, but most will not because they have LEARNED that your Hospice doesn't take that kind of patient. This concept applies to ALL referral sources, but it is especially pronounced in Physicians because of their training and self-image as a professional. A Non-Admit translates into FAILURE or questioning of his or her technical competence.



Real-Life Illustration:

A 15-bed Hospice IPU in a cosmopolitan city is literally surrounded by 3 hospitals with 1,200 beds between them with all operating at near capacity...and the Hospice IPU has 3 GIP patients. One day, a new bright IPU Manager begins her new job and wants to find out what the Physicians and Discharge Planners at the 3 hospitals think about the Hospice IPU. "You're always full..." "We can't get patients in because they don't qualify..." The Hospice had TRAINED all of the Physicians and Discharge Planners EXACTLY what types of patients they want and when to refer. And all it takes is a single NEGATIVE experience and the tap is shut off... The beliefs of the hospital Physicians and Discharge Planners needed to be changed. The new IPU Manager worked on this and FILLED the unit!

Therefore, whenever a patient is referred and is NOT admitted to Homecare or the Hospice IPU, USE KID GLOVES!!!

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"

This means that the "letdown" must be handled with ultra-ultra care with special sensitivity to the FEELINGS of the referral source.

"We have looked at this from different angles and we can't see that Mr. Jones is dying or meets criteria for the IPU... Of course, you have much more insight than we do and perhaps we are missing something?"

It's not always about what you say, but how you say it. The language, the tone of the person breaking the bad news, the setting and other factors all must be considered. You don't want a nuts and bolts, monotone, oblivious person handling this communication.

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



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

The occupancy of an IPU is directly impacted by the practices and mindsets of the IPU physicians. This normally involves the Hospice Medical Director as well. An overly controlling or fearful Physician will constipate an IPU. He or she will make it overly difficult to “qualify” for GIP as well as constipate the admission process by insisting that they are intimately involved with every admission decision. This is a difficult situation to overcome unless the Physician is willing to adopt a more liberal paradigm of what a Hospice GIP patient looks like. Most often, we have found we have had to remove the limiting Physician to cure the problem.

Many times, Physicians get scared and scarred when they go to CMS educational programs. They come back and start discharging large volumes of patients, especially those with long LOS, or get overly conservative regarding the use of the IPU. A Hospice would do well to become particularly choosy about what “educational” programs they send their Physicians to as well as what Physicians. Physicians that are sent to such educational events should be “armed” beforehand so that they won’t return and devastate the Hospice or IPU!

Example: With one of our Magic! clients, where we directly assist in the implementation of their Model, the 14-bed IPU only had a couple of GIP patients at a time and too many Residential patients. A few inquiries quickly revealed frustrated clinical staff. The Medical Director was the problem. The Physician was a control freak and was overly conservative in their paradigm of what a Hospice GIP patient looked like. In addition, the Hospice Homecare census was lower than it should have been because the community was trained not to send “gray” or “borderline” patients to the Hospice. Therefore, these “grays” were referred to other more liberal Hospices. The courageous CEO faced the problem and fired the limiting Medical Director and hired a new one with an expanded paradigm. Within weeks, the IPU and the Homecare census were at record levels!

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!**

This is a tough move for many CEOs, but you will radically change your Hospice for the better with this structural move! HR needs to make sure this characteristic is in the Physician hiring profile.



6) Build Confidence in IPU Documentation

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

If people have confidence in IPU documentation, usually there is not much of an issue regarding IPU utilization. Confidence in documentation means that you are not worried if you are audited or receive a ZPIC or UPIC or undergo other scrutiny. Confidence in documentation is critical for a Hospice IPU census as well as census in general. Extreme FOCUS on documentation is necessary and has enormous payoffs. Yet, most Hospices have ultra-poor documentation as clinicians are not taught how to document well nor are they held Accountable for their documentation in any meaningful way. 99% of the time when MVI does a Magic! engagement and we ask for a single “perfect chart” for any diagnosis or patient setting, the Education or Compliance people can’t produce one....not even one chart!

If Education or Compliance can’t produce a Perfect or Ideal chart, how can a clinician be expected to document well?

What needs to be done is that Perfect Documentation (Perfect = to the Standards of the organization) needs to be: 1) defined, 2) taught and 3) clinicians held Accountable to the Standards of Documentation. We recommend teaching documentation via *System7* (covered in the Accountability & Standards section of this manual).

Examples of Perfect Charts need to be produced and made available to teach clinical staff what Documentation to Standard looks like.

In an IPU setting, we start with the most common diagnosis groups, work on the top 3 or 4 and then move to others. An example “Perfect Chart” is produced for each diagnosis group. We also define the language we use and HIGHLY depend upon the written narrative to communicate the “picture” of the situation, always documenting from the Start of Care (SOC) perspective rather than just “what’s happening today.”



7) Tie IPU Staff Compensation to Unit GIP Occupancy

Paying IPU staff straight salaries and hourly rates is the worst way to compensate. Why? Because when the IPU is full and census is high, IPU staff normally complain that they are “too busy.” When census goes down, they say: “It is good to be back to normal and that we don’t have that many patients.” This is exactly the OPPOSITE of what you want! Incentives need to be created where the IPU staff are happy and are grateful when the IPU census is high and sad or feel pressure when the census is low.

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

The truth is that they just “got used” to working light...and the additional patients are an inconvenience.

Historically, IPU compensation has been difficult to define and measure. However, good headway has been made in this area. Performance compensation of Hospice Inpatient Unit (IPU) staff should be based on

- 1) Meeting the Standards of the IPU and
- 2) Census of the IPU

The Standards Bonus would involve 100% adherence to quality, no complaints, documentation to Standard, etc. The GIP census becomes the IPU staff’s productivity measure. Note: GIP census becomes the productivity measure. Not Residential or Respite patients.

We recommend a system where clinicians received a base salary or hourly rate and there is a portion of their pay that is structured as a bonus (Standards Bonus for doing the Standards) that moves up or down dependent upon the IPU census of GIP patients. That is, when census is up, the IPU staff make more. When census is down, they make less.

You want to provide natural incentives for IPU staff to WANT the IPU filled.

This is a structural move that usually requires CEO authorization.



Why Use the Overall GIP Census Level as a Component of IPU Pay? We specifically link this to GIP as you DON'T want Residential patients or patients at a Routine level of care or even Respite. Routine level should NEVER exceed 10% of a unit's census (See the *Inpatient Unit & the Model manual for specifics regarding this.*)

The reason behind this is because an IPU census is everyone's job. You WANT everyone at the IPU to be CONCERNED. You want to foster a sense of urgency to fill up the unit, to get new patients admitted. CENSUS IS THE BIG DEAL IN AN IPU!

In addition, you don't want IPU staff bitching when the unit is full. By tying census to pay, you pretty much wipe out this "bitch factor."

This also creates a healthy flexing of costs of an IPU. When the IPU census is down, you aren't paying out as much. This is a structural tool to keep an IPU full.

This also puts a bit of pressure on an IPU Manager to fill a unit. So, not only are they being paid on the performance of an IPU (Just like any Clinical Team Manager using SuperPay!) on a percentage of savings based on NPR (Net Patient Revenue), but they know that their team will suffer if they don't fill the unit. YOU WANT THIS PRESSURE.

So what would the structure look like?

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	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
Semi Monthly	24	24	24	24	24	24	24	24	24	24
Pay Period	1,666.67	1,666.67	1,666.67	1,666.67	1,666.67	1,666.67	1,666.67	1,666.67	1,666.67	1,666.67
	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%
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, a 10% Dig is deducted from the pay period.

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

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

As you can see from this template, nothing extra is given for any census level below the "Magic Number" (one above breakeven). However, once that number is reached, the incentives increase dramatically. Of course, the "magic" number is different for every IPU and it must be calculated independently. Here is a section from the *Hospice Inpatient Units & the Model Workbook* regarding the Magic Number.



- **The Magic Number.** Many clients know that I refer to the “Magic Number” regarding units. This is the one additional bed average that is expected to be filled annually ABOVE breakeven. The Magic Number has to be discovered... and discovered in the planning stages. Some Hospices have built units that were one bed short and as a result, they lose money all the time or struggle at best. Let’s face it, once a unit is built you just can’t snap your fingers and add a room. This is a “structural” problem. The Magic Number has to be found. The difference that one additional ongoing occupied bed can make is tremendous. I did a pro forma the other day and the Magic Bed moved the model from a loss of \$35,000 per year to a gain of \$150,000. Now, which would you rather have? I suggest that MVI clients look hard at the IPU and Continuous Care Management and Costing Model and discover the Magic Number. Within a few minutes or hours, you can know your “Magic Number.” This number is burned into the brain of the IPU Manager.

We will cover more on the topic of Compensation in a later section of this manual as Compensation is a critical structure that impacts cost.



8) Understand the How to Take Care of Your IPU People

This seems like a basic idea. Yet, when I speak with many Managers, I hear: “Turnover is high here,” or “We can’t keep people.” Comments like these are giveaways that the Manager does not really understand their part in Attracting and Retaining Talent. The IPU Manager in this case provides a work atmosphere...and that work atmosphere should be inspirational and electric! It should give Energy rather than take Energy!

70% of the development¹, morale² and retention³ of an employee will come directly from the immediate, front-line Manager!

This is an astonishing percentage! However, too many Managers blame external factors rather than themselves such as the culture, compensation, benefits, the industry, competition and other things!

Taking Care of Your People

Virtually all of our problems, issues and challenges come from our People Systems... They are quality issues... Quality arising from the quality of our people...

Why do people come to work at a Hospice?

What are the words that they use to describe their “attraction” to this type of work? They use the words “Called” or “Led” or some other Spiritually-oriented language to describe divine guidance to the organization. What are they seeking? What do they want?

The short answer is that they want more than a job...**they want “meaning and purpose.”** They want to do work that matters. This is how they enter the world of Hospice. They even are willing to take a “pay cut” in order to do this type of work. For some people, this may even make it more “spiritual” as they believe that they are sacrificing for the cause. Hospice people want to FEEL special...chosen...part of a “revolution” or “movement” in healthcare... Think about it... Hospice is supposed to be a Volunteer-Driven, Spiritual, Holistic form of Managed Care with the patient and caregiver in the control seat... That was the idea... However, the



typical Hospice, the 50th percentile, is a long-way from this ideal...a long way... Now we are primarily a clinical model, with low volunteerism (most struggle even with the measly 5%) and things like Spirituality and Bereavement are being marginalized and cut back... We want more physicians in the mix because of this “clinical model” morph... Physicians are great, but they also bring new sets of issues... They are major “clinical” drivers in power positions of authority...they command attention...they are often carpenters where every issue becomes a nail... Thus, other disciplines are lessened... And of course, physicians are so easy and malleable people to manage... Ask the hospitals and health systems that purchased their practices in droves...

So, most of us probably agree that Hospice people seek “meaning and purpose” right? And that clinicians even seem to be willing to take a “pay cut” to work in Hospice for the sake of the mission. So what are we doing as CEOs to nurture this?

If we are doing a good job at “nurturing meaning and purpose,” then why is clinician turnover a major problem in Hospices? Why are turnover rates so high? The turnover of RNs is approximately 27% annually nationally. 26% for SWs. 23% for Aides. A Hospice can have almost ZERO claim to true quality with anything even close to these percentages as turnover of Talent is the *#1 Destroyer of Value* in ANY company! If your organization is constantly having to train “replacements” you are losing valuable experience and are wasting a lot of money in the process... This brings us to “taking care of your people...”

NOTE: Hospices never really “got” the Managed Care part of the founding concept as reimbursement was ample and organizations did not have to exert themselves to manage well. If they would have, Hospices would be teaching ACOs, MCOs and Health Systems how to do it! They would have precise knowledge of the cost of each diagnosis group, patient, referral source, payer, clinical, clinical team, time-slice and other demographics such as age, sex, care setting, zip code and eye-color, just to name a few! In minutes, the cost-savings could be demonstrated to Health Systems and other players...But this opportunity has been squandered by CEOs without the desire or vision to understand the business value of Hospice. We are a business of heart for sure...but we must clearly understand that we are a business of huge economic value as approximately a third or \$175,000,000,000 is spent annually, by Medicare alone, in the final year of life. If every person that died in the United States were put on an entire year of Hospice at Tier 1 rates, it would SAVE the Medicare system over \$80 billion dollars annually! That is how much opportunity is Hospice care...



Most Managers Do Not Grasp Their Part in Taking Care of Their People

I have found that most Managers have traditional views and blame turnover and the loss of talented employees on poor morale, pay, benefits, work-hours, culture, HR, the CEO, etc. They blame anything external BESIDES themselves. One would think that it is obvious that a Manager would want the people they lead to be happy and satisfied in their work...and to be fair, they probably do...but they don't know how or are unwilling or incapable of expending the effort.

You will find "patterns" of retention. Normally, a Manager that understands how to take care of their people will have little turnover. A prickly Manager will lose people. A World-Class organization cannot afford to lose talented people! And taking care of your people does not mean not being productive and fulfilling the requirements of the organization. On the contrary, it means fulfilling the purpose at an extraordinarily high level while keeping talented employees!

People would rather work at a crappy job for a super Manager rather than at a great job for a crappy Manager.

This is why highly, highly paid people quit great jobs... They don't want to work with their boss. Their boss makes life miserable and the money isn't worth it.

With Benchmarking, there was a Clinical Manager that set nearly all of the MVI Benchmarks for 10 years until he retired. Pay was not great at the organization. He had ultra-ultra-high Standards that he held his people Accountable to. Yet, there were hardly any voluntary separations! That's right! It was RARE for anyone to quit! Why? Alan took care of his people! Alan had genuine concern for the welfare of his staff. And they FELT it! When he was interacting with his team before they set out for their visits, Alan was there with them, making sure they were in a great mood and that they had everything they needed! This all sounds so common sense doesn't it? Yet, most Managers lose far too many talented people because their staff do not FEEL they care for them personally. By the way, Alan was a Hospice Chaplin with no clinical background leading a clinical team...



Where Do Problems Come From?

Most of the issues in running a Hospice, or really any organization, stem from people issues. I have found that most people want to do a good job. However, they are FAILED by the processes and structures they are given by the organization. This is why service failures are common in most organizations. In fact, they happen sometimes DAILY if you can get your head around that! People don't even blink when a complaint or service failure is reported. It is often viewed as "just part of the job" or even "normal!" This is mind-blowing! The processes and structures of an organization are the means by which predictability and quality are achieved. Therefore...if we want to solve the problems of the organization, we have to address the processes and structures that support our people.

This brings us to the Model...which, if you really break it down, is 100% about processes and structure. Ranging from the financial processes and structures to the words, phrases, smells, look, inflections, specific actions, sequence and FEELINGS that are created with every Visit, Phone Interaction and physical product touched. All can be simplified and de-complicated to create FOCUS on quality...the basis by which we compete in Hospice...

What are the issues created by not taking care of our people?

- Turnover of Talent – The #1 Destroyer of Value
- Inability to Attract the most Talented people in a service area into the organization
- Continual Waste, as new people are constantly having to be trained... Training is expensive in financial terms as well as in loss of reputation when mistakes and errors occur.
- Loss of Reputation for Quality
- Inability to Grow...not much value to sell...
- Weaking, non-talented, Weenie, mediocre people remain...

There are probably many more, but this short list is sufficient to get the point. We must FOCUS on our people! Especially our front lines!



How Do We “Take Care” of Our People?

By providing them with what you are able...as that is all you can give! And what you can provide? You can provide the “conditions for success” or a “lifestyle” that is highly supportive of your staff’s goals and desires. What might this entail?

- An Electric, Motivating, Life-Changing, Transformative Work Environment! **Recognize the Immediate Manager is the #1 Factor in the Retention of Talent!**
- An Atmosphere where they FEEL they are growing and progressing as a person and as a professional!
- Great Pay! Pay that they can control!
- Elimination of 8-5 work hours!
- Simplification of the EMR! Too many organizations have over-complicated these via customization! Make documentation EASY through better-written narratives!
- Enough “time” to rest, relax, release and reflect on their life...
- Make Phone and Visit work EASY by using IRMs strategically placed in the patient/employee work environment.
- Where they “believe” that they are working for a World-Class, Outlier organization that is so well managed with “unheard of” quality and economic performance...where everyone is extraordinarily well-trained and really work together as a true interdisciplinary team where 100% of its people can be relied upon to do their jobs to 100% of the Standards on a day-to-day basis.
- By providing people with Standards, processes and structures that make work EASY!
- Remove from Clinical Managers the need to 1) Monitor Documentation, 2) Monitor Productivity and 3) Annual Reviews.
- Have “few” meetings throughout the organization. IDTs are to be highly focused, enjoyable and renewing!
- Have “massive” amounts of work done by Volunteers.

The point is, the IPU Manager of a Hospice can create ALL of this for your people! Every one of these points is being done NOW by top IPU Managers in our movement! How Hospices are operated can be done SO differently! We, fortunately, have a reimbursement system that allows for great flexibility and creativity! The few “constraints” that we have provide the fuel to unleash our problem/challenge-solving skills!

But this has to come from the IPU Manager, the Teacher...the Transformational Leader from whom everyone is taking his or her behavioral and performance cues... The IPU Manager has to “see it” before it can ever be built. This is part of the reason you are MVI Networking clients as it is our job in this relationship to make you aware of the “Best Known Practices” within our movement.



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

This is all part of your People Development System really... Understanding what people desire (both explicitly expressed or not) and fulfilling them with the tools and methods that are “known...” They have to be “known” or we must be aware of them...otherwise they can’t be employed... In addition to being “known” – they must be operationalized. This takes courage, which comes from the domain of Integrity combined with the domains of Intelligence and Energy... However, Integrity is really where most CEOs miss it. They get a “Best Known Practice” intellectually. They have the Energy to do it as well... But they “just can’t bring themselves to pull the trigger and do it.” It takes guts to do what the minority does or deviate from the “Herd” or the “huddled masses.” But the truth is that your people WANT you to do this! They want to FEEL they work for an elite organization. They want to work with a WINNER!



You Have Tremendous Power!

What does this mean? It is within all of us, but it is especially an aspect of Managers and the CEO. Each of us has tremendous power to help others. It is done with positive and helpful thoughts, words and actions! In all situations, an individual that is radiating positive Energy will impact all... We will not get too wide in this discussion, but it is my opinion that everything we think, say or do has impact and is important and that nothing goes unnoticed...

In practical terms, consider something as simple as checking out at a convenience store. A person can have BIG impact on people, especially the check-out clerk! You can shoot that person a shot of love and positivity that WILL make an impression on the person. It might be in response to "How are you today?" and you say "It's the BEST day of my Life!" They don't hear that every day! It jolts them! It is NOT common! It gets a person "thinking" in a benign, non-threatening and loving way! If questioned about it might be *"I have a choice in how I want to experience or live my Life! So I choose to be positive!"*

OR if the clerk is negative you could say something like this *"I love your shirt! You have taste!"* or some point of positivity! Everyone should be able to find some positive thing about every single person! An intelligent person can see positivity! And it is not just the words that make the impact... It is the Energy! The shot of Love! The display of actual kindness...that there are actually kind and caring people in this world...and YOU could be one of them! It is a choice!

With every text, every email, every look, every thought towards others, everything you touch LIVES CAN BE IMPACTED! I can win over, or at least profoundly predispose, a person or person representing a company to WANT to live a better Life! To want to be around you! To want to do significant things with their lives! THAT IS THE POWER EVERY PERSON HAS!

When you, as the Manager (or CEO) enters a space filled with your staff, the Energy should RISE immediately! You will see it physically in their eyes and in their body language (93% of communication is non-verbal). If this "spike" does not happen, you need to work on yourself! And the great thing is that ANYONE can do this! It is a matter of Integrity and choice!

In Hospices that I have owned or am part of the management team such as with Magic clients, we teach this... Yes, we TEACH about the power each person has in every interaction whether on the phone, visit or at random! And it is teachable!



Letting Go – Release – Forgiveness – Trusting God

This is perhaps the most profound aspect of Spirituality... And it ties DIRECTLY to what we do in Hospice care...

If you want to increase the *Meaning & Purpose* of your people, a great place to start (and stay) is in the area of “Letting Go...” What does this mean? (*See the chapter dedicated to this topic in this manual*)

Letting Go can be stylized in many ways....Release, Forgiveness, Trusting God, Faith, Surrender, Relinquishment of Control, Stop Resisting, etc.... All of this involves the same thing... *Letting Go* of what Andrew? *Letting Go* of trying to control Life and especially *Letting Go* of Negative Emotions! If we are really “doing the Model” we understand that EVERYTHING in the Model is based on the FEELINGS and Emotions of people as FEELINGS and Emotions are the foundation of 100% of human recall and memory. If we can release our negative Emotions such as Anger, Grief, Shame, Guilt, Apathy, Sadness, Depression, Anxiety, Resentment, Desire and Fear (the basis for all of them). Most of us can agree that the release of these would make a person Happier right!!!

The point is there are specific things a person can do to surrender negative Emotions and FEELINGS! Consider the Hospice experience in relation to *Letting Go*...

What are our patients and families having to let go of?

- The physical body
- Relationships
- Normal routines of living
- The ability to communicate
- And a multitude of things beyond our comprehension...

In my opinion, we need to be experts at *Letting Go*... *Letting Go* is a skill set... A skill-set that can be taught... But even this, will require a person to surrender to it and release his or her control of their Life... Whoa! That is enough on this for now!



Be Prepared to Have Your Heart Broken

As a Manager, prepare to have your heart broken, crushed and demolished... Perhaps no truer words have been uttered regarding the FEELING the Manager experienced when disappointed after TRUST has been given to others. However, TRUST is the only way to fulfill the mission on any material scale as the help of others is needed. You MUST TRUST OTHERS! A culture of “dis-trust” costs is a high-cost culture as Managers are needed to be hired to “make sure” people do their jobs. What a waste! Just hire people who don’t need to be managed! Hire professionals! Treat them as professionals! A true professional does NOT need much management Energy! However, from time to time, a person will violate a Standard or do something that is non-beneficial (to say it nicely) to the organization. At this point, the Extraordinary and True Professional Manager administers Accountability (Pain) to the appropriate degree with the transgression. It is not pleasant, and I don’t think a professional ever gets used to it as the professional is “gullible...” The professional must know that people will disappoint you...but you must REALLY TRUST PEOPLE! And people must FEEL this Trust!!!

A professional may sometimes appear to be a tough and strong person, but the person is also very sensitive and aware of others... Aware of the FEELINGS of others! Trust is an Emotional action! Anything with Emotion and FEELING will produce a broken heart when the Trust is violated... But we must Trust again!!! This takes courage... And courage comes from a place of Integrity...and love for others!



The Enlightened IPU Manager

Spirituality – An Unobvious Link to Phenomenal Quality and Profits

Creating a Workplace of Spirituality and Meaning

One of the keys to creating a sustainable, high-quality organization is the ability to **attract** and **retain** talented people. Turnover is extremely expensive and destroys quality. Loss of talented staff greatly harms an organization. The loss of talent destroys consistency/predictability at minimum. Loss of talented leaders is the quickest and the greatest destroyer of value as the loss has a multiplier factor.

Meaning is essential in the workplace. If a workplace is not meaningful, it is not a healthy workplace. Most successful people have found that they derive tremendous satisfaction from work. In fact, work is an essential part of their lives and their lives would be far less fulfilling if they did not work. In addition, they are compensated not only monetarily in the form of money, but also mentally and spiritually. *Meaningful work* is a delight and makes work sustainable.

Believe it or not, there is a direct and unobvious link to a number of our Hospice clients with some of the highest quality and profit levels...and the link is Spirituality. Yes...no kidding! I can hear people saying “Andrew, now you have drank too much of the Kool-Aid!” In fact, the HIGHEST profit levels we have EVER witnessed, are Hospices with incredible levels of Spirituality...with profits almost beyond belief. These are Not-For-Profit as well as For-Profit Hospices, so tax status has little to do with this. Now any organization can chop quality and expenses in the *short-term* to increase profits (a super “dumb” move as an organization’s reputation is compromised). That is not what you want. You want *long-term* profits THROUGH high-quality and a reputation for an absolutely predictable World-Class experience...every patient, every time!

Where Spirituality comes into play in a big-time way (that rhymes) is in the People Attraction and People Retention processes of your People System. The primary reasons that people come and stay at organizations are:

- Compensation
- Vibrant/Exciting/Meaningful Atmosphere

I have written about compensation at length, so I’ll leave that alone in this piece. But the “atmosphere” is equally important, and is sometimes more important. However, with that said, do not believe that Hospice’s can’t pay their staff members well. That “poverty mentality” needs to be eradicated through running better Hospice businesses.



The individuals that come to work at Hospices tend to seek meaning and purpose. This is a primary demographic of people that work in Hospice care. However, most Hospices DO NOT nourish this need for meaning and purpose in any material sense. They pay little more than lip service to Spirituality. Contrast this with the “few” Hospices that actively nourish Spiritual Values, the ones with these high levels of productivity, quality, retention of staff and profit.

When we refer to Spirituality, we are not favoring any particular belief system, but rather are admonishing Spiritual Values. Spiritual Values would include fairly generalized concepts that would be common to many faiths and belief systems. They are presented not as “doctrine” or “the way it is” dogmatically but rather as “this is how things might work.” This might include the ideas of Intuition, Energy, Relaxation, Release & Surrender, Pain, Accountability, etc. All topics that relate to our Hospice workplace and that usually have overlap into our personal lives as well.

“Rot Your Competitors from Within” By Attracting Their Talent

“This doesn’t sounds like a very spiritual thing to do Andrew!” you might think. However, I think it is part of an organization’s job to advance Spirituality and Spiritual Values as far as you can. After all, each person and organization is accountable for their learning/advancement. And there are definitely payoffs for structurally nourishing Spirituality!

One of the biggest payoffs is that you will naturally attract the top talent in an area. Since most organizations do NOT nourish Spiritual Values intentionally, this makes it extremely easy to differentiate your Hospice. They will come to you. When the “word on the street” is that your Hospice is a fantastic place to work, where people feel fulfilled, a Hospice will no longer need to do very much advertising for talent. You will have many candidates applying for positions. This alone is a great payoff. But it doesn’t stop there!

If top talent leaves your competitors to work at your Hospice, it is a double whammy hit... Not only does your Hospice get the talented, top-rung people but your competitor **LOSES** capability. And what is the biggest destroyer of value? Loss of talented people! This double whammy can be devastating... Spirituality has a **HUGE** payoff... You are also challenging your competitor to “up their game” and if that is accomplished, Hospice is better in that community. Everyone wins! Ultimately, all of us are on the same team in this totally integrated and interdependent world! No one is alone or is solo...



Record Volunteer Levels

Imagine having as much a 50% of the labor of your organization done by volunteers...that is, the members of community themselves because they are so “into” what you do. Again, this is the reality for a few Hospices that intentionally incorporate Spirituality. People are grateful for organizations that truly love and care. People appreciate organizations that love their communities *enough* to meticulously create a high-quality, predictable experience so that virtually NOTHING is unconsidered. Communities understand that organizations dedicated to higher spiritual ideals will have higher levels of compassion and love. They are thankful for this and show their thankfulness by volunteering on these extraordinary levels. They give their time to these organizations whether they are Not-For-Profit or For-Profit. It is the QUALITY of the program ultimately that attracts volunteers...and a central demographic of volunteers is they, like most human beings, seek meaning and purpose. Building great karma or finding spiritual benefit is their compensation. The obvious also happens to a Hospice’s bottom-line. But this is simply a natural by-product of Spirituality.

Happier Hospice Cultures

Just the fact that you will have a happier Hospice culture is *enough* of a reason to embrace Spirituality! However, bringing Spirituality into a Hospice culture isn’t that easy...

Why a Hospice Can’t Just “Become Spiritual”

The reason that a Hospice can’t just “become Spiritual” is that Spirituality inherently comes from “beingness” – that is, it emulates from the collective “essence” of an organization. It is an energy or a “field” that impacts all surroundings, just by your presence...even without you doing anything! Spiritually is beyond intellect and calibrates on various levels if one were to evaluate it on a scale.

Most organizational cultures emulate from the CEO. Yes other leaders play a role as well, but none have the power of the CEO. And if a CEO doesn’t “get” Spirituality, then it is HIGHLY doubtful that your Hospice will ever be able to raise Spirituality to the levels we are recommending.

This may strike some as funny or paradoxical. However, the spiritually inclined CEO is more powerful and can lead more effectively than those that are primarily materialists or adhere to other linear paradigms. I will say it again, this is due to the fact that most people that work in Hospice DEEPLY desire meaning and purpose in their lives. Hospice naturally attracts mission



oriented people. Yet, most Hospices do not formally nourish this demographic. The payoff for nourishing this desire/need is lower turnover, lower stress, higher quality and yes, more profit.

The kicker here is that the CEO must be enlightened. You could say that the CEO needs to have a high consciousness level, increased Spirituality or whatever. This takes a Revelation or Damascus type experience on a personal level. *It is a personal experience and it usually happens when a person is “ready.”* It usually involves a person desiring truth, no matter what that pursuit will bring, losing individual identification and learning to see all with unconditional love. These are big moves. A Revelation or Damascus experience can be stimulated by an event (such as the MVI *Deep Retreat –August 3rd and 4th*), a person or can be self-invoked. There is no magic wand or path. It can't be purchased with money. Most CEOs do not have a heightened sense of Spirituality above average as “average is average” by definition...and the Bell Curve is always with us! However, generally speaking, the overall level of consciousness is increasing every day believe it or not! It is a moving average!

Normally, Spirituality can't be faked over extended periods of time. How a person conducts their life in their leisure time is telling as well as in the business setting. Spiritually inclined people can sniff out fakes or unauthentic people...eventually. Therefore, this is difficult to fake over long periods of time. However, there are “charlatans” that are very good at deceiving naïve people. But the more spiritually developed tend to smoke these people out. Here are a few spiritual ideas that I ponder. Spiritual truth:

- Does not seek gain, fame or money to become “Enlightened”...
- Understands that Unconditional Love is paramount...
- Sees “all that is” as perfect...
- Has nothing to prove...
- Has no one to convert...
- Recognizes that Spirituality has more to do with “surrender” and “letting go” than control...after all, isn't faith about placing trust in a Power that is supposedly more capable and wise than oneself? This takes humility...and humility calibrates higher than pride...
- Is thankful...

These are things to think about...



4 The 1st Duty of the IPU Manager

What is perhaps the most important and valuable thing you can be doing?

What is your Role as an IPU Manager?

What do people expect of you?

How do you know if you are effective?



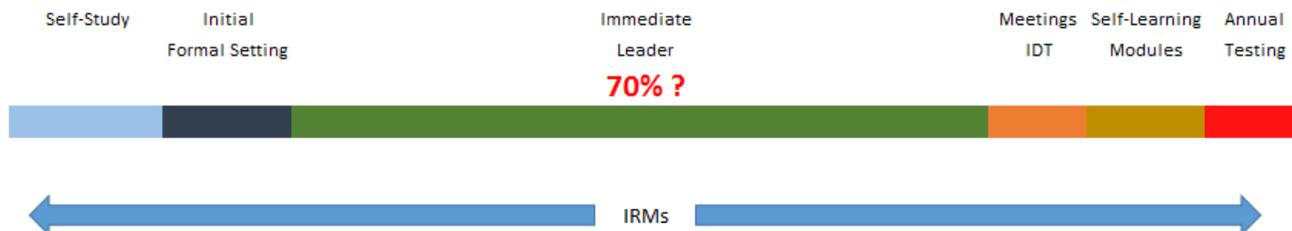
You are a
teacher! It is
your **1st Duty.**



Where Does Learning Take Place?

The illustration below shows areas where learning takes place or potentially takes place in an organization. Our belief is that a great deal, the largest percentage, of learning is provided by the immediate Manager of an area.

Where Does Learning Take Place in Our Organization?



In the Hospice world, this would translate into the Managers of every department and business segment. However, the Manager with the most impact on the frontlines of care is the Clinical Manager. Therefore, in our opinion, the Clinical Manager is the primary position of focus. This is why we call it the

1st Duty

The 1st Duty of all Managers is the responsibility to train the people they lead. This is the ONLY way excellence can be replicated and multiplied.



Where/How People Learn?

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



Therefore, EXTREME focus would be on the development of **Clinical Managers**, giving them the resources, attention and tools to be extraordinary.

All Supporting Departments live to serve the **Clinical Managers** as they influence the frontlines of care more than any other position.



Moving from Providers of Care to Teaching Organizations

The World-Class Hospice organization views itself not as a “provider of care” but rather as a teaching organization. This fundamental mindset difference changes the behavior and improves the experience of everyone the Hospice touches. The benefits are multi-dimensional, ranging from increased confidence, higher satisfaction, lower costs and, most importantly, diminished suffering. Though we certainly provide care, we know that much suffering is due to anxiety-related issues and uncertainty. To the degree that a Hospice can address anxiety-related pain through the educational experience, it will reduce suffering and improve the comfort of patients and families. It will also lessen clinical burnout as the “burden of care” decreases as more help is available through empowering others, including caregivers and other support personalities, to assist in the care of loved ones. By teaching, we are increasing capacities as well as improving the self-image of individuals. *When teaching, we are leading.* Teaching and leading in this way are enormously positive for everyone... perhaps because learning is the essence of living life itself.

The Learner & Teacher Paradigm

This is the mindset of the modern Hospice. As we proceed through this program, hopefully it will become clear that adopting the image of “learner & teacher” (individually as well as organizationally) is superior to the image that our Hospice is the “provider of care.” This simple change (which is probably not so simple) will have enormous impact on everything from quality to economic performance. When asked to help design a new Hospice, I make education “the center of the universe” or “the heart of the Hospice.” It is THAT significant.

For example, if your Hospice assimilates this cultural idea, I would predict that your turnover rate would decrease by 50%. Your clinicians and Managers would be calmer and experience less stress. They would fundamentally do their jobs from a different perspective...from the identity of a learner and teacher. Additionally, this change would cost a Hospice virtually nothing. This is just one of the benefits.

Dreams of World-Class are pipedreams without World-Class People Development processes. The effort and focus our Hospices place on learning and teaching will determine how far our Hospice goes along the path of excellence.

When I visit a Hospice, one of the first places I want to see is the training space. You can tell almost immediately where a Hospice’s quality and culture stand by visiting the training space. The training space is sacred ground. It should make you want to learn...and the teachers should be extraordinary!



You are a Teacher

If you are a Manager at this Hospice, you are automatically in a teaching role. It is part of our culture. The only way to World-Class Hospice is through People Development. People Development involves teaching. The thriving and energized Hospice has a learning culture. It recognizes the importance of learning new things and incorporating discovered Best Practices into operations. A Hospice is only as good as the people that work in it. Therefore, learning and teaching are important.

You are a Teacher!

On a deeper level, or more essential level, you are also a FEELING. As a Teacher,

Learn to teach to the
feeling...



What are People?

This is perhaps the most difficult question we face. Do we really know “what” we are? If we did, perhaps we would understand how to conduct our lives better. However, I would like to introduce a possible definition that may help us as we become Teaching Organizations.

People are essentially “feelings”

or “walking balls of sensations” from moment to moment in a body or physical container.

At any moment, we know at minimum that we are feeling and are conscious. The driver for most people is to feel good or to avoid pain. Even the most anal-retentive scientist or Wall Street analyst - those that make sure every “t” is cross and “i” dotted – that has to have every fine point in the master plan – does this for a reason. The reason may be to “have the **feeling** of control.” Perhaps feelings are the drivers of everything human.

If this is true, then as we teach, we need to learn to teach to the feeling. It is important to recognize that a feeling is created in every Hospice interaction, whether it is a phone call, a visit or a physical product that a person sees or handles. A feeling is created by each interaction.

If being Learners and Teachers is part of our culture, then great effort should be devoted to the educational experience. Top teachers would have great tools, structures, props, training space, methods, etc.

The big question is

How do people learn?



How Do People Learn?

The big question is

How do people learn?

Or maybe the bigger (or equal) question is

“How do people remember?”

And the ultimate question in an organizational context is

“How can people remember what to do and then do it?”

I do not know of anyone who has mastered the art of learning or teaching. However, here are a few points to consider:

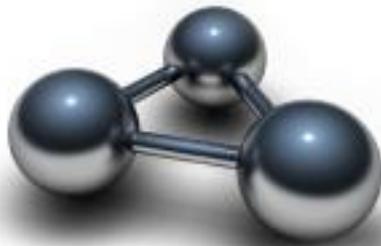
- Feelings play a huge role in driving human behavior. In fact, feelings are primary.
- The Images (or beliefs) in our minds drive our behavior as well.
- Pictures usually facilitate communication and understanding.
- Sensations make learning more memorable.
- Association is used for recall.
- We learn in many ways, through the five physical senses and perhaps in others ways yet undefined.
- People learn in different ways. There is a broad range of learner “styles.”



All Memory is Filed by Feelings and Images

According to research, all thoughts are filed in memory based on the associated feelings and tone, not fact...

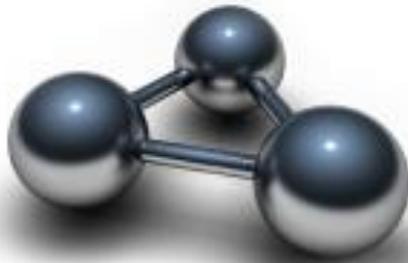
According to scientific findings, **ALL** thoughts are stored in the memory's filing system based upon the associated feelings. They are filed according to feeling and tone, not fact..



Gray-LaViolette, 1982



Learn to teach to the
feeling ...



This involves emotion or causing our students to experience emotions in the learning environment. Joy, stress, pain, happiness and confidence... all of which are feelings.



In a very, very real sense, we are... feelings... at least from a consciousness standpoint.

Images also play an important role, as “the images” in our minds often run our lives.

The images in our minds run our lives...

These “images” include our beliefs that are based on our understanding of the world and how the world works...not how the world *actually* works, but how we *perceive* that it works! Therefore, in addition to feelings, images play an important role in learning and remembering/recall. Put another way

“If you can’t see it, you can’t be it.”

If you (we) can place the right pictures into people’s minds (kids, fellow staff members, neighbors), we will change or influence their behaviors toward emulating those pictures. The images in our minds do run our lives...

You will note that much of the subsequent material presented in this manual focuses on the use of “feeling” and “images” to foster the behaviors deemed necessary at our organizations.



Confidence: One of the Ideal Outcomes from your People Development System

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.



One of the primary outcomes from your People Development efforts should be an increase in confidence levels throughout the organization. In fact, at least annually and after each training topic, you should have students rate their confidence levels. Confidence should be measured.

When you start using strong words like “guaranteeing” as you teach about your Model, immediately the question of confidence arises.

Do you have an ultra-high level of confidence in your Hospice’s guarantees and promises?

IF the Model is done well, the level of confidence in our ability to predictably replicate a World-Class and individualized care experience is greatly increased. Why? Because there is a “system” that everyone understands and it is one that is well thought through. Things that we can’t do well are deleted from our promises and only things that we can do day-in and day-out



are represented. **In short, perhaps the biggest benefit of the Model is the increase in confidence levels**, which is reflected in increased census, increased satisfaction scores from all parties as well as financial sustainability. Confidence is a big, big... gargantuan proportion thing of importance.

When one ponders the role of confidence, it is certainly one of the most important factors to consider when anything needs to be accomplished that is significantly different from today. Without confidence, people do not move. Lack of confidence holds people back. Fear keeps us from being and doing new things. With that said, confidence is linked to Management. Stated more directly,

If we want people to lead change,
the Managers must be **confident**.

How do we get more confidence? Certainly, we all lack confidence at times or in particular areas. However, the ultimate goal of our People Development efforts should lead to increased confidence and this should be measured. Here is what I know so far. Confidence comes from:

- Positive personal experiences
- Practice & repetition
- Seeing others succeed (examples to emulate)
- Beliefs

Confidence, and the building of confidence, is complex. Perhaps the greatest confidence builder is success and accomplishment. Believing that you are able to do something goes a long way towards actually doing it.

Confidence is tied to our beliefs... beliefs in self and how the world works. Our self-images run our lives. Our beliefs about how the world works dictates what we think is possible and how we go about it. We behave according to our perceptions of reality. Confidence... the word normally denotes a degree of certainty and carries a positive connotation. Confidence is much like faith...

Confidence is a **FEELING**.



Find Your Own Confident Voice

To be effective in your Management role involves finding your own voice; that is, be who you are... do your duties with your personality and positive personal traits. So you are encouraged to find your own style.

What you are doing with this training manual is preparation. All top performers are in a state of continual preparation. Preparation is a key to confidence.

“Confidence is being adequately prepared and believing that your abilities will take care of the rest.”
Jack Nicklaus

Confidence is important, as a Manager must have the ability to inspire and motivate others. It is VERY difficult to follow people who lack confidence. To lead best will require you to lead out of your personal identity and personality... confidently!

Confidence Can Be Increased Through Knowing Your Numbers

Knowing your numbers can give you confidence. Even if your numbers are bad, at least you have some fairly firm footing where you stand. Managers should feel uneasy when they don't know the numbers. And when you know your numbers, it spills into everything you do.

The first thing we need is a desire to know the numbers. The point is this: you have an INTEREST in knowing the numbers to be a better Manager. This is the starting place and with that desire, you will certainly achieve it!

Many people with clinician backgrounds have fear about the numbers. Somehow they feel that “number land” isn't their thing. Let's blow that myth away. People with a clinical background can do it with the best of them!

Once you know your numbers, you can begin to operate within the Model. You will take pride in achieving great numbers and it will become a tradition and mindset at your Hospice. You will always know if you are “in” or “out” of the Model.



What are an IPU Manager's Primary Functions?

There are at least 2 essential functions of an IPU Manager, (1) Vision and (2) Resource Allocation. These functions are essentially the same as a CEO's but on a smaller scale.

(1) Vision

An IPU Manager must cast and effectively communicate the Vision. The IPU Manager must cast not only a Vision, but also a “captivating vision” that motivates. This Vision must move people to action. It is a continual process of re-enforcement and refinement, making the Vision clearer and more powerful continually. This is the only way to effectively build a team.

The most profitable IPU Managers have very, very clear Visions of what they want to build. The clearer the Vision, the more effective we will be.

How Do You Build a Team? You Need a Compelling Vision!

Descartes had it figured out. The key to building a team is to capture people's imaginations. In this case, it is about becoming something special, an outlier...something that each individual personally identifies with and takes pride in!

Forget “team building” exercises in which people are asked to catch a brave person as they fall backwards, paintball wars or being beaten with foam bats. These are not productive uses of time.

What motivates people is a vision that captures the imagination! The Vision should stimulate creativity and action. People need to be excited about where they are going! You have to create INTEREST and be INTERESTING!

(2) Resource Allocation

The IPU Manager must effectively allocate resources. The direction of capital, people, energy and other assets or resources is the direct responsibility of an IPU Manager. All IPU Managers own the function of Resource Allocation. The Model (at least the financial NPR percentages) is your primary roadmap or tool of resource allocation. The IPU Manager deploys assets to create ROI (Return on Investment). This ROI must come in the form of effectiveness/quality returns and/or financial returns.



Your Biggest Profit Moves will come from Movements in Talent and the Compensation of the Talent

Your biggest profit moves will come from movements in talent and the compensation of the talent. Profitability in Hospice is largely about people management. Who do we have on our team (staff and vendors) and how do we pay them? We include vendors because the 90th percentile of Hospices views vendors as a critical part of the value-chain. This is a practice of Baldrige winners. In fact, an organization is only as good as its weakest vendor. A weak vendor breaks your Model.

Right now, if you are not highly profitable, you will need to make moves in the direction of talent, how to compensate talent or a combination of both. With this said, all organizations have talent. Often it simply has not been cultivated. Perhaps you don't have talent or the time to develop the talent. If this is your situation, then it must be brought in from the outside.

Talent – Fulfills a purpose in the organization by creating value, which results in increased revenue or a reduction of expense, both of a seemingly natural origin. A person can be taught knowledge and skills. However, talent is often that something “extra.” People that have a “knack” for doing something or pick up quickly are deemed to have talent. However, it is debatable whether talent is learned or innate. I think it is a combination of both.

The talent you are concerned with in this program is the talent for making money and profit.

A broad “People Classification” scheme might separate people into two groups:

- Creators & Movers
- Maintainers

I think organizations need both. In addition, sometimes people move between these classifications at times. It just seems that people are more inclined to be one or the other predominantly. When becoming profitable and highly profitable, you will need Creators & Movers. There are many more Maintainers than there are Creators & Movers.

Farm Less Ground Well

More and bigger does not always translate into more profitable business. Often, “more” just complicates matters and, if there are efficiency problems, compounds them. If an organization has efficiency problems, growing exacerbates problems. While it is true that “high water covers a lot of stumps,” high water will not last for long if quality is not there. This is the quality/efficiency (profit) relationship.



It is better from multiple perspectives to do less well. Less is simpler. Complicated doesn't work well. Simple does. Less is easier on the mind. Stress levels decrease. Less gives you better focus. As an IPU Manager, I would be more interested in allocating resources to those things that contribute to our core competence or vision than things that are peripheral. Outsource peripheral things, if they are needed at all. Stick to what you know. Bring laser beam focus to your competencies.

The fact is that an organization can have higher profits with less revenue if the organization is managed well. We have Hospices with ADC's of 50 that have more profit, in dollars, than Hospices with ADC's of 2,000.

With this said, Wall Street loves big numbers. It is sometimes hard to attract big dollars if the volume is not there. Big numbers impress. However, quality is also impressive. When you are smaller, the vision of scale usually has to be sold. Can the quality you create be replicated on a larger scale? If it can, you have a gold mine.

Use the Constraints of Time, Energy & Money to Fuel Results

As part of the Allocation of Resources to create higher ROI, use the constraints of time, energy and money to fuel creatively and results. If you give people LESS to complete projects, you will, more often than not, get better results than if you provide more, whether it is time, energy or money. Chop meeting times and frequency and create deadlines. Deadlines are incredible focus vehicles. A limitation of money creates frugality and the creative use of existing resources. People only have a limited amount of energy for activities. They will naturally direct this limited energy in the directions with the most probable odds of success. Human beings are programmed to solve problems in the most efficient way possible. The human brain constantly strives for more efficiency naturally. We are programmed for this via evolution and the survival instinct. When the brain recognizes a limitation, a challenge that is a potential threat, it kicks into another gear to satisfy or alleviate the situation. It starts its work immediately once the problem or project is defined. It is amazing how well this works. You will be surprised at the results. You will spend less time, energy and money and get innovations implemented in a fraction of the time compared to other slow moving organizations. If an individual cannot meet the assigned deadline, then reassign the task as soon as possible and reconsider the person's abilities. Usually this means that you downgrade them in your mind as we all make these judgments automatically. You might even define default positions if tasks aren't accomplished by your deadline. Example: If your team cannot come to an agreement regarding its financial Model, DEFAULT to the MVI Model since it is proven.



Resource Allocation or Mis-Allocation in Hospiceland

I think one can boil several key points down that directly relate to the Allocation of Resources.

- Hospice management is People Management. We are only successful to the degree we can manage people.
- Hospice profits must be based on efficiencies. In our movement, we can't increase prices.
- Most Hospices grow and then impale themselves on their Indirect Costs when census falls.
- Hospices should have been building training centers to develop their people rather than Inpatient Units.
- Hospices are not good at cutting losses quickly, a discipline ALL wildly successful investors have developed. This especially applies to extracurricular programs.



The Primary Role of the IPU Manager is that of a Teacher

The IPU Manager is a walking billboard of the IPU's future, at least current future. Employees are either thinking, "This person is a winner and has horsepower to lead us to success" or "We're screwed!" People quickly evaluate and judge the capabilities of a person thanks to millions of years of evolution. In fact, people usually form a very accurate picture of a person's abilities within seconds. So what do people think of you when they meet you?

As an IPU Manager, your role is that of influence. You are always influencing policy and practice. All Managers are selling ideas...all the time. In fact, ALL MANAGERS ARE IDEA SALES PEOPLE! If you are leading, you are selling to the people you lead. Ideas need to be sold in order to be replicated. So selling ALWAYS has to be considered. Teaching is directly linked to selling. In fact,

Teaching is Selling Ideas.

How skilled are you at selling? The evidence is in your results. How do you sell ideas? Teaching is essentially a Management skill. However, by far the most powerful form of teaching is to *Lead by Example* or, as we like to say, *Lead from the Front!*

Profitability - is it Nature or Nurture?

Profitability is in our wiring, our DNA, as well as in our environmental conditioning. I personally think it is probably a 50/50 split between nature and nurture. Therefore, profitability, like any other behavior, can be altered with direct intention. We will discuss this topic at length for IF we can recognize and become conscious of it, we can improve this profit quality in ourselves as well as identify it in others AND help others to increase it.



Destroying the NFP Mentalities Regarding Profitability

I am on a mission to keep as many NFP Hospices as possible from tanking. This directly relates to profitability. So at the risk of staying in trouble, let's destroy many of the NFP ideas that plague our movement (again, it is not an industry unless we've surrendered to the idea of being a homogenized form of healthcare). Frankly, I think that many FP players have it right from a business standpoint...and NFPs need to take some lessons. With this said, there are bottom feeders in both the NFP and FP domains that need to be wiped from the Hospice slate. From an objective standpoint of seeing hundreds and hundreds of Hospices, I can say unequivocally that the majority of truly creative "management" innovations in the Hospice movement have come from FP Hospices. Now don't get me wrong, many FPs have plenty to learn from NFPs as well. However, the management practices of many FPs should be emulated. It is interesting to note how many of the really, really successful Hospice CEOs in the FP domain have come from NFPs. The fact that the ADC size of FP Hospices is growing, sometimes at phenomenal rates, tells us that they know something about managing Hospices. Many times, FPs are even among the most spiritual Hospices with healthy cultures that know how to balance purpose and profit. There is no monopoly on best practices by either FP or NFP Hospice organizations.

If I am helping to build a Hospice business platform, I construct the operational methodologies with basically the same components, tweaked for overarching philosophies of who is paying for the assistance. Community Support does not even come into the picture for me. Deborah Dailey trained me well in this regard as she refused to operate a Hospice on the kindness of others. My directive was that Community Support didn't exist...and that I MUST learn to operate a Hospice only on earned dollars from Medicare, Medicaid, Commercial Insurance and Private Pay.

Being a NFP organization is not an excuse for being wasteful. In fact, it is the just the opposite. An NFP must be even more prudent regarding its allocation of resources.

Here are some common, confused and misplaced NFP Ideas:

- Hospices need Community Support in order to operate.
- NFPs shouldn't make a lot of money.
- NFPs care more about patients and families.
- FPs have some mystic "advantage" over NFPs.
- FPs skimp on care.
- NFPs provide higher quality care.



- NFPs can't pay their staff well.
- Volunteers prefer to give their time to NFPs.
- “If we are highly profitable, Medicare is going to cut our rates.”
- “If we are highly profitable, people won't give.”
- NFP Boards of Directors are more committed than FP Boards.

All of these ideas are false. Yes, you can find specific instances for each of these statements that is contrary and “weenie-out” to escape the overall reality. However, if ONE organization deviates, it proves that the view does not necessarily apply to the whole. Again, we find ourselves in the world of the outlier...

Some NFP CEOs may wonder why they don't get the big offers to run FP Hospices. Look at the quality and profits. Are they impressive enough to create interest?

Community Support & Fundraising

Many people wonder why there is such little reference to Community Support or Fundraising in MVI materials. The reason is that too many Hospices are “dependent” upon community dollars. As mentioned in the [Communicating the Need to Balance the Ideas of Purpose and Profit](#) section, a Hospice that is dependent upon community dollars is only 1 public relations disaster away from becoming extinct. It is a very unhealthy state for a Hospice. A Hospice needs funds to weather PR (Public Relations) disasters. If your Hospice is accused of killing a person, I guarantee that you will have a few “dry” years in the Community Support department. We have seen “large” Hospices cease to exist in a matter of months after a major PR disaster.

On the other hand, if a Hospice is strong and can operate on earned revenue, then Community Support becomes a competitive edge. These funds can be funneled into valued-adding products and services. They can be used to build large reserves in a short period of time. Community Support is a good thing and we encourage Hospices to garner it and be excellent stewards. However, it should NEVER be relied upon. Knowing that community dollars are available can make a Hospice undisciplined and wasteful. The point is **“Operate your Hospice as if you receive ZERO support from the community.”**



Selling Ourselves on WHY We Must Be Profitable.

Many people in Hospice think that profitability is wrong. They think that it is “evil” to do this work and make money... and the idea of making a lot of money is an abomination. This mindset must go. This “**Great Dilemma**” and internal conflict (financial indigestion) must be resolved as well as poverty thinking and “the sky is falling” attitudes presently in Hospiceland. The Great Dilemma is this:

Many Hospiceland people have trouble with the idea that “Hospice is a business.” There is an “internal conflict” that some find disturbing as there is a perception that the linkage to money somehow lessens the commitment to the mission.

This type of thinking has to be obliterated!!!! It is not only right for our Hospices to be profitable; it is the only way to survive as an organization! This anti-profit mindset is not compatible with reality. If you know people with this mindset, put them on your “gotta go” list.

Profit should be the natural by-product of providing an extraordinary care experience in a stunningly efficient and effective way. Whoa!

When we consider the factors of Hospice profitability, many people think that it is about things like the environment, the economy, being in the right place at the right time, connections, knowing the right people, having inside information, providing low quality care, skimping, etc. However, when looking at profitability I have learned that most of the time I need not look any further than the CEO, the Manager. Profitability in Hospice is a choice. Profitability is largely an internally driven result and is, to a much lesser extent, a result of external forces.

The #1 Factor in profitability (or performance, for that matter) is the Manager. *If any business segment, department or company is not performing, normally you need not look any further than the Manager.* The Manager is the key element. If MVI is not accomplishing its goals, it is because of me. I must face the fact. Let’s consider some other examples:

- If a Thrift Shop is unprofitable... look at the Manager.
- If your Hospice Nursing Home Program is anemic... look at the Manager.
- If your Hospice Inpatient Unit is half empty and costs are out of control... look at the Manager.
- If a Hospice finance department is not leading a Hospice to financial victories...look at the CFO.
- If a Hospice is underachieving... look at the CEO.



It is about the Law of the Lid. Our departments, business segments and organizations cannot exceed our level of Management. I have known of situations that have become “accepted” by Hospices over the years... until a new Manager is introduced and it seems that everything changes... for better or worse. But when that dynamic Manager comes on the scene, it is as though magic dust has been thrown on the situation. As the CEO, you need to be able to identify Management talents in people.

Magic Dust?

At one of my Hospice CFO stints many years ago, the Hospice had a county that averaged 6 patients a day for years and everyone accepted this as “the way it is.” One day, I was walking in the hall and noticed a nurse who had incredible energy and life. I talked to her for a moment and then marched into the CEO’s office and asked, “Why don’t we make Diane the Manager of X county?” The CEO looked at me and paused. “Do you really think so? She’s new and barely knows Hospice!” I said, “Yes, I do...and besides that, what do we have to lose?” Well, we moved Diane out to that county and census shot up to 16 within 2 weeks. Magic Dust? No...just a new Manager with some spunk!

**If you have an area that is
underperforming, change the
Manager!!!**



Communicating the Need to Balance the Ideas of Profit and Purpose

This is perhaps the most important characteristic of the EFFECTIVE IPU Manager. It does little good to be a great accountant and have a quantified Hospice if you are unable to INFLUENCE others to positive action. Management is about getting people to follow...and it is your responsibility to see that the organization is proceeding in the right BUSINESS direction. People need to know WHY!

Through this entire program, I want you to focus on your communication skills in this particular area. I want you to become great at being able to explain WHY the Hospice needs to make money. Again, the goal is to become EFFECTIVE... and that involves communication of ideas.

The IPU Manager as an Idea Salesperson

As the IPU Manager, you are a salesperson of ideas. You have much to introduce to the Hospice. Staffing models, financial models, hiring systems, new programs, training methods, caseload management and productivity needs, are just a few of the ideas that YOU need to introduce. These ideas need to be SOLD to staff.

The Economic Model Must Work!

In order for an entity to remain in existence, the economic model must work. In other words, there must be “enough” revenue to cover expenses and provide for a positive residual or profit. Every Hospice works within a model whether it knows it or not. The model or “way” that things are done may have evolved over time... organically... or it may be intentional. But you have a model.

When the Hospice Medicare Benefit was introduced, it made a big impact on Hospice and the way it is delivered. Hospice became a real business. Currently, Medicare funds Hospice to the tune of \$10,000,000,000 per year... and the amount is increasing every year. Hospice is no longer “budget dust.” We are on the radar screen of our national Managers. Historically, Hospices have operated with a not-for-profit mindset that had pluses and minuses. We have created a culture and tradition of incredible care that differentiates us from the other flavors of healthcare. However, we also have not been good financial stewards, historically speaking, often spending more than we receive from Medicare and expecting the community to fund the deficiency even though our reimbursement is excellent. There is MORE THAN ENOUGH to fund World-Class Hospice care.



Personalizing Profitability

The profit mindset must be present in an IPU Manager if the unit is going to be profitable. A *highly* profitable mindset must be present in an IPU Manager if an organization is going to be *highly* profitable. A mindset is a personal thing.

You must personalize profitability in your own thinking as well as in the thinking of the Managers you lead. Make it real for them! They have to want it nearly as badly as you (you have to want it more or you become a drag on those with higher aspirations).

How to do “personalize” profitability in yourself? Tie your compensation to overall organizational performance. The greater the proportion or amount, the more you will personalize it. Make it such that if you don’t perform well, it HURTS. That is, *it hurts enough to alter your lifestyle.* Ouch!

How do you “personalize” profitability in your Management team? Since this has to do with money, tie each Manager’s compensation to performance. It is as simple and difficult as that! In addition, provide the structures to make them interested... truly interested, in performance. You want owners and not renters. If you are interested, they will be interested. However, they will usually only be interested to the degree you are, unless I was working for you or some other highly profit-minded individual. If that were the case, you would have to up your game or the more motivated would become disinterested quickly and leave the organization.

All of the most profitable CEOs and Managers in Hospiceland are really interested in the numbers and how they translate into money. They get a kick or thrill out of large profits. They think about it a great deal and take a healthy (and sometimes unhealthy) degree of pride in their organization’s performance. They love it when they do well. They love it even more when their teams do well! They look forward with great anticipation to the financial statements. It is thrill-time!

This is one place where FP Hospices have a great advantage over NFP Hospices. The owners and shareholders care a great deal because it’s their money at risk! Therefore, FP Hospices are often more closely managed. However, a NFP can use many of the same methodologies and principles to motivate. But most won’t because they are afraid...



The Importance of Speed when Addressing Non-Standard Performance

The greater the speed in addressing performance or behaviors that deviate from your Standards, the more profitable your organization will be. This relates directly to accountability. Your team needs to know that you review work and if there are issues, you address it almost immediately. You are building a reputation with your staff. If you create a reputation of being late or “conflict-adverse” then you AUTOMATICALLY cripple your profitability potential. The longer the issue exists, the more damage can be done as it spreads. The higher the position (with issues) in the organization, the more damage can be done over time as the replication principle kicks in.

It is BAD Business Not to Have Skin in the Game

It is a BAD idea to roll the dice with other people’s money. This is a BAD business model. Skin in the game, YOURS and your Managers’ skins, makes for more prudent and careful decisions. The higher the stakes, the more prudent and considerate you will be. This is the human condition. Example: I often discover that Hospices will keep certain vendors due to personal favoritism over good business sense. This could be pharmacy, insurance, consultants, state organization, etc. And these are not small deals. I recently learned of a CFO that would not even consider working with a new insurance group. Finally, the CEO forced the CFO to review and then change to the new company. The result was a \$250,000 annual savings. The CFO never even acknowledge the savings. Perhaps he didn’t like missing those cushy golf outings...

Hit the Scales

Measurement is critical because it tells us where we are. Measurement is also objective in nature, meaning that it is quantified within some Standard unit of reference. We know from observing highly profitable CEOs and Managers that they value measurement and measure often. Regarding our physical bodies, weight overages that many people face are most effectively “managed” with frequent, objective measurement. Trying to manage weight by feelings is highly inaccurate and does not lend itself to good results. Hitting the scales on a frequent basis and at a consistence time of the day or week is important. The same holds true for financial and operational measurements. This also helps to personalize profit.



Frugal IPU Managers

The most profitable Managers are not usually lavish. They are not big spenders. They know how to save money and can discriminate fairly quickly what is needed as opposed to what is simply wanted. They can discern good value from poor value. They are thinking of ROI and what will be needed down the road. They are not chasing fads, nor are they coming back from conferences with 100 new things to do.

It takes no special talent to spend money.

It takes no special talent to spend money. It does take talent to make and keep money. I have seen new CEOs come into successful Hospice program and blow MILLIONS remodeling or doing wild new ventures. They don't know or understand the discipline or pains required to acquire the money because they didn't sweat to earn it!

As money is highly emotional and is to varying degrees tied to our self-concept, how much of our spending is due to our egos? Do we have to have the big building to feel good? To feel successful? We can also be stuck in a small-minded trap where we don't spend out of insecurity or fear. The point is to spend where you get the ROI. After all, we're talking about the Allocation of Resources.



5 Our Training Commitment

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.

Training is creating “**habits**” in people of doing things right under all circumstances – busy or non-busy times... It is NOT just being able to do the job.

100% is the only acceptable Standard. 90% trained is not good enough. Compound a 10% knowledge deficit by 100 employees and your screw-up factor is multiplied by an enormous amount.

Learning is evaluated. Testing is employed. Testing is timed.



Empowerment - Never pass work to the next step in the process that does not fully meet the Hospice's Standards. No exceptions. An example of this is documentation. If documentation is discovered by anyone reading a chart that does not meet our Hospice's Standard, the situation must be addressed immediately. The same would be true if an IDT meeting is not being run according to the Standards. Any employee can "reboot" the meeting. The Standards need to be clear.

Key Points for All Staff:

- Set High Expectations
- Inclusion
- Empowerment and Self-Control – **Any employee has the power to shut down any process that does not fully meet your Hospice's Standards of quality.**
- Accountability
- Share Information with staff

How much time it takes to train people is the key variable. All human activity is time-controlled.

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.



BAD IDEAS: When you train people, you should expect them to make mistakes. New staff need to make mistakes in order to learn.

NO! NO! NO! If this is the case, your Standards are not high enough.

People Development is an investment and not a cost. You will make money with great training. It is indeed an investment. The ROI is almost incalculable in terms of creating value through building a sterling reputation in addition to the economic results of efficiency of process. When an organization understands this, it will transform itself and become very interested in becoming a teaching organization, first and foremost.



Habits

If part of our commitment to training is the formation of habits, how are they formed? There are many theories about how habits are formed. However most all include

- Repeated thoughts
- Repeated actions

It has been said that a habit can be created in as little as 3 weeks. Studies vary.

The reality is, habits are easier to make than they are to break. If you repeat a behavior often enough, those synaptic pathways are going to get worn in. The human brain is a very adaptive piece of machinery. But does that take 21 days? Who knows? Everyone's brain is different, and habit formation also relies on aspects of experience and personality.

In the workplace and in life, we are little more than the sum of our habits. Who we are and what we accomplish depends largely on a vast network of routines and behaviors that we carry out with little to no thought whatsoever. As neuroscientist David Eagleman writes in Incognito, “Brains are in the business of gathering information and steering behavior appropriately. It doesn’t matter whether consciousness is involved in the decision-making. And most of the time, it’s not.”

Habits are the brain’s own internal productivity drivers. Constantly striving for more efficiency, the brain quickly transforms as many tasks and behaviors as possible into habits so that we can do them without thinking, thus freeing up more brainpower to tackle new challenges.

How Habits Are Formed

- Charles Duhigg

When we first engage in a new task, our brains are working hard—processing tons of new information as we find our way. But, as soon as we understand how a task works, the behavior starts becoming automatic and the mental activity required to do the task decreases dramatically.

Think about how much brainpower and concentration you had to use the first time you parallel parked or even the first time you tied your shoelaces. Then compare that to the amount of mental effort you exert doing those activities now.



This process—in which the brain converts a sequence of actions into an automatic routine—is known as “chunking,” and it’s at the root of how habits form. There are dozens—if not hundreds—of behavioral chunks that we rely on every day.

How Habit Loops Work

Habits consist of a simple, but extremely powerful, three-step loop.

First, there is a cue, a trigger that tells your brain to go into automatic mode and which habit to use. Then there is the routine, which can be physical or mental or emotional. Finally, there is a reward, which helps your brain figure out if this particular loop is worth remembering for the future. Over time, this loop becomes more and more automatic. The cue and reward become intertwined until a powerful sense of anticipation and craving emerges.

How to Change a Habit

The first rule of habit changing is that you have to play by the rules. That is, there’s no escaping the three-step loop (e.g. cue, routine, reward) because it’s hard-wired into our brains.

If you want to get rid of a bad habit, you have to find out how to implement a healthier routine to yield the same reward. Let’s say you like to go out with your coworkers at the end of a long day and have a few drinks. In this situation, there are actually two rewards: (1) the socializing that inevitably occurs, and (2) the relaxing effects of the alcohol on your nervous system.

Both of those rewards are valid and necessary. If you remove drinking from your life, but replace it with nothing else, you’ll likely be unhappy. The trick is to keep the cue (e.g. tired after a long day) and the rewards (e.g. social time, relaxation) while changing the routine (e.g. drinking).

An alternative routine could be to convince a co-worker or friend to start exercising with you after work—running, yoga, rock climbing, or whatever works for you. Then you have a healthy routine (exercise) that replaces the negative routine (drinking) while yielding the same rewards (social time, relaxation).

If you want to get rid of a bad habit, you have to find out how to implement a healthier routine to yield the same reward.

When you’re trying to get the new routine integrated into your life, don’t be afraid to dwell on the rewards. It’s actually a good thing.



Want to exercise more? Choose a cue, such as going to the gym as soon as you wake up, and a reward, such as a smoothie after each workout. Then think about that smoothie, or about the endorphin rush you'll feel. Allow yourself to anticipate the reward. Eventually that craving will make it easier to push throughout the gym doors every day.

Of course, it's not quite that simple. As we all know, forming new habits is hard. Just because you're telling your brain that there's a reward, doesn't mean the habit will stick. It only really sinks in when—through enough repetition—your brain comes to crave the reward.

Countless studies have shown that a cue and a reward, on their own, aren't enough for a new habit to last. Only when your brain starts expecting the reward—craving the endorphins or sense of accomplishment—will it become automatic to lace up your jogging shoes each morning. The cue, in addition to triggering a routine, must also trigger a craving for the reward to come.

But that's still not everything. We've all managed to implement new habits for a month or two, only to have them compromised when we're under extreme stress. If we truly want to avoid backsliding into our old ways, there's a final key ingredient: Belief. "For a habit to stay changed, people must believe that change is possible. And most often, that belief only emerges with the help of a group." Taking the classic example of one of the most effective habit-changing organizations ever, Alcoholics Anonymous, those alcoholics who believed that some higher power had entered their lives were more likely to make it through the stressful periods with their sobriety intact.

It wasn't God that mattered, the researchers figured out. It was belief itself that made a difference. Once people learned how to believe in something, that skill started spilling over to other parts of their lives until they started believing they could change. Belief was the ingredient that made a reworked habit loop into a permanent behavior.

Groups create accountability and belief—key ingredients in helping us stick with new habits. Thus, if you want to write more, consider joining a writing group. If you want to run more, consider joining a running club. The more positive reinforcement you can surround yourself with, the easier it will be to make difficult changes.

The 3 Step Pattern of Habit Change

Every habit you have — good or bad — follows the same 3–step pattern.

1. Trigger, Cue Reminder (the trigger or cue that initiates the behavior)
2. Routine, Behavior (the behavior itself; the action you take)
3. Reward (the benefit you gain from doing the behavior)



This framework 3-step pattern has been proven over and over again by behavioral psychology researchers including Stanford professor, BJ Fogg and more recently, in Charles Duhigg's best-selling book, *The Power of Habit*.

Duhigg's book refers to the three steps of the "Habit Loop" as cue, routine, reward. BJ Fogg uses the word "trigger" instead of "cue." The word "reminder" is simply another word for remembering.

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)



How Long Does It Take to Create a Habit?

There are many theories that have been published regarding the length of time it takes to form or create habits, with the most popular being 21 DAYS of repetition. However, I believe this is flawed. Habits are “energy saving mechanisms” and the human brain is an incredible efficiency-seeking structure, which automatically tries to identify improvement and things that provide betterment (better feeling, make easier, do quicker, etc.). With this in mind, I believe that habits can be formed as soon as cause is linked to effect with a personal benefit.

**Habits can be formed
as soon as cause is
linked to effect with a
personal benefit.**

Example: I stay in a lot of hotels, often on the 2nd floor. Let’s say that the first time I want to go down to the lobby and try to take the elevator, I notice it is very slow. I take the elevator this time. The next time I try to use the elevator to go to the lobby, I notice it is slow again, but I also noticed that the stairs are near the elevator. This time I again take the elevator since I have already invested time into it. The third time I want to go to the lobby, I take the stairs... **THIS IS HOW QUICKLY HABITS ARE FORMED.** Once the link between cause and effect with a personal benefit is in our consciousness, we use the new behavior. That is how quickly habits are formed.



Moving the Feeling

The reason so many attempts at forming new habits or behaviors fail is because the “reward” step is not done. The reward step comes primary from “teaching well” – linking cause and effect AND creating a feeling or experience that is associated with the habit. The feeling is the personal payoff for doing the behavior or habit. Therefore,

To Change a Habit...

You Must Change the Feeling associated with it...

Feeling only comes from the Experiential...

People must feel “better” about doing the behavior than not doing it. Examples: Clinicians must feel better about “teaching rather than doing” rather than just “doing” everything. This involves “moving” the feeling. When managing weight, for it to be sustainable, it takes an emotional change where the “feeling” to moderate eating (hopefully accompanied by exercise) is better than the feeling of eating too much or too few healthy foods. This is self-regulation with a focus on the payoff. When overcoming drug addictions or other unhealthy habits, the biggest moves forward come when the individual comes to believe and feel that the payoff is not to his or her personal interest emotionally.

This is the truth regarding much of human behavior...

**As a person thinks or
feels, so he or she
is...**



IRMs

IRMs™

Image Recall Mechanisms

A premise and foundational principle of the Model is this:

“No practice can be operationalized unless it can be remembered.”

This simple statement seems self-evident. However, most policies and procedures are NOT created with this key idea in mind. To take it further,

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



In order to Standardize high quality, all practices and policies must be able to be memorized OR be easily recalled via memory support means. This is a radical departure from traditional operational thinking. The use of IRMs™ has less to do with textbook organizational/operational theory and much more to do with how the human mind works and how behaviors are established and reinforced. It is about making the ideals of your Hospice reality and living in the DNA of each person.

“The images in our minds run our lives.” This is a powerful statement. It has been said that a picture is worth a thousand words...this is probably an understatement. We believe visual images with attached meaning can be intentionally crafted for practical use. Through the use of IRMs™, images can be fixed in the minds of viewers, meaning they can be attached and mechanisms can be positioned to facilitate recall. If one were to trace the success of MVI, much would be owed to the use of educational media, beginning with cassette tapes in 1996 directed towards CEOs and senior management. Though this was simply an audio experience, the “theater of the mind” automatically took over, as each listener would create visual images that they associated with the message. It was our method of spreading knowledge quickly and with consistent quality to hundreds of organizations. In addition, the favored time for listening was during the busy executive’s daily commute to work, which allowed undivided attention and the redemption of “windshield” time. The difference with the introduction of Standardized visual images is that the images that are evoked are not as subjective to the listener. The exact images are provided in the video. Subsequently, when an audio MP3 or CD is listened to, the images in your training media will be replayed in the minds of the listeners. This provides a Hospice with tremendous opportunity to redeem value from the vast amount of “windshield time” for training that is otherwise wasted. Audio messages are an example of “recall” mechanisms. As you read this information, you have probably viewed the Model Hospice Nursing Visit DVD. If one were to mention the importance of keeping the inside of your vehicle clean, most likely, you will see (in milliseconds) the image on the DVD about this subject matter in your mind.

Here are recommended steps to use when creating IRMs for your organization. Notice that they are linked to the creation of habits:

Steps to Create



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)



Steps to Create



1. Define What (Habit Creation: Action)
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4. Attach a Word or Phrase (Habit Creation: Cue/Trigger)



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



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



IRM Development Template

“No practice can be operationalized unless it can be remembered.”

Using the template below, create a list of tasks that are important to your organization. Prioritize them, selecting five to ten items to start. Describe an imaginary/idealized picture for each task. Associate a word or phrase to each task. The more sensory and feeling-oriented the words and phrases, the better they will be remembered and operationalized.

Priority # Sequence	Item of Importance What? (ACTION)	Attached Meaning Why? (REWARD)	Visual Image/Recall Aid (CUE)	Associated Word or Phrase (CUE)



6 Accountability & Standards

Standards are the *basis* of all People Development and Accountability Systems.

A huge aspect of the Model is Accountability. *Standards* are of incredible importance in the Model as they are the *basis* of all People Development and Accountability. Accountability is Spiritual. It give meaning to work. We are Accountable to each other in an organization as we a “system of mutual reliance.” A High Accountability organization will be a quality organization. It will attract the most talented people in a community. It will drive mediocre and low-performance people from the organization. Accountability is important.... And most **Health Systems do a horrible job holding people Accountable.** Not at this Hospice!

What is Accountability? Our definition of Accountability is “Owning one’s Life and everything about it.” This means that we are not going to blame others or circumstances for what we are or what we are experiencing. We are going to own and take responsibility for every result in our lives. We are going to “own” our thinking and how we choose to experience the world, including what we perceive as negative. If something is perceived as negative, we are going to embrace it and do what we can to move it to the positive. This definition is a very grownup and mature view as it gets people out of “victimhood,” which is so prevalent in humanity.

There has been a rash of “downsizing,” “rightsizing” and other RIF (Reduction in Force) activities as of late in the Hospice world. Certainly, there are times where it is the right move, maybe 5% of the time. The remaining 95% of these layoffs are unnecessary and point to larger and deeper problems within organizations. Layoffs usually occur because it is an “easy way” of not addressing Accountability problems – “Let people go as a group so we don’t have to face each one and confront them with their performance shortcomings.” The fact is, layoffs and RIFs, though widely accepted, only bring temporary financial relief as usually similar people with different names and faces will be rehired in the future, at more cost, unless the organization has changed operational STRUCTURES and has learned discipline. In my career, I have never implemented a layoff, even when faced with bloated overstaffing. I have gotten rid of as many as 100 Hospice FTEs in a six-month period without layoffs. I believe in establishing *Standards* and holding people accountable to those *Standards*.

RIFs, layoffs, rightsizings, downsizings or whatever buzzword you want to use, are the result of low, unclear *Standards* and a lack of Accountability structures. With the right structures, an



organization will NEVER have to do a layoff because the structures automatically regulate operations and profit levels with changes in census volume. Sound crazy? Again, welcome to the world of the Outlier...the world of non-exception.

Hospice employee evaluations are usually a joke. They often are “glowing” even though actual performance can be poor or substandard. I have found that usually 30-50% are behind their completion date. A better direction would be for continual evaluation and feedback. A stronger system would enable each person to self-evaluate his or her performance and judge it according to the *Standards*. This leads us back to the absolute need for the creation of *Standards*.



What is a *Standard*?

A *Standard* is not a goal. A *Standard* is a norm, an everyday operational result or practice. 100% is the **ONLY** acceptable *Standard*. Compound a 10% knowledge deficit by 100 employees and your screw-up factor is exponentially multiplied. The documentation *Standard* of a Hospice should be 100%. 90% documentation will kill you. You may say “And I want world peace as well, Andrew.” Forgive me, but this is the very basis of our organization’s existence! Shouldn’t we be great at it? If 100% is not your *Standard*, then what is? A *Standard* is a *Standard*. Blood should be on the floor if *Standards* are not upheld. Not upholding *Standards* renders *Standards* meaningless. Is it doable? Well, do you have clinicians that are near-perfect in their documentation (within your definition of perfect or *Standard*)? Don’t call *Standards* a *Standard* if they aren’t. Call them *suggestions*...

The idea of performing 100% of the *Standards* on a day-to-day basis sometimes confuses people. Day-to-day is just that! From one day to another. 100% is perfect and nothing is perfect all the time, right? That is correct. Nothing is perfect (to *Standard*) over long periods of time as invariably someone or something will go wrong. However, can you maintain a *Standard* at 100% for an hour? For a day? For a week? Maybe even a month? If you can maintain a *Standard* of 100% for shorter periods of time, then you can increase the period of time with effort! Yes, there will be instances where someone deviates from *Standards* on a given day. But that is the exception in the short-term. With corrective measures (Self-Control), you are immediately back within *Standard*, unless Accountability is sorry at the organization.

The establishment of ***Clear Behavior and Productivity Standards*** cannot be overstated.

Standards are the foundation of Accountability. The reality is this...

You really can’t even begin to have a meaningful discussion about Accountability without establishing clear *Standards*.

With all the talk about “measurements, measurements don’t do anything unless people are held Accountable to them.



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



**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.



Standards are a Vow or Promise

Standards are a vow or a promise. They carry spiritual weight with them which could be considered a form of spiritual merit or favor or karma. Each time a service failure occurs, it is a broken promise or vow. All human beings have perceived short-comings or fall short from time to time. This is part of the natural cycle of learning. These perceived failures produce pain, which help us learn! This is why any non-*Standards* behavior or performance must involve a degree of pain that is appropriate for the violation of trust. These “vows” help guide us!

Teaching *Standards* from this perspective helps to “spiritualize” them. It gives the idea of *Standards* greater meaning and significance. Again, the central demographic of the people that are attracted to Hospice is that of Spirituality/Meaning/Purpose. Teaching the importance of Standards feeds this desire for meaning. It gives VALUE to the work we do. It helps Hospice employee have healthy organizational pride. And high *Standards* require high Accountability, another high-spiritual topic.

Standards are a Requirement of Self-Regulation

The concept of Self-Regulation is a deep topic embedded into the Model. Self-Regulation is the quality of the most successful people in the concrete world. One can't Self-Regulate within an organizational context without knowing the rules...that is, the Standards of the organization. When Standards are understood, they can be adhered to on a personal level of the employee. When a front-line employee learns to Self-Regulate, he or she doesn't need a great deal of supervision. This helps to eliminate or reduce the amount work Managers need to expend. A Manager's scope of supervision (number of employees) can increase.

Establish an Overarching Guiding Standard

This really has to do with accomplishing the ultimate goal of the organization, which is really to serve the customer! In the case of Hospice or Homecare, the customers are patients, families, referral sources and others! And we want HAPPY CUSTOMERS! Sometimes when trying to adhere to a multitude of Standards, the overarching purpose can be lost. Sometimes an organization will fall into the trap of creating so many Standards it actual *paralyzes* people and *inhibits* creativity! People can get “scared” of doing things that may get them in trouble! If this is the case, you have gone too far with your Standards! If customers are happy, then normally business is good!

Having a firmly established **Guiding Standard** or principle such as Complete Customer Satisfaction helps give employees professional perspective and helps them make “on the spot”



decisions within the organizational goals! It simplifies Standards because all Standards should be designed to make happy customers. Happiness is a FEELING! Therefore, in an organization that is doing the Model, the Guiding Standard might be as simple as this,

Do what will help the patients and families FEEL good!

This gets us in the realm of professional judgment, which we will explore, in a subsequent section. It is about expectation management! Knowing when to do things or when not to do something. A mature person understands the “experience” from a complete interdisciplinary context and that they are creating expectations with every word or action. Anything that does not meet or exceed a client’s expectation results in disappointment. If a clinician needs to deviate from a Standard visit or phone interaction because he or she “intuits” a different need...then GO FOR IT as long as it is sustainable and you are not setting yourself or a team member up for failure! Also, recognize that this is an exception! The deviation from Standard was to make the client FEEL better which is EXTERNAL. INTERNALLY there would be little room for non-Standard behavior or performance, such as non-adherence to clinical documentation or not logging calls into your tracking systems so that you know if there are any outstanding client situations.

Structures and processes fall apart without “meaning and belief.” We are not building a “House of Rules” with Standards but rather a way of “Being.” Jesus was constantly in trouble and being persecuted by pious people because of breaking rules. There were “tons” of rules about the Sabbath...what you could or couldn’t do, what you could or couldn’t eat, how many steps you could take in a day, etc. Jesus healed on the Sabbath. He spoke [paraphrased] “Who would not help his neighbor get his ox out of the mire if it happened on the Sabbath?” He applied the “spirit of the law” over the law itself. The same should be done by an organization regarding customer service. Serve the customer! And sometimes that means doing things that are not typical. It is about judgment! Professional judgment is a mature view of things... It is big picture as well as detail-oriented. It takes into account all known factors including compassion, competence, time, resources and above all, the FEELING that is created with each client interaction....as the FEELING is the only thing that is going to be remembered!



Create a World of Non-Exception

Doing work to 100% of *Standard* is required to create a world of non-exception. A world of non-exception is where, on a day-to-day basis, work is done according to the Standards of the organization. When this happens, AMAZING things happen at an organization!

- There is less overall stress in the organization as “promises” are being kept.
- There is a need for less Managers as each person is self-regulating to Standard. The number of employees under a Manager’s care can be increased.
- There is a drastic decrease in the number of routine meetings. There simply is no need for many routine meetings as things are operating to Standard. There are not a lot of problems to discuss.
- Indirect Costs plummet as less Indirect Staff are need to make sure people are doing their jobs.
- Money can be redirected to highly compensate Direct and Indirect staff as well as build healthy organizational bottom-lines.

Basically, when everyone is doing their job, it makes work and management EASIER! Why? Because nothing is breaking! But here is the kicker!

The key to creating this “world of non-exception” is tying Accountability to your Standards without relying upon the personal inspection of work.

That is, without Managers having to make sure people are doing their jobs! If Managers are not making sure, who is? Your Systems! You would “sensitize your systems” to detect any deviation from your Standards with minimal expenditure of Energy. The easiest to do with clinicians which we will explore in the section on Compensation! Compensation is your most powerful Accountability tool!



**A world of non-exception
saves time, stress & money. There
simply is not a great need for many
meetings as things aren't breaking
and new issues are minimal.**



**If there is no “pain”
attached to non-standard
performance, your system is
weak... This includes, but is
not limited, to compensation.**



This is perhaps the most startling ideas in the Model. It is a concept that must “soak in” over time. It took me a long time to reconcile this... In fact, it is still something I wrestle with occasionally because nobody likes pain...

Understanding the Value of Pain

Pain must be FELT whenever there is non-*Standard* behavior or performance. Pain is valuable! It is through pain that some of our deepest learning takes place. We remember pain.

Pain is valuable as it is a signal or message that something is wrong or there is a problem.

If we did not FEEL pain physically, we would bang around, drink too much, take lots of drugs and do all kinds of harmful things because there would be no signals that anything was wrong.

We are wired to avoid pain. When we experience pain, we seek to remove it as quickly as possible! Pain gets our attention whether it is a small pebble in our shoe, a mosquito bite or slamming our hand in the car door! Pain is not only physical, but it is Emotional. In fact, it has been estimated that 70-80% of our pain is non-physical. It is in the Emotional domain.

Pain is a Master Teacher.

Pain is a Master Teacher. And Emotional pain is perhaps the most powerful in terms of learning! Physical pain is usually drastically less powerful than Emotional pain. Example: Childbirth is extremely painful for the Mother. Yet, is this what she remembers about the experience? No. It is usually the love of the child. It is the Emotion linked to “meaning” – LOVE!

In Hospice, pain should be an easy topic to understand and to teach about. But the fact is that we don't understand pain as well as we should or our organizations would operate much better by USING PAIN!



Pain is Spiritual and Its Value Must be Taught

Pain is Spiritual. It is through suffering that many of our shortcomings are addressed. Here is the question, “Do you learn more from your accomplishments or your failures?” Pain right! Therefore,

God designed a PERFECT world PERFECTLY designed to help us grow!”

Wow! Think about that! We have been placed in an ideal learning environment to help us evolve into the best person we can be to fulfill our Spiritual potential! You can say this many ways, but you get the idea! It means that we can trust God and have faith that everything is taken care of! And that each situation or person we meet in our journey is a “lesson.” For some reason, we tend to learn deeper from pain. Sure, we need successes, especially to build confidence, but there is something about pain that truly motives us!

Pain can be seen operationalized in an organizational setting in many ways outlined in this manual. To teach it well, it must be characterized as a benefit and as part of one’s Spiritual progress. Shouldn’t pain be experienced when a person lies, deceives or breaks a vow? Of course! All service failures are a lie, a deception or a broken promise or vow. To not administer some pain (pain equivalent to the offence) in such cases, makes a *Standard* meaningless. A meaningless, weak organization is not attractive. If you are a Manager, people need to know you stand for something and that you mean what you say.



The 3 Attributes of Every Standard

The Model is about creating *Standards*. When doing the Model, *Standards* should be (1) Clear, (2) Impressive and (3) Sustainable.

CLEAR – Where everyone understands the *Standards* and can determine if they or others are “in” or “out” of *Standard*. Combine this self-awareness with empowerment and ANY employee can self-regulate and correct anything that is not to the *Standards*. We want to remove the excuse, “I didn’t know that!”

IMPRESSIVE – Impressive *Standards* are motivating. We want staff to take pride in the *Standards*. We want people to look at the *Standards* and say “I can win!” They should motivate and not demotivate. The only acceptable *Standard* is 100%. A *Standard* is not a goal. A *Standard* is a norm, an everyday operational result or practice.

SUSTAINABLE – All work should be designed to be completed in an 8-hour day according to the *Standards*. We can’t burn people out and expect quality. We can’t keep ratcheting up everything continually because we get greedy. This is one reason I don’t like incremental “goals” when implementing the Model. Set the *Standards* and don’t change them often! Yes, change as needed, but don’t confuse your staff with “annual budgets” and new *Standards* every year. When we set Model *Standards*, they are for a decade time-frame...a 10-year period. In addition, the workplace should be uplifting and “give life” back to us instead of sending us home as “juiceless” rinds. Work must be sustainable to retain talent. *Overtime is evil*. Overtime is evil in the Model world.

Overtime is EVIL!

You want Sustainable *Standards*.



The 3 Steps to Implement *Standards*

Standards are the basis of all People Development. In order to get *Standards* into a culture, 3 things are needed for each:

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

1) Clearly Define Each *Standard*

Each *Standard* must be clearly defined. But first they must be created. I advise to “imagine” an ideal organization. Do not look at your current operations or behaviors to create your *Standards* as these just cloud thinking. Think in terms of “ideals” and make these your *Standards*.

When creating *Standards*, I also advise to give them some “pizazz.” You want people to remember the *Standards*. Try to avoid just giving “do this” and “don’t do that” directives. You want *Standards* that you can “teach” to. Here is an example of 5 *Standards*:

1. Perfect Phone Interactions.
2. Dress in SD apparel according to our *Standards* of hygiene and grooming.
3. Perfect Visits with Perfect Documentation
4. Time to Meet, Ass in the Seat! – *Eight28, Eleven17, Transformation Four29* Meetings
5. Report all service failures to the CEO/Chief Teaching Officer. Remedy before the Sun sets.

We have found we can operate an award-winning Hospice with only 5 *Standards*. Each of these would probably not be understood without some teaching regarding their meaning. This is fine! The fact that your organization is creating its own language makes people feel like they are part of a unique and special group. There is power in this unity!

2) Teach Each *Standard* to *System7*

Each *Standard* has to be taught. Here we are removing the excuse: “I didn’t know that.” Think about how you would effectively teach EACH *Standard*. This is much more than handing out *Standards* cards. It is about teaching well...teaching, beyond an intellectual understanding to an emotional level. This should include testing and student involvement where emotion is attached to the learning. To Teach Well, we recommend *System7*.



System7

1. Self-Study Module
2. Tell – The Why & How
3. Show (Visual)
4. Test (Evaluate Learning)
5. Practice (Demonstrate)
6. Evaluate Practice (Test)
7. Certify (On-Boarding, Annually)

3) Attach Uniform Accountability to Each *Standard*

For each Standard, specific Accountability or “pain” should be attached for any non-Standard behavior or performance. If there is no pain attached, your Standards aren’t Standards and don’t mean very much. Call them “suggestions” rather than Standards. Most organizations that get less than ideal results when implementing the Model, or really any important initiative, usually have weak Accountability.

This Accountability must be uniform throughout the organization. Each Manager must apply the same method of Accountability to individuals when behavior or performance is non-Standard or your system is weakened. This is critical. You don’t want Billy Bob’s team to operate differently than Mary Sunshine’s. Both need to have similar structures.



Understanding the Steps of *System7* and Why it Works

Let us break *System7* down.

1. Issue Self-Learning Modules

- a. This starts the intellectual process of becoming familiar with the material.
- b. On a deeper level, it is also where the linking of “meaning and purpose” begins.
- c. It is also empowering as the Student knows that he or she can access this information ANYTIME! This gives the Student a “FEELING of Control” over their development/growth/progress! This FEELS good!
- d. Emotionally, the Student learns that he or she will be held Accountable for their learning, especially in the Testing and Demonstration steps. During Tell and Show, a degree of tension is used by Master Teachers to establish Accountability.
- e. If this is part of Transformation (Orientation, On-Boarding), it is communicated that they are a “trainee” or a “cadet,” and therefore are really not officially part of the organization until they are certified to 100% of the *Standards* of the organization.

2. Tell – The Why and the How

- a. This is the formal classroom or One-on-One teaching setting.
- b. This is where the transfer of Energy from the Teacher to the Student is strongest.
- c. The “First Day of Class” phenomena occurs and powerful impressions are received by the Student.
- d. It reinforces “meaning and purpose” even more powerfully than the Self-Learning Module.
- a. The material is reinforced as Students come to class already knowing 50-60% of the material.
- e. Each time the Student sees the Teacher, beliefs are reinforced positively if the Teacher models what was taught.

3. Show

- a. The Teacher must learn how to teach to visuals.
- b. This step recognizes that 85-93% of all communication is nonverbal.
- c. This “imprints” or “burns” a mental image into a Student’s memory. These are “specific still images.” Videos with movement are good! But “still images” tend to be more powerful. A combination is probably best!
- d. Still images help the Students “visualize.” This is a technique you will use repeatedly in your organization’s People Development System. These are



“anchors” that can be used when needed by the Student to navigate through stress conditions.

- e. This also helps the Teacher conserve Energy as well as creating a consistent experience for the Students.

4. Test

- a. Accountability is taught here.
- b. Emotion is high as there is an actual risk of failure.
- c. Testing is timed.
- d. All testing is done to Pass/Fail.
- e. If a Student can't demonstrate the material intellectually, they can't do it in actuality.
- f. The intellectual understanding (thought-patterns or habits) of the material are demonstrated under stress conditions.
- b. The FEELING of confidence is created when the Student is successful and passes the test.
- g. Self-doubt is replaced with confidence.
- c. NEVER waste lab time on a Student until they've passed 100% on the intellectual testing.

5. Practice

- a. Students practice what they have been taught and tested on. These are videoed.
- b. This is the PHYSICAL creation of Energy or state of Emotion. It is bio-physical, which releases the chemicals needed to support the Emotional/Energetic state.
- c. A degree of tension is created. Under stress conditions, people default to their lowest level of understanding or habits.
- d. The ability to apply the intellectual understanding of the material is demonstrated or not demonstrated (Pass/Fail).
- e. Habits are created as thought-patterns are linked to personal benefit and the FEELING of accomplishment/progress as well as pain of missteps.
- f. The idea of the Visit and Phone Interactions are understood from a “performance” perspective and that all most all teaching in a Hospice or Homecare setting is a type of performance.

6. Evaluate Practice

- a. Practice videos are reviewed by the Student and peer group.
- b. Humility is learned from the objective observation of performance and behavior. The video makes it difficult for the Student to escape or deny objective reality.
- c. Self-Awareness is heightened as the Student sees themselves as they really are and not what they perceive themselves to be.



- d. Great Emotion is created as the Student is far more critical of themselves than the Teacher would ever be. A degree of tension is created.
- a. The FEELING of confidence soars as the Student's performances improve with each iteration!
- e. Confidence increases where a Perfect Visit with Perfect Documentation can be done on cue like a performance.

7. Certify/Annual Recertification

- a. The FEELING of accomplishment/progress is experienced based on successful completion of a program with very high *Standards*. High *Standards* with Accountability provide employees with the FEELING of meaning and purpose.
- b. There is great joy as the Student moves from being a "candidate or a cadet" to part of the organization. There is the FEELING of belonging and significance.
- c. The confidence of the Student further increases as they believe in their abilities.
- d. The confidence of the Student increases because they FEEL they were well-trained. In fact, extraordinarily well-trained! Ideally, you want people to believe that they have NEVER been trained as well as they have been at your organization. Healthy organizational pride is created.
- e. There is a degree of tension that this is not the end, but that they will be held Accountable every day and re-evaluated every year where they demonstrate their learning again.

Teaching-Well

Teaching-well is a phrase we use to describe the 2-step process of Teaching we prescribe.

1. You Teach on an Intellectual Level first,
2. Then MOVE the learning to the Emotional/FEELING Level.

In this order if possible. If a Student can't remember to do something intellectually, he or she can't do it! They must prove it through testing.

We use the "degrees of tension" in *System7* to MOVE the learning to emotion/FEELING memory through repetitions of stress and accomplishment. In order to use tension as a learning tool, there must be something at risk. This increases the "FEELING" of confidence, a self-assessed state. Healthy organizational and individual pride is built.



Professional Judgment

An *Extraordinary Manager* MUST have great judgment. In fact, a Manager's judgment must be better than the people he or she leads. If the Manager does not have great judgment, he or she will not inspire others. What is meant by "judgment?"

The definition of judgment in this context is "the ability to make considered decisions or come to sensible conclusions." A person with Self-Control usually has good judgment. Judgment is used in decision-making... when selecting an option from a number of alternatives. Judgment involves all 3 of the Characteristics of Managers in an organization: Intelligence, Energy and Integrity.

Why would one person speed on the highway and another would not? Why would one person drink too much and another would not? Why would one person smoke dope and another would not? Why would one person organize their work into an efficient system and another would not? Judgment!

The word judgment has a negative connotation in contemporary society. However, the truth of the matter is that EVERYONE exercises judgment and makes thousands of judgments a day, choosing one direction after another from a vast array of alternatives! Now most people don't discriminate based on race, religion, age, nationality or other demographic in a "right/wrong" sense, but we do assess people based on perceived abilities in the workplace... and we do this within seconds! Don't beat yourself up about this! We do this because we are not so far removed from millions of years of survival programming! A person's life often depends upon making quick judgments! And if not a *quick* judgment, it had to be a *good* judgment as eating the wrong thing could mean death and if you were the leader, the death of the tribe! The good news now is, though we like to make efficient decisions, we have more time and more tools to evaluate people! However, a Manager often has to make quick decisions. Your people sometimes expect it! And good judgment would tell you if a quick decision is necessary or if perhaps it would be best to think about it awhile. It does not take long for staff to recognize if their Manager has good, poor or mediocre judgment. Staff will make very quick judgments about the abilities of their leader... and they will not rally behind a Manager with poor judgment.

The authority on Judgment is Dr. Steve Byrum. Dr. Byrum created a special version of the Hartman Value Profile System which evaluates an individual's judgment within minutes just by completing a puzzle. This system is used by the Citadel, Mayo Clinic, MD Anderson and other elite organizations. These organizations use Byrum's version of the Hartman Value Profile instead of other personality categorization systems such as Predictive Index, Myers Briggs, Disc, Caliper, etc. We are not so interested in whether you are a Blue and the other Manager is a Red and if this or that is how a Blue and Red communicate. Though this may be



interesting and perhaps helpful, we are much more interested in a person's JUDGMENT! We want the person that thinks it is a bad idea to smoke dope, or text and drive!

In Hospice, most of our work is done autonomously. Therefore, we MUST have systems that evaluate judgment right from the start! An organization's reputation is at risk with every visit and interaction. WE MUST HAVE PEOPLE WITH EXCELLENT JUDGMENT!

Not everyone is equal in ability and judgment. This must be taken into account when we consider Predictability. Predictability is of HIGH value. It is what makes repeat customers. Predictability is why we have designed and used Visit Structures and why we devote time to every aspect of the care experience. We want to make people FEEL good. THEREFORE, we recognize that personal judgment varies and, to the extent practical,

We remove discretion at the operating level. This increases predictability.

Spending time on D or C players does not give you a great ROI. A Manager with good judgment, perhaps after some instruction, would see the cause and effect relationship. While you spend valuable time on a D or C player, your A and B players are not getting attention. Then your A or B players aren't receiving focus... Therefore, an A might become a B, or choose to be an A player for your competitor...

Professional Judgment is Needed with Standards

Standards are structures of an organization. They are needed to create predictability. Standards tell us what to do in our normal course of work. However, a Manager will face times where he or she will need to make professional judgments regarding the application of Standards in light of the welfare of the organization and ROI.

Example: A highly talented employee goes "haywire," openly breaking a Standard due to a personal gripe with Management. The Standard that has been violated would normally be a firing offence; however, it does not impact customers and clients, as it is internal. The department is also facing several other expected as well as unexpected departures of staff and is coming into a busy work period. What is the Manager to do?

In this case, the Manager's professional judgment comes into play. The Manager would contemplate the situation from many angles considering the result of each course. To cut through the possible alternatives, the Manager must look at the "overall" or best course for all involved and the ROI to the organization... and sometimes this means relaxing a Standard temporarily. In this case, the Manager makes a decision, takes full responsibility and also explains the rational why he or she is deviating from the normally Uniform Accountability defined for the Standard. This communication is critical as you don't want to confuse your team



with your unexplained actions. If this communication is not done, not only does it confuse staff, it makes Standards become meaningless. *“After speaking with the boots on the ground (the front-line people that will be directly impacted by the decision), I have determined that it is best for the company if Mr. Haywire continue for now, at least until we get some a replacement in place. Our customers are happy with his services and if we terminate him right now, it would make things very difficult for the staff that will have to cover for his absence, thereby increasing the likelihood of a service failure as well as unnecessarily stressing out present staff. This gripe is a personal attack against me... He has been directly confronted and counseled on the matter... After we get through this, I want to revisit his employment status and we can make final decision based on his behavior...”* This is an example of an explanation for a deviation from Standard so that everyone understands. Those impacted normally will be agreement! If they are not, get rid of Mr. Haywire. And, if Mr. Haywire does not come back into Standard immediately, terminate Mr. Haywire’s employment

The military, a highly structured organization, has had to handle deviations from Standard forever. A deviation from Standard is NOT the norm... but on occasion, it does and should happen. Example: The soldier that disobeys a direct order to leave his post because he believes he would be most useful delaying the enemy and giving an opportunity for his buddies to retreat and survive.

In the case of a termination or confrontation, the adage “choose your time and place of battle if possible” applies. This means if you need to fire the Biller, it is better to do it after the billing has gone out! If a Manager needs to deliver a difficult message or do a difficult task, the Manager needs to prepare as best he or she can as expediently as possible (FEELING prepared gives the Manager more confidence) and then execute the decision. Sometimes during the delivery, new information will come to light and the Manager will again have to make a professional judgment. A good illustration of this is when emotions are running hot. If a person is very stressed and is predisposed to explode in a rage, a Manager with good judgment will wait until the person cools down.

Standards are guidelines...but there is a time to deviate from Standards like in the case of United Airlines flight 3411 where the paying passenger was “dragged” off the plane to accommodate United crew at the last minute traveling elsewhere. In this situation, were the United employees “bad people?” Were the police “bad police?” Or were both just trying to do their jobs and follow company/department policy? Were they all scared of losing their jobs if they didn’t force the man off the plane? **This is an example of where “professional judgment” was lacking.** Could this situation have been handled differently by those at the gate? Could someone in charge have said “This is not going to go well, I’m going to make a decision right now and I’LL take RESPONSIBILITY for the results...” Offer \$1,000, \$2,000, \$3,000!” What is a negative PR disaster worth? This is what good judgment is about!

To make matters worse, the CEO was so “out of touch” with consumers that he issued a statement of support for the way the situation was handled! Then backed off...went before a



congressional hearing...and told of all the ways United was changing policy...only to have more and more incidents happen! He was NOT being accountable... Again, poor judgment at the top in this case!

Accountability Structures and Practices

There are multiple ways to increase and maintain Accountability. Here are a few:

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.


The Model™
Balancing Purpose and Profit...

All Accountability contains some “pain” when a Standard is not maintained.

Self-Control – Self-Awareness

The concept of “Self-Control” or “Self-Awareness” relates back to Our Training Commitment where any individual that recognizes a deviation from our *Standards* is empowered to correct/regulate the situation. This could range from correcting the running of an IDT meeting (rebooting the meeting) to documentation of how a phone call was answered. This is an enormously powerful Accountability enhancement that is cultural in nature. However, for “Self-Control” to be implemented, CLEAR *Standards* need to be established. These *Standards* would include operational *Standards* as well as behavioral *Standards*. This Accountability structure conserves Energy as Accountability is distributed among all staff members.

Peer Reviews

Peer Reviews are a popular trend. They can be used in different ways. The point is to use what works best. Several award-winning organization do not include supervisors in the peer review process as it became a “bitch list” against the superiors. This could be argued or debated both ways. The point is that the concept is good and you have the liberty to tailor it to your organizational needs. I am not a huge peer review guy yet, but with the right influence, I could be swayed.

Public Posting of Performance

The public posting of performance works. This shows attention to work and clearly identifies what the organization values or desires. Regarding financial and operational reports, we highly recommend that reports show the name of the Manager of each area. *We do not recommend that Hospices issue separate financial/operational reports to area Managers.* A single report that shows every area accomplishes two things, - (1) it simplifies the reporting process and (2) it also creates Accountability as everyone knows how each department is performing and if *Standards* are being hit or missed. An element of peer pressure is introduced. In addition, best practices can more easily be identified if everyone is compared to each other. If Accountability or Empowerment compensation is established as well, motivated staff members will seek to “work for a winner” or a team that consistently hits or exceeds *Standards* and is therefore rewarded every pay period or month. We recommend a report for the overall organization as well as one specifically for all clinical teams (*See the examples at the end of this section*).

The public posting of score and results for individual team members is also a powerful motivator. Again, an element of peer pressure is introduced. This public posting could range from clinical certifications to clinical productivity. An example would be clinicians that have completed their annual recertification in the Visit Structure as well as a list of those that are still incomplete. This is a great way to signal what the Hospice values and desires. Examples include the *Standard MVI Team/Location Report* and the *One-Page Model Report*. This Accountability structure conserves Energy so that Self-Control can be maintained.



The Personal Inspection of Work

This is where a typical Hospice's Accountability system breaks down. IF our Accountability system is completely or near-completely reliant upon the supervisor, your system is not very robust. However, the personal inspection of work is still one of the essentials to a great Accountability system. The constraint of the human physical container is time and Energy. Therefore, when building a position, all work must be engineered to be completed within the constraints of time and Energy. For a sustainable job or position, it must be engineered so that all tasks can be completed to 100% of the *Standard*. This includes the personal inspection of work. A Manager should lead from the front. The Manager will get the behaviors they exhibit and the reward. A constant Management presence on the front line motivates people to do well. Again, this must be "built" into the design of a position. More on this in the following sections.

Cash in the Can

This is a GREAT Accountability method!!! It is immediate, visible and involves only a small bit of pain. This is a fantastic method to discourage the use of "outlawed" words and phrases as well as promptness for meetings! Dropping an F-bomb might cost someone \$100!

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 document a visit to the Hospice's *Standards*. Upon detection (by Compliance or other), the RN must come into the office that day, 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.

Use of Video

The use of video is an ultra-Accountability method!!! This method forces a Student or employee to demonstrate what they have learned. This is a form of public Accountability as the videos will be reviewed by their Teacher, their peer group, the Clinical Manager, sometimes Executive Management, the Clinical Team they will be assigned to, and, of course, themselves. Student understand that all Clinical Visits and interactions are a type of performance. They learn the difference between the "perceived self" and the "objective self" that others experience. This method is *extremely effective* and also conserves a Teacher's Energy and time. In addition, Students will be far more critical of themselves than a Teacher would ever be...and thus, posture, verbal ticks, body language and such are all brought to the



Student's awareness where they will start to autocorrect or improve. This method offers PROOF that a person can do the Standards of the organization. This is Accountability.

Here is an example of what we expect when developing truly professional Clinical Managers:

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**


The Model™

Testing

Testing is a form of Accountability. Students need to understand that they are Accountable for the investment an organization makes into their development and that they are Accountable for their learning. With strong testing, an organization will increase its quality by hundreds and sometimes thousands of percent.

No Committees

There are no “committees” in the Model. Why? Because it is difficult to hold a committee Accountable. Governments use committees all the time. How is that working? Rather, INDIVIDUALS are charged with tasks. This FOCUSES Accountability directly. With this said, an intelligent and humble person will seek out knowledge and input from others. But they also know that they are ultimately responsible and that there is no one to blame if things go badly. Assign tasks to people with Talent who can SEE the vision of the task and are inspired by it! If a person can't see it, they can't build it!



Accountability Contracts

These can replace Job or Position Descriptions. The use of an Accountability Contract further deepens the meaning of Accountability. It is recommended for a Management Position that Managers attach their plan of how they will keep their costs at or below the Model NPR% within 10% increases or decreases in patient-volume.

Compensation

Compensation is your most POWERFUL structural tool for addressing Accountability and creating healthy cultures/workplaces. People behave the way they are paid. This compensation can take the form of financial or non-financial rewards such as emotional satisfaction or an increased inner sense of wellness. However, here the focus is financial. Before I came to Hospice, I worked for a company that specialized in compensation systems. In my first Hospice experience, we implemented a Accountability-based compensation system for clinical staff (quite awkwardly at that...and not for non-clinical because we didn't know how to do it at that time...now Indirects are a breeze). The result was a 100% increase in productivity, for all disciplines except one, and a 100% increase in the timeliness and quality of documentation. I've seen similar results at ANY Hospice that has a well-thought-through, SIMPLE Accountability compensation system (Complicated, stingy or infrequent systems don't work well). Compensation is the fastest way out of financial trouble and the fastest way to create a healthy Hospice culture. Why not let every paycheck become an automatic report card?

Accountability Contracts

This is a quite revolutionary tool as it is a powerful communication of the importance of Standards and establishes Accountability as well as setting up legal protections for the organization. The Accountability Contract can replace or augment Job or Position Descriptions. The use of an Accountability Contract further deepens the meaning of Accountability. For all Management positions, it is also recommended that each Manager provide a written plan of how they will keep their costs at or below the Model NPR percentages within 10% increases or decreases in patient-volume. We recommend rolling out Accountability Contracts before or along with the Accountability/Empowerment pay system to help set the stage.



Here is an example of an Accountability Contract:

May 19, 2017

Yes! I _____ want to be part of Sunny Day!

As a Life-Changing organization, I want to be part of this movement towards the highest ideals of quality and performance! I realize that Sunny Day is a teaching organization first and foremost, therefore, my ability to advance (in most positions) will be determined by my ability to teach others.

I understand that all people ultimately set their own compensation via the VALUE they create. That, in fact, in order to earn more, one must do more than one is already being paid from a philosophical viewpoint. That is, it is earned.

I take personal responsibility for my life and my circumstances. I am an adult and not a child. Therefore, I want to be held Accountable for my performance, both behavioral and productivity. I am a true professional and should be treated as such. Therefore, as a true professional, I will not need to be supervised or managed to make sure I am doing my job. I understand the concept of Self-Control or Self-Regulation and how important this is to Sunny Day to build strong team members which others can totally rely upon as we are an organization of mutual reliance.

I understand the Standards of Sunny Day. They are 1) Clear, 2) Impressive and 3) Sustainable. I certify that I can do them 100% of the time on a day-to-day basis as there is nothing unreasonable in the Standards of Sunny Day. In fact, the Standards are just “doing my job.” If I am a Manager, I must also manage costs at or below Standards within 10% increases or decreases of Average Daily Census. If I am a Manager, I have prepared a written plan of how I will keep my NPR (Net Patient Revenue) percentages at or below the established NPR Standards and have given it to the CEO or COO. If I exceed the NPR Standard, my Standards Bonus or a portion of it, which I am expected to receive 100% of the time, will not be given. The Standards Bonus is a bonus that Sunny Day expects all team members to receive every pay period. Clinical Managers manage to a Contribution Margin and NOT by line item in order to allow creativity and innovation.

I further acknowledge my understanding and complete agreement with the following:

- The Standards of Sunny Day can be changed at any time as needed.*



- I do not need an annual review regarding my performance as I know every day whether or not I am doing my job. If I do not know, I will immediately (within 1 day) inform my Manager.
- At any time, I may be asked to do work which is outside my position or field on a permanent or temporary basis.
- My compensation rates or methods can be changed at any time. In fact, I expect this to be done periodically as a normal part of the evolution of Sunny Day in its search for the best ways of operating.
- If I am ever in a Supporting or Indirect position (Clinical Management, Faculty, HR, IT, Finance, Compliance, etc.), I will work at least two (2) non-concurrent months of the year in another (dissimilar) position. This is for internal control and cross-training purposes.
- All passwords must be disclosed if requested by immediate Manager, CEO or COO.

I, _____, having read and fully acknowledge my understanding of this Accountability Contract, do certify that I WANT TO DO THIS! In fact, I am happy to be with this organization by my own free will!

Sincerely,

Jill Nice, CEO & Chief Teaching Officer
Sunny Day

APPROVED:

_____ Date

(Person Approving Agreement)

(Print Name)

There are several important points that should be included in an Accountability Contract:

- A single agreement should be used to make it simple as well as to communicate the essence of what it means to be a Manager.
- It is a free and willing acknowledgement of Standards and what the employee or candidate are committing to.
- It includes a provision for the modification of compensation at any time. This is needed as the organization evolves and different things are needed.



- It is a teaching document. The Accountability Contract itself teaches.
- It emphasizes that teaching is the core of the company and is the skill that will enable advancement.
- It incorporates protective measures to such as job rotation and cross-training so that the organization is not dependent upon a single person for a key function.
- Incorporates *internal controls* as a result of job rotation as things as embezzlement and fraud can be identified when another person performs a duty and can recognize irregularities.
- It provides a philosophical explanation of the organization's compensation practices with emphasis on the creation of value.
- It teaches how Managers are “asset allocators” and are directing Energy and Resources...and that they have additional Accountability to manage the ups and downs of census.



Accountability & Acceptance – The Topics of Transformation

Why does the topic of Accountability matter so much? Like all things, there is no singular explanation. It is a deep and rich topic. It applies on a personal level as well as in an organizational context. It is spiritually rich... In fact, it is *transformational*... It is transformational in that it is perhaps the beginning of positive change... As I write this, the topic is so deep, I can barely wrap my mind around its significance and explain it though scrawny language...but within my being, I feel its power to free and liberate...

Accountability... It is a word... Like all words, it is a symbol of language mutually agreed upon to mean something... And this word often carries a negative connotation because of its implications... There is an “owing-ness” or “non-separate” or “non-independent” or “obligation” or “duty” or “owning” – it carries a notion that others are depending upon us... In short, **it tells us that our lives matter to others...**

This “owning” of one’s life, viewpoint or attitude towards life also has a direct connection to **Acceptance**. When one blames others or circumstances for one’s state, one is saying that he or she is powerless to the outside force, person or thing. However, if one “accepts” where he or she is (“This is where I am...”) and then starts to seek ways of improving the situation rather than doing nothing or complaining about it, one is then on the road of advancement and growth. Understanding this link between Acceptance and Accountability can be seen in the effectiveness of AA (Alcoholics Anonymous) where millions of hopeless alcohol dependent people have been helped. Before AA, it was rare for an alcoholic to recover, except in the case of an occasional transformative religious/spiritual experience. If one reviews the 12-Step program you will see Acceptance or Ownership of one’s state as the very beginning of recovery or growth. You will also see Accountability throughout the steps.

Accepting or Owing one’s shortcomings is the starting place for constructive and positive action!

As you read this section, when you see the word Accountability, it would be helpful to add Acceptance to it as well. Acceptance as a word is viewed more favorable than Accountability. Acceptance has the Energy of Release or Letting Go...which feels good! Whereas Accountability to the fearful, can cause people to tense up.



How is a Deep Understanding of Accountability & Acceptance Transformative?

Victimhood and blame are not very empowering...

We live in a world of excuse. We live in a world of victimization. In fact, there is almost a competition to see who can be the most “victimized.” People have a tendency to blame others and circumstances for their lives. The news media promotes victimization and people *love* to hear and read about it. People promote victimization to sway public opinion to advance an agenda and/or to get a *payoff* of sympathy or attention. There seems so often to be an external reason why things happen that are beyond ourselves and are beyond our ability to do anything about it. This makes us feel powerless... And thus, this *idea* of victimization defeats people and makes them feel sad, angry, depressed, despondent, apathetic, fearful...all feelings that normally do NOT lead people to take positive action... Personal power is diminished...

However, when a person accepts their state or conditions in Life and makes the best of it or chooses to have a good attitude about it, it is coming from a place of Humility and Positivity... *“This is where I find myself...it will do me little good to sit here and cry and give up...so I better get moving...”* **This is the beginning of growth or advancement!** This is where a person moves towards the Positive and away from the Negative!

The feeling of victimhood leads to a feeling or belief of powerlessness...

It seems that the design of Life has natural resistance built-in...obstacles, setbacks, difficult personalities, careless people, mean people, illness, death, natural disasters, storms... These are normal and are, in fact, inescapable...YET, within ourselves we feel we can do something about it! To improve the situation or make it less painful! And surely we can! Even if we are simply (which is not so simple) adjusting our attitude towards something that appears negative!

Projecting oneself as “Being a Victim” does not impress others much as others may say “Too bad...how unfortunate...tough luck...glad I’m not them...” Whereas naturally projecting oneself as an overcomer though authentic personal action has much greater Energy and power! It gives hope to people as to what is possible! The overcomer inspires!



But Bad Things Happen... How Can I be Accountable for That?

As apparently negative things “happen” in our lives, as part of the design of Life itself, then perhaps there is a purpose in pain and negative experiences! It would seem so! That we have Ying & Yang, Night and Day, Positive and Negative ends of the magnet that inform us about the patterns of Life. (In fact, you can cut off the negative end of a magnet and it will reform!) In the natural world, positive and negative are needed to propel movement...and we live in a world of constant movement and motion...and it is an electro-magnetic world. To spiritualize it, there is value in everything... There is great value in negative states... In fact, they are necessary and essential. So one doesn't want to demonize any state or feeling as they all have value and are useful... Sometimes a person has to hit rock bottom and suffer “enough” pain in order to turn around and go into a positive direction! Also, it could be argued that there is positivity in victimhood when movements are created to “rectify an injustice.” Protests, riots, wars, complaints, criticisms, belittling or acting out in public to bring awareness for perceived corrective action can result in progress. But most of these public appeals for change are rooted in the non-acceptance that the individual played *any role* in the incident or event. In most of these public acts, we can sense that there is negativity behind them. People “act out” their negativity by breaking windows, destroying the property of others, hurting people physically and such under a camouflage to correct a societal issue – but all too often, this public acting out is for the payoff of from being “right” or revenge or moral superiority... However, in each case, the individual played a role... We don't know why things happen really. When we are honest with ourselves, we don't even know where our decisions come from. There is no possible way for us to completely understand the reasons behind things. Often it is “for reasons unknown” and that would include karmic reasons...

So what are we left with after we have blamed others or circumstances? We are left with perhaps the only positive option, the only thing we have a fair degree of control over...**our personal will, viewpoint, and at minimum, our attitude.** Even if 50% of your being is determined by DNA, your genes and your environment or how you were raised, you have 50% remaining according to studies at Duke and other academic institutions! And one can do a lot with this 50%! So it should not be underestimated! Even if one is in an iron lung or a concentration camp with all family gassed, one, at a minimum, can choose his or her attitude. Victor Frankl called this “the last of the human freedoms” in his powerful book, *Man's Search for Meaning* about his concentration camp experience during World War II. This is truly something to ponder...as well as the man in the iron lung that built a huge company from the ideas in his mind rather than feeling sorry for himself!



So even simply taking responsibility for one's attitude is a CHOICE and is the beginning of positive change!

It can be contrasted with this...

The least talented people complain and are critical. They are quick to point out faults and slow to complement others... This is attitudinal...

In Accountability, there is also an element of Acceptance.

Here is Merriam-Webster's definition of Accountability:

accountability noun

ac·count·abil·i·ty | \ ə-ˌkaʊn-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*

This is a pretty good quick definition, but it is incomplete at best. The *quality* or *state* of being accountable... Accountability can surely be an action or attitude one takes from time to time. But a "state" can also be a prolonged thing or a regular mode of consciousness. Accountability can be a state of "beingness" or an ongoing view of the world.



This “ongoing state” idea is important as so many issues and problems of an individual or organization can be solved IF ACCOUNTABILITY IS UNDERSTOOD, and more importantly, IS INTEGRATED INTO ONE’S BEINGNESS. But it has to be taught...and in MVI’s experience, **taught continually** as it is normal for most individuals to shy away from the topic because of its pedestrian negative connotation of punishment for not living-up to an obligation or duty.

The Value of Effectively Teaching Accountability

As we apply Accountability and teach it to the people we work and live with, we will find incredible benefits both personally and organizationally, as well as how it positively impacts others. Within an organizational context, effectively teaching the topic of Accountability is tremendously beneficial. If a person will analyze complaints from employees, one will note that most of them can be linked back to Accountability or lack of Accountability. There are many benefits from teaching Accountability effectively:

- 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.

All of these are extremely positive aspects of teaching Accountability effectively. And I know there are more!

1) Create a Standardized Definition of Accountability

What does Accountability mean to your organization? This is important because if there is no standardized definition, you will get all kinds of imprecise language/understanding and therefore shallow and sloppy teaching of Accountability which will confuse your staff. The understanding must be deep in all Managers or they can’t replicate Accountability within themselves or others.



Here is the definition of Accountability used by MVI and what we recommend for clients:

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

This definition doesn't leave much room for blame or victimization. This definition calibrates high spiritually and will take an organization to a great place! And of course, the higher you take Accountability, the more you will benefit from it as will the external world!

2) Accountability needs to be Hired For as well as Cultivated Culturally

Accountability needs to be a quality that candidates are "hired for" as well as something that is cultivated culturally. HR, or those doing the People Selection Process, should have methods to reveal a candidate's level of Accountability. It should be assumed that most people will have an average understanding of Accountability. Therefore, the HR person should have an understanding of what an average, superficial or pedestrian understanding of Accountability is so that he or she can identify those with higher or lower understandings of Accountability. If someone says to you: "That is a very, very deep topic"...and then precedes to explain a multitude of reasons it is so, chances are, you have a winner! But don't expect it or you will be disappointed. An HR person should, for practical reasons, hire people that have an interest in growing and advancing! Then, through the use of the topic of Accountability, the person will learn of its value and how it transforms Life. This is where "the words get in the way" as many songs say... Use of different words that are easier to digest can be helpful...

Other indications of Accountability when hiring might include:

- **Past Success** – Highly accountable people usually have success where they have worked. They probably were highly trusted to do their work to Standard. Trust is increased when people are willing to be held responsible for their work.
- **Confidence** – Evidenced by the willingness to "bet" a significant portion of their compensation on their individual performance.
- **High Follow-Through** – They "get" that others are disappointed or are impacted when they don't do their work to Standard.
- **Awareness and Consideration for Others** – One that is Accountable, realizes that he or she impacts others and is not separate from the whole. So one is not oblivious to the feelings and emotions of others.
- **Setting a Good Example** – A person that has a deep understanding of Accountability understands the importance of good role models and the impressions he or she might give...especially if the behavior is negative.



- **Self-Control or Self-Regulation** – If a person was successful in the past, there is an excellent chance that he or she has a high degree of Self-Control...the quality of the most successful people on the planet!

3) *The Ongoing Cultivation of Accountability*

“What Day is It?”

One method of ongoing cultivation of the quality of Accountability might look like this:

Before IDT and All-Staff meetings, ask the question: “*What day is it?*”

The response we look for is “*The Best Day of our Lives.*” Then, we use a Call-Out of a single individual and ask them what this means? We are looking for something like this:

“This question has to do with Accountability. That I can choose my attitude, at minimum, in any situation. It is about personal power and realizing that I have more power than sometimes I think... Accountability is the starting point of growth and is linked to Humility whereas blaming others or circumstances or victimization does not promote personal power and growth.”

With this type of response the Energy in the room lifts! Ha! You may be thinking that this would be quite a stretch for most employees...but you will discover how quickly people start to internalize Accountability when it is taught on a regular basis with effective methods used by effective Teachers!

System7

System7 is an effective way to teach Accountability. In fact, the topic of Accountability, though we advise it to be peppered in nearly all of your materials and systems, but really, it should be its own topic because of its huge implications and payoffs. If *System7* is used, it is IMPOSSIBLE for any employee to NOT understand Accountability, at least on an intellectual level... Spiritual or Emotional understanding is another matter...!

Use of Negative Examples

Use of negative examples of the hurt, harm and damage caused by people that do not take ownership of their work or performance is very effective, especially early in an employee’s development. Negative examples register more powerfully than positive examples and when really negative examples are illustrated, the employee says to him or herself: “I’m not going to



do that!” With one or two examples or stories you will have knocked down tons of immature behaviors!

Managers Learn to Model and Teach Accountability

Accountability, both in concept and practice, should be a pre-requisite of a Management position. It must be learned on a practical level as well as a spiritual level.

Accountability is Taught from a Practical to Spiritual Depth

In the ongoing effort or unfolding of Accountability, the topic can be kept fresh because of its sheer depth... Accountability is linked to karma, spiritual merit, non-separateness, holistic, interdisciplinary, integration of all, etc. The fact that Accountability actually gives meaning to our lives and our work is huge! People normally do not burn-out due to the physical demands of the job...but rather because they lose their sense of purpose... Accountability is a great asset to this issue!

Teaching the Spirituality of Accountability

Hospices are the only flavor of Medicare with mandated Spirituality. Hospices are PAID to be spiritual! This opens up the degree which a Hospice culture can be shaped! Spiritual teachings for nearly all traditions tend to recognize Accountability. This can be karma in Eastern teachings or spiritual merit in Western faiths. Karma is in Christianity, but it is not stylized as such. But ideas like “inherited sin” – “Every hair is counted” – “What you sow, so shall you reap” are all subtle giveaways that what we do with our lives matters and is registered in some way... “You get what you give” pretty much sums it up!

The idea of Accountability helps one integrate with the whole of Life. This spiritual concept is of an extremely high order and understanding and helps a person lose their sense of loneliness or separateness from the universe. No longer does my life and actions have little consequence or impact. I belong! I am essential to the operation of Life!

Accountability is Humility. This is tied to spiritual merit or karma in that if one does not blame others and circumstances for one’s state, then forgiveness and understanding are possible. There is room to perhaps see others in a compassionate light...

For reasons unknown... This is quite a truth as we wrestle to understand our lives... This spiritual idea helps us with **acceptance and tolerance** of others. We don’t know all the factors involved with “why” this or that happened... If we don’t understand, can’t we just accept that it is not always helpful to know? Can’t we just accept it and do the best we can with the situation or circumstance and be as helpful as we can be?



I can't control others or many circumstances of my life...but to some extent, I can direct my mind and actions and do my best...

This is an attitude of Accountability! What else could be expected of a person?

On a different level of understanding,

The world, and all that is in it is me... We are not separate... And I wouldn't even know myself without the fascinating interplay between what I perceive as external and internal... It is a perfectly operating process called Life! Ha!



Remove 4 HUGE Duties from Clinical Managers!

There are 3 duties that can be removed from Clinical Managers with a Compensation System linked to Standards. The only known way to remove these is via the Compensation System. They are the need to:

- Monitor Documentation
- Monitor Productivity
- Annual Evaluations
- Need to Fire Employees

All 4 of these things can be eliminated! It is almost hard to believe! The question that comes to most people's mind is "If the Manager isn't doing these things, who is?" The answer is, "Your systems!" Part of the design of a great Compensation System is that all supporting systems are "sensitized" to detect any deviation from Standard. You want your systems to do the work for you. This includes getting rid of negative aspects of Management.

The purpose of removing these duties is to free up time to do the *1st Duty* of a Manager, the duty to teach as all quality comes from the quality of our people. The *Extraordinary Manager* will devote most of his or her time to teaching. Therefore, we design *structures and systems* in the Model that remove common and often unpleasant tasks of management and work where possible.

Sensitize Your Systems

As part of the Compensation System, several Indirect and Supportive areas will change the way they operate. There are really only 3 things that will be monitored and apply to all clinical disciplines in all areas. They are 1) Documentation, 2) Productivity and 3) Quality. If you can't get the Quality component, you can do it with only the first two! However, normally there is something in the EMR that be pulled in report form that can easily indicate Quality.

Compliance/QA – Compliance samples charts on a weekly basis to a 90% statistical confidence interval. This is a surprising small number of charts. It randomly picks charts like an auditor would and reviews it. If ANY element of the chart is not to Standard:

1. A checkmark is placed on a simple manual employee list, denoting a deviation from a Standard. This will be turned into Payroll before the next payroll run.
2. A Standardized email is sent to the individual with a link to the Documentation Self-Learning Module and the Manager is copied on the email. The clinician has 1 day to



complete the self-learning module. The Manager at this point has awareness of an area to teach and coach providing an opportunity for “ride-a-longs” or other teaching.

- Standards Pay is not paid. This is structured as a bonus of 10%, a bonus that is paid for simply doing one’s job with no stretch or goals.

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											
	Pay Period	Period	Period	Period	Period	Period	Period	Period	Period	Period	Period	Period	Period
		1	2	3	4	5	6	7	8	9	10	11	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

For this sequence to happen, ideal charts must be created for the most prevalent diagnosis groups.

IT – Creates or modifies output reports from the EMR for 1) Productivity and 2) Quality, which could be Average Pain Scores, satisfaction scores or any other indication of satisfaction with services. They key is that it must be EASY to access in the EMR. An “exception report” is recommended that isolates only clinicians that are not at Standard in Productivity or Quality. These reports would be run by Payroll immediately before a payroll run. Any person that is below Standard:

- A checkmark would be put next to the employee’s name.
- A Standardized email is sent to the individual with a link to the Productivity or Standards Self-Learning Module and the Manager is copied on the email. The clinician has 1 day to complete the self-learning module. The Manager at this point has awareness of an area to teach and coach providing an opportunity for “ride-a-longs” or other teaching.
- Standards Pay is not paid. This is structured as a bonus of 10%, a bonus that is paid for simply doing one’s job with no stretch or goals.

Finance – Finance is involved with the calculation of payouts based on “Savings” from performance that is LESS than Team or Department Standard of Net Patient Revenue (NPR). This calculation normally comes from the MVI Comprehensive and Team/Location Reports. Finance must denominate this “Savings” difference in dollars, where it is distributed in the



established proportions to the Manager and on an FTE basis. This is why the NPR Standards are not “ratcheted” down too tight. Many think that the 38% Direct Labor or 17% Patient-Related amounts are difficult. The truth is that the 38% is only 3% less than the median Hospice! And the 17% is only 1.5% less than the median! This means that with a little effort and the adoption of a few “best known practices,” a Hospice Clinical Manager can MASSIVELY outperform the MVI Model! Direct Labor can be driven down to 32%! And by just using Wise Hospice Options (Grant F.) Patient-Relateds can drop to 14%! This opens up tremendous bonuses based on SAVINGS! There are no other words to describe it! These savings are calculated and bonuses are cut out on a monthly basis after the financial reports are run (which should be by the 3rd week of the month). It is literally that simple! The discipline that is involved is DON'T GET GREEDY! Even though you know that Clinical Managers can beat the Model, don't change it! Settle for the CUMULATIVE 14%!

Payroll – Before a payroll run, the person (as it only takes ONE person for even thousands of employees) reviews the lists and reports. Anyone with a check, the Standard Pay is not given. It is that simple...

This small disappointment in Self...does the work for the organization. The denial of Standards Pay (a bonus for just “doing your job”) is not enough to materially impact a person's Life...but it may be enough to rethink Starbucks the next week! The impact is normally an EMOTIONAL impact as we all want to FEEL we are doing our job! The slightest idea we are somehow “isolated” or “let down” the group, even for a brief period, is enough to motivate most people to do the Standards of the organization! Standards Bonus is a form of pain...and there is HIGH value in pain. It is a slight pinch that helps our organizations become WORLD-CLASS! It is Accountability! A trait of all top-rung organizations! And it requires little expenditure of Energy!



Self-Control – Self-Regulation – The Delay of Gratification

This quality is present in most highly successful people over extended periods of time and throughout human history. Studies show that this quality is present in most highly successful people, especially in the financial domain and it may be *the skill that matters most*.

The person that has the foresight not to gobble down all their food, when food is not plentiful, has a greater probability of surviving during hard times. All of human history is filled with cycles of abundance followed by periods of lack. This conservation of resources plays a key role in surviving dangerous situations as well as in the business world. Organizations and people that have a great deal of debt (especially low ROI debt) usually lack Self-Control. Self-Control is linked to Intelligence and discipline. Self-Control is the ability to delay gratification until a future time. Self-Control has a great deal to do with one's emotions. Self-Control is (paraphrased), the ability to say no in the face of temptation and to take sustained action, despite the difficulty of a given challenge. At its heart, Self-Control requires the ability to delay gratification. More commonly, it's called discipline or willpower. Without Self-Control, we can't accomplish really anything of enduring value. And we rarely pay much attention to this quality.

Here's a textbook definition:

Self-Control is the ability to control one's emotions, behavior, and desires in order to obtain some reward, or avoid some punishment. Presumably, some (smaller) reward or punishment is operating in the short term which precludes, or reduces, the later reward or punishment. In psychology it is sometimes called self-regulation. Self-Control is essential in behavior to achieve goals and to avoid impulses and/or emotions that could prove to be negative.

Some say that Self-Control is the skill that matters most in business such as Nathan DeWall of the University of Kentucky. If this is the skill that matters the most, then shouldn't it be cultivated in our people?

Self-Control is greatly influenced by Energy levels. When one is tired or weary, one's willpower decreases and Self-Control decreases as well. This is a core concept regarding Self-Control. Therefore, diet, exercise and sleep all play a role on a physical level. However, a HUGE amount of Energy is utilized mentally, especially when solving problems. The demands of work often dictate solving problems. For a CEO, there is a constant demand for Energy...and it can deplete an executive's Energy reservoir quickly, leaving a CEO in a lax state or oblivious to the needs of the organization.

If you use your Energy at prudent times, in prudent ways, you spend less of it, which leaves more in your reservoir to exercise Self-Control. For example, it serves us best to do our most



challenging work in the mornings, when our Energy reserves are highest and the number of potential distractions we face are fewer.

The most undervalued way to increase Self-Control (and effectiveness) is to renew our Energy reservoir more frequently. For example, the researcher Anders Ericsson has shown that great performers sleep as much as two hours a night more than the rest of us — at least eight hours a night on average, compared to just over six hours a night for the average American. Teaching and leading is a form of performance.

The irony is that the more conscious effort you expend to build new behaviors, the more you will use. The quicker you burn your reservoir, the more likely you are to revert to your old behaviors (habits).

That's why the ultimate practice to increase and maintain Self-Control is to build “rituals” or habits. Rituals (habits) meaning highly precise behaviors, done at specific times, until they become automatic so they no longer drain your reservoir and undermine your capacity for Self-Control. This directly links to MVI's use of IRMs (Image Recall Mechanisms and the creation of habits). IRMs allow staff members to conserve Energy so they can direct it towards the highest consideration of patients and families.

It is good advice to build powerful habits around everything from when you do your most important work, to how you respond when you feel triggered, to how you do a clinical visit, to how you answer the phone, to when you work out, to what time you turn out the light at night.

“Civilization advances,” said the mathematician Alfred North Whitehead, “by extending the number of important operations which we can perform without thinking about them.” Thinking takes Energy. Thinking too much decreases Self-Control. This leads us directly into the development of habits, which is addressed in People Development, the most important topic for any organization, and “Our Training Commitment.”

High profits & large financial reserves, personally and organizationally, are signs of Self-Control.



Accountability is Spiritual

A Hospice needs to nurture spiritual values by teaching them. Since spirituality is something a Hospice wants to foster based on the demographics of people that are drawn to Hospice work, a Hospice may consider attaching a “spiritual principle” with each *Standard*. This takes some of the “punitive feel” out of Accountability. Accountability is spiritual! Most faith communities and traditions hold a position that we are all accountable for how we spend our lives.

Accountability is Spiritual!

**How does an organization
take the
“Punitive Feel”
out of Accountability?**

828-698-5885

MVI Multi-View
Incorporated 

 The Model™

**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 Leader's personal enlightenment...

828-698-5885

MVI Multi-View
Incorporated 

 The Model™



Here are the *Standards* of this Organization with the 3 Keys to Implementation

We use only **ONE** method of Accountability for each *Standard!* Limit discretion at the operating level!

	(1) Establish <i>Standard</i>	(2) How to Teach the <i>Standard</i>?	(3) Attach Accountability
1	Teach Well and use SD Language.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class Internally, we use a 7 step teaching method for most topics. It is based on both intellectual and emotional learning. It is referred to as our Teaching Well system. 3. Demonstrate 4. Written Test 5. Practice 6. Evaluate Learning 7. Certify and retest annually <p><u>Spiritual Principle</u> Teaching is one of the most important spiritual skills a person can develop. As we teach, we grow and advance and in turn help others do so as well. This creates great karma!</p>	<p>Complete Self-Learning Module Link is emailed and is to be completed within 24 hours.</p> <p>\$2.00 in the clear glass “RESPECT” jar in the meeting room.</p>



	(1) Establish <i>Standard</i>	(2) How to Teach the <i>Standard</i>?	(3) Attach Accountability
2	Never pass work on that doesn't meet 100% of SD <i>Standards!</i>	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class Use Documentation as the example. Show a chart with an error. What do you do? 3. Demonstrate 4. Written Test 5. Have CL and other Managers Setup a room. 6. Practice: Give student a few charts to review with one having an error. Have the student address the issue. 7. Certify and retest annually <p><u>Spiritual Principle</u> We are all dependent upon each other. Each of us must exercise Self-Control to make sure that our work as well as the work of other team members is at <i>Standard</i> all the time.</p>	Complete Incident Report and Essay "How My Error" impacts the Team. Sign the Incident Report.



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
3	<p>Perfect Phone Interactions.</p> <p>All phone calls answered within 3 rings by a real person in the SD Way!</p>	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class 3. Demonstrate 4. Written Test 5. Have students field practice calls. 6. Record 3 test calls 7. Certify and retest annually <p>Mystery/Quality Call Program – Performed monthly.</p> <p><u>Spiritual Principle</u> We develop spiritually when we are in the service of others and help people feel better or inspire them.</p>	<p>Complete Self-Learning Module Link is emailed and is to be completed within 24 hours.</p>
4	<p>Response to referrals: “Yes! We can help!”</p>	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class 3. Demonstrate 4. Written Test 5. Have students field practice calls. Most of this can be done when training <i>Standard 3</i>. 6. Record 3 test calls 7. Certify and retest annually <p><u>Spiritual Principle</u> We can always help! No one calls Hospice without a reason. We exist to help and to be of service to others.</p>	<p>Complete Self-Learning Module Link is emailed and is to be completed within 24 hours.</p>



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
5	<p>Perfect Visits.</p> <p>This includes Perfect Documentation.</p>	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class 3. Demonstrate 4. Written Test 5. Practice in Synthetic Lab with various scenarios. 6. Evaluate lab practice. Have students view their videos and critique their visits. 7. Certify and retest annually <p><u>Spiritual Principle</u> A visit or phone interaction contains many spiritual elements. We want patients/families to experience the feeling of comfort and compassion from a system of care than they can have faith in. We want our visits and phone work to have a similar look and feel as to not confuse or cause anxiety or pain. This comes from a <i>Standardized</i> way of doing visits and answering the phone. The visit/phone structures are aids to help us not miss important things, to make work easier, to inspire and to help your personality come through.</p>	<p>Complete Self-Learning Module Link is emailed and is to be completed within 24 hours.</p> <p><i>Standards Pay bonus is not given (normally 10%) in the next payroll run.</i></p>



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
6	Dress in SD apparel according to our <i>Standards</i> of hygiene and grooming.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class. Dress the example. Teach how dress increases confidence levels of patients/families and makes us “visible” in facilities instead of “invisible.” No uniforms are issued until a person completes onboarding. 3. Demonstrate 4. Written Test 5. Issue Uniform 6. Have students come in uniform. Verbal scenarios. 7. Certify and retest annually <p><u>Spiritual Principle</u> Patients/Families/Referral Sources feel more confident when working with uniformed people. Groups that have uniforms are more powerful than ununiformed groups.</p>	Immediately send home any person that reports to work out of <i>Standard</i> . When the person returns in <i>Standard</i> dress, have the person complete an Incident Report and Essay explaining how it impacts the team.
7	Team rooms, workplace and teaching environments maintained and setup to SD <i>Standards</i> . Everything has a place.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class Provide room layout and setup plan. 3. Demonstrate 4. Written Test 5. Have GM and other Managers Setup a room 6. Teacher observes and signs off 7. Certify and retest annually <p><u>Spiritual Principle</u> Teaching and meeting rooms are special and sacred spaces. Clean and organized environments help people feel better and help them focus on the topic at hand.</p>	Complete Self-Learning Module Link is emailed and is to be completed within 24 hours.



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
8	Time to Meet, Ass in the Seat!	<ol style="list-style-type: none"> 1. Explain Why & How in Class 2. Demonstrate 3. Written Test, annually <p>Managers model or “act” the Accountability attached to this <i>Standard</i> in front of each other.</p> <p>Lateness disrespects people’s time. If a person is late to meetings, they are probably late on visits as well. Timeliness matters.</p> <p><u>Spiritual Principle</u> We are “respecters of time.” We are considerate of this valuable and unredeemable constraint in our atmosphere of mutual respect.</p>	A “late” jar is placed on the meeting room table or in front of the class. All individuals that are late must put in \$5 when they arrive at the meeting.
9	Meetings run according to the <i>TAMS</i> System.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class. A Manager needs to think ahead, then delegate resources effectively and make sure that things get done. Thus the acronym <i>TAMS</i>. T - Think A - Assign MS – Make Sure 3. Demonstrate 4. Written Test 5. Have Managers run a meeting according to this system 6. Teacher observes and signs off 7. Certify and retest annually <p><u>Spiritual Principle</u> Meetings are to be effective. Every meeting has a Manager and that Manager is accountable for the time and resources used to further advance the mission.</p>	Complete Incident Report and Essay “Why the <i>TAMS</i> is used.” Sign the Incident Report.



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
10	A Task List is used for all ongoing maintenance.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class This document helps people make sure that our buildings and grounds are well maintained. 3. Written Test <p><u>Spiritual Principle</u> Our buildings and surroundings are reflective of our inner state. Therefore, we want our soundings to be neat and orderly.</p>	Complete Incident Report and Essay “Why our Buildings and Grounds need to reflect our Inner State of Being.” Sign the Incident Report.
11	All service failures reported immediately to the CEO (Chief Teaching Officer/COO.) Remedy before the sun sets or at most, within 24 hours.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class 3. Demonstrate 4. Written Test 5. Practice: Use Standup Call-Outs “What would you do if XXX happened?” 6. Evaluate responses 7. Certify and retest annually <p><u>Spiritual Principle</u> When we fall short or miss the mark, it is our duty to seek reconciliation with those that are offended or harmed. The sooner this is done, the better.</p>	<p><i>Standards Pay bonus is not given (normally 10%) in the next payroll run.</i></p> <p><i>Failure to report material service failures or “gifts” can result in immediate termination of employment as this breaks our entire system.</i></p>



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
12	Live the NPR percentages and productivity Standards.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class Show the Management Reports used by the organization with NPR percentages and the Managers' names. Using Call-Outs, demonstrate that if a Manager is over by .1 or more of the NPR percentage that the Manager's Standards Pay is not given in the next payroll run. All Managers must learn to manage within 10% swings of census volume. Managers are being paid to be PROFESSIONAL Managers! 3. Demonstrate 4. Written Test 5. Practice: Use Standup Call-Outs "What would you do if XXX happened?" Provide example report scenarios. 6. Evaluate responses 7. Certify and retest annually <p><u>Spiritual Principle</u> Money is a spiritual tool where we learn spiritual lessons. We learn in lack as well as abundance. It is spiritual not to be wasteful with what we have been entrusted.</p>	<p><i>Manager's Standards Pay bonus is not given (normally 10%) in the next payroll run if the department's NPR% exceeds the NPR% Standard.</i></p>
13	Financial/Operational reports Accountability/ Empowerment Compensation on time. Financials out by the end of the 3rd week after month-end.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class Teach that financial and operational reports lose their value if people can't link cause and effect. 3. Demonstrate 4. Written Test 5. Practice: Standup Call-Outs "Why are timely reports important?" 6. Evaluate responses 7. Certify and retest annually <p><u>Spiritual Principle</u> Learning is facilitated with timely information where we understand the cause and effect of activities and methods.</p>	<p><i>The CFO's Standards Pay bonus is not given (normally 10%) in the next payroll run.</i></p>



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
14	All procurements are processed via protocol with approved value-chain vendors.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class Teach that we have a specific list of vendors and that all orders must be done a certain way. Provide multiple concrete examples of how to use the procurement system. 3. Demonstrate 4. Written Test 5. Practice: Use Standup Call-Outs “What do you do if you need XXX?” 6. Evaluate responses 7. Certify and retest annually <p><u>Spiritual Principle</u> In order to create a high-quality, predictable experience for everyone, we need to use <i>Standard</i> and established vendors. This also helps us be better stewards of resources.</p>	Complete Incident Report and Essay “How Use of Non-Approved Vendors Breaks our System.” Sign the Incident Report.
15	100% documentation to SD Standards. <i>This can be omitted when standard Visit Structures are in place and are used.</i>	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class Teach how it is only via “the chart” that we can operate as a true interdisciplinary team or have any such claim. It is our basis of existence. Teach that 70% of the detail of the visit is lost after 6 hours. 3. Demonstrate 4. Written Test 5. Practice: Done in the Synthetic Lab during Visit practice as well as in Documentation practice. 6. Evaluate responses 7. Certify and retest annually <p><u>Spiritual Principle</u> To help patients/families feel confident that we are communicating as a team, we utilize our EMR. We don’t put patients/families through the agony of asking the same questions over and over.</p>	Complete Link to Self-Learning Module with Test to be completed within 24 hours. <i>Standards Pay bonus is not given (normally 10%) in the next payroll run.</i>



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
16	Internal ADR requests (from QAPI Department) within 2 business days.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class <p>Show Managers how to process a request.</p> <ol style="list-style-type: none"> 3. Demonstrate 4. Written Test 5. Practice: Provide synthetic ADR requests have the Manager process them. 6. Evaluate 7. Certify and retest annually <p><u>Spiritual Principle</u> We are in the service of each other. As we are dependent upon each other economically, we must make sure that we comply with rules of the land. This enables us to continue to serve.</p>	<i>Standards Pay bonus is not given (normally 10%) in the next payroll run.</i>
17	TJC/CHAP accreditation without deficiencies.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class 3. Demonstrate 4. Written Test 5. Practice 6. Evaluate 7. Certify and retest annually <p><u>Spiritual Principle</u> Growing and becoming better are spiritual endeavors. This accreditation helps motivate us to be better as well as helps us correct things that may be overlooked.</p>	<i>The Managers' Standards Pay bonus is not given (normally 10%) in the next payroll run.</i>
18	Live the <i>Sunny Day Way</i> and the <i>Description of Culture</i> .	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class 3. Written Test <p><u>Spiritual Principle</u> We want a productive, peaceful and spiritual culture. This atmosphere helps to cultivate the Talent within our organization.</p>	Complete Self-Learning Module Link is emailed and is to be completed within 24 hours.



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
19	All staff credentials – CME/CEU/CPE and annual certifications completed on time.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class 3. Demonstrate 4. Written Test 5. Practice 6. Evaluate 7. Certify and retest annually <p><u>Spiritual Principle</u> We are interested in the personal evolution of each person. Growth is part of life, professionally and personally. We, therefore, recognize and use systems and methods to help individuals advance.</p>	<i>Standards Pay bonus is not given (normally 10%) in the next payroll run.</i>
20	No training is considered done unless testing has been done.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class Managers are trained in testing and the evaluation of student learning including: Call-Outs, Stand-Up/Call-Outs 3. Demonstrate 4. Written Test 5. Practice 6. Evaluate 7. Certify and retest annually <p><u>Spiritual Principle</u> We are teachers. Master teachers incorporate the evaluation of student learning so that we know that learning has resulted. This is a principle that can be used in our professional as well as our personal life.</p>	Complete Incident Report and Essay “Why Is It Important to Evaluate Student Learning?” Sign the Incident Report.



	(1) Establish Standard	(2) How to Teach the Standard?	(3) Attach Accountability
21	All teaching is done according to <i>System7</i> based on the methods of Master Teachers.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class All training, if possible and practical should be done according to System7, which is used when training nearly all of our Standards. 3. Demonstrate 4. Written Test 5. Practice 6. Evaluate 7. Certify and retest annually <p><u>Spiritual Principle</u> We are teachers. This system is proven to help students learn intellectually and emotionally. To Teach Well means to teach on both an intellectual and emotional basis.</p>	Complete Self-Learning Module Link is emailed and is to be completed within 24 hours.
22	Spiritual values, meaning & purpose are formally nourished bi-weekly via the <i>Letting Go/Surrender</i> and <i>Transformation Four29</i> Meetings.	<ol style="list-style-type: none"> 1. Issue Self-Study Module 2. Explain Why & How in Class Managers are shown the various programs that can be presented. Manager “models” a spiritual class. 3. Demonstrate 4. Written Test 5. Practice 6. Evaluate 7. Certify and retest annually <p><u>Spiritual Principle</u> We highly value spirituality and spiritual values as a company. They are part of our DNA. We recognize that people in our work seek meaning and purpose. Therefore, we create an atmosphere that nurtures this important dimension of life.</p>	Complete Self-Learning Module Link is emailed and is to be completed within 24 hours.



Examples of *Standards* (The Simplest)

Creating the Sunny Day Experience for Every Person, Every Time!

The 5 Sunny Day *Standards*! **100%** is the Sunny Day Way!

We are here simply to help people FEEL better!

Creating an Extraordinary Experience

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 to the CEO/Chief Teaching Officer. Remedy before the Sun sets.

Examples of *Standards* (Simple)

Creating the Sunny Day Experience for Every Person, Every Time!

The 12 Sunny Day *Standards*! **100%** is the Sunny Day Way!

We are here simply to help people FEEL better!

Creating an Extraordinary Experience

1. Teach Well and use SD Language!
2. Perfect Phone Interactions. All phone calls answered within 3 rings by a competent, real person in the SD way.
3. Perfect Visits. This includes Perfect Documentation.
4. Dress in SD apparel according to our *Standards* of hygiene and grooming.
5. Team rooms, workplace and teaching environments maintained and setup to SD *Standards*. Everything has a place.
6. Time to Meet, Ass in the Seat! – *Eight58, Eleven17, Transformation Four29* Meetings
7. Report all service failures to the CEO/Chief Teaching Officer. Remedy before the Sun sets, or at most, within 24 hours.

Financial & Time Management Excellence

8. Live the NPR percentages and productivity *Standards*.
9. Financial/Operational reports and Accountability Compensation on time. Financials out by the end of the 3rd week after month-end.



Compliance Excellence

10. TJC/CHAP accreditation without deficiencies.

Professional & Personal Development/Evolution

11. All teaching is done according to *System7* based on the methods of Master Teachers.
12. Spiritual values, meaning & purpose are formally nourished bi-weekly via the *Letting Go/Surrender* and *Transformation Four29* Meetings.

Examples of *Standards* (Expanded)

Creating the Sunny Day Experience for Every Person, Every Time!

The 22 Sunny Day *Standards*! **100%** is the Sunny Day Way!
Learning¹ & Teaching² are the primary drivers of Sunny Day. Learn¹ and Teach² Well!

Creating an Extraordinary Experience

1. Teach Well and use SD Language!
2. Never pass work on that doesn't meet 100% of SD *Standards*.
3. Perfect Phone Interactions. All phone calls answered within 3 rings by a competent, real person in the SD way.
4. Response to referrals: "Yes! We can help!"
5. Perfect Visits. This includes Perfect Documentation.
6. Dress in SD apparel according to our *Standards* of hygiene and grooming.
7. Team rooms and workplace maintained and setup to SD *Standards*. Everything has a place.
8. Time to Meet, Ass in the Seat! – *Eight58, Eleven17, Transformation Four29* Meetings
9. Meetings run according to the TAMS System.
10. A Task List is used for all ongoing maintenance.
11. Report all service failures to the CEO/Chief Teaching Officer. Remedy before the Sun sets, or at most, within 24 hours.

Financial & Time Management Excellence

12. Live the NPR percentages and productivity *Standards*.



13. Financial/Operational reports and Accountability Compensation on time. Financials out by the end of the 3rd week after month-end.
14. All procurements are processed via protocol with approved value-chain vendors/partners.

Compliance Excellence

15. 100% documentation to SD *Standards* - timely, complete & accurate.
16. Internal ADR requests (from QAPI Department) turned around within 2 business days.
17. TJC/CHAP accreditation without deficiencies.

Professional & Personal Development/Evolution

18. Live the *Sunny Day Way* and the *Description of Culture*.
19. All staff credentials/CME/CEU/CPE and annual certifications completed on time.
20. No teaching or people development has been done without testing.
21. All teaching is done according to *System7* based on the methods of Master Teachers.
22. Spiritual values, meaning & purpose are formally nourished bi-weekly via the *Letting Go/Surrender* and *Transformation Four29* Meetings.

Self-Control and Empowerment! Every **Talent** at Sunny Day should understand our way and has the power to address ANY activity or behavior that deviates from our Standards. It is everyone's duty to help others adhere to Sunny Day's Standards as well as to regulate one's own behavior within our incredibly positive, life-giving culture. If any person identifies a deviation from any Standard, immediately and tactfully address the deviation with the person responsible first. For recurring issues or for major breaks in protocol, such as breaching confidentiality, always notify the Manager. We all are essential and valuable contributors to the whole...dependent upon each other to create the Sunny Day Experience for every person, every time!

Description of Culture

Systematically delighting clients in a peaceful and productive atmosphere where each talent has the opportunity to explore their personal potentials.



Inpatient Units & the Model

In the table below, you can record some of your own ideas about *Standards* and go through the 3-step process.

	(1) Establish <i>Standard</i>	(2) How to Teach the <i>Standard</i> ?	(3) Attach Accountability
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			



How to Implement *Standards*

Preparation

1. CEO announces the *Standards* creation process and solicits input.
2. Create your *Standards* with the attributes of
 - a. Clear
 - b. Impressive
 - c. Sustainable
3. CEO finalizes *Standards*.
4. Print *Standards* Cards. These will be changed as needed as *Standards* are a tool to shape behavior and performance. There will probably be some changes that you'd like *immediately!* However, they are usually small changes. You will change these over time, ideally *decreasing* the number of *Standards* over time.
5. Attach uniform Accountability (involving pain) for all behavior or performance that is non-*Standard*. **THIS IS AN ABSOLUTELY CRITICAL STEP THAT CAN'T BE SKIPPED!** Use the template provided. Some Accountability practices may not be able to be implemented quickly (like an Accountability compensation system). In this case, use low-tech approaches like Incident Reports with Essays.
6. Attach a Spiritual Principle to each *Standard*. This takes the punitive “feel” out of Accountability and provide meaning and purpose, something virtually all Hospice clinicians seek. The Spiritual Principle must be taught for each *Standard*.
7. Determine how you are going to teach each *Standards* according to *System7*, teaching on an intellectual basis first and then on an emotional basis where applicable.
 - a. **Self-Learning Modules** - Create Self-Learning Modules. We suggest the following:
 - i. Behavior *Standards* (General)
 - ii. Numeric *Standards* (Explanation of these *Standards* in general terms. Not too detailed.)
 - iii. Visit *Standards*
 - iv. Phone Interaction *Standards*
 - b. **Tell** - Create the Presentation – Verbal with complete emphasis on the *Why?*
 - c. **Show** - Create the Presentation – Visuals with complete emphasis on the *Why?* This would include the creation of:
 - i. *Standards* Cards
 - ii. Manuals – Needed for any serious teaching
 - iii. PowerPoints – Simple but effective
 - iv. *Standards* Flash Cards
 - v. Videos – Where applicable and effective
 - vi. Props – Where applicable and effective
 - vii. Audio – Where applicable and effective



- d. **Test** - Create written tests for the *Standards* and grading method. Objective grading is best.
- e. **Practice** - Create Practice Scenarios where applicable.
- f. **Evaluate Practice** – Create *Standard* criteria for the evaluation of student performance in scenario practice.
- g. **Certification/Annual Recertification** – Create tracking system or log to track completion or non-completion. Create this so that it can be used during initial on-boarding of staff as well as annually.

Standards Implementation - Managers

8. Train your Managers using *System7* so they can teach/coach to the *Standards*.
 - a. **Self-Learning Modules** – Give Managers access to the Behavioral and Numeric *Standards* Self-Learning Modules to review on their own.
 - b. **Tell** – Have your top *Standards* teacher teach the *Standards* in a formal class, teaching to the *Why?*. The *Why?* links cause to effect and the personal benefit for adhering to each *Standard*.
 - a. **Show** – Teach to each *Standard* using a 1) PowerPoint, 2) *Standards* Cards and 3) the *Standards* Manual, teaching to the *Why?*. Use Call-Outs to keep some tension in the learning environment. Flashcards are a very good tool in this learning setting.
 - c. **Test** – Test using a ZipScan machine or other objective and speedy grading system. 100% is the only acceptable score. Give each person a limited number of attempts. Example: 3 or 4.
 - d. **Practice** – Have each Manager teach the *Standards* back to the teacher with each *Teach Back* being videoed. Have each Manager review and critique their performance.
 - e. **Evaluate Practice** – Grade each Manager on each of the major points within the *Standards*, making sure none were missed and that each was taught well, ideally on an intellectual as well as an emotional basis.
 - f. **Certification/Annual Recertification** – Record the completion or non-completion of each Manager with a date.

Standards Implementation – All Staff

9. Train your All Staff using *System7*.
 - b. **Self-Learning Modules** – Give All Staff access to the Behavioral and Numeric *Standards* Self-Learning Modules to review on their own.
 - c. **Tell** – Have your top *Standards* teacher, or each Manager, teach the *Standards* in a formal class, teaching to the *Why?*.
 - d. **Show** – Teach to each *Standard* in a 1) PowerPoint, 2) *Standards* Cards and 3) in the *Standards* Manual, teaching to the *Why?*. Use Call-Outs to keep some



- tension in the learning environment. Flashcards are a very good tool in this learning setting.
- e. **Test** – Test using a ZipScan machine or other objective and speedy grading system. 100% is the only acceptable score. Give each person a limited number of attempts. Example: 3 or 4.
 - f. **Practice** – Have each staff member demonstrate their learning in the following scenarios:
 - i. *Teach Back* the general purpose of *Standards* and why they are important.
 - ii. Identification of a Documentation Error of a Co-Worker. Have each staff member demonstrate *Self-Control* and the principle of “*Never pass work on that does not meet 100% of the Standard.*”
 - g. **Evaluate Practice** – Grade each person on each of the major points the *Standards*, making sure none were missed.
 - h. **Certification/Annual Recertification** – Record the completion or non-completion of each team member with a date.

Uniform Accountability

10. Uniform Accountability must be maintained or the *Standards* mean nothing. Avoid “exceptions” as exceptions break the system. All Managers must hold each other accountable. This is part of “*Never pass work on that does not meet 100% of the Standards.*” If it is discovered that a Manager is not practicing uniform Accountability, the Manager should complete an Incident Report with an Essay on “How My Allowance of Non-*Standard* Impacted the Team and the Organization.” Additionally, the Manager’s *Standards Bonus* will be deducted in the next payroll.



Accountability – Financial Operational Reports

A great Best Practice idea is the Comprehensive or One Page Financial Model Report. Basically, these reports show on a single page how every functional area of a Hospice is performing regarding the Model as well as who is accountable. It might look like this:

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%	



Inpatient Units & the Model

Comprehensive Model Report

Sunny Day Hospice

YTD December, 2008

Area/Program	Leader	Direct Labor	NPR% Model	Patient Related	NPR% Model	Contribution Margin	NPR% Model	Performance Pay
Hospice-Location 4	Johnny Rattler	34.7%	35.0%	4.5%	17.0%	60.9%	48.0%	0.0%
Hospice-Location 5	Jolly Roger	76.8%	35.0%	0.0%	17.0%	23.2%	48.0%	0.0%
Hospice-Location 6	Shivers Dunkin	0.0%	35.0%	0.0%	17.0%	0.0%	48.0%	0.0%
Hospice-Location 7	Jonas White	0.0%	35.0%	0.0%	17.0%	0.0%	48.0%	0.0%
Hospice-Location 8	Carrie Slasher	0.0%	35.0%	0.0%	17.0%	0.0%	48.0%	0.0%
Hospice-Location 9	Betty Horn	0.0%	35.0%	0.0%	17.0%	0.0%	48.0%	0.0%
Inpatient Unit (Loc 3)	Harriet Mackie	53.7%	59.0%	0.0%	17.0%	46.3%	24.0%	0.0%
Palliative Care (Loc 2)	Jill Scallywag	0.0%	70.0%	0.0%	17.0%	0.0%	13.0%	0.0%
Total Organizational		39.8%	40.0%	3.6%	17.0%	56.6%	43.0%	0.0%
Centralized Direct	Leader	Labor		Other		Total %	Model %	Performance
On-Call	Chris Davis	3.2%	3.00%	0.0%	0.05%	3.2%	3.1%	0.0%
Admissions	Ella Blue Ramsay	1.2%	3.00%	0.0%	0.05%	1.2%	3.1%	0.0%
Bereavement	Lil Timbers	3.1%	1.00%	0.0%	0.05%	3.1%	1.1%	0.0%
Volunteer	Mabel Barrels	1.4%	1.00%	0.0%	0.05%	1.4%	1.1%	0.0%
Total Centralized		9.0%		0.0%		9.0%	8.2%	0.0%
Indirect Areas	Leader	Labor		Other		Total %	Model %	Performance
Administration	John Rugged	3.9%	3.50%	0.0%	0.05%	3.9%	3.6%	0.0%
Clinical Management	Sal Prisk	7.2%	5.50%	12.7%	0.05%	19.9%	5.6%	0.0%
Compliance/QAPI	Moll Biscuit	0.9%	1.50%	0.0%	0.05%	0.9%	1.6%	0.0%
Education	Vera Skewers	1.6%	1.00%	0.0%	0.05%	1.6%	1.1%	0.0%
Finance	Tobias Story	2.6%	2.25%	0.0%	0.05%	2.6%	2.3%	0.0%
HR	Nancy Harpo	1.1%	0.75%	0.0%	0.05%	1.1%	0.8%	0.0%
Marketing	Roger Sellick	0.6%	2.00%	0.0%	0.05%	0.6%	2.1%	0.0%
Medical Director	Jacob Haul	0.0%	1.25%	0.0%	0.05%	0.0%	1.3%	0.0%
Medical Records	Eli Goodwin	1.5%	1.00%	0.0%	0.05%	1.5%	1.1%	0.0%
MIS	Mack Sweet	1.0%	1.25%	0.0%	0.05%	1.0%	1.3%	0.0%
Other	Lin Marko	0.0%	0.00%	0.0%	0.05%	0.0%	0.1%	0.0%
Total Indirect		20.3%		12.7%		33.1%	20.6%	0.0%
Operating/Facility	Leader					Total %	Model %	
Operating	Sammy Quick					8.20%	8.0%	
Facility-Related	George Fry					1.73%	4.0%	
Total Operating/Facility						9.9%	12.0%	
Total Operating Indirects						43.0%	32.6%	
Total Operating Expenses						95.3%	97.8%	
						Total	Model	
Operating Income/(Loss)						4.7%	2.3%	
Non-Operating Income								
Support								
Fundraising								
Investment and Interest								
Other Programs								
Total Non-Operating Income (Loss)								
Net Income (Loss)								
MVI Multi-View Incorporated		Multi-View Incorporated Systems						
		PO Box 2327						
		Hendersonville, NC 28793						
		828-698-5885 or multivewinc.com						
Control Total								



How to get Documentation to 100% of *Standard*

Some Hospices do not believe that clinical documentation can be done to a 100% *Standard*. Here is how it can be done.

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 REMOVED from their duties.
5. If any 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 has fix the issue if possible and complete the Self-Learning Module within 1 day.
7. In addition, the Standards Bonus pay is revoked. Normally this is 5-10% for 1 pay cycle.



The Model™ 
Balancing Purpose and Profit...



Examples of Performance Standards.

Hospice HomeCare	Number of Patients Visited/FTE Staffing Model		Visit Duration	Weekly Visits		Visits Per Patient, Per Week	
	Minimum	Excellent	Average*	Minimum	Excellent	Min	Max
RN	12	14	60	20	22	1.2	1.7
LPN	25	30	60	22	24	0.8	1.0
Aides	10	12	60	22	24	1.8	2.2
SW	28	32	60	20	22	0.45	0.75
Spiritual Care	80	100	60	22	24	0.2	0.4
Bereavement	100	120	x	x	x	X	X
Volunteer	100	120	x	x	x	X	X
Physicians/NPs	150	x	50	x	x	X	X
Admissions RN	50	x	90	10	12	X	X

* Travel Time is NOT included. Average Travel Time is 15 minutes.

Hospice NH/ALF	Number of Patients Visited/FTE Staffing Model		Visit Duration	Weekly Visits		Visits Per Patient, Per Week	
	Minimum	Excellent	Average*	Minimum	Excellent	Min	Max
RN	16	18	45	26	28	1.2	1.7
LPN	30	35	45	28	30	0.8	1.0
Aides	12	14	55	25	27	1.8	2.2
SW	32	34	50	24	26	0.45	0.75
Spiritual Care	100	120	50	28	30	0.20	0.4
Bereavement	100	120	x	x	x	X	X
Volunteer	100	120	x	x	x	X	X
Physicians/NPs	150	x	50	x	x	X	X
Admissions RN	50	x	90	10	12	X	X

* Travel Time is NOT included. Average Travel Time is 15 minutes.



Hospice IPU		
Hospice Unit	Caseloads	
Category	Minimum	Excellent
Nursing	5	6
Aides	5	6
SW	12	13

Cost Category	Homecare	Palliative Care	IP Units
Total Direct Labor	38%	100%	50.5%
Total Patient-Related	17%	11%	12%
Contribution Margin	45%	-11%	37.5%
Indirect: Salary Costs	20%		14%
Indirect: Operational Cost	7%		6.5%
Indirect: Facility Costs	4%		7%
Total Indirect	31%		27.5
Surplus (For capacity and sustainability)	14%	Limited to -2% of Homecare NPR	10%
Direct Labor			
Nursing	14%		33%
Aides	7%		15%
SW	4%		2.5%
Spiritual Care	2%		
Physician/NP	2%	100%	(Net to Zero)
On-Call	3%		
Admissions	3%		
Bereavement	1%		
Volunteer	2%		
Patient-Related Items			
Medical Supplies	1.5%		2%
Therapies & Outpatient	.5%		.5%
DME	4.25%		.2%
Pharmacy	4%		4%



Inpatient Units & the Model

Mileage	3%	3%	
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Indirect Salaries <i>(Total Organization)</i>	Model
Administrative Salaries	3.5%
Clinical Management Salaries	5.5%
Compliance/QAPI	1.5%
Education	1%
Finance	2.25%
HR	.75%
Marketing	2%
Medical Director	1.25%
Medical Records	1%
IT/MIS	1.25%
Total	20%

Measurement	Minimum	Excellent
Admission/Inquiry %	75	85
Median LOS (Living)	120	<145
Days in Accounts Receivable	48	45
Facility Mix %	40%	
Patient Mix over 365 Days	10%	<25%
Death Service %	50%	
Same Day Visit %	65%	
Development Ratio	3:1	
Pain Reduced (within 24 hours)	90%	
Family Satisfaction <small>(via App 10 Point Scale)</small>	8.0	
Hospital Readmits	<5%	
Clinical Manager Satisfaction <small>Overall Satisfaction w/ Supporting Areas - 10 Point Scale</small>	>7.0	
Turnover of Talent %	<6%	



7 The Business of Hospice

Definitions & Terms

Here are some definitions that MUST be mastered to understand the business of Hospice:

- **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.
- **Indirect Costs** – 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** – 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 40% Contribution.
- **Development** – The area that is responsible for garnering Community Support. This would include: Fundraising, Contributions, Memorials, etc. A Development Department has both revenue and expense. Both revenue and expense for Development is segregated from all other segments in our analysis of Hospice business.

The Use of Net Patient Revenue (NPR)

MVI encourages the use of Percentages of Net Patient Revenue rather than Patient-Day costs for Hospice financial measurement. This deviates from traditional Hospice practice and the explanation will follow.

An Example of How to Compute Net Patient Revenue Measurement

Medication costs are \$25,000 for the month. Net Patient Revenue is \$300,000.

To compute Medication costs as a Percentage of Net Patient Revenue, you would divide \$25,000 by \$300,000.

$$\$25,000 \text{ divided by } \$300,000 = .083 \text{ (rounded)}$$

Convert .083 to a percentage (multiply by 100) and you get 8.3%.

Medication costs in this example are 8.3% of Net Patient Revenue.

Why should have Hospice use Percentages of Net Patient Revenue rather than Patient-Day costs for Hospice financial measurement?

- **Comparability** – Percentages are comparable with other Hospice programs to help us gain perspective (The difference between Professional versus Amateur Hospice Manager). Patient-Day amounts are OK for a few areas, like Patient-Related. They fall apart when comparing differing areas of the country, especially anything that relates to salaries and wages. Salaries and wages can vary widely throughout the country. These differences, however, are often offset by reimbursement that takes these labor factors into account such as CBSA codes for Medicare. Thus, the Percentages of Net Patient Revenue would be more similar while Patient-Day amounts would vary greatly.



- **Creation of a Model** – Percentages are better suited for the creation of a Model. Percentages are “scalable,” meaning they can be used by any size of Hospice. In addition, when rate changes occur, percentages easily translate to operational measures.
- **People Understand Percentages** – Most people can conceptualize percentages pretty well. If everyone knows that the pie is 90% (10% set aside for profit), they can understand that if something is increased something else has to decrease.

We are not saying that Patient-Day measurement is wrong or that it should not be used. It works very well with Patient-Related costs. However, recognize its shortcomings whenever there is a labor component.

Classifying Costs

	Classification Item	Patient Revenue	Direct Labor	Patient-Related	Pass-Through Revenue	Pass-Through Expense	Indirect Labor	Operational Expense	Facility-Related	Other Program	Dev
	Example: Medicaid Routine Revenue	X									
1.	RN Salaries		X								
2.	CNA Salaries		X								
3.	Medications			X							
4.	DME			X							
5.	Therapies			X							
6.	Medicare Routine Revenue	X									
7.	Medicaid Room & Board Revenue				X						
8.	Contracted Medicare IP Revenue				X						
9.	CEO						X				
10.	Finance Salaries						X				
11.	Rent								X		
12.	Development Salaries										X
13.	Pediatrics Salaries									X	
14.	Admissions		X								
15.	Director of Nursing						X				



	Classification Item	Patient Revenue	Direct Labor	Patient-Related	Pass-Through Revenue	Pass-Through Expense	Indirect Labor	Operational Expense	Facility-Related	Other Program	Dev
16.	Medical Director (oversight function)						X				
17.	Physician (performs visits)		X								
18.	Office Supplies							X			
19.	HR						X				
20.	Clinical Team Manager						X				
21.	Computer Expense							X			
22.	Telephone							X			
23.	Continuing Education							X			
24.	Education Salaries						X				
25.	QI/PI/Compliance						X				
26.	Utilities								X		
27.	Nursing Home Room & Board Expense					X					
28.	Community Bereavement									X	

Classifications in the MVI Benchmarking System

When using the MVI Benchmarking Systems for management and gaining perspective, it is important to have an understanding of “what” is grouped “where.” This knowledge helps a person identify problems and helps in the interpretation of the information. The information contained in this manual contains the classifications used by MVI for Benchmarking and other reporting. If you are using the MVI Benchmarking Systems and need further classification breakdown, please contact our Benchmarking office at 772-569-9811.



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.** Patient-Days are the most common Hospice financial measurements. They are relatively easy to compute and are accepted in other forms of healthcare such as hospitals and nursing homes. Patient-Day measurements are inferior to Percentage of Net Patient Revenue.
- **ADC or Average Daily Census = Total patient days in a period/number of period days.** This is the Standard measurement of Hospice size.
- **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. On a weekly basis, it is normally 40 hours. If an employee worked 1040 hours, they would be considered half an FTE or 0.5. An FTE of 1.0 means that the person is equivalent to a full-time worker, while an FTE of 0.5 signals that the worker is only half-time.
- **Average Length of Stay (Terminated Patients) = Total patient-days for terminated patients/The number of terminated patients.** Average Length of Stay (ALOS), like most measurements, has its flaws. ALOS should be looked at suspiciously. First, does the measurement number include the Inpatient Unit? This will skew overall Hospice numbers downward. Also, low ALOS in the Inpatient Unit isn't a bad thing. You want EVERY patient - whether they live one minute or one hour for CAP purposes. However, you want Hospice Homecare ALOS as high as possible without exceeding CAP. Second, ALOS, as most Hospices compute it, only counts terminated patients via death or discharge. Therefore, some patients will NEVER be included in the calculation! It can be a dangerous measurement to rely on and it has misguided many Hospices into millions of dollars in CAP paybacks.
- **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.



- **Number of Visits Per Week** – This is the count of the number of visits per clinician per week (see the chart for goals). This practice provides a sense of respect for the professionalism for each discipline and allows clinicians to “take as long as needed to do a World-Class visit”. However, it also should be stressed that the minimum expectation is the minimum. If the minimum is 20 visits a week for an RN, then 19 is not acceptable on a routine basis.
- **Number of Admissions Per Week** – This is the count of the number of admissions per Marketing FTE per week. Weekly measurement has become the Best Practice for monitoring effectiveness. All admissions (not referrals) from the assigned “paper routes”, accounts, or territories are credited to the Marketing person. A top Hospice marketer will produce 8-12 admissions per week from their assigned territories or accounts. 5 is considered a minimum.
- **Number of Visits by Discipline per 8-Hour Day = $\text{Total number of visits}/(\text{Total time worked}/8)$** . This is the best way to judge clinical productivity on a daily basis, in our opinion, as it converts all time worked into an 8-hour day. The focus should be on WEEKLY visits. However, to determine what is needed on a weekly basis, a daily amount is often needed. Avoid communicating productivity in daily terms.
- **Visit-Hours by Discipline per 8-Hour Day = $\text{Total number of visit-hours}/(\text{Total time worked}/8)$** . This measurement provides the best measurement of visit-hours of clinical staff. This measurement helps productivity and is critical if a Hospice wants to understand costs by patient, diagnosis, payer, referral source, physician, clinician, etc.
- **Computed Caseloads = $\text{ADC}/(\text{Salaries}/\text{Average Hourly Rate}/\text{FTE Hours})$** NOTE: Normally an FTE is 2080 hours annually or approximately 173 per month. Salaries would be for a specific discipline such as RNs, CNAs, SW, etc. This measurement cuts through “perceived” or reported caseloads, which tend to be exaggerated by 2 to 3 on average. It provides a “real” caseload per FTE.
- **Days in Accounts Receivable = $\text{Accounts Receivable}/\text{Annual Revenue} \times 365$ or $\text{Period Days}/\text{AR Turnover Rate}$ which is $\text{Net Patient Revenue}/\text{Patient Accounts Receivable}$** . This is a measure that most managers and Managers should be at least familiar with. It provides the average number of days it takes to collect a bill.
- **Facility Mix = $\text{Total number of patients in nursing homes and assisted living communities}/\text{Total number of Hospice patients}$** . This is a key measurement that can have a huge bearing on a Hospice’s profitability. It measures the percentage of patients residing in nursing homes and assisted living communities.
- **Patient Mix over 365 Days = $\text{Number of patients that have been on Hospice service for more than a year}/\text{Total number of patients}$** . An often-overlooked measure that is



vital to financial success. An adequate number of patients must live for extended periods of time to offset short-living patients.

- **Revenue Per Payroll Dollar = *Net Patient Revenue/Total Payroll Dollars*.** Since payroll is the primary key to mastery of Hospice finance, then the relationship between revenue and payroll costs is significant.
- **Death Service Percentage = *Total Program Deaths/Total Deaths in Service Area*.** This is the true indicator of Hospice penetration.
- **Admission/Inquiry Percentage = *Total Number of Admissions/Total Number of Inquiries*.** Notice this is NOT Referral/Admissions. Many Hospices live in the world of excuse and “sanitize” their conversion numbers. All inquiries should be counted.
- **Same Day Visit Percentage = *Total number of admission or informational visits in a day/Total number of Inquiries in that same day*.** This is an important measurement that provides some indication of the ability to “sell” services. The goal of Intake is to get same day visits.
- **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. They are:
 - Nursing Home Room & Board
 - General Inpatient in Contracted Hospitals
 - Consulting Physician Services.
 - Respite Care in Contracted Facilities

What is the best practice discovered for treating Pass-Throughs and why?

Pass-Throughs are controlled by grouping them in the Patient-Related section of the Chart of Accounts. An account is created for each Pass-Through revenue and expense so they can be analyzed for specific problems. The “net” amount is displayed on the Statement of Income and should be mathematically explainable. If Pass-Through revenue is used in calculation of Net Patient Revenue, it has historically caused Hospices to falsely believe their financial performance is better than it actually is, as the offsetting expenses have not been properly accrued.

It can also materially diminish comparability with other Hospices based on Net Patient-Revenue, as the inclusion of Pass-Throughs inflates revenue. Grouping the revenue and expenses provides an easy and practical “**control**” for users of financial statements. The



wording also creates questions from Board Members and others that allow an educational opportunity. Not using this type of control has resulted in numerous Hospices closing their doors as they operate with artificially inflated bottom-lines.

- **Development Return Ratio = Total revenue from Community Support and Fundraising/Total expense for the Development Function.** This measurement is basically an ROI (Return on Investment) calculation. It measures the number of dollars returned from each dollar invested in the attempt to garner community funds.
- **Contribution Margin - Contribution Margin is computed by subtracting Direct Expenses from Direct Revenue.** It is used to measure the performance of revenue-producing Hospice segments like homecare teams and inpatient units. The “contribution” is the amount of excess from direct operational costs left to pay for Indirect Costs and provide for some level of profit. 36-40% is a solid Contribution Margin for a Hospice team.

	Measurement	Median	Model	Excellent
a.	Average Length of Stay (Terminated)	76.1	90	??
b.	Median Length of Stay (Living)		140	<165
c.	Days in Accounts Receivable	43	45	42
d.	Facility Mix	31.8%	35%	50%
e.	Patient Mix over 365 Days		10%	<30%
f.	Death Service Percentage	52%	40%	50%
g.	Admission/Inquiry Percentage	65%	75%	85%
h.	Same Day Visit Percentage			80%
i.	Development Ratio	3:1	4:1	6:1

Lower Costs Are Not Always Better

When reviewing the Percentage of Net Patient Revenue financial measurements in the following sections, please understand that we tend to look at lower costs as better. However, this is not always the case. In fact, many times it is better for some costs to INCREASE. The point is that there is a need to lower costs in some areas and increase costs in others to create a World-Class Hospice. If you could lower ALL costs and still provide World-Class care, it would be great. However, that is usually not the case. Example: If you believe that increased CNA services are World-Class, then this cost would increase. If you believe that Open Access involves increased Therapies expense, then you would plan on this element of cost increasing. However, at the end of the day, the bottom-line needs to be producing at least 14%.



The War of Single Percentage Points

You may not think a single percentage point variance is a big deal. But each percentage point is a big deal. As we look at profitability in the Hospice world, it often boils down to single percentage points. So many times, a Hospice is doing well financially, but the operational profit is not attributed to one area of excellence. Rather, it is a percentage here and a percentage there and the CUMULATIVE effect is surprising. Now, this may be fine and all... but if a single area or category of cost goes out of control, the entire positive residual may be in jeopardy. If your profit is due to a percentage point here and a percentage point there... and you know it, then you know just what a balancing act you are performing!

“Profitability is a war of single percentage points.”

Many people think that profitability is about having great cost controls in one or multiple areas of a Hospice. That is not usually the case. It is more about having good costs in MOST areas...and it comes down to single percentage improvements. It is easy to self-justify if we are over industry averages in a cost category and rationalize that it is not a big deal. But it is. It is this attitude that robs us from performing to our full capabilities.

“If you are a single percentage point over in an area where you should not be, don’t be passive... attack the situation.”

This is a mindset that will keep your Hospice on track and not settling into a groove towards mediocrity.

One thing that you should realize is “what” is possible. A Hospice can achieve a 20% Operational Net Income WITHOUT compromising quality.

“We must realize that most Hospices waste tremendous amounts of money.”

You Can’t Operate Your Hospice Based on Averages

In the following charts of Hospice costs on a Percentage of Net Patient Revenue, you will notice that the total of averages does not match the totals for categories such as Direct Labor, Patient-Related or Indirect Costs. All data points in our benchmarking systems are independent calculations, including totals for categories. In our validation processes, we EXCLUDE elements that we believe are suspect. However, just because a data point is



excluded does not mean that the TOTAL is invalid. It may mean that data points may not be segregated and therefore are lumped together so that individual data points are not accurate, but the total is.

Most Hospices have a combination of areas that are higher or lower than the averages. It is the mix that is important. **Realize that you must have some areas that are below the reported averages to be financially successful.**

Perspective on Hospice Reimbursement

Hospice reimbursement is good when compared to other flavors of healthcare. If a hospital or nursing home gets a 5% return, they consider it a great year. There is “enough” money in Hospice to cover all costs of providing care and having money left over.

“It is unethical to run a sloppy and overweight organization and then rely on the community to bail it out. Why should an organization rely on the ‘kindness of others’ to cover losses from inefficient operations?”

Deborah Dailey

Unfortunately, Hospice has a tradition of losing money from operations. It has taken the introduction of for-profit Hospices to teach us about efficiencies and working smarter. In fact, from my experience, much of the advancement of Hospice has come from the for-profit sector of Hospices. It is here that I see the most radical differences in management...some good, some not so good. But many of the accepted practices in Hospice come from the for-profit world.

The economic model must always work. In addition,

“The World-Class Hospice of tomorrow will provide superior Hospice care at less cost than today.”

Many people equate high cost with high quality. This is flawed thinking. Just because you spend \$25 a patient-day on medications does NOT mean that patients are getting better care. It simply means that your Hospice is wasting money. The SAME outcome could be achieved at two-thirds LESS cost. The same lesson applies to Direct Labor as well as to other Patient-Related costs.

“It is incorrect to believe low costs indicate a Hospice is skimping on services.”



How much “positive residual” or profit should your Hospice have?

The answer to this question will come from your vision of Hospice care and what you think your Hospice will need in the future regarding funds. My rule of thumb is that a Hospice should have a net operating income of approximately 14% regardless of whether you are for-profit or not-for-profit. But what is important is that your Hospice is what your community needs or it is fulfilling your vision of Hospice. Therefore 5%, 14% or even 20% might be what you need to do.

Running a Hospice at “break-even” is very unattractive considering our current great reimbursement levels, unless we hold to the mindset that the community needs to bail us out. Here is the advice from my first Hospice CEO:

“Learn to ignore Community Support. Pretend that it isn’t there.”

This is a healthy idea that has served me well over the years. It keeps a Hospice sharp and FOCUSED on making it on operations.

The Illusion of Profitability

Growth in ADC can create an illusion of organizational financial health. In the case of rapid growth, a Hospice’s staffing needs out-pace its ability to hire clinical staff. Therefore, the Hospice builds census on the backs of overworked clinicians. However, when the ADC slows down, profitability reverses or lessens as the Hospice’s normal staffing patterns and habits of clinical practice and management catch up. Be aware that your profitability could only be due to this situation. This situation can also create a false expectation in management and Boards of Directors. They may ask, “Where did our margins go?” The fact is that we were working short and unless we are willing to change our model of care, we will not see those profit margins again.



Understanding Costs

Hospice Homecare

In the table below are costs expressed as Percentages of Net Patient Revenue (NPR). Median, Model and 90th percentile amounts are displayed for each measure.

	Cost Category	Median	Model	90th
a.	Total Direct Labor	41%	39%	30%
b.	Total Patient-Related	17%	15.5%	12%
c.	Contribution Margin	41%	45.5%	52%*
d.	Total Indirect Costs	36%	33%	27%*
e.	Indirect: Salary Costs	23%	22%	15%
f.	Indirect: Operational Costs	9%	7%	5%
g.	Indirect: Facility-Related	4%	4%	2%
h.	Net Operational Income	6%	12.5%	27%*
	Direct Labor <i>(Benefits included, 22%)</i>			
i.	Nursing	17.75%	14%	12.77%
j.	Aides	5.69%	7%	3.63%
k.	SW	4.16%	4%	2.40%
l.	Spiritual Care	2.05%	2%	1.08%
m.	Physician	2.01%	2%	1.37%
n.	On-Call	3.96%	3%	1.63%
o.	Admissions	3.45%	3%	1.89%
p.	Bereavement	1.27%	1%	.38%
q.	Volunteer	1.03%	2%	.54%
r.	Call Center/Triage	1.03%	1%	.54%
	<i>Direct Labor Subtotal</i>	41.03*	39.00%	30.06%*
	Primary Patient-Related Items			
s.	Medical Supplies	1.61%	1.5%	.89%
t.	Therapies & Outpatient	.46%	.5% to 3%	.08%
u.	DME	4.30%	4.25%	2.96%
v.	Imaging & Diagnostics	.06%	.07%	.02%
w.	Ambulance	.36%	.35%	.07%
x.	Pharmacy	5.43%	5%	3.55%
y.	Lab	.08%	.15%	.03%
z.	Mileage	2.55%	2.5%	1.43%
	Pass-Throughs & Other	.70%	1%	-1.37%
	<i>Patient-Related Subtotal</i>	17.28%*	15.5%	12.16%*

* - 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.



Indirect Costs

In the table below are costs expressed as Percentages of Net Patient Revenue (NPR). Median, Model and 90th percentile amounts are displayed for each measure. Salaries INCLUDE benefits.

	Indirect Salaries <i>(Total Organization)</i>	Median	Model	90th
a.	Administrative Salaries **	5.96%	3.5%	2.52%
b.	Clinical Management Salaries **	5.41%	5.0%	2.05%
c.	Compliance/QAPI	1.31%	1.25%	.57%
d.	Education	.91%	1.25%	.27%
e.	Finance Salaries	2.55%	2.25%	1.08%
f.	HR	1.17%	.75%	.51%
g.	Marketing Salaries	2.54%	3.75%	.76%
h.	Medical Director	1.89%	2%	.48%
i.	Medical Records Salaries	1.00%	1%	.36%
j.	IT Salaries	1.25%	1.25%	.39%
k.	Other	.83%	0%	.05%
	<i>Indirect Salaries Subtotal</i>	22.92*	22.00%	15.34%*
	Indirect Operational <i>(Total Organization)</i>			
l.	Computer Expenses	1.21%	1%	.18%
m.	Continuing Education+	.26%	.3%	.06%
n.	Dues, Licenses & Subscriptions	.75%	.3%	.14%
o.	Insurance	.60%	.60%	.21%
p.	Office Supplies	.31%	.35%	.03%
q.	Postage/Mailings/Printing	.28%	.38%	.06%
r.	Telephone	.52%	.50%	.18%
s.	Marketing	.72%	1%	.16%
	<i>Indirect Operational Subtotal</i>	8.65%*	7.0%	5.44%*

* - 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.

** - These areas are the most “messy” regarding benchmarking because accounting can lack sufficient breakout. Administration can also be impacted substantially by economies of scale. A Hospice’s Administrative Salaries DECREASE with size. Clinical Management Salaries can also decrease with increased census, although sometimes it is less impacted than Administrative Salaries.



Inpatient Units

In the table below are costs expressed as Percentages of Net Patient Revenue (NPR). Median, Model and 90th percentile amounts are displayed for each measure.

	Cost Category	Median	Model	90th
a.	Total Direct Labor <i>(includes all unit staff)</i>	74.25%	68%	52.64%
b.	Total Patient-Related	14.19%	11.5%	8.19%
c.	Contribution Margin	11.93%	20.5%	32.91%
d.	Indirect Costs <i>(includes some allocated costs)</i>	33.08%	12.5%	16.81%
	Segment Net Income	-23.68%*	8%	11.41%*
	Direct Labor <i>(Benefits included, 22%)</i>			
e.	Nursing	46.36%	35%	33.00%
f.	Aide	15.02%	15%	7.73%
g.	SW	3.03%	3.0%	1.69%
h.	Manager/Charge Nurse <i>(RN preferred w/ IPU 15 bed or <)</i>		6.5%	
i.	Ward Clerks		5%	
j.	Physician (NET) <i>(should pay for themselves through billings)</i>		1%	
k.	Grounds and Maintenance <i>(may be part of Indirect.)</i>		2.5%	
	<i>Total</i>		68%	
	Patient-Related			
l.	Ambulance	.99%	1%	.14
	Bio hazardous	.17%	.15%	.03
m.	Dietary	.20%	.2%	.02
n.	DME	.37%	.3%	.14
o.	Food <i>(includes labor)</i>	2.49%	2.3%	.62
p.	Imaging	.07%	.01%	.01
q.	Lab	.05%	.05%	.01
r.	Linen	1.00%	.7%	.18
s.	Medical Supplies	2.07%	1.75%	1.16
t.	Mileage	.14%	.1%	.02
u.	Mobile Phone	.08%	.1%	.02
	Other	.19%		.01
v.	Outpatient	.12%	.1%	.01
w.	Oxygen	.63%	.65%	.18
x.	Pharmacy	4.17%	3.5%	1.83
y.	Therapies	.37%	.4%	.03
z.	Subtotal	14.19%*	11.50%*	8.19%*

* - 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.

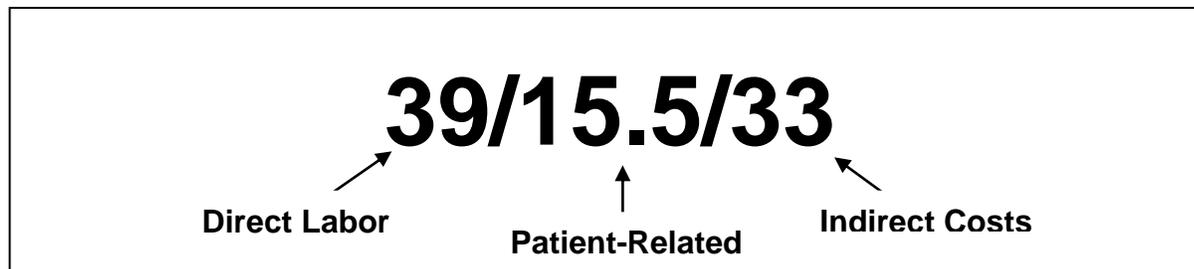
Note: VC and BC are NOT dedicated to the IPU but rather serve the IPU as though they are serving a Nursing Home or an ALF. These amounts differ from the MVI Benchmarking system due to classification and operational differences in VCs and BCs.



Benefits are usually 22% of Salaries and Wages.

Examples of NPR Model Designs

There are many examples of Hospice overall Models. For convenience, when discussing Models, we often use three consecutive numbers which represent the various major categories of cost. For example, 39/15.5/33 would mean:



The MVI Model – 38/17/31

This produces a profit of 14%. This profit level is achievable for a typical Hospice in America based on “very” doable practices.

Typical Hospice Model – 41/18/36

A typical Hospice will have a Model of 41/18/35. This is often an “organic” model of business that has evolved over time. This produces a profit of 5%.

A Tight Model – 35/14/28

Many people think that the MVI Model is Andrew’s Model. However, it is not. *The MVI Model is a model that is “achievable” for a typical Hospice.* Andrew’s Model would be 35/14/28 which would render a 23% profit. Key deviations would be:

- Increasing RN/Nursing/SW/PC Caseloads
- Doubling Hospice Aid Services
- Doubling Volunteer Services
- Adding Homemakers as a service component
- Patient-Related costs would be reduced to the 80% percentile simply by using select vendors
- Most Indirect Costs would be slightly less than the MVI Model producing a CUMULATIVE 4% savings
- 50% of the patients would come from Nursing Homes and ALFs.

Maximum Efficiency Hospice Model – 32/12/23



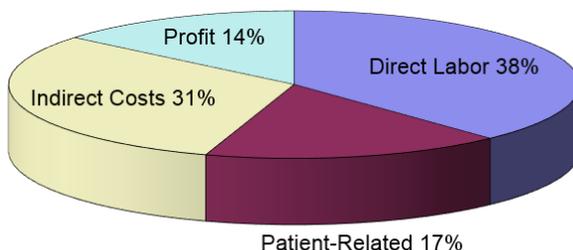
How efficient can a Hospice become? We don't know. However, a Hospice can provide a high quality service for far less cost than most Hospices can imagine.

Models

A key to being profitable and building reserves is the use of financial models. All Hospices operate within a model whether they are conscious of it or not. Most have evolved over time. Few Hospices have models that were intentionally created. Even fewer Hospices have the discipline to live within the models they create. The best driver for financial models is Net Patient Revenue. This reduces everything to a percentage that can fluctuate based on Net Patient Revenue. This makes it easy to know whether or not an area is "in" or "out" of the model. That is really the only question besides, "Is the model right?"

Here is the MVI model. We are looking for a 12.5% operational profit.

Model Based on NPR Percentages



12.5!

Hospice reimbursement provides more than enough to provide World-Class services. 14% is what MVI recommends a Hospice have as Net Operational Income. Net Operational Income does not include Community Support, Development Costs, or the costs of extracurricular programs. Our best advice is to use the MA/BA monthly and manage the exceptions. To achieve a Net Operational Income of 12.54%, a model is needed. Our recommended model or targets expressed as a percentage of Net Patient Revenue are:

- Direct Labor 39%
- Patient-Related 15.5%
- Indirect Costs 32%

That's the model! Add these percentages up and subtract the sum from 100% and you have 12.5%. If there was a time to be bold about building reserves, the time is NOW!



CAP – Aggregate and Inpatient

CMS has two forms of capitation for Hospices: The **Inpatient CAP**, which does not allow total GIP Patient-Days to exceed 20% of total Medicare days. I have personally never witnessed a Hospice exceed the Inpatient CAP. The highest I have seen a Hospice run is about 19%. The other is the **Aggregate CAP**, which is the maximum amount of cash a Hospice can receive from Medicare during a period that runs from October 1st to September 30th. The Aggregate CAP is computed by multiplying the number of Medicare admissions by an annual rate set by CMS, currently \$29,205.44. If a Hospice exceeds either of these CAPs, the “excess” monies must be returned to your FI. Usually, payment plans can be set up if you don’t have the cash, but it is not pretty in any case. ALL Medicare payments to the Hospice are counted including Routine, General Inpatient, Respite, Continuous Care, Consulting Physician, Medical Director payments, etc.

Too many Hospices take pride in saying “we are far under CAP.” Well, the truth of the matter is that this is not a good thing. It means that we are providing perhaps “brink of death” care and that we haven’t gotten the message out that the best Hospice care is when we have patients for longer periods of time. **Hospices need to be managing “to CAP” and not away from it.** Whoever thought of the idea of an “Aggregate CAP” should be commended. While there are certain entities that want to complain about the CAP (usually folks who have gone over) and call it “unfair,” it is, in the MVI mind, a good thing. However, it should be managed! Here are some questions to ask yourself:

- Is our Hospice uneasy about keeping long living patients?
- Do we understand that to make the fiscal model work, we must have long living patients to offset short living patients?
- Could our documentation education process be improved so that the documentation would support keeping more patients on service? (Think of Clinical Educators as revenue makers!)
- Are we training the medical community to refer late by the types of patients we admit or don’t admit?

When does CAP hit? Is it a version of Hospice Hell?

Hospices exceed the aggregate CAP when times are GOOD. The financial statements couldn’t be better. Census is at an all-time high. Everybody is FEELING great! Then the LETTER arrives stating that your Hospice has exceeded the aggregate CAP and that you need to return \$XXXXX to the FI. Not only do you owe for the last CAP year, you are already into the NEXT CAP year...and unless you take some immediate action, you will owe even more! Then, if the FI is in the mood and feels that their CAP calculation methodology was incorrect in



prior years, they might even dig back into past years to see if you exceeded the aggregate CAP according to the new calculations. I would say that this definitely lends itself to a flavor of Hospice Hell.

Perhaps we should look at what leads to CAP issues, not as an admissions problem, but a discharge problem. Hospices need to admit patients that meet criteria, but determining “when their time will come” is far from an exact science. Therefore, it is better to err on the side of admitting the “grays,” gaining a firsthand experience and history with the patient, and then discharging if necessary according to the facts that you know. If the discharge process or utilization review is flawed, then you could face a CAP problem.

Dealing with the Medicare Aggregate CAP

If you’ve hit the Aggregate CAP, here are some suggestions:

- **Pump up Admissions.** The closer you get to September 30th the MORE valuable each admission becomes. Get an admission on September 30th and you redeem \$29,205.44 in CAP money if you are over. Hire more marketers. If they get two admissions, they’ve almost paid for themselves. Goal: MAXIMIZE admissions!
- **Chances are you have a disproportionate percentage of patients who are not declining and may need to be discharged.** The closer you get to November 1st the LESS valuable it is to discharge patients. Earlier discharges are better. You must always do the right thing. Palliative Care is a good backdoor.
- **Open an IP Unit!** It would have to be a quick deal, but theoretically it would work. IP units draw short-living patients. Optionally, run more IP in qualified facilities. This would be your best bet in an excess CAP situation.

It is important that we recognize that CAP is calculated on “**cash**” payments from the Medicare System. It is NOT based on the accrual basis or on your Accounts Receivable.

What is the Cause and Fix for CAP problems?

1. Cause: Long-Living Patients
 - a. The Residual – Sneak up Effect
 - b. Happens when financial times are best
 - c. If you have spent the CASH you may be out of business...then you have real problems
 - d. Ineffective UR process
 - e. Compute the Median LOS of Living Patients
 - f. Divide Annual CAP amount by Routine Rate to get an approximation
2. Fix:
 - a. Start to Manage the Patient Mix



- b. Discharge patients if inappropriate
- c. #1 Strategy – Staff up in Admissions and Marketing
 - i. It only takes 2 admissions to pay a salary
- d. Run more inpatient on a contract basis

“As far as CAP is concerned, all Medicare admissions are good. It doesn’t matter if we are only able to serve the patient for 1 day, 1 hour or 1 minute! Each admission frees up about \$20,000 of CAP headroom, plus it should be part of our mission.” AR

Here is an illustration of the Medicare 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

The Aggregate CAP is Good, but there is a Flaw

I think that the Hospice CAPs are good. They help to protect the industry from abuse. To remove the CAP would be a mistake. If there is a flaw in the Aggregate CAP, it is that the CAP amount is not indexed by service area. A Hospice in California being paid a routine rate of \$175 a day will use up its CAP more quickly than someone in Corn County, Iowa, who is getting \$112 per day.

Monitoring Medicare CAPs

I rarely see a Hospice with an Inpatient CAP problem. But I have seen many Hospices have problems with the Aggregate CAP. The Aggregate CAP can creep up on an unsuspecting Hospice and turn “what appeared to be a great year” into a “nightmare year.” A healthy Hospice has a “residual” of long-living patients. They are needed to offset short-living patients. However, this residual “build-up” of patients is what catches Hospices off guard. And then one day, you exceed the CAP. The key is to deal with it early or even better, remedy the situation BEFORE you have an Aggregate CAP problem. Here is how to monitor the CAP:



8 Benchmarking

Benchmarking is the ONLY means by which a Hospice Manager can move from the ranks of the amateur to the ranks of the professional. A true professional Manager or manager gets clinical operations as well as the financial domain... and can balance both. Without benchmarking, a Manager is operating in a void regarding the trends and current reality of our Hospice movement. Benchmarking is the ONLY way to become an outlier as one needs to be conscious of what the 90th percentile is in order to know what is possible.

Benchmarking is really just an external reference. We need external references. Though some say “we only compete with ourselves” and this may be true to a certain extent. However, the fact is that organizations that do not pay attention to the outside world ultimately get smashed. Inevitably complacency and laxness creep into organizations that become insulated and isolated.

The MVI Benchmarking System provides for easy installation, uploading and comparison of a Hospice’s performance with the 50th, 10th and 90th percentiles denoted. A Hospice’s percentile ranking is displayed for every data point. If the CFO doesn’t “get benchmarking” - this MOST important measurement system - I would seriously question his or her judgment. The person probably suffers from insecurities and is not fit for the position. Remove them from your Hospice as soon as practical.



Your Financials are your Most Important Measurement

The brute reality for any business organization is the worn-out expression, “No Money, No Mission.” I avoid using the phrase, but it is true. One does not completely understand this until the day one watches a Hospice close its doors and become assimilated by the Borg Hospice. The dreams of compassionate care at one of the greatest transitional periods in life are lost as the Hospice becomes another cog in the wheel with little-to-no voice in its future. This is why, when setting up a new Hospice platform, the first **system** we implement is the financial system. Note however that the financial system is not the most important system! Your People Development System should be #1!

There are two numbers/measurements I want to emphasize:

14% and 6-9 Months

Quick Refresher

[14% - the amount of Net Hospice Homecare Operational Income]

[6-9 Months – the amount of cash or near-cash your Hospice will need to withstand the intentional financial constipation of regulatory scrutiny...the remedy for thinning out the number of Hospices in our country.]

Benchmarking gives you powerful perspective...so that you can always judge your Hospice's performance in relation to the rest of the Hospice world. It also elevates amateur Hospice Managers to the ranks of professionals in the business dimension quickly, as they can easily point out areas of excellence as well as areas that need work.

NOTE: We highly recommend providing a copy of the **Executive Dashboard**, **Hospice%Rev** and the **Indirect Analysis** reports to your Management team on a monthly basis using an unfiltered selection criteria. **Measure yourself against ALL Hospices in the database first.** THEN use the filters such as ADC, region of the country, tax status, patient-management system and other filter criteria for secondary information and to answer specific questions. You want your Managers to be able to speak from a confident “national” perspective and understand your proprietary Model. If significant deviations exist in specific areas from the 50th percentile, then Managers and ideally all staff should understand why and how your Hospice achieves these results. At this point, you truly know your Hospice is working within the Model approach. We have found that Hospices that provide their Managers with “filtered” data (like only NFP or Hospices of a certain size) “dumb down” their teams. You want your team to have a true national perspective so they can be professionals and not amateurs.



Benchmarking – External References

Benchmarks are absolutely necessary to move from the ranks of *amateur* leader to the ranks of the hospice *professional*. Our movement is overflowing with people masquerading as hospice professional leaders. This is evidenced by poor financial performance. **HOW** can a leader 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...



There is a Practice behind Every Data-Point

There is a practice behind each data point. Associated with each line in the Benchmarking Application (BA) is a practice... and a practice of the outliers. The difficult part of this is finding out what these outliers are doing. We know who they are, but sometimes do not know what specifically is driving a data point. We investigate. Obviously we can't post who is scoring because we have our confidentiality Standards. We also won't disclose highly guarded and proprietary practices IF they are indeed unique. However, most practices are founded in very sound ideological foundations based on cause and effect, applied for a specific result(s). They are not that "far out" or different. The MVI advantage is that we have the unique vantage point of having the data of hundreds of Hospices and are able to most often COMBINE the practices of multiple Hospices to form a best practice. The very basis of Multi-View is to "multi-view" things based on the proverb "there is safety in the counsel of many (perspectives)." Our perspectives come from our large network of clients combined with our own insights. Now you know the basis from which we approach nearly everything!



Gaining Confidence Through Knowing Your Numbers

Knowing your numbers gives you confidence. I get uneasy when I don't know the numbers. And when you know your numbers, it spills into everything you do.

The first thing we need is a desire to know the numbers. The point is this: you have an INTEREST in knowing the numbers and to be a better Manager. This is the starting place and with that desire, you will certainly achieve it!

Many people with clinician backgrounds have fear about the numbers. Somehow they feel that "number land" isn't their thing. Let's blow that myth away. People with a clinical background can do it with the best of them!

Once you know your numbers, you can begin to operate within a model. You will take pride in achieving great numbers and it will become a tradition and mindset at your Hospice. You will always know if you are "in" or "out" of the model.

Getting Comfortable with Measurements and Quantification

Measurement helps a Hospice develop behaviors that support its direction. Here I'm talking about the behaviors of people that translate into the behavior of the organization. The better a Hospice aligns the measurement of meaningful indicators with accepted behavior, the quicker it will achieve its goals. The old saying, "what gets measured gets done," is true. The more frequently we measure our performance, the better we can adjust our course towards improvement.

Many Hospice Managers feel the idea of "numbers" and measurements don't align with the goals and ideals of Hospice. Somewhere along the line the idea of measurement was not explained well to these Managers. Measurement and quantification are simply indicators of the care that we provide. The next time you hear an ill-informed clinician or Hospice worker say, "**You're just focusing on the numbers.**" reply, "**That is not true. I am intensely passionate about the care that we are providing and am interested in the numbers because they tell me how we are doing.**"

MVI has been tracking Hospice performance for more than a decade. The one fact that is inescapable is this:



Hospices that measure dramatically outperform those that don't.

For example, Hospices that are very quantified always have the highest productivity, the highest Net Income, the lowest costs, the least compliance problems, etc. Let me take it a bit further. We analyzed the Hospices that submit data to the MVI Benchmarking System the most often and found that those Hospices that submit data most frequently ARE THE BEST in terms of financial performance... no question. Why? They are interested in the numbers and measurement. Measurement means something to them.

Here are some things to keep in mind regarding measurement and quantification. The main idea is this:

**All
measurements
are flawed, so
MEASURE
ANYWAY!!!**



- **All measurement is flawed.** All accounting contains mistakes and misclassifications. All measures of time are different. The value of money changes by the second. Consider how you calculate your age! The temperature changes constantly. Most counting of large quantities is not 100% accurate. Accept that all measurement is flawed and do not reject measures and data just because you perceive a degree of inaccuracy or flaw. Measure the best you can with what you have NOW. In most situations, a frequent measurement of flawed data will still yield meaningful and useful perspective of performance. Chances are that your frequent measurements will be “consistently” flawed which makes it comparable. By all means, seek to improve data collection and processing efforts to increase accuracy. But NEVER stop measuring important things just because the data has flaws.
- **Measure what is important.** It is not important that we measure everything. It is important that we measure the things that truly help us get to World-Class. Our computerized systems can give us so much information that we can be overwhelmed. Being overwhelmed distracts us and diminishes our FOCUS. Laser beam focus is what we need regarding the important things. We don’t need more distractions. We want to be able to put our limited energy into the things that will really have impact. So what is really important? What should we measure?
- **Measurement tells us that “we” are important.** Believe it or not, people want to be measured. Individuals WANT to know on a frequent basis how well they are doing. They even want to be able to access their measures themselves if possible. To NOT be measured gives people a sense of insignificance and can create apathy. If a Hospice wants to create a more satisfying work environment, give everyone the chance to be measured.
- **Measurement communicates to the organization what is important.** This point is too often overlooked. If something is being monitored, especially with an expectation attached, people within the organization tend to make special effort to conform or reach the measurement. Measurements provide very clear messages regarding what is important.
- **Give people their scores.** Don’t hide individual or group scores. Make them available so that everyone can see what is happening. You want EVERYBODY to be interested in what we are trying to do and how we are doing. This could be team productivity, compliance, the financial model, etc.
- **Post the scores.** This is about making the quantified performance public. There is no hidden agenda at our Hospice. Posting measurements puts everyone on the same page.
- **When clear goals are combined with consistent measurement and aligned behaviors, results will come.**
- **Give people measurements as often as possible.** Some people want to “shoot” the data saying that it is not “accurate” enough or “reliable” enough. This is a cop-out (a weenie-ism?). All measurement and quantification has its flaws. Measurement is a tool to help us positively change behavior. If data is measured



frequently it becomes valid and reliable. If things are measured frequently, trends are created that are meaningful.

- **The more we measure significant elements of our Hospice, the more we'll know about our progress.**

All quantification and measurement is flawed in some way, but as long as we are measuring important elements, we have something that can tell us how we are doing. So measure with the best you have!

All numerical elements have measures of central tendency (average/mean, median or mode). These are usually quite beneficial when creating Model Standards.

NEVER expect perfection when creating the Model and delaying its implementation. Get the best numbers you can and start using them... remind people that all measurements are flawed.



Advice on Using the MVI Benchmarking System

When I am asked to review MVI Benchmarking data for a Hospice, I look at the Executive Dashboard first to gain a quick overall organizational picture of performance. I look at the Hospice's performance against the Median and the percentile rankings for Direct Labor costs, Patient-Related costs, the 3 categories of Indirect Cost AND the Number of Visits by Discipline Per Patient Per Week, Visit-Hours by Discipline Per Patient Per Week, plus Visit Durations. Then I delve into the detail reports. One quickly understands what patients are actually receiving relative to cost. After evaluating hundreds of Hospices, I have come to understand that high cost is not an indicator of quality. There is no direct relationship between cost and quality. Quality has a cost...but it is not excessive in financial terms. The real cost to achieve quality is the cost of effort in establishing and maintaining high expectations...Management issues. High costs often just equate to sheer waste...and there is plenty of waste in Hospice.

Percentile rankings provide powerful insight. They provide a concrete and current perspective. This is not old data. It's not data from 3 or 6 months ago, but data as of last month...the closest to NOW regarding financial matters for most organizations. You can load your information for an individual month or on an YTD basis and see your rankings. Monthly information shows the impact of actions more prominently than YTD uploads. Percentile rankings provide true perspective...and perspective is what separates the professional Hospice Manager from the amateur. Also know that your rankings will change, not only based on your actions, but on what is happening in the Hospice world simultaneously. As we are changing our respective Hospice, the Hospice world is changing as well. And the Hospice world is changing rapidly. Practices that are now "good enough" will not be even at the 50th percentile in the near future. If you look at benchmarking information on a monthly basis, you will see the numbers change every month. It is surprising how much change can happen in a 6-month period.

Using the BA to drive operational initiatives is the obvious use of the system. Benchmarking can be done for the entire Hospice or by team or location depending upon how your Hospice categorizes service segments in its accounting system. It is so obvious where a Hospice or Hospice segment is deviating from the norm (the median in this case). If a Hospice will take the time to establish operational goals based on percentile rankings or strict Percentage of Net Patient Revenue or Patient-Day amounts, it will have a solid perspective of whether its Managers or methods are effective. If your Hospice does not have clear goals or ideas for goals, I advise you to use the MVI Model amounts until you establish your own. They will lead you to a 14% residual.

When reviewing percentile rankings, I look for the extremities. What is sticking out, high or low? The areas where your Hospice ranks poorly can be used to motivate performance. "What



are we doing or not doing that gives us this negative result?” If your Hospice is performing well in an area, exploit it, publicize it, and let the community know you are great and that they are behind a winner. This is a VERY effective marketing practice. I advise marketing reps to point out key measurements of efficiency and care. Then add, “It is unlikely that the other Hospices in the area even know their rankings or even value measurement like Sunny Day...ask them”. The point is we measure what is important so that we can improve.

The MVI Benchmarking system provides a true “apples to apples” comparison based on similar grouping and categorizations. Data is processed through our Data Validator system, which excludes suspect data so as to not to comprise the database. Rankings are done on a Percentage of Net Patient Revenue (NPR) and Patient-Day (PD) basis. However, the Percentage of Net Patient Revenue basis is the superior method for comparison purposes. Each Hospice’s data is in the “Your Data” column. I recommend that the Benchmarking System is installed on the computers of the CEO, CFO, Clinical Managers, Controller, VP of Marketing, and other key team members. The most effective management systems give Managers the ability to get their own scores. This places the burden of performance squarely on the Manager and simplifies the scoring system. This will give your Managers the power of perspective so they can truly be professionals rather than amateur Hospice Managers. A key to using data to facilitate positive change is the frequency of measurement. Monthly percentile rankings do the trick in the financial area.

Monthly Benchmarking

In my opinion, a Hospice should benchmark monthly amounts (a single period) as well as Year-to-Date (YTD) amounts. This allows a Hospice the ability to see month-to-month changes and percentile rankings in all benchmarked areas. If your Hospice has established goals for percentile rankings, you will be able to see the improvements or declines for the month that is uploaded. Once the monthly amounts have been uploaded and reported on, then you would upload your normal YTD amounts. This new feature will help those Hospices that are really striving to be World-Class achieve their goals. What would World-Class goals be? Here’s a starting goal. Try to get Direct Labor, Patient-Related, Indirect Costs and the Number of Visits Per Patient Per Week above the 80th percentile simultaneously. This would be quite a feat!

NOTE: High percentile rankings are usually better. We have designed the system so that each area is ranked similarly to avoid confusion.



MVI: Define Your Search
⌵
⌵
✖

4 Digit MVI ID Number

9 Digit MVI Pass Word



BENCHMARKING

Benchmarking Application (BA)



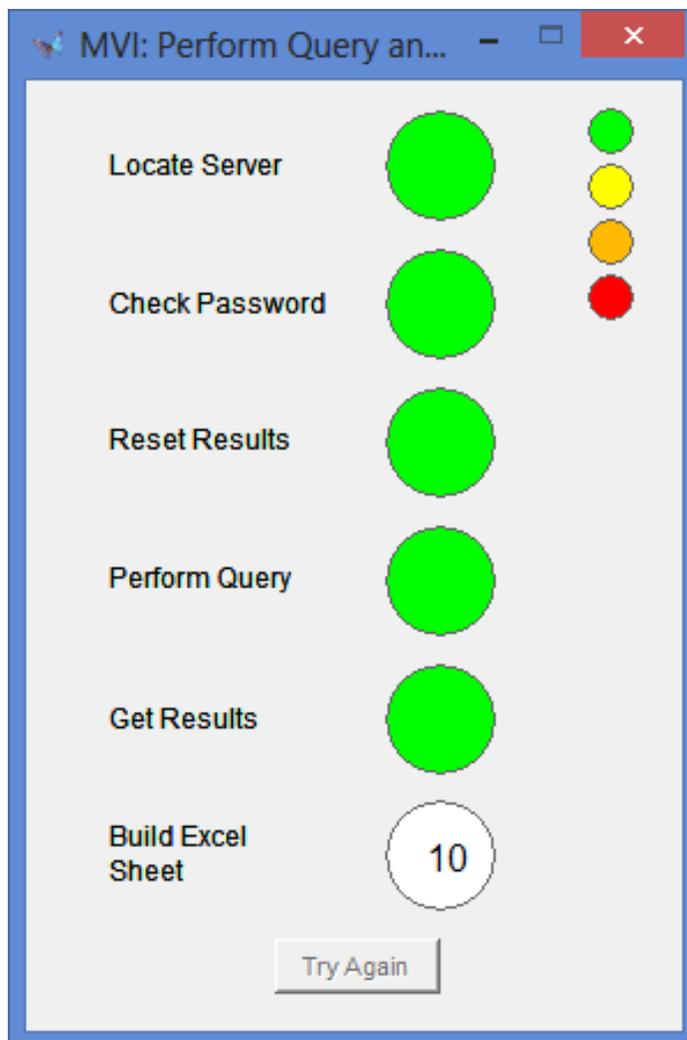

It is recommended to limit your query parameters to one or two selections in order to Benchmark against the largest number of Hospices. If you leave a query field blank, it will retrieve all records for that field. The query will not retrieve any results if there are not at least three Hospices that match your query selections.

GENERAL OPTIONS	VENDOR COMPARISON	MODEL PRACTICES	HISTORICAL REPORTS
Region <input type="text" value=""/>		Tax Status <input type="text" value=""/>	
Avg. Daily Census Range <input type="text" value=""/>		Certificate of Need <input type="text" value=""/>	
State <input type="text" value=""/>		Accreditation <input type="text" value=""/>	
Service Area <input type="text" value=""/>		Special Group ID <input type="text" value=""/>	
Fiscal Intermediary <input type="text" value=""/>			
IP Unit(s) - GIP Percent <input type="text" value=""/>			
Palliative Care <input type="text" value=""/>			
Ownership <input type="text" value=""/>			

Ver: MVI 13.0.0_1.0.0

With the Define Your Search screen, users can select the data they want retrieved from the MVI Benchmarking Application (BA). The BA retrieves the “entire” dataset based on the input criteria. Users can employ single, multiple or no filters. Of course, each filter or selection criteria returns a smaller group. At least 3 Hospices must fit your criteria in order for data to be retrieved. This protects the identity of any single Hospice. When you use benchmarking with your Management team, ALWAYS compare your performance with ALL Hospices in the database. Provide your team with a national view. THEN use the filters to answer questions and gain more insight.





With a normal internet connection, your dataset, based on your selection criteria, will be retrieved in about 20 seconds. Many Hospices keep the BA loaded during meetings so they can field questions that arise quickly and with precise information.



Executive Dashboard

The Executive Dashboard is a summary report that enables a decision-maker to get a quick picture of the current status of the Hospice. This report was designed for CEOs and other top Hospice management. It shows performance measures in numerical representations. Below is a partial view of the report.

Executive Dashboard
Sunny Day Hospice

2013 - YTD November

Locations: 643 Count: 338



Version: 13.0	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %
Average Daily Census	666.9	117.7		93%	55.8	12.1		92%		6.3		
Average Length of Stay		75.8				8.5				59.4		
Median Length of Stay		20.5				6.0				41.3		
Net Patient Revenue/Patient-Day	143.41	138.91		59%	555.99	566.30		48%	0.00	90.00		
Direct Labor/Patient-Day	59.06	57.44	50.05	45%	354.57	380.14	326.62	61%	0.00	118.03	0.00	
Patient-Related/Patient-Day	19.50	25.34	23.71	86%	70.37	73.25	65.32	52%	0.00	3.21	0.00	
Direct Labor % of Net Revenue	41.2%	41.2%	38.0%	50%	63.8%	67.9%	60.0%	64%	0.0%	144.6%	0.0%	
Patient-Related % of Net Revenue	13.6%	18.2%	17.0%	85%	12.7%	13.3%	12.0%	55%	0.0%	4.9%	0.0%	
Indirect % of Net Revenue (Segment)	43.1%	34.8%	30.0%	18%	27.5%	32.2%	24.0%	65%	0.0%	48.0%	0.0%	
Net Operational Income %	2.1%	5.5%	15.0%	37%	-4.0%	-17.9%	4.0%	71%		-107.6%		
Segment Net Income \$ (Thousands)	674	198		38%	(410)	(276)		71%		(108)		
IP Unit(s) Building Cost Statistics												
Indirect % of Net Revenue	39.3%	35.0%	30.0%	30%	IP Unit(s) Building Cost		14,850,000	3,670,000	-	6%		
Indirect Labor	20.6%	22.2%	19.0%	63%	IP Unit(s) Cost Square Foot		245	206	-	35%		
Operations	12.3%	8.3%	7.0%	14%	IP Unit(s) Cost per Bed		185,625	217,464	-	63%		
Facility-Related	6.4%	4.0%	4.0%	19%								

Executive Dashboard Reporting - For quick graphical and numeric monitoring of critical performance measures including ADC, Costs, Clinical Productivity, Average Visits Per Week by Discipline, Average Visit-Hours Per Week by Discipline, Facility Mix, Benefits %, Debt to Equity Ratio, Development Return Ratio, etc.



Productivity and Clinical Measures on the Executive Dashboard

[Executive Dashboard](#)
Sunny Day Hospice

2013 - YTD November

Locations: 643 Count: 338



Version: 13.0



	Hospice				IP Unit				Palliative Care			
	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %
Est Weekly Visits per Patient												
RN	1.9	1.5	1.8	81%	16.8	22.1		34%		0.2		
LPN		0.3	0.6			4.5				0.0		
Hospice Aide	1.8	1.9	2.0	42%	9.8	19.5		12%		0.3		
SW	0.6	0.5	0.5	68%	1.7	2.0		40%		0.1		
Spiritual Care	0.2	0.3	0.3	19%	0.7	1.5		25%		0.0		
Physician	0.1	0.1	0.3	68%	4.3	4.2		52%		0.2		
On-Call		0.2	0.2			0.1				0.0		
Admissions	0.1	0.1	0.1	6%		0.6				0.0		
Bereavement		0.1	0.1			0.4				0.0		
Volunteer	0.4	0.2	0.2	82%	1.6	1.6		47%		0.0		

	Hospice				IP Unit				Palliative Care			
	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %
Est Weekly Visit-Hours per Patient												
RN	2:30	1:46	2:00	90%	8:10	11:27		75%		0:15		
LPN		0:20	0:36			2:54				0:01		
Hospice Aide	2:25	2:12	2:00	62%	22:57	11:38		68%		0:26		
SW	0:35	0:30	0:30	63%	1:39	1:31		52%		0:04		
Spiritual Care	0:08	0:14	0:18	18%	0:28	0:51		27%		0:01		
Physician	0:07	0:04	0:12	74%	4:18	2:00		90%		0:07		
On-Call		0:14	0:15			0:09				0:01		
Admissions	0:05	0:16	0:15	4%		0:52				0:04		
Bereavement		0:05	0:24			0:16				0:00		
Volunteer	0:10	0:18	0:24	20%	0:44	1:42		27%		0:02		

	Hospice				IP Unit				Palliative Care			
	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %
Average Visit Duration												
RN	1:18	1:11	1:00	66%	1:54	0:36		80%		0:58		
LPN		1:11	1:00			0:34				0:51		
Hospice Aide	1:22	1:08	1:00	80%	2:20	0:30		87%		1:03		
SW	1:03	0:59	1:05	58%	0:57	0:46		67%		1:00		
Spiritual Care	0:46	0:54	1:00	34%	0:37	0:37		52%		0:55		
Physician	1:00	0:51	0:40	66%	1:00	0:35		88%		0:57		



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Productivity and Quality Measures in the Executive Dashboard

Version: 13.0 

	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %	Your Data	Median	MVI Model	Your Rank %
Computed Caseload	Hospice				IP Unit				Palliative Care			
RN	10.8	8.7	12.0	74%	4.3	6.0			1.4			
LPN		26.8	12.0		6.0	6.0			0.0			
Hospice Aide	12.5	10.3	10.0	68%	5.1	6.0			2.7			
SW	27.1	26.3	30.0	52%	12.0	15.0			2.5			
Spiritual Care	70.6	48.8	60.0	89%	18.2	75.0			4.4			
Physician		129.4	100.0		11.9				2.7			
On-Call		34.9	50.0		13.3							
Admissions	30.4	42.9	50.0	28%	15.4	40.0			9.2			
Bereavement		86.9	100.0		31.5							
Volunteer	45.5	88.8	100.0	6%	13.5							

Hospice Quality Reporting Requirements	Hospices w/Program	Your Data	Median	Count	Your Rank %
NQF #203: The percentage of patients reporting pain brought to a comfortable level within 48 hours of initial assessment.			61%	20	
Does your hospice have a QAPI program that addresses at least 3 indicators related to patient care?	100%			35	

FEHC	Your Data	Median	Count	Your Rank %
G1: Care patient received while under care of hospice (% of Excellent)		75%	54	
G2: Hospice team response to evening/weekend needs (% of Excellent)		70%	54	
D8: Confident knew what to expect when patient was dying (% Very Confident)		59%	55	
D3: Confident doing what was needed to take care of patient (% Very Confident)		71%	55	
C1: Patient's personal needs take care of (% of Always)		75%	55	

AIM Quality Measures	Your Data	Median	Count	Your Rank %
M1: Percent of patients who are assessed for physical symptoms and screened for psychological symptoms during the admission visit.		100%	15	
M2: Percent of patients with comprehensive assessment completed within 5 days of admission.		100%	20	
M3: For patients who assessed positive for pain, the percent whose pain was at a rating of none or mild at the second pain assessment.		91%	15	
M4: For patients who assessed positive for dyspnea at rest, the percent of patients who improved within 1 day of assessment.		90%	10	
M5: For the patients who assessed positive for nausea, the percent who received treatment within 1 day of assessment.		100%	9	
M6: Percent of patients on regularly scheduled opioids that have a bowel regimen initiated within 1 day of opioid initiation.		89%	12	
M7: For patients who screened positive for anxiety, the percent who receive treatment within two weeks of screening.		100%	7	



Hospice Home Care - Percentage of Net Patient Revenue (NPR) Comparison Report

This report shows Hospice Home Care performance as a percentage of Net Patient Revenue. This comparison is more powerful than the patient-day measurement since all amounts are in direct proportion to the related revenue.

Hospice Home Care – Percentage of Net Revenue Comparison Sunny Day Hospice 2013 - YTD November



	Locations						
	645						
Count	338						
YTD							
Year Data	Variance to Median	Median	10th Percentile	90th Percentile	MVI Model	Year Rank	Count
Direct Labor						50%	
Nurses	14.78%	-2.67%	17.45%	25.14%	14.00%	73%	310
Hospice Aide	4.66%	-1.32%	5.98%	10.12%	7.00%	79%	317
S/W	4.31%	-0.17%	4.48%	6.98%	4.00%	53%	308
Spiritual Care	1.66%	-0.40%	2.06%	3.30%	2.00%	70%	303
Physician	5.53%	3.74%	1.80%	4.20%	2.00%	3%	211
On-Call	1.69%	-2.07%	3.76%	7.33%	3.00%	78%	237
Admissions	4.63%	1.22%	3.41%	6.13%	3.00%	24%	209
Bereavement	0.67%	-0.70%	1.37%	2.92%	1.00%	78%	268
Volunteer	1.66%	0.52%	1.14%	2.00%	2.00%	17%	275
Triage	1.59%	0.14%	1.45%	3.61%	0.00%	46%	50
<i>Total</i>	41.18%	0.03%	41.15%	51.28%	38.00%	50%	315
Direct Patient Related Expenses							
Ambulance	0.55%	0.20%	0.35%	0.87%	0.35%	29%	294
Bio Hazardous	0.08%	0.06%	0.02%	0.08%	0.02%	10%	112
Crisis Care	2.07%	1.83%	0.25%	1.81%	-0.63%	4%	91
Dietary	0.10%	0.04%	0.06%	0.37%	0.01%	38%	109
DME	1.97%	-2.44%	4.41%	5.96%	2.89%	97%	312
ER	0.00%	-0.08%	0.08%	0.24%	0.01%	0.08%	130
Food	0.00%	-0.06%	0.06%	0.24%	0.00%	0.06%	38
Imaging	0.24%	0.17%	0.07%	0.31%	0.01%	14%	186
Lab	0.00%	-0.11%	0.11%	0.46%	0.02%	0.15%	284
Linen	0.00%	0.00%	0.00%	0.07%	0.00%	0.00%	6
Medical Supplies	0.78%	-0.72%	1.50%	2.38%	0.74%	89%	308
Mileage	2.28%	-0.44%	2.72%	4.88%	1.55%	67%	311
Mobile Phone	0.30%	-0.15%	0.45%	0.97%	0.11%	74%	263
Other	0.04%	-0.05%	0.09%	0.67%	0.00%	66%	180
Outpatient	0.06%	-0.06%	0.12%	0.80%	0.02%	69%	200
Oxygen	0.00%	0.00%	0.00%	0.00%	0.00%	0.00%	0
Pagers	0.00%	-0.06%	0.06%	0.25%	0.00%	0.00%	111
Pharmacy	3.71%	-2.35%	6.06%	9.11%	3.71%	90%	316
Therapies	1.09%	0.53%	0.50%	2.04%	0.03%	24%	273
Pass-Through Residual	0.32%	-0.02%	0.34%	2.70%	-2.17%	52%	286
<i>Total</i>	13.60%	-4.55%	18.15%	24.03%	17.00%	85%	314
Total Direct Expense	54.78%	-4.76%	59.54%	70.74%	47.19%	74%	313
Contribution Margin	45.22%	5.30%	39.93%	29.21%	50.39%	77%	307



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Inpatient Unit – Percentage of Net Patient Revenue Comparison

IP Unit – Percentage of Net Revenue Comparison		MVI Multi-View Incorporated BENCHMARKING						Locations	
Sunny Day Hospice 2013 – YTD November								644	
	Your Data	Variance of Median	Median	10th Percentile	90th Percentile	MVI Model	Your Rank	Count	
		10.00%					50%	338	
Direct Labor									
Nurses	40.08%	-1.18%	41.26%	70.81%	32.20%	33.00%	57%	142	
Hospice Aide	15.32%	1.14%	14.18%	21.83%	8.21%	15.00%	40%	134	
SW	2.13%	-0.54%	2.67%	4.77%	1.61%	2.50%	71%	123	
Spiritual Care	1.05%	-0.29%	1.34%	2.48%	0.59%	1.00%	64%	101	
Physician	0.02%	-6.54%	6.56%	12.42%	0.84%	4.00%	100%	107	
On-Call	0.00%	-0.27%	0.27%	2.37%	0.01%	0.00%		25	
Admissions	0.00%	-2.34%	2.34%	7.27%	0.62%	2.00%		69	
Bereavement	2.36%	1.41%	0.95%	2.55%	0.30%	1.00%	16%	74	
Volunteer	0.00%	-1.07%	1.07%	2.41%	0.30%	1.50%		79	
Triage	0.00%	-1.07%	1.07%	3.83%	0.52%	0.00%		10	
<i>Total</i>	60.96%	-7.30%	68.27%	98.37%	55.28%	60.00%	77%	141	
Direct Patient Related Expenses									
Ambulance	1.76%	0.76%	1.00%	3.01%	0.22%	1.00%	31%	126	
Bio Hazardous	0.00%	-0.14%	0.14%	0.40%	0.03%	0.10%		70	
Crisis Care	0.00%	-0.09%	0.09%	0.66%	-0.02%	0.15%		11	
Dietary	0.01%	-0.17%	0.18%	3.29%	0.02%	0.08%	97%	47	
DME	0.09%	-0.31%	0.40%	1.82%	0.06%	0.40%	85%	121	
ER	0.00%	-0.03%	0.03%	0.29%	0.00%	0.00%		19	
Food	6.52%	4.37%	2.15%	6.79%	0.58%	1.75%	12%	120	
Imaging	0.13%	0.05%	0.08%	0.32%	0.01%	0.10%	29%	56	
Lab	0.11%	0.04%	0.07%	0.35%	0.01%	0.10%	32%	99	
Linen	2.01%	1.01%	1.01%	1.94%	0.10%	1.00%	9%	113	
Medical Supplies	2.77%	0.77%	2.00%	3.32%	1.14%	2.00%	22%	135	
Mileage	0.13%	-0.02%	0.15%	0.38%	0.02%	0.12%	52%	116	
Mobile Phone	0.21%	0.14%	0.07%	0.30%	0.02%	0.07%	20%	66	
Other	0.00%	-0.17%	0.17%	0.73%	0.02%	0.00%		87	
Outpatient	0.01%	-0.06%	0.07%	0.27%	0.02%	0.15%	95%	49	
Oxygen	0.62%	0.10%	0.53%	1.55%	0.14%	0.48%	42%	85	
Pagers	0.00%	-0.01%	0.01%	0.05%	0.00%	0.00%		9	
Pharmacy	4.87%	0.87%	4.00%	8.28%	2.22%	4.00%	39%	136	
Therapies	3.03%	2.48%	0.56%	3.02%	0.05%	0.50%	11%	95	
Pass-Through Resid	0.35%	0.35%	0.00%	2.41%	-3.26%	0.00%	26%	46	
<i>Total</i>	22.62%	9.33%	13.29%	23.41%	8.03%	12.00%	13%	139	
Total Direct Expense	83.59%	0.73%	82.86%	115.12%	67.37%	72.00%	49%	137	
Contribution Margin	16.41%	0.03%	16.38%	-19.04%	30.57%	28.00%	50%	139	
Indirect Expense	41.03%	8.57%	32.47%	58.62%	18.65%	24.00%	36%	133	
Net Segment Income	-24.62%	-6.57%	-18.05%	-72.45%	9.27%	4.00%	37%	140	



Analysis of Indirect Costs (Part 1)

Analysis of Indirect Costs

Sunny Day Hospice

2013 - YTD November



Locations
643
Count
338

Your Data	Variance of Median	Median	10th Percentile	90th Percentile	MVI Model	Your Rank	Count	
Alerts	10.00%					50%		
Indirect Labor								
Administration	2.12%	-3.55%	5.67%	13.49%	2.81%	3.50%	97%	288
Clinical Management	6.87%	1.36%	5.51%	8.91%	2.55%	5.50%	30%	265
Compliance/QAPI	1.05%	-0.19%	1.24%	2.95%	0.43%	1.00%	61%	195
Education	0.90%	0.01%	0.89%	1.98%	0.16%	1.00%	50%	17
Finance	1.59%	-1.14%	2.73%	4.82%	1.31%	2.25%	85%	224
HR	1.46%	0.33%	1.14%	1.98%	0.56%	0.75%	34%	191
Marketing	3.46%	0.98%	2.48%	5.04%	0.77%	2.00%	27%	235
Medical Director	0.00%	-1.59%	1.59%	3.62%	0.51%	1.00%		211
Medical Records	1.13%	0.01%	1.12%	2.24%	0.44%	1.00%	50%	184
MIS	2.03%	0.72%	1.31%	2.27%	0.57%	1.00%	16%	174
Other	0.01%	-0.66%	0.67%	3.67%	0.03%	0.00%	97%	134
<i>Total</i>	20.62%	-1.55%	22.17%	30.83%	15.43%	19.00%	63%	284
Operational Costs								
Answering Service	0.00%	-0.10%	0.10%	0.28%	0.03%	0.10%		187
Accounting/Audit	0.19%	-0.16%	0.35%	1.11%	0.12%	0.35%	75%	252
Bank Service	0.01%	-0.04%	0.05%	0.22%	0.01%	0.05%	87%	235
Computer Expenses	1.41%	0.49%	0.92%	2.00%	0.19%	0.70%	23%	270
Consulting/Professional Fees	3.39%	3.05%	0.34%	1.43%	0.08%	0.30%	3%	222
Continuing Education	0.28%	0.00%	0.28%	0.86%	0.06%	1.00%	50%	282
Copier Expense	0.00%	-0.20%	0.20%	0.42%	0.05%	0.20%		180
Depreciation-Major Moveable	0.99%	0.08%	0.91%	2.03%	0.21%	0.75%	47%	178
Dues, Licenses & Subscription	0.44%	0.10%	0.34%	0.72%	0.17%	0.30%	34%	284
Insurance	0.78%	0.15%	0.63%	1.17%	0.31%	0.65%	33%	272
Interest-Operating	0.00%	-0.12%	0.12%	0.79%	0.01%	0.00%		124
Lease/Rent Equipment	0.00%	-0.12%	0.12%	0.51%	0.01%	0.10%		171
Legal	0.48%	0.33%	0.15%	0.65%	0.02%	0.10%	15%	204



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Analysis of Indirect Costs (Part 2)

Analysis of Indirect Costs

Sunny Day Hospice

2013 - YTD November



Locations
643

	Your Data	Variance of Median	Median	10th Percentile	90th Percentile	MVI Model	Your Rank	Count
Alerts		10.00%					50%	338
Office Supplies	0.28%	-0.07%	0.35%	0.77%	0.16%	0.35%	67%	290
Other Expenses	0.22%	0.08%	0.14%	0.68%	0.02%	0.00%	37%	172
Pagers (Non-Patient)	0.03%	0.00%	0.03%	0.14%	0.00%	0.00%	54%	51
Postage/Mailings	0.13%	-0.01%	0.14%	0.31%	0.06%	0.18%	55%	279
Printing	0.35%	0.14%	0.21%	0.50%	0.05%	0.20%	22%	248
Service Contracts-Operating	0.00%	-0.11%	0.11%	0.65%	0.01%	0.10%		149
Telephone	0.83%	0.26%	0.57%	1.12%	0.24%	0.50%	24%	286
Training-Groups	0.00%	-0.03%	0.03%	0.17%	0.00%	0.00%		127
Vehicle Exp-Owned/Lease	0.21%	0.16%	0.05%	0.56%	0.01%	0.04%	23%	106
<i>Total</i>	12.32%	4.05%	8.27%	13.15%	5.52%	7.00%	14%	278
Facility-Related Costs								
Alarm System	0.01%	-0.02%	0.03%	0.10%	0.01%	0.03%	81%	129
Cleaning & Paper	0.25%	0.10%	0.15%	0.49%	0.03%	0.15%	31%	231
Depreciation-Building	1.72%	0.49%	1.23%	3.42%	0.30%	1.00%	38%	216
Exterminating	0.00%	-0.02%	0.02%	0.04%	0.01%	0.02%		107
Interest-Facility	0.39%	-0.08%	0.47%	1.33%	0.08%	0.00%	56%	60
Landscaping	0.00%	-0.10%	0.10%	0.35%	0.01%	0.06%		167
Maintenance	0.98%	0.75%	0.23%	0.69%	0.03%	0.20%	6%	270
Maintenance Salaries	0.77%	0.14%	0.63%	1.49%	0.27%	0.50%	36%	227
Other-Facility	0.00%	-0.06%	0.06%	0.40%	0.01%	0.06%		68
Property Taxes	0.02%	-0.02%	0.04%	0.18%	0.01%	0.03%	63%	105
Rent	0.73%	-0.56%	1.29%	3.54%	0.10%	1.30%	65%	248
Service Contracts-Facilities	0.00%	-0.13%	0.13%	0.64%	0.02%	0.15%		189
Utilities	1.48%	0.96%	0.52%	1.20%	0.18%	0.50%	6%	268
<i>Total</i>	6.35%	2.38%	3.98%	7.79%	1.70%	4.00%	19%	281
Total Indirect Costs	39.29%	4.27%	35.03%	46.58%	27.85%	30.00%	30%	283



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9 The Practices of IPU Outliers

MVI has put out a great deal of IPU advice in the past. However, the fact is that **the majority of Hospices do not follow this advice**. In this section, we elaborate on the points as well as include newer practices.

As we review these practices, I want you to write – YES or NO in the appropriate area, indicating if your Hospice does or doesn't incorporate the practice. If a practice is not religiously employed (everyday - a norm) or is only occasionally used, then indicate NO.

	Practice	Yes	No	Thoughts/Comments
1	Unit Marketed as a Specialty Unit. Not as a "Hospice House" or "Residence"			
2	Built in Pods or Wings of 7 beds.			
3	At least a 6:1 Nurse and Aide ratio is maintained.			
4	The Magic Number is known. The precise financial impact of 1 patient, plus or minus, is understood.			
5	Residential Mix is managed to less than 10%.			
6	The Discharge process is started aggressively on the day of admission.			
7	12-Hour shifts are the predominant shift lengths.			
8	The MVI IPU-CC Planning & Management Tool is used.			
9	The IPU does NOT have a dedicated Spiritual Care person.			
10	The IPU does NOT have a dedicated Volunteer Coordinator.			
11	Physician rounding averages 15-30 minutes per patient.			
12	A SW or designated person effectively communicates that the IPU is only for 4-8 days maximum and that the unit was not designed for long-stays.			
13	A protocol is established to fill the unit when occupancy is close to the Magic Number.			



14	Discharge Planners and other referral sources are contacted when occupancy nears the Magic Number.			
15	All Teams and Team Managers are notified when occupancy nears the Magic Number. The IPU Case Manager Referral Report is reviewed as well as Daily Pain Scores (Homecare).			
16	The IPU Manager reviews the Case Manager Referral Report. This may lead to an in-service or improvement in the People Development System.			
17	Marketing Reps understand how to juice up the Value Proposition when IPU occupancy levels near the Magic Number. They are specifically trained to do this.			
18	If there is a need for “blocks” of patients to fill an IPU, the IPU Manager personally visits referral sources. This is an on-going cultivation process and is part of the position. <i>The IPU Manager is a Marketer!</i>			
19	There is ALWAYS room at the Inn! This means you NEVER say or have said that you can't take a GIP patient.			
20	If the unit has 15 or less beds, it is run by an RN that helps admit patients.			
21	PRN and Flex Staff are trained in the Standards of the IPU at the same levels as regular IPU staff.			
22	Contract Staff are NEVER used in the IPU.			
23	Task Lists are used to systematize the maintenance and upkeep of the IPU.			
24	The IPU is managed on a Contribution Margin basis.			
25	Continuous Care is used if the unit has licensed Residential beds.			
26	Marketing Reps are incentivized to fill the unit.			
27	IF the IPU is losing money, the CEO or COO moves his or her office to the IPU.			
28	If the IPU is too large, it is staffed by people that “want to walk” as means of achieving fitness and health.			
29	The IPU is an outrageously attractive place to work, filled with purpose, spirituality and energy.			



30	There is an “On-Stage, Off-Stage” sign above the door in the break area.			
31	A method of achieving the 50 th percentile costs in the Food service area has been implemented.			
32	All IPU vendors are held to Standards and function at 100% of the Standard on a day-to-day basis.			
33	Patient-Related costs are at the 50 th percentile or are 13% of NPR or less.			
34	Weaning conversations and proactive measures are employed to keep IV and other Therapy costs low.			
35	IPU staff wear sharp and comfortable uniforms.			
36	Documentation is at 100% on a day-to-day basis and incorporates Self-Learning Modules as well as a performance pay component.			
37	The performance of the IPU 90 th percentile is reviewed at least bi-monthly in the MVI Benchmarking Application (BA).			
38	IF a unit is designed for Residential patients, they are in a special location that is separate from GIP patients and it is staffed with a Hospice Aide.			
39	The IPU is EASY to refer to, internally and externally. It has been designed this way intentionally and as a Standard.			
40	Respite Care is not utilized on a material scale.			
41	The IPU Manager has a substantial financial stake (at least 25% of his or her compensation) in the financial performance of the IPU.			
42	The IPU Manager is given “sweeping” powers to “bring patients into the IPU from Hospice Homecare.			



Inpatient Units

A Hospice with an Inpatient Unit (IPU) can provide a level of service that patients and families really appreciate. I used to not favor Inpatient Units, as my first experience with them was negative financially. However, I have changed my mind after working with over 250 of them. In many cases, they are good for a Hospice AND can be good financially as well, IF properly managed. **If not managed well, they become Hospice killers and act like financial cement boots.** Note that I am NOT speaking about Residential Units. Residential Units are financial losers, as they have nearly the SAME costs as GIP care if there is a mix of GIP and Residential patients. A pure play Residential unit CAN be operated differently, but beware that you are becoming a potential competitor to some of your most important referral sources with this move. Currently, the typical IP Unit loses -24.37% of IPU NPR. However, the top IPUs (that operate in the 90th percentile regarding profitability) operate with a 14.13% “positive residual.”

Why Have an IP Unit?

There are at least three reasons to have a Hospice IP unit:

- **Mission Fulfillment** – It should be your goal to serve everyone that could benefit from Hospice services in the market you have chosen.
- **Competitive Edge** – If your Hospice has one and the others don't, you have an edge. Patients and families love these units.
- **Increased Revenue Opportunity** – Properly managed units provide good financial results.

The Three Major Factors to IP Unit Financial Success:

1. **Design of Unit/Location of the Unit**
2. **Clinical Manager**
 - a. Bed Management
 - b. Staffing within the Model
 - c. Control of Patient-Related Costs
3. **Clinical Practices of Unit Physicians**

The #1, most important, super factor of an IPU's success is the Manager of the unit! Never overlook this! I have been fooled in my career with overfamiliarity with a Manager and have crossed this off my list too early when a unit is underperforming. This Manager needs to be a great relationship builder, salesperson, aggressive (calling the health systems on Thursday/Friday to fill the unit up before the weekends), understands “heads in beds” and understands how to flex staffing as needed.



Inpatient Unit Financial Problems

There are a lot of Hospice IP units and more being built or implemented. Why? Many have figured out how to make IP units financially viable, understand their importance with the aggregate CAP and how much communities appreciate them. However, there are a growing number of Hospice IP units that are falling on tough financial times... through their own doing for the most part, with the median loss being around -24.37% of NPR of IP Unit revenue at the time of this printing.

Most of the problem is in staffing. There is a trend in Hospice IP units to reduce staffing ratios for RNs and CNAs to 4:1 and sometimes even less. Think about this. Where else in healthcare do you find these ratios? Consider what staffing is like in ICUs and Critical Care Units. Hospice units are often staffed at similar levels. The question is, "Is this the way it needs to be?" Or perhaps the better question is, "Is this the way we *want* our Hospice IP unit staffed?" The Standard in Hospice IP units is one RN and one CNA per 6 patients, translating to 3 patients per team member, excluding SW and Chaplains. Less than 5:1 ratios for RNs and CNAs does not "pencil" very well. 5:1 works in "rare" situations. Some Hospices add additional staff when the census is at capacity, as the revenues generated can easily cover the additional positions. Spiritual Care and Bereavement are treated just as a Hospice would serve Nursing and Assisted Living facilities. A 14+ bed unit needs a full-time, devoted SW [more on this later].

The other contributing factor is bed management. You must "design" your intake processes so that you keep the IP census at an acceptable level. This means weekend admissions, tracking nurses to identify ones who are not referring patients to the unit, evaluating your criteria, looking at how you have "trained" your referrals sources, etc. Do your clinicians really understand the value and benefits of the unit?

Productivity has traditionally been lower than it should be in Hospice since the first day I started... with the visit average usually one less than it should be. IP units are following the same path. We have to be strong Managers and managers. We have to listen to our staff, but we have to make it work economically... or move over and let someone else do it.



Hospice IP Management Declines

There is a noticeable trend in Hospice IP unit financial performance... downward. We are finding that Hospice units that have historically performed well financially are struggling. Why? Yes, there are FI/MAC pressures, scrutinizing GIP, but as much of the reason is that Managers aren't Managing well! Here are the major problems:

- **Coddling Staff** – Lowering Standards, more pay for less work, lowering patient/staff ratios. It needs to be at least 5:1 for Nurses and Hospice Aides - 6:1 is better - 4:1 has never worked financially.
- **Rampant Overuse of PRN** – There is an epidemic of PRN use in units. This is another “coddling” issue. Why are we often paying more for PRN and letting them set their schedules as well? Hmm... Could our incentives be out of whack?
- **Bed Management** – If the census in the unit is down on Monday mornings, we may have an admission problem. As an organization, we may not be training staff on how to utilize the unit. Some paradigms of care may need to be changed.



Top Inpatient Unit Practices

1. **Design/Location of the IP Unit.** If you mess this up, your Hospice will NEVER be profitable. Our rule of thumb is that people will only drive, at maximum, 30 minutes to IP Units. Not 45 minutes, but 30 minutes or less. The size of the “pods” is important, which we will cover in a subsequent section. However, the distance from the nursing station to the furthest room in that pod makes all the difference between burning people out (both physically and emotionally) or having a sustainable environment. I have heard that 90 feet is a maximum, but you will want to check with an expert.
2. **The Manager of the IP Unit is the Primary Factor in making a Hospice IP Unit Successful.** The talent of the IPU Manager is the most critical factor. This is as much of a marketing position as anything else. A winning personality that conveys comfort and trustworthiness will win over referral sources. I have seen time and time again. The IPU Manager also must get “heads in beds,” management of labor and patient-related costs. Units that have hemorrhaged cash for years can change almost overnight when a good IP Unit Manager come on the scene. These people do not have to have a clinical background, though it helps, especially with the admission process. With smaller units in the 6-8 bed size range, an RN Manager is ideal as this person can help with admissions. You might explore Managers that come from the hospitality industry such as hotels chains. People from the hotel business understand occupancy and labor management. **BEST PRACTICE:** If you are the CEO of a Hospice with an underperforming IP unit, temporarily move your office into the unit. You will be surprised how the unit will “magically” fill up and be better managed!
3. **Physician Practices.** When you hire a physician for an IP Unit (normally you will need 1.5 FTEs for a 14 bed unit), be aware of their ideas regarding clinical practice. You may be paying a very high wage for the physician AND the physician may be bringing an additional \$250,000 in extra therapies and practices... and perhaps an attitude to boot! KEEP YOUR PATIENT-RELATED COSTS at 13% of IP NPR. You Docs that get this, keep on rockin’! The IPU Doc can make your or break you when trying to fill the IPU or controlling Patient-Related costs!
4. **The IPU Manager is given “Sweeping Powers” to “bring patients” into the IPU from Hospice Homecare.** This is one of the most powerful moves a Hospice can make that will have the biggest impact! When the census nears the Magic Number, the IPU Manager has the authority to review pain scores or other data from the EMR and request that Homecare patients be brought in the IPU. Only in rare situations would such a request not be fulfilled as in the case as the patient really did not wish it. These “orders” are mandatory. This practices comes from the most profitable Hospice with many IPUs MVI has witnessed.



5. **The IPU Manager is Has Skin in the Game.** The IPU Manager should earn a large proportion of their monthly compensation based on the IPU's financial performance. This is normally part of the Team Pay in the compensation system (SuperPay!) based on a percentage of savings below the Standard IPU costs. The percentages can vary and can be greater than 50% if that is needed to create enough incentive. It has to be "enough" to be motivational and help you attract Talent for this major business segment of cost. Again, compound a \$100,000 loss annually for a decade contrasted with an IPU that doesn't lose money! That Manager is worth a lot! Even if a poorly designed or too small IPU can't make money, you can bonus the IPU Manager based on not losing as much as your Modeled loss! This is similar to how we run Palliative Care programs, Managers manage to a calculated loss, and no more! The great thing is that most IPUs can be made profitable!
6. **Manage on a Contribution Margin basis.** A contribution margin is calculated by subtracting Direct Expense from Direct Revenue. It normally would not contain any allocated Indirect Costs, with the exception of benefits. In the case of a Hospice IPU, this would be Direct Labor and Patient-Related expenses. Both are subtracted from IPU Revenue and the result would be the IPU's Contribution Margin. Many times Indirect Costs are not controllable by the IPU Manager. Under a true Responsibility accounting system, a manager should ONLY have the things that they can control or influence on their management reports. Contribution for what? An IPU's Contribution Margin is for paying for Indirect/Corporate costs and providing for profit.
7. **All IPU Staff's Compensation Increases or Decreases with Census Changes.** This is a big "gulp" for some Hospices. But if you are losing a ton of money now, what do you have to lose? A portion of IPU staff's compensation can be tied to the census of an IPU. When the IPU has a high census, staff make more. When the IPU census is low, staff make less. If compensation does NOT have this component, IPU staff will complain when the IPU is full and be glad when the census is light. In fact, they will tend to self-regulate the IPU census. This is human nature. This can be a special feature or component in addition to their normal compensation. Some will say, "A nurse or a CNA doesn't have any power over an IPU census. Really? They can put extreme pressure on their IPU Manager to WIN! Skin in the game gets results! See the section of this manual on IPU compensation for more information.
8. **Propensity Reports:** Your Hospice needs to find the average "propensity" of a clinician to refer to the IP unit and then design an "exception report" to identify clinicians who are not referring patients. *ALL clinicians statistically should be referring a proportion of their patients to the unit based on need.* If you discover that a clinician is not referring patients to the IP unit, you have a Lone Ranger! These clinicians basically are doing their own clinical practice and are dangerous on many levels. Just the fact that you are monitoring this will cause IPU census to increase. I usually recommend that each Case Manager, within a 30-minute drive-time range of the unit, send a



minimum of 4-5 patients to the IP unit every quarter. I do not know the ideal number and it may depend upon the unit.

9. **Speed Up Physician Rounding.** Have a nurse accompany the physician on when rounding the unit. A rounding visit should last between 15 and 30 minutes. The nurse's presence cuts down on chit chat and the nurse can help with documentation as well as provide a second opinion or reminder of details. The nurse can also keep the physician at a good pace in order to get the job done within the time allotted. All human activities are time-controlled so this must be kept in mind. This move also gets the Physician and Clinicians on the same page. One week of this practice can cure the problem.

10. **Market it as a "Specialty Unit."** If you don't want to create ill-will with nursing homes and other KEY referral sources, you must not market the unit as anything that would possibly compete with them. Your language and wording are important. This is a specialty unit that serves patients at an acute level of care. Even if you have a patient or two who are Residential, it is still primarily an IP unit. Relationships with nursing homes and ALFs are vital to a Hospice's existence. To unintentionally damage these relationships would be foolish and can be avoided. **NEVER call your unit "the Hospice House" or "Residence."** Instead, call it a "Care Center" or "Comfort Center" or IP Unit. Be creative! Don't set yourself up to be perceived as competition for nursing homes and ALFs. **Set the right Mindset and Expectations regarding the use of the unit.** If I were building a unit, I would state, "The unit is exclusively an Inpatient Unit." I realize that this may not be the case with every Hospice due to CONs and regulations. However, failure to make this point clear will result in a financially sick mix of Residential patients. Now, if you have a strictly Residential Unit, this is not an option, but too many Hospices that fail to define the use of the unit, suffer.

11. **A Well-Managed IP Unit makes Money.** Notice that I say *Inpatient* and not *Residential*. Currently, Hospice units have the ability to make money, or at least break even, IF THEY ARE PROPERLY MANAGED and are not "structurally" defective. Hospice IP units should do well financially. Reimbursement is high enough and we have figured out how to better design and manage them. Therefore, they should make money. Mixed units of inpatient and Residential patients usually lose money due to the fact that it normally costs the same for inpatient as it does Residential... for one-third of inpatient revenue. Yes, there are some differences, but they are minimal. Staffing usually costs 60-65% of IP Unit NPR. You may think that acute patients will receive more care... not the case... I see Residential patients ringing for the nurse or aide every 5 minutes just for attention! Patient-related costs differ modestly. This is due to the fact that "patterns of care" develop where inpatient ideas regarding care get mixed with Residential ideas of care. (It's just easier to treat everyone the same, right?) Usually Patient-Related costs are about 13% of IP NPR. I think the biggest factor in



profitability is the increase in IP reimbursement relative to salary increases. It's easier to make the numbers work in today's environment.

12. **Units allow a Hospice serve a new class of patient.** These are patients we call the “dumps...” where you get a patient facing imminent death. Often you only serve these patients for a day or two, sometimes only hours, which is a shame. Certainly we have “the dumps” with home care Hospice as well, but Hospices that build units will testify about this new class of patient. These patients are referred late, often by other healthcare entities. As a Hospice, we should welcome this new class of patient as it fulfills the mission.
13. **The Over Looked Value of IP Units on the Hospice Aggregate CAP.** A Hospice with an IPU can have a larger Hospice homecare census than a Hospice without one. Why? Because an IP unit naturally attracts patients that live for very short periods of time. Even though you are receiving an increased per diem for this level of service, the stays are short. These short stays help you keep homecare patients longer. So when you review financial statements and the IP unit is losing a “bit” (NOT 18% of NPR) or is at breakeven, do not lose track of the impact of the unit on the Medicare Hospice Aggregate CAP. And of Course, ALWAYS use the “Streamlined” method instead of the “Proportional” method of Aggregate CAP calculation. NEVER select the Proportional method unless you want to lose complete control of your ability to manage the Aggregate CAP and devalue your Hospice by MILLIONS of dollars of value with a single move. Remember, a Hospice provider (number) can only have 20% of its Medicare patient-days at the GIP level of care. That is, the maximum number of GIP days that your Hospice can be reimbursed from Medicare is 20% of your total Medicare days. Thus, if you have an average census of 20 for the year with an 80% mix of Medicare patients, you will only be able to get paid for 3.2 patients or 1,168 patient-days for the year at the GIP level! Going over the CAP results in a payback to Medicare, which can be quite painful.
14. **The Magic Number.** Many clients know that I refer to the “Magic Number” regarding units. This is the one additional bed average that is expected to be filled annually ABOVE breakeven. The Magic Number has to be discovered... and discovered in the planning stages. Some Hospices have built units that were one bed short and as a result, they lose money all the time or struggle at best. Let's face it, once a unit is built you just can't snap your fingers and add a room. This is a “structural” problem. The Magic Number has to be found. The difference that one additional ongoing occupied bed is in the range of \$150,000 to \$225,000! This is tremendous. I suggest that MVI clients look hard at the [Inpatient Unit and CC Management and Planning Tool](#) and discover the Magic Number. Within a few minutes or hours, you can know your “Magic” number. This number is burned into the brain of the unit Manager.



15. **There is ALWAYS Room at the Inn! NEVER NO!** This applies to the IPU as well as for Hospice homecare. All Hospices train their communities and referral sources regarding the patients they admit or don't by virtue of the patients they have admitted or have not admitted historically. Referral sources REMEMBER NON-ADMISSIONS WELL! IPU's also train their communities if they are full or not... and how they handle both situations. NEVER SAY OR INDICATE THAT YOU CAN'T TAKE A PATIENT! If the IPU is full, MAKE A BED available. You must make room! For the same psychological reasons that apply to Hospices that say they can't take patients, for whatever reason, referral sources WILL NOT FORGET OR FORGIVE YOU if you don't take a patient. This may sound harsh, but it is the truth. Burn this message into everyone and fire any person that says it or indicates to a referral source that the IPU is full. **NEVER NO!**
16. **The "Zone" is to manage the IPU between the Magic Number and capacity. This is a type of "self-regulation."** This range of occupancy is the number between the Magic Number and being full. A Hospice IPU can never say "it is full" or "it has a waiting list" or "we can't take a patient" to an external referral source. However, it can use internal referrals to regulate the IPU census, bringing it up or down as needed without doing damage with external referral sources. This is the toughest aspect of leading an IPU.
17. **An Occupancy Protocol should be Automatically used when the IPU Census Nears the Magic Number.** It may be: 1) The IPU Manager is given the "Sweeping Powers" to bring in patients. The IPU Manager reviews pain scores in EMR and orders Hospice Homecare patients into the unit. 2) Call discharge planners (especially before weekends); 3) Get the word out to all teams that the IPU needs patients (Clinicians or the Clinical Managers can quickly review their referral percentages to see if they are in the Model); 4) Marketing Reps juicing up the IPU language in their pitch and make targeted contacts; 5) The IPU Manager visits referral sources. The education of the Hospice homecare should ALREADY have been done so that they understand the value of the IPU.
18. **Use the MVI F9 IPU-Continuous Care Planning & Management Tool to Manage Your Unit on an On-Going Basis.** *It is through this tool, that a Hospice will determine its Magic Number.* MVI has an excellent IP Unit planning and management model called the Inpatient Unit-Continuous Care Planning and Management Tool that works with F9 (the most powerful financial report writer in the world - that MVI sells and supports). Any MVI client can have this extensive tool that has been used by over 160 Hospices for not only planning an IP unit, but for on-going management! If you want the latest IP tool, just contact MVI and we'll email it to you! No problemo! It's just one of the hundreds of products a Hospice can get for being an MVI client! It's a good idea to search the MVI Website for tools/advice when you have questions or are just looking to save time and energy!



19. **Averaging ONE Patient above the breakeven or to the Magic Number translates to \$150,000 to \$225,000 profit.** The difference of a single patient above breakeven or the Magic Number occupancy level is huge. The amount varies from IPU to IPU as the operational costs vary. This is why the Magic Number is so important.
20. **The On-Going Cultivation of Referral Sources.** If there is a need for “blocks” of patients to fill an IPU, the IPU Manager personally visits referral sources. This is an on-going cultivation process and is part of the position. Hospices grow based on personal relationships. If referral sources know, love and trust you, they will refer. Personal relationships are essential. **The IPU Manager is a marketer!!!!!!**
21. **Feasibility Studies?** Most feasibility studies for IPUs are not very valuable. Why do we say this? It is because the utilization of an IPU is a manufactured thing based upon the practices of the Hospice. Utilization is self-determined! Also, once an IPU is introduced to a community, the dynamics of the community are altered. For construction projects, normally Boards of Directors want a feasibility study. If you decide to get one, I would advise that you don't spend a lot of money on it... as little as possible.
22. **Will Other Hospices Contract with your IPU for GIP care?** The answer is, 99% of the time, no... No Hospice wants to lose control of its patients. They MIGHT contract with you, but you will not see many, if any, patients. The ones you do get... BEWARE! They might be really costly!
23. **“Build it and They Will Come?”** This is NOT good advice. Often patients do NOT come in the volumes predicted.
24. **Ideal Size of Units.** This topic is closely related to the “Magic Number.” A unit that does not have “enough” beds will be a continual cash drain on the organization. The governing factors are: (1) state regulations and (2) scope of beds clinicians can serve. The design of the unit is critical. Large areas are more difficult than smaller ones... common sense stuff. I think that 7-bed increments are the ideal number for Inpatient Care. You are shooting to have 6 beds occupied at the GIP level of care continually. Having the 7th bed allows a Hospice pod to have a “transitional” bed to be able to maintain 6 continuously. A 6-bed “pod” is a bit light and a full pod of 8 beds can be a bit much. However, I would go for 8 instead of 7, just to have the headroom if the state required it. Less than 6 is difficult to “pencil” (make work financially). Build 7-8 bed pods with the Standard of keeping 6 filled AT ALL TIMES.
25. **Use Professionals.** Regarding design, experience is king. However, some “established” Hospice architects have put up outrageously expensive IPUs that suck the life out of Hospices! Enough units have now been constructed that we should be getting pretty good at it. But I still see these “grandiose” designs that are too



“spacious...” no wonder these lose money. Often, I walk into some Hospices and can tell you immediately who designed it. You can hear the “sucking sound” when you walk down the halls as the unit is bleeding the Hospice dry! The expertise of a pro in design work should result in clinicians who will be happier and less tired and patients who get better care. The physical layout is critical.

26. **Build something that is marked by Excellence!** If you are going to build something, give your community something to be proud of without overdoing it. You are making a statement about your vision and the type of organization you are. It will affect your staff and how they feel about the organization... so why not create something special? I’m not saying to be dumb and build something you can’t afford. But I will say this “Usually we can go farther than we originally thought.” I think that the unit should “fit” your community. The style of the unit should be accepted in your community. For Hospices doing the “Model” – people should “feel” the intention behind the design of the unit. Wow them with intention! Excellence does not have to be BIG!
27. **If the Design of the Unit is too Large, then staff it with People that want to Walk...** Some grandiose IPUs have been built... large spaces, beautiful and NON-FUNCTIONAL. They are so big, they are impractical and you need track stars to tend to a pod of patients. You can gut and redo the IPU interior, but that is expensive. One thing you may consider is using the IPU to promote employee health since they will be walking a lot. Recognize the physical demands of your unit and hire accordingly. Market it as “a fitness center” – it can even be only for a few months for field staff. A lot of walking in this situation is just “part of the job!”
28. **Make your IPU an Outrageously Attractive Place to Work.** This attractiveness must come from the IPU Manager. The IPU Manager sets the tone and creates the atmosphere. Is your unit a place where people burn out or is it a place of personal advancement and self-renewal? Do IPU staff feel energized or leave as “empty” rinds? Are you spiritual and do you “get” profit as a spiritual concept?
29. **On-Stage, Off-Stage.** This is a Disney idea. Have a sign over the door in your break area that says “On-Stage.” This demarks when an IPU team member is ready to serve! The team member has to be happy, positive and full of compassion.
30. **Food Services - 65% of IPU Patients Don’t Eat (substantially).** Recognize and use this fact. Feeding families is a nice but impractical gesture. IF you want to feed families then involve volunteers. However, if volunteers are going to be used, they must be reliable and the effort must be sustainable. Volunteers must know the Standards regarding food services. You might not provide full meals, but snacks. Find the best cookie recipes in your area. Hold an annual contest for it! Showcase a new cookie recipe every day for a week or two! Let the smell fill your unit! There are creative ways to provide and use food without breaking the bank. There are multiple



ways to get this cost to the 50% percentile or better. The outsourcing or use of Volunteers or simply the use of a cost-minded Manager are options. The point is – Hospice patients don't eat very much. Use Volunteers and lower-wage workers in this area.

31. **Staffing Model.** Normally, for a 6-7 bed pod, there is an RN and CNA team. Usually if the unit has at least 12 beds, there is also a single SW. At night, many Hospices work with less staff, depending upon the size of the unit.
32. **12-Hour Shifts.** Any time you have to change shifts, you have communication transfers, miscommunication and non-productive time. We recommend the 12-hour shift to minimize the negative effects of the change. How you handle the 4-hour difference is up to you. Have them work it or factor it into their pay. There are creative ways to do it. Many times a Hospice will mix a number of 8-hour shifts in with the 12-hour shifts.
33. **Some IPU's are staffed 100% with Flex positions.** When hired, it is understood that if the IPU is not full or near capacity, you will not be working as much. IPU staff will work in proportion to the occupancy levels. This move kills off complaints about being busy! With this practice in place, IPU staff want to fill the unit!
34. **Don't have a Dedicated Spiritual Care or Volunteer Coordinators at the IPU.** In planning IPU operations, I don't recommend having a dedicated Spiritual Care (Chaplain) positions or a dedicated Volunteer Coordinator or any other positions than those listed in the Model for IPU's. Simply use Hospice homecare staff for VC and SC and use them just as you would when they serve a nursing home. Accounting may want to allocate these costs, but it is not always necessary and may, in fact, simply go against good "responsibility" accounting principles if the manager of the IPU can't directly control these costs.
35. **With smaller units, the IPU Manager should be an RN.** This is necessary for intake purposes. With larger units, usually there are more RNs available for admissions. An IPU of 15 or less should have an RN manager that can and will help with the admissions process. It is part of the job.
36. **NEVER use Contracted staff for your IPU.** Contracted staff are renters. They have no ownership or allegiance to your IPU. They will destroy Standards and your IPU's reputation. This ties to the next point.
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.** You don't want to incentivize PRN by making it more attractive. Standards are Standards. They apply to everyone. They are the basis of quality and accountability. Standards help create a high-quality, predictable experience. IPU Managers must understand accountability and not be



conflict-averse when addressing ANY deviation of Standards. Deviations in Standards need to be addressed immediately. Staffing is one of the difficult aspects of being an IPU Manager. In fact, an IPU Manager needs to maintain a level of flex staff so that he or she may adjust staffing levels as needed to meet operational Standards. You will have flex staff, but they must be as well-trained as regular IPU staff.

38. **Marketers Need to Play a Role in Keeping the IPU filled.** How are they compensated for IPU admissions? Little skin in the game, little results...
39. **The CEO or COO should move their office to IPU if the IPU is losing money.** At Palm Beach, I visited the IPU nearly every day. Especially if the unit census was down. I did have a reputation for being extremely helpful and for getting rid of people that weren't productive quickly. I was on a mission. When I was around, people got busy. This may not be the most attractive way to help fill a unit, but it worked. We often had occupancy rates over 100%, occasionally with 3 patients in a bed in a single day!
40. **Mix of Patients (Inpatient vs. Residential).** The mix is critical. This is where the IP Unit Costing Model comes into play. Mix has to be managed. It only takes one patient to knock you off your Magic Number. Your goal is 100% GIP level of care or to maintain an ultra-high percentage. It is surprising how a "few" Residential patients will affect break-even.
41. **Keep Residential Bed Utilization at LESS than 10%.** The only Residential patients are ones in transition. A double digit number is a no no... This should be monitored with a control or exception report.
42. **Residential Patients cost nearly the same as GIP Patients, UNLESS they are in a completely separate facility.** Residential patients can cost as much as GIP patients. Though Patient-Related costs like medications and supplies might be less, these patients usually eat more and can require more staff time/attention. The only way to even come close to reducing this expense is to physically separate them from GIP. Usually, a Residential unit will be staffed by a Hospice aide and no more. All other disciplines would serve the unit like they serve Assisted Living and Nursing Homes.
43. **Start the Discharge Process on the Day of Admission.** That's right. Failure to do this will result in an unhealthy mix of Inpatient and Residential patients. You will have patients who need Inpatient Care and NOT be able to access it if you accumulate Residential patients. The SW, or whoever owns the responsibility at your Hospice, has to be looking at discharge right from the start.
44. **The Profile of the IPU SW needs to be TOUGH and FAST.** The SW holds much of the profitability of an IPU within his or her ability to move patients out of the unit if they



are no longer acute. The SW needs to communicate with patients BEFORE they arrive and communicate that the IPU is NOT a place where patients may reside on a long-term basis. It is for 4-8 days and that's it! Patients that no longer need GIP care will be transferred back home or to other facilities. The SW needs to aid the IPU Manager in creating relationships with ALFs and Nursing Homes to provide fast and as comfortable as possible patient transfers according to your IPU Standards.

45. **Educate your Homecare Staff about the Unit.** Hospice homecare staff members need to understand and appreciate the unit. They need to be educated about the value and benefits that patients and families can gain from them. ALL clinicians should refer a proportion of their patients to the IP unit as stated previously.
46. **Sell the IPU Internally.** An IPU must make it EASY for Hospice homecare team members to refer patients. Make it easy. An IPU is a *service* to field staff. We want to make field members' work lives better. If they are having any trouble addressing pain in the home setting or if there are other issues that could be aided by the IPU, then they should refer to the unit.
47. **Utilizing existing facilities.** Many communities have existing facilities that may be converted to Hospice units. These should be explored. This is known by seasoned Hospice business people as "an entrenching strategy." The community may very well welcome such a move. However, understand that there are cases in which these units do well and cases in which they don't. It's a mixed bag. It depends upon the relationship between the Hospice and the entity providing the facilities. I have seen many hospital-converted IPUs go away over time (usually within half a decade) due to the dynamics of the relationship. But that may be OK. It allows you to test the water and see if a unit is right for your community. Other units have thrived for years... creating a win/win for all involved. You may even have your own IP unit and contract for beds as well as an "entrenching" strategy. It really depends upon your vision and the needs of your community. One thing to keep in mind is that Hospice staff and facility staff will probably talk about compensation and work issues through the course of interaction. Rarely is the situation equal and thus, one side may feel that they are not being paid enough or some other factor could adversely affect morale. A Hospice should think through ways to minimize this situation. If the Hospice's work environment and pay is better than the facility's, the facility may lose staff to the Hospice and the relationship could be damaged or vice versa.
48. **Contributions Usually Increase.** Normally, community contributions increase with the construction of a "Hospice building," whether it is an Inpatient Unit or administrative offices. We attribute this to the awareness that a physical structure brings to the community.



49. **How do you pay for your unit?** Raise it, borrow it, use reserves or just plan on paying for it through earnings. It seems to me that if well managed units are making money, it is a good business move and fulfills the mission. Even proprietary For-Profit Hospices have built IPUs. Obviously, a NFP should have a capital campaign and raise as much money as possible. It's nice to have the structure paid for up front. However, there are NFP Hospices that have decided to forego capital campaigns since their prior units have done well... high earnings are their rationale. However, it is not the case now since most IPUs lose 18%. Now, if you are doing a capital campaign and do not have an incredible Development person on staff (and I mean *incredible!*), use a professional. We like local companies with proven track records of success. They should already have the relationships with the people from whom you will get 80% of your money. I'm not saying that fundraising firms from the "outside" can't do the job. Many have done an excellent job. But the relationship factor is a critical piece and outsiders have a lot of learning to do to know your area. Also, get your fundraising software in place and learn to use it. Knowing who you've served in the past that can contribute is important knowledge. It's an ideal opportunity to reach out. **HOWEVER, your Hospice needs 6-9 months of cash or near-cash in reserves with or without an IP unit. I would not let an IPU project and operations dig deeply into the Hospice's reserves!**
50. **Task Lists are used to Systematize the Maintenance and Upkeep of the IPU.** This on-going list shows what needs to be done, who needs to do it and with what frequency maintenance tasks need to be performed. This is part of your Standards.
51. **Billing Options?** Across the country, Hospices are billing for Inpatient and Continuous Care (Crisis Care for the more savvy Hospices) in their units. Patients in Residential beds where CON restricts the number of IP beds can possibly bill Crisis Care. In fact, if your CON limits the number of GIP beds, then you can use your Crisis Care billing as evidence to support your case and file a "special needs" petition to get more GIP beds. Most Hospices already have the staff to do Crisis Care. We are not "gaming the system" here. There are legitimate reasons why patients need Crisis Care. Crisis Care was created for a purpose... and to deny patients access to the care they need is wrong. So, if your IP beds are full, resort to Crisis Care for the patients who have more than Residential needs. NOTE: If your unit is full, you can also contract with qualified nursing homes (24-hour RN coverage, etc.) and bill at an GIP level of care. Many Hospices are doing this... and splitting the rate with the NH. It is wise to have spillover contingency plans.
52. **Run Continuous Care in your IPU if the state has limited your GIP Beds.** If your IPU is not 100% GIP due to state regulations, then run Continuous Care in those beds to "prove the need." Use this as justification to file a Special Needs Petition with your state utilization department to convert your Residential beds to GIP. This is somewhat of a repeat of a prior point, but it needs to be stated explicitly.



53. **An IPU is only as Good as its Weakest Vendor.** Vendor selection is critical. Your vendors are part of your value-chain. When a vendor fails on its promises, the care system is compromised. Search the MVI Benchmarking Application by vendor to find quality and cost effective partners. Vendors should be given “Vendor Specifications” that provide a vendor the Standards to which they will be held. Keep contracts short, in terms of time, and have clauses that enable you to terminate relationships when your IPU Standards are not being met.
54. **“Patients are Sicker Today” – They need more IVs.** Develop better protocols when patients come into the IPU with IVs. This is a clinical practice issue. Usually, therapy expense is driven by the IPU physicians. Sometimes patients come into the IPU with these therapies. In this case, you need to work with referral sources, a delicate but deliberate educational effort. You may need to work with your IPU staff on “weaning” conversations. Do allow this area of cost to be dictated by IPU physicians when costs are above the MVI median.
55. **IPU Staff should have Uniforms.** A uniform provides comfort. People, in general, have more confidence in clinicians that wear uniforms. This is reason enough to have Standardized dress for all IPU staff members. What color? It really doesn’t matter very much as long as the clinicians “feel” good and look good. Comfort is paramount as we want all clinicians to feel good because if clinicians feel good, they will provide better care. Fleece is nice in colder weather. Design your uniforms so that clinicians believe they look great. Black is a great complementary color to your Hospice’s colors. Backup uniforms should be kept in supply in case a person’s uniform gets soiled or dirty.
56. **Documentation – Before coming to the IPU, During the Stay and upon Discharge or Death.** Self-Learning Modules for each of these phases of an IPU patient should be created. A similar process should be used by an IPU as a QI/Compliance department. Establish a Standard of 100% compliance regarding documentation. Sample charts to obtain a statistical confidence interval of 90 or 95%. ANY error or shortcoming in the documentation results in the associated employee being directed to take a self-learning module on documentation, including a small test. Also all performance compensation is negated with any documentation shortcoming.
57. **In the MVI Benchmarking Application, pay a great deal of attention to the 90th Percentile!** The rest don’t count. If a unit evaluates its Hospice IPU performance against the 50% percentile or median, mediocrity will be encouraged. Measure yourself against the 90th percentile. What are the top IPUs doing?
58. **Respite Care – Use it sparingly.** The 155% rate increase makes it much better, BUT it is GIP that you want! So design your methods of filling your IPU around GIP. Respite



Inpatient Units & the Model

is the EASY BUTTON...and you can fill an IPU like Kudzu! If you fill the IPU with Respite Patients, you don't have room for GIP, which is your objective. Now you should include a certain percentage mix of Respite patients in your Model, but not where it hurts you. Remember, you can NEVER say "WE'RE FULL" to an external referral source!



10 Continuous Care (Crisis Care Program)

One of the current trends for the savvy Hospice is to really provide Continuous Care. The fact is, most Hospices don't due to the staffing involved and the pitfalls of meeting the criteria to get paid. However, many Hospices are taking a new view on the subject and considering it an opportunity rather than something that is not practical to provide. Some Hospices have as much as 20% of their total patient days as Continuous Care. Do not think that this is some abuse of the Medicare Benefit. It has always been there and patients need it. That's why it was included when the Medicare Hospice Benefit was crafted. This part of Hospice is not going to go away. In the future, most Hospices will have a Continuous Care program just to remain competitive.

Here are some pointers for those Hospices that are implementing an aggressive Continuous Care or, perhaps better-called, a Crisis Care program.

- Don't Timidly Implement!!! If you are going to do it, jump in with both feet. If you do this half-way, you stand the chance of burning out your staff and the program will get a bad reputation from the outset.
- You will need to become excellent at scheduling. If your Hospice has an aversion toward scheduling clinicians and using computerized scheduling systems, DON'T try to do Continuous Care. To really be successful at this, you will have to discipline yourself to schedule.
- As a rule of thumb, for every case that you plan to have, you will need about 5 FTEs. Therefore, if you believe that your Hospice will have 4 cases going at any given time, you will need about 20 people.
- Program "exception reports" for Continuous Care (and IP if you have a unit) that show the average propensity for clinicians to refer to the Crisis Care Program. This propensity is an average. All clinicians should provide a certain number of patients to the Crisis Care program based on need. Clinicians who do not refer a certain number of patients to Crisis Care are probably Lone Rangers and are just doing their own form of Hospice anyway. You don't need Lone Rangers.
- Change corporate language to "Crisis Care" to set a proper patient/family expectation. Get all staff on message. You don't want, in any way, to lead people to believe that it is 24-hour-a-day care.



- Can be as much as 18% of all patient days
- Hire a manager to coordinate the Crisis Care Program.
- Need a staffing manager to recruit and hire with a large program.
- Also, schedulers (sometimes several) are needed to work staggered shifts (6:00am to 9:00pm). The model can be as little as 20% full-time employees and 80% part-time. The mix can be 60% LPNs and 40% CNAs or perhaps even 50% LPN and 50% CNA with a supervisory RN checking in once a day to put the case over 50% nursing. In some cases, Hospices are using 99% LPN or LVN and 1% RN.
- Get staff in place first. If your homecare nurses get a bad taste about the Crisis Care program, they will not want to use it. Your nurses are your referral source so you have to sell it to them. Give them examples of when patients would have benefited from the program.
- Focus on Nursing Home census first. As you are working the kinks out of your CC program, you can experience service issues. It is more noticeable when someone is late in a Homecare environment than in a facility. Though this is NOT acceptable performance (patients in facilities need the same World-Class experience as Hospice Homecare), at least there are people at the facility that can help.
- A Hospice can have as much as 65% of Crisis Care in Nursing Homes.
- If Crisis Care is put in for more than 5 days, a Dr. goes out.
- Can get a 25% margin on Crisis Care.
- Create reports that show which home care nurses are referring to Crisis Care and which ones are not. Make the nurses who use the most Crisis Care, the hero. Pay them a bonus!
- Don't pay staff a differential as it is too hard to track. Have them sign an agreement that they will accept X number of cases per month for particular time slots, weekend work and build the differential into their pay structure. (Make sure managers use this appropriately and don't do this with all staff. This is to help staff the off-hours.) In the MVI world, this is known as Composite Pay.



11 Reports to Manage an IPU

There are several MVI reports that can be used to manage Hospice IPU's. These are F9 reports meaning that they can be modified to fit your Hospice and can be run automatically each month.

The IPU Management Report

Simple reports work well as they create FOCUS on what is important. In all good Responsibility Accounting systems (a term used by cost accountants in Cost Accounting II), managers should only be held accountable for the revenues and costs that they can control. This means that costs that are "allocated" or assigned should not be on your financial reports. MVI recommends operating all areas, including an IPU on a Responsibility accounting basis using a Contribution Margin approach.

Contribution Margin for a Hospice IPU. A contribution margin is calculated by subtracting Direct Expense from Direct Revenue. It normally would not contain Indirect Costs or allocated costs, with the exception of benefits. In the case of a Hospice IPU, this would be Direct Labor, Patient-Related and other expenses that are directly traceable to the IPU. These are subtracted from the IPU Revenue and the result would be the IPU's Contribution Margin. Many times Indirect Costs are not controllable by the IPU Manager. Under a true Responsibility accounting system, a manager should ONLY have the things that they can control or influence on their management reports. Contribution for what? Contribution for paying for Indirect/Corporate costs and providing for profit. For a typical Hospice IPU the Contribution Margin should be around 25 to 35% of IPU Net Patient Revenue (NPR).



Inpatient Units & the Model

This Inpatient Unit Management Report is an F9 report. F9 is a powerful report writer that extracts data directly from the accounting system via dynamic data exchange (DDE). This means that if the accounting department is using an F9 compatible system, this report will AUTOMATICALLY be populated with your IPU data within any time-frame you request!

This area (which does not print on your report) is where your accounts are “mapped” to the report. This is done by simply typing in your account numbers by account segment.

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		F9 Parameters		
						Period from Standard	YTD from Standard	Location	Dept/Disc	Na
Manager/Charge RN	-	0.00%	-	0.00%	6.50%	6.50%	6.50%	3	C0	40
Ward Clerks	67,875.89	56.85%	197,205.20	58.13%	3.50%	-53.35%	-54.63%	3		40
Nurses	35,098.67	29.40%	102,830.72	30.31%	33.00%	3.60%	2.69%	3	61,62	40
Hospice Aide	27,135.76	22.73%	77,838.65	22.94%	15.00%	-7.73%	-7.94%	3	65	40
SW	-	0.00%	-	0.00%	2.50%	2.50%	2.50%	3	66	40
Spiritual Care	1,304.37	1.09%	3,772.32	1.11%	1.00%	-0.09%	-0.11%	4	67	40
Physician	-	0.00%	-	0.00%	1.00%	1.00%	1.00%		6M	58
Nurse Practitioner	-	0.00%	-	0.00%	1.00%	1.00%	1.00%		6N	
On-Call	5,115.84	4.29%	14,648.86	4.32%	1.00%	-3.29%	-3.32%	4	63,64	40
Admissions	2,432.12	2.04%	6,056.94	1.79%	1.00%	-1.04%	-0.79%	4	I?	40
Bereavement	-	0.00%	-	0.00%	1.00%	1.00%	1.00%	4	B?	40
Volunteer	-	0.00%	-	0.00%	1.00%	1.00%	1.00%	4	V0	40
Other/Maintenance	-	0.00%	-	0.00%	1.00%	1.00%	1.00%	4	6F,6G	40
Total	138,962.64	1.16	402,352.70	1.19	68.50%	-47.90%	-50.10%			



Inpatient Units & the Model

This report is a Contribution Margin based report. It shows period (monthly) as well as Year-to-Date (YTD) activity. Notice that NPR% are used instead of PPD or dollar amounts. NPR percentages are more effective unit of measurement than Patient Days from a managerial standpoint. However, dollar amounts are important as well. So I would advise to get this same format in dollars as well.

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	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%
IPU Labor						Desirable Non Desirable	Desirable NonDesirable
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%



Inpatient Units & the Model

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	YTD from
						Desirable	Desirable
						NonDesirable	NonDesirable
Direct Patient Related Expenses							
Ambulance	135.00	0.11%	508.30	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%	0.58%
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
GIP	-	-	-	6.0	6.00	6.00
Residential	-	-	-	1.0	1.00	1.00
CC	-	-	-	1.0	1.00	1.00
Paqle	-	-	-	1.0	0.00	0.00
ALOG	-	-	-	6.0	6.00	6.00
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
Paqle	-	-	-	0.1	0.07	0.07
% of Occupancy	-	-	-	0.1	0.07	0.07



Inpatient Units & the Model

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	YTD from Standard
Statistics							
ADC	-		-		10.0	10.00	10.00
<i>GIP</i>	-		-		8.0	8.00	8.00
<i>Residential</i>	-		-		1.0	1.00	1.00
<i>CC</i>	-		-		1.0	1.00	1.00
<i>Respite</i>	-		-		-	0.00	0.00
ALOS	-		-		8.0	8.00	8.00
Number of Patient Days	-		-		0.1	0.07	0.07
<i>GIP</i>	-		-		0.1	0.07	0.07
<i>Residential</i>	-		-		0.1	0.07	0.07
<i>CC</i>	-		-		0.1	0.07	0.07
<i>Respite</i>	-		-		0.1	0.07	0.07
% of Occupancy	-		-		0.1	0.07	0.07

Again, this is an F9 report so it can be modified and run with ease.



The Inpatient Unit – Continuous Care Management and Planning Model

We will use the *Inpatient Unit – Continuous Care Management and Planning Model* for understanding and planning how we are going to manage our IPU. This type of tool is absolutely essential to understand because if we don't understand how costs behave in our particular unit, we can't manage with precision. Costs behave differently for each unit. Many factors impact the profitability and operations of a Hospice IPU including the relationship of revenue to wage levels and the design/layout of the IPU. The *Inpatient Unit – Continuous Care Management and Planning Model* allows IPU Managers to see mathematically the sensitivity of the unit to fluctuations of patient volume and the results of proposed changes BEFORE the changes are implemented. It is very much a forecasting and planning tool.

		Month 1	Year 2	May	June	Half-July	Average	
1	Percentage of Net Patient Revenue Analysis	13						
2								
3	Primary Drivers							
4	Average Daily Census-Acute	12.00	12.00	12.00	12.00	12.00		
5	Average Daily Census-Residential	1.00	1.00	1.00	1.00	1.00		
6	Average Daily Census-Crisis Care/Respite	-	-	-	-	-		
7	Days of Care-Acute	372	4,380	372	360	180	5,664	
8	Days of Care-Residential	31	365	31	30	15	472	
9	Days of Care-Crisis Care/Respite	-	-	-	-	-	-	
10	Days in Period	31	365	31	30	15	472	
11								
12	Revenue							
13	Acute Care	83.9%	84.3%	84.7%	85.1%	85.4%	84.7%	
14	Residential Care	1.9%	1.9%	1.9%	1.9%	1.9%	1.9%	
15	Continuous/Crisis Care	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
16	Less Unpaid Care - Acute	-2.5%	-2.5%	-2.5%	-2.6%	-2.6%	-2.5%	
17	Less Unpaid Care - Residential	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	-0.1%	
18	Less Unpaid Care - Crisis Care/Respite	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	
19	Physician Revenue Offset	16.8%	16.4%	16.0%	15.6%	15.3%	16.0%	
20	Total Revenue	100%	100%	100%	100%	100%	100.0%	
21								
22	Expense							
23	Personnel							
24	RN	28.9%	29.1%	29.2%	29.3%	29.5%	29.2%	
25	LPN	4.3%	4.3%	4.3%	4.3%	4.3%	4.3%	
26	CNA	11.8%	11.8%	11.9%	11.9%	12.0%	11.9%	
27	SW	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	
28	Chaplain	0.8%	0.8%	0.8%	0.8%	0.8%	0.8%	
29	Ward Clerk	3.0%	3.0%	3.0%	3.0%	3.1%	3.0%	
30	Facilities/Cleaning/Other	2.5%	2.6%	2.6%	2.6%	2.6%	2.6%	
31	Manager	3.3%	3.3%	3.4%	3.4%	3.4%	3.4%	



Inpatient Units & the Model

This tool has been used for hundreds of IPUs during the planning and construction process. It is used for CON (Certificate of Need) applications as well. It has been around for a long, long time so it has been tested a great deal.

This tool was designed not only for the construction and planning phase on an inpatient unit, but also for on-going operations. With the tool, an IP Unit Manager can forecast staffing and perform "what if" scenarios with ease. In our opinion, ALL IP UNIT MANAGERS SHOULD BE USING THIS TOOL. The comparison of actual performance with your IPU "Model" is in the Model Comparison tab. This is also where your F9 account parameters would be aligned. To calculate the tool, press the F9 key. This tool can also be used to plan, forecast and manage Continuous Care programs. A Continuous Care program is much like a "mobile IPU." Therefore, the staffing, Patient-Related and infrastructures components can be addressed with ease.

You will notice that this tool has many tabs or sheets. Each tab relates to another. However, it is usually not too difficult a tool to use. Within a few hours, a few precious hours, you will have a good grasp of it. The Master Items tab is important when you first start using the tool. But really, the primary tab is the Pro Forma IS (Income Statement). The Pro Forma IS tab is where everything comes together using all of the information in the other tabs. Once you have all of the other tabs completed, the census cells (yellow cells) in the Pro Forma IS tab can be manipulated to see the impact of changes in ADC for various levels of care.

Q12		Sunny Day IPU Operational Report						Version: 13							
A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	
1	Projected Statement of Income						Month 1	Year 2	May	June	Half-July	Total	Name:	Sunny Day Hospice	
2	Primary Drivers												CON File Number:	XX-XXXX	
3	Average Daily Census-Acute						12.00	12.00	12.00	12.00	12.00		Section:	M	CA
4	Average Daily Census-Residential						1.00	1.00	1.00	1.00	1.00		Page:	1	7/27/13
5	Average Daily Census-Crisis Care/Respite						-	-	-	-	-				
6	Days of Care-Acute						372	4,380	372	360	180	5,664			
7	Days of Care-Residential						31	365	31	30	15	472			
8	Days of Care-Crisis Care/Respite						-	-	-	-	-	-			
9	Days in Period						31	365	31	30	15	472			
10															
11	Revenue														
12	Acute Care						204,656	2,481,952	216,936	215,879	110,910	3,230,334			
13	Residential Care						4,577	55,505	4,851	4,828	2,480	72,242			
14	Continuous/Crisis Care						-	-	-	-	-	-			
15	Less Unpaid Care - Acute						(6,140)	(74,459)	(6,508)	(6,476)	(3,327)	(96,910)			
16	Less Unpaid Care - Residential						(137)	(1,665)	(146)	(145)	(74)	(2,167)			
17	Less Unpaid Care - Crisis Care/Respite						-	-	-	-	-	-			
18	Physician Revenue						41,021	482,990	41,021	39,698	19,849	624,579			
19	Net Patient Revenue						243,977	2,944,324	256,155	253,784	129,838	3,828,077			
20															
21	Expense														
22	Personnel						151,201	1,833,675	160,273	159,492	81,941	2,386,582			
23	Patient Related - Acute						27,904	338,400	29,578	29,434	15,122	440,438			
24	Patient Related - Residential						1,178	14,286	1,249	1,243	638	18,594			
25	Patient Related - Crisis Care/Respite						-	-	-	-	-	-			
26	Operational						36,459	442,149	38,646	38,458	19,758	575,470			
27	Total Direct Costs						216,741	2,628,510	229,746	228,627	117,460	3,421,084			
28															
29	Contribution Margin						27,236	315,813	28,409	25,157	12,378	406,993			
30	(without Support or Depreciation)														
31															

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Inpatient Units & the Model

There are a few tabs that are key to using the *Inpatient Unit – Continuous Care Management and Planning Model* including the Revenue, Staffing, Patient-Related and Operational tabs.

All tabs are protected so you can't screw up the tool! You can unprotect it if you want. But beware, it is a complicated bugger with everything connected. Here are a few high points regarding using the tool.

The tool can be used for different periods of time.

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 <i>(without Support or Depreciation)</i>	27,236	315,813	26,409	25,157	12,378	406,993		

This is important for comparing different periods of time.



Inpatient Units & the Model

These are inflation or adjustment factors over a period of time.

Revenue										Name: Sunny Day Hospice	
Rate Change % over Base Year										COM File Number: XX-XXXX	
										Section: 0 CA	
										Page: 1 7/27/13	
		0%	3%	6%	9%	12%			Total		
		Month 1	Year 2	May	June	Half-July					
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		

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

Adjust your payer mix and rates here.



Inpatient Units & the Model

The Staffing tab is where a great deal of your work will be done. The key here is to understand that, under most circumstances, it will take 5.5 FTEs to staff 1 position 24/7. The tool can be used with 12-hour and 8-hour shift as well as a combination of both. For all disciplines, you use an AVERAGE ANNUAL wage level.

Use for inflation, cost of living and other period adjustments.

B31

Unit Staffing Information								Name:	Sunny Day Hospice	
								CON File Number:	XX-XXX	
								Section:	0	CA
								Page:	1	7/27/13
Rate Change % over Base Year		0%	3%	6%	9%	12%				
12-Hour Shift		Annual Salary	Month 1	Year 2	May	June	Half-July	Total	FTE Computation	
8am to 8pm										
Manager	76,960	6,556	79,511	6,950	6,916	3,553	103,486	5.57	24-Hour	
FTEs		1.00	1.00	1.00	1.00	1.00		2.79	12-Hour	
# Per Shift		0.36	0.36	0.36	0.36	0.36		4.66	24-Hour w/8	
RN	60,320	28,548	346,218	30,261	30,114	15,471	450,613	1.55	8-Hour	
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				

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

READY CALCULATE

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



12 Perfect Visits with Perfect Documentation Design

There are Hospices that are going days, sometimes weeks, without a single service failure, complaint or documentation error. Hospices have had to cancel weekly quality meetings as there was nothing to report.

These almost unbelievable results are achieved by a few Hospices with truly impressive Standards combined with unique training methods fused with strong Accountability.

Even if you don't get to "days or weeks or thousands of visits" without a complaint, service failure or documentation error...wouldn't it be good to decrease the number of current incidences by 50%?



Perfect = To the Standards of the Organization

Several years ago, we discovered that if a Hospice or Homecare organization would FOCUS on Perfect Visits with Perfect Documentation, this single move would cure most quality and financial woes of an organization.

How Perfect Visits Cure Most 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 radical increases in 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!

All of these outcomes seem self-evident. Yet, how many Hospice and Homecare organizations are completely meticulous and obsessive about their Visits and Documentation? Not many in our experience. Yet, in this reality lies the opportunity for YOU! All you have to do is imitate what other organizations have already done that yielded these results and your organization will separate from the Herd!

Like many of the concepts of the Model, Perfect Visits with Perfect Documentation is pretty straightforward and makes logical sense. Yet, it will take work and effort. But most of the work is emotional as MVI has already done the "what to do" work AND has the critical materials you will need. The emotional work is fighting fear. The fear tends to be: "Everyone will quit," or "We might lose good people." But that is not what happens. I have never seen these fears realized on any material scale in my career.



Perfect Visits with Perfect Documentation: The Cure for Nearly All Quality & Financial Woes!

The “breakthrough” can be summed up in the following:

If an organization will FOCUS on Perfect Visits (which includes Perfect Documentation) by teaching clinicians the Visit according to *System7* and adopting a version of *SuperPay!* (the compensation system), almost all ills of an organization will go away.

This is what is allowing Hospices to remedy most all quality and financial woes. This is an almost unbelievable statement. Never-the-less, it is true. We have Hospices that have had to cancel quality meetings as there are no service failures or complaints to report. Financials have rocketed from 0-1% to 14-16% profit *in 5 months!* In addition, ADC increases from 25-35% without even working with Marketers directly on Marketing! There is no hype here... It is penicillin for a Hospice or any Homecare entity. But like penicillin, this “cure” will be rejected by most for a long time, even if the results are obvious and undeniable.

Here we are at MVI, doing this work for over 20 years...and it is only in the last 2 where Bill Taylor recognized while implementing a compensation system and Visit Structure, “If we just focus on the Visit, it will fix pretty much the entire organization.” BUT the caveat is that *System7* and a version of *SuperPay!* must be implemented. A lot of times, Hospices pick and choose what they implement from MVI. This is one place where we find deviation is the difference between *spectacular* and average results.

Here is what happens:

- *Standards* are defined, which include Perfect Visits with Perfect Documentation. All *Standards* are sustainable with no goals, no stretch, nothing unreasonable and all clinical work done in an 8-hour day.
- The Visit Structure and *SuperPay!* are announced to happen at a near-future date. We explain what we are doing and why. We show a Visit Structure and explain each aspect. Regarding the compensation system, we privately show each individual what they



currently make and contrast it with what they would be making in the new system. This makes it a “no brainer” to the productive. The less productive immediately start to improve their performance. The truly unconfident and weak start to seek other employment. We repeatedly emphasize that if we make any mistakes or if something is not fair, we will correct it, not in days or weeks, but in hours! There is much more on the Rollout in the *Compensation & the Model* workshop.

- One of the *Standards* is to do Perfect Visits with Perfect Documentation. We start training the best clinicians first according to *System7*, which includes written testing and video recording of clinicians in the synthetic lab using pre-recorded scenarios with peer their group as well as individual review.
- Marketers are also trained in the Visit...and completely “get” its impact on quality. Thus, their confidence in what they are selling increases. Not just a bit, but MASSIVELY as they understand why things won’t fall through the cracks and that what they promise is true.
- In 2 months or less, the compensation system is implemented. It is a RICH system that allows the organization to pay better than other employers. It rewards for individual, team and company performance. It also *automatically* holds all employees Accountable to the *Standards* of the organization with very little effort. But the upward momentum starts as soon as the Visit with the compensation system are explained and the Visit work is initiated. Why? Because they perceive that this is real!

Let’s explore what is impacted by Perfect Visits with Perfect Documentation:

Less Staff Paid Well

- Less staff paid well. This is the formula you will operate from. You will discover that you need less staff than you currently have...and that they are more professional and are easier to manage. You’ll also see that the quality of care has increased dramatically as well. Here is what will happen. It is predictable.
- Clinicians (and all staff) become more productive.
- Clinicians (and all staff) become more professional and self-regulating.
- Compliance Costs decrease. You can audit charts all day and not find much. You need less cost in Compliance.
- Billing costs less. Billers don’t have to chase paper or do follow-up with clinicians. The documentation is all there and it is Perfect (to your *Standards*).
- You need less in HR because hiring becomes much, much easier as you have become a much more attractive place to work.
- The scope of Clinical Managers can be increased as they can manage more clinicians. Time is freed up so that Clinical Managers can teach and conduct ride-alongs on a regular basis as you have removed from their job description the need for them to:
 - Monitor Documentation



- Monitor Productivity
- Do Annual Reviews
- Terminate Employees

Bottom-Line: Direct Clinical Labor, as well as Indirect Labor costs, shrink because of the increase in quality. You don't have to expend energy and resources fixing low quality and service failures. You don't need many layers of redundancy. You don't need as many meetings. You have a largely self-regulating organization that behaves much more like the natural world.

But there is more Bottom-Line! You get these 2 things as well:

- Perfect Documentation makes a coherent, integrated care experience possible! It legitimizes the claim of Hospice being a true interdisciplinary team.
- Near-flawless documentation equals few deficiencies. This is HUGE! There are no "time bombs" under the hood where someday you find you owe "millions" to Medicare!

Will every Hospice be able to do this? No... It will take an enlightened and courageous CEO. There are a lot of Hospices, especially Not-For-Profits, trying to band together and such. But most are merging with organizations that are, in fact, struggling themselves (loss of market share, financial losses, etc.) and somehow think these business combinations will "fix" the problem. They won't... They never have... You have to go the root of the problem...and it is the Management of the organization, the leadership, structures and processes. These have to be addressed! So if you find yourself in a pickle, just do the above. FOCUS on the Visit using *System7* and *SuperPay!* Download our materials on these topics. Call us if you need help. We have Hospices all over this country doing this...and it is AMAZING to watch!



No Visit Design Committees

One thing you must NOT do when implementing Perfect Visits with Perfect Documentation is form a committee.

When implementing Perfect Visits with Perfect Documentation DO NOT form committees. This will defeat you... NO COMMITTEES!

Here is our definition of a committee:

com·mit·tee kə'midē/

noun

1. Where people get together as a group and spend enormous amounts of time making concessions, showing how clever they are, neutering out important nutrients, devastating value and ending up with a mediocre result.

One of the **BIGGEST MISTAKES** a CEO can allow is a committee to be formed for visit and documentation work. Regarding Perfect Visits with Perfect Documentation, **JUST IMPLEMENT WHAT HAS WORKED!** Get everyone trained in what MVI recommends and **THEN CHANGE** after you have gained experience. A committee will ignorantly neuter key points of value from the structure and deviate from the training playbook...and your result will be unpredictable and in all probability, it will be less than what it could have been. After all, if the people on the committee knew how to actually do this, they would already be doing it... In addition to screwing up the Visit and Documentation work, they will constipate the process and slow progress to the point where all the Energy of the initiative is lost...

A committee to me is often a form of constipation or is like making commercial bread, where all the nutrients are stripped away. Perhaps later, if we are lucky, the nutrients will be added back. Of course, only if the group agrees, especially the less insightful group members, can the initiative go forward. A committee is like an engine covered in molasses, at subzero temperatures, going uphill.

Instead of forming a committee when you need something done, just appoint **ONE** person to be responsible for a **RESULT**. Why? Because it is hard to hold a committee responsible! It is quite difficult to fire a committee. Accountability is what gives an organization meaning and muscle! Governments love committees. How is that working for them? How much



Accountability is being administered? Most true innovations and advancements come from or originate with a SINGLE person! When MVI does Magic! with a client, one of the tasks in the initial part of the transformation process is the identification of Talent. One of the Talents that we need is to find the most creative person in the organization. This person will be involved with all creative matters regarding the design of physical products and related items. There are NO committees. And the CEO says: “Yes, No or Park” to each design or element just like Steve Jobs did.

The “words” or language or names you are after are the conventions to be used to refer to your vision and values and such. They can you come from a single individual or from the group. However, the SINGLE PERSON with others giving input is what I would advise. Then of course, the CEO makes the final determination. With this said, I highly advise the use of collaboration. But I’m not going let it neuter a great idea! You always want to get people involved. You want to signal that people’s input is valued. However, you don’t want a situation, like what is so typical in most organizations, where it is “death by committee.” Where really great ideas are killed and are stripped of value. Where even the nutritional ingredients are removed in order to appease and make concessions to all members.

The CEO in all cases, must be accountable for the end result. I like to use Steve Jobs as an example. Apple took a lot of time to name things. He highly valued input from others who he viewed as smart and capable...and he build companies around collaboration (Apple, Pixar). But at the end of the day, if the name or any detail of a product did not sit well with him, it was a no go. This is the way it must be...as the CEO is accountable to the Board of Directors, all staff, and of course the community or customers it serves. Jobs “got” branding. And he was a master teacher! In my mind, he is one that should be emulated!



The Steps in Sequence to Implement Perfect Visits with Perfect Documentation

Exploration of the Practices of Hospices Achieving this Level of Quality

1. The Visit Structure is defined for all Clinical Disciplines. *We even use these for Marketing Visits!*
2. Perfect Documentation is defined for the most common & anxiety-ridden diagnosis groups.
3. All materials for System7 are created - Self-Learning Modules, Manuals, PowerPoints, Pre-Recorded Scenarios, etc.
4. IRMs are embedded into physical products to cue behaviors.
5. Clinical Managers are trained using a non-deviating 7-step system under-stress conditions using Pre-Recorded Visit Scenarios of escalating complexity in Synthetic Labs .
6. Clinicians are trained using the same non-deviating 7-step system under-stress conditions using Pre-Recorded Visit Scenarios of escalating complexity in Synthetic Labs .
7. A portion of compensation is directly attached to doing the Visit and Documentation Standards to 100%. Every paycheck is impacted. *Systems are sensitized to detect deviations from Standards.*



The Model™ 
Balancing Purpose and Profit...

1. **The Visit Structure is defined for all Clinical Disciplines.** We start with the Nursing Visit and other disciplines such as SW, Hospice Aide, Spiritual Care and Physician. We really only need to modify some of the elements in Phase 3, Professional Judgment. Yes, only one section needs to be modified by discipline! Usually only 2 or 3 elements need to be altered. *We even use these for Marketing Visits! What that means is that even Marketers can use the same or a similar Visit Structure based on Best Known Practices in Marketing!*
2. **Perfect Documentation is defined for the most common & anxiety-ridden diagnosis groups.** We need 4 perfect charts, COPD, CHF, Dementia and a generic



Cancer. These are physical charts that will be used to SHOW clinicians what Perfect Documentation looks like.

3. **IRMs are embedded into physical products to cue behaviors.** IRMs are Image Recall Mechanisms. The human brain remembers things based on feelings and emotions and these feelings are normally accompanied by images. So we think in terms of FEELINGS and IMAGES. IRMs can be written words or phrases. OR, specific pictures. When you get started creating IRMs is easier just to use words. You will use Velcro, stickers, baggage tags, and eventually start embedding these IRMs onto physical items we use in conjunction with our work such as car visors, clinical bags, bag mats, sanitizers, etc. These are used to “cue or trigger” clinicians “what” to do and “when,” especially in low-energy states. These discreet reminders are more elegant than a clinician continually looking at a “to-do” checklist and give a natural flow and non-mechanical feeling to a visit.
4. **Self-Learning Modules, Written Manuals, Written Tests, PowerPoint Presentations, Synthetic Labs, Pre-Recorded Visit Scenarios are created.** All of these are needed to support and teach by the 7-step training method called *System7*.
5. **Clinical Managers are trained using a non-deviating 7-step system under-stress conditions using Pre-Recorded Visit Scenarios of escalating complexity in Synthetic Labs.** As 70% of the development of an employee will come from the immediate Manager, the Clinical Managers must be MASTERS OF THE VISIT AND DOCUMENTATION! If Clinical Managers aren’t masters of the visit and documentation they will defeat you. They will say to people that come out of your Transformation Program (no Orientation here!): “Oh I know what you were taught up at corporate...but let me tell you how it is done in the real world...” They will undo all your training efforts in minutes! We demand that we have videos as EVIDENCE that each Clinical Manager has a COMMAND of the material and can teach it effectively with supreme CONFIDENCE! All Clinical Managers have to be certified in Perfect Visits with Perfect Documentation and be able to run Synthetic Labs in their office! If the Clinical Manager doesn’t know the Visit and Documentation cold, how will the Manager be able to judge visits and documentation when they do semi-monthly ride-alongs?
6. **Clinicians are trained using the same non-deviating 7-step system under-stress conditions using Pre-Recorded Visit Scenarios of escalating complexity in Synthetic Labs.** With the Clinical Managers trained, you start training your clinicians using your TOP Visit and Documentation Teacher or Teachers in small 4-6 clinicians groups in 2 half-day sessions. You start with your A Clinicians first, then B Clinicians and then C Clinicians. *System7* is used and is NOT deviated from.
7. **A portion of compensation is directly attached to doing the Visit and Documentation Standards to 100%. Every paycheck is impacted. Systems are sensitized to detect deviations from Standards.** Compensation is the most effective means known to tie Accountability to Perfect Visits with Perfect Documentation. Clinicians are incentivized to do Perfect Visits with Perfect Documentation using a Standards Bonus every pay period. If the “system” detects non-Standard visits or documentation, the Standards Bonus is removed for a pay period automatically.



Teaching the Visit

Why use a Visit Structure? How do you teach a Visit Structure? How do we teach the primary way that care is demonstrated? Few Hospices have taken the time or cared enough about the patient/family experience to intentionally design visit structures. This is another reason why there is such variability in Hospice care among Hospices and clinicians within each Hospice. Teaching the visit should be so common in Hospice that nearly everyone in the organization should be able to teach the basics. It should be second nature and be a habit.

Why Use a Visit Structure? Breaking Through Pride & Fear!

It is common when introducing the idea of a “visit structure” that seasoned clinicians push-back, fold their arms and reject it. Why? It is ignorance. It is pride and fear. It is perhaps a belief they already know how to do a visit because they have done lots of visits in the past.

To breakthrough, you have to breakthrough on 2 levels, the emotional level and on the intellectual level. Like other “purchase decisions in life, they are usually emotional first and later justified intellectually. Selling the “visit structure” is the same. So the first thing you want to do is touch the clinician emotionally. There are various ways of accomplishing this.

- Use the Patient/Family Chair! Virtually all decisions can be made by placing ourselves into the Patient/Family Chair! Ask questions relating to receiving a visit? Does it FEEL better when the clinician has a smile? Does it FEEL better if the clinician is dressed in a great uniform or has a great look? Does it FEEL better if certain words & phrases are used instead of other words and phrases?
- The Visit Structure will make your work EASIER. It will help you have more energy and FEEL less stressed.
- The Visit Structure will help patients and families FEEL better as they want CERTAINTY in every visit they receive. They want to be able to COUNT ON US and our promises.
- Referral sources will TRUST their patients to you as they know there is a structure in place.



What is the Goal of the Visit?

Because the visit is the primary way of delivering our compassion and care, deliberate Visit Design is perhaps the most important work that needs to be done in Hospice.

Why?

The implications of THE VISIT are far reaching from quality of care to financial matters. Few Hospices have intentionally designed the visit for each discipline. The primary reason a Hospice should have a defined visit structure is to decrease the “variability of care” from one clinician to another. There is great variability of quality among Hospice team members and this has gotten our movement in trouble. A visit structure is only 30% prescriptive. The remaining 70% of the visit is dependent upon the clinician’s independent judgment. Thus the structure supports/helps clinicians especially when they are tired. In addition, a structure helps a Hospice brand its services. By using it, we can guarantee that things will not fall through the cracks or be overlooked.

However, before we go far into this familiar but yet overlooked area, we should ask this question.



What is the goal of the Visit?

To Make the Caregiver the Hero!



Teaching During the Visit

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

If a Hospice has moved from the paradigm of being “a provider of care” to that of being “a teaching organization” first and foremost, then teaching clinicians “how to teach” during the visit would be a topic that would receive tremendous attention. It should not be assumed that clinicians inherently have these skills. These teaching skills would be based on the methods employed by the most effective Teachers that a Hospice can find and the practices would be translated to the visit setting. Of course, the teaching methods employed during visits are altered and adapted as the teaching environment, Students (patients/families), timeframe and subject matter are different from a traditional setting. The basic learning concepts remain the same whether in a classroom (controlled) or a visit (uncontrolled) setting.

What must be firmly established in the clinician’s mind and self-image is that they see themselves as a Teacher. They must be confident that they have been trained extraordinarily well based on a conceptual framework that allows them to address many different scenarios with relative ease to create a high-quality, predictable experience. They should understand their defined role in the creation of this orchestrated care experience and why it is essential that they teach well.



Clinicians should understand that taking the time to teach well, especially with the first few visits, will radically enhance the care experience as we empower caregivers to be confident in their participation in that experience. This confidence will lessen worry and anxiety issues which are forms of non-physical pain. This participation will create a much more satisfactory experience for caregivers, even if they cannot see this point at first. When a caregiver provides extraordinary care, we have truly done our job! It is the optimal Hospice experience. In addition, we are often teaching “life skills” which have much broader applications for our Students (caregivers in this case) that continue long after Hospice is out of the picture. Essentially, the good “FEELING” has to be moved from “doing” to “teaching.”

Major Point: It is critical to note that this teaching emphasis goes directly against what most clinicians have been taught. Many clinicians “feel” that if they are not “providing the care” or “doing certain things” they are not doing their job. This task-oriented mindset makes clinicians actually “feel” bad about themselves as their image of an ideal clinician is not being fulfilled. Often clinicians do not recognize that by “providing the care” they are actually fostering unnecessary dependence and are “disabling” caregivers... believing that they are providing a great service in the process. This “provider of care” mindset must be replaced by new thought habits where the clinician “feels” good about themselves as they understand emotionally and intellectually why teaching is superior to doing. This is another reason the experiential learning created in the synthetic lab is so important. The habits of success must become natural and the norm.

The Environment

The environment or setting of the visit is a huge variable in the teaching activities of a clinician. A patient’s space, whether in a home or a facility, is an uncontrolled teaching environment as the degree of control is limited. However, the principles of great teaching still apply. Room management must be taken into consideration. Can the clinician make a few movements and prepare the room for their “class?” This could simply be the act of closing or opening doors or windows as needed. It could be arranging the position of the clinician and the Student (caregivers/patient). It would certainly mean being “prepared to teach” emotionally, mentally and physically (having your materials in order and readily available).

The Students (Caregivers and Patients)

This area needs the utmost consideration when teaching during a visit. There are times to formally teach as well as times to teach by performing tasks (although this is not ideal). Optimally teaching during a visit requires a great deal of intuition and sensitivity. What is the state of the Student? Are they able to learn? What tone and language are needed to effectively teach? If the Energy of the Student is low or the person is fragile, what are most important



points you need to get across? How do you know if your teaching was effective? How confident is the caregiver?

The Timeframe

During a visit, a clinician does not have a great deal of time. This is yet another area where the visit structure comes to the rescue as the broad body of knowledge and experience that was used to formulate the structure minimizes the number of unfamiliar scenarios and challenges a clinician may face. It enables a clinician to get right to the point without wasted “windups” or clumsy explanations for routine situations. This is also where the use of common language comes into play. A top Teacher builds a fairly substantial teaching arsenal over time with cues and tools to radically facilitate the teaching of topics and the ability to address concerns. Again, taking MORE time during the first few visits is the norm at a teaching Hospice. It is expected that these initial visits may be 2x the normal duration. The multiple benefits of this “special time” must be understood such as decreased on-call visits and a tremendous reduction of non-physical suffering as well as the higher satisfaction that is created through confident and participatory caregivers.

Subject Matter

The topics addressed during the visit are highly personalized according to the situation, needs and wants of patients and families. However, pain, both physical as well as in the non-physical domain, is common to most all Hospice experiences and varies in degrees. The physical pain of the patient is normally the first consideration. Failure to address this causes the overall pain of everyone involved to cascade with time. Therefore, it is first. It should also be measured, whether in hours or even minutes. After physical pain is addressed to the degree possible, then the work of addressing non-physical pain takes a more prominent place in the visit. Again, it has been estimated by some that 70-80% of pain is non-physical. This is heightened when a person is dying. Therefore, teaching on this topic becomes paramount to the creation of an extraordinary care experience.

We cannot be with patient and families all the time. In fact, for most, it is only a small amount of time. Conversely, to visit too long robs the family of sacred, nonredeemable time. Therefore, increasing the amount of time is normally not the answer. We must empower caregivers to be confident so they can become powerful extensions of Sunny Day. They are part of our team. This will only come about by teaching. Teaching-well matters.



Why Design a Visit Structure?

The Visit

Too many hospices have mistakenly “assumed” that clinicians know how to do a great visit. If we are under this illusion, I guarantee that we are NOT providing as high of quality hospice care as possible.



MVI Multi-View Incorporated 

Why Design Visits?

- Diminish the variability of care
- Brand our care/Hospice
- Liberate clinicians and conserve Energy by providing Energy-saving structures & tools
- It is the starting point for addressing productivity.
- Documentation is to Standard so an integrated, coherent & competent care experience can be created...which is impossible without such intention...
- Because ***we care enough...***



Each of these points is important. However, “we care enough” to do this is perhaps the most powerful and important. Do we love our patients and families enough to consider their FEELINGS?



Quick Guide for Teachers when Teaching the Visit According to System7

1. Issue Self-Learning Modules. We recommend a “modular approach” where each step is simply the “best” you have and assemble them together. This makes updates easier.
2. Why a use a Visit Structure?
 - a. **Because we care enough, love enough and have the humility to strive for the best ways to help patients and families FEEL our compassion.**
 - b. The Visit is the most basic thing a Hospice does. Surprisingly, FEW Hospices have really established overarching structures to make sure that visits are predictable and high-quality. Our job is to create a high-quality, predictable experience (FEELING) for patients and families.
 - c. Patients, families and referral sources find comfort knowing there is a structure or process and that it is not “make-it-up-as-you-go” Hospice care.
 - d. The Visit Structure is only 30% prescriptive. The remaining 70% is based on your professional judgment. We are not making robots nor are we using scripts! We don't want visits to have a mechanical feel. The structure liberates your personality!
 - e. The Visit becomes our brand. Our visits distinguish us from all other Hospices in the area.
 - f. The Goal of the Visit – Make the Caregiver the Hero! What does this mean?
 - g. Understand the Visit Structure.
 - h. The 4 Ideas that Must Be Eradicated when Teaching the Visit.
 - i. More Time = Higher Quality
 - ii. It is OK to Document at a later time
 - iii. It is OK to make Unnecessary Visits
 - iv. It is OK to make Non-*Standard* Visits
 - i. As a Teacher, you must care enough about your Students, as well as for patients and families, that you are EXACTING in your teaching – *where no Student gets past you until they can do a Visit perfectly to Standard under stress conditions.*
3. Show the Visit Structure and IRMs. This is normally done along with teaching the Why?
4. Complete Written Tests on the Visit Structure. Conceptual Test and the Timed 5-Minute Test.
5. Practice: Use Pre-Recorded Visit Scenarios with escalating levels of complexity.
 - a. STEPS: Have clinicians call-out each Step of the structure without interactions.
 - b. FEEL: Have clinicians do basic scenarios focusing on creating the FEELING.
 - c. ESCALATION: Once STEPS & FEEL are mastered, start to run clinicians through complex and stressful scenarios.
6. Evaluate Practice: Have Clinicians Watch Themselves, and as a Group, Doing their Visit via Smart Phone Video.
 - a. This is a highly personal and public evaluation of learning.
 - b. This builds CONFIDENCE in clinicians and creates professionals.
 - c. Normally, we are harder on ourselves than others are...
 - d. Clinicians see the “objective” self rather than the “perceived” self.
7. Certify/Annually Recertify – Ride-Alongs at least every 2 months.



Teaching the Visit According to *System7*

We teach the Visit Structure accordingly to *System7* to eliminate any knowledge deficits and to ensure that 100% of clinicians know 100% of the Standards of the visit. It is the best system we are aware of and it has evolved from some of the most stunning organizations known. As stated previously, the Visit Structure is NOT clinical as clinical skills are taught with specific Modules that focus on clinical practice. The Visit Structure is to ensure that nothing is missed and that all visits have a fantastic flow and feel.

Here is how we apply *System7* to teaching the Visit Structure!

1. Self-Learning Modules
2. Tell – The Why & How
3. Show (Visual)
4. Test (Evaluate Learning)
5. Practice (Demonstrate)
6. Evaluate Practice (Test)
7. Certify (On-Boarding, Annually)

How Much Time? Two-Three Half-Days!

Half-Day 1 (Start-Time around Noon)

We recommend 2 half-day sessions, starting around noon on the first day and then resuming in the morning the second day or around noon, if a morning session is not possible. The logic is this: On the first half-day, you teach the Visit Structure (Step #2 Tell and Step #3 Show). Self-Learning Modules (Step #1) should have already been issued PRIOR to the session. Then Test (Step #4) with the written exams. Those that don't get 100% after a few attempts can go home and study or study in the classroom with others. Those that score 100% are then qualified to demonstrate or Practice (Step #5) their learning in the Synthetic Lab. Using easy Pre-Recorded Visit Scenarios, #1 and/or #3 or #9), the clinicians first demonstrate a command of the Steps by simply calling the Steps out verbally without much interaction with the manikins using the IRMs. As the Student's Energy is low at this point in the day, it is the PERFECT time to practice the Steps of the visit. Clinicians quickly see the obvious need for IRMs and why they work. This is where you hook clinicians on the value of IRMs! If time permits, and after the Teacher is satisfied with the effort, the Teacher can move to observing and coaching of the clinicians in the Feeling of the visit. Usually just getting the Steps done the first half-day is sufficient, but if you have time, go ahead and move to the Feeling phase. As there is only one clinician in the lab at a time, the other clinicians are watching their videos with self-critique sheets or doing study or using flashcards with each other or such learning activities.



Half-Day 2 (Start-Time optimally in the Morning but Afternoon is OK too)

After the Steps are mastered to the satisfaction of the Teacher, the next day is spent working on the Feeling of the visit. Continue using Pre-Recorded Visit Scenarios #1 and/or #3 or #9 as they are relatively straightforward scenarios. Next move to the Escalation phase with more complex scenarios. These complex scenarios include: 1) Service Failure, 2) Reluctant Caregiver, 3) Caregiver Refusal to Participate and 4) the Visit from Hell, which includes inappropriate advances, threats and such. The organization must determine WHEN and HOW to terminate a visit. During this phase, you are evaluating your clinicians under stress conditions. This is critical because under stress, people default to their lowest level of learning. You will spend the most time in the labs with your clinicians on this phase unless you have excellent Self-Learning Modules on each of these situations.

Once the WOW! Teacher is confident (Yes, once the Teacher is satisfied!), the Student can be certified. We would recommend this be done AFTER this half-day...on a day where you can maximize public recognition! However, they can wear your “look” or uniform right after they are certified in the lab so you can get them in the field!

The Steps!

1. Self-Learning Modules

Self-Learning Modules enable independent learning. These can be Videos, MP3s, CDs, Manuals, Tests, Flashcards, etc. We recommend you use ALL of these if possible as people learn differently and you are covering so many modes of learning. Videos are great! Many of the “best” and the “worst” videos can be culled from your videos of clinicians in your Synthetic Labs! And it is easy to transfer the audio to MP3s and CDs without making special audio files. The audio files can be listened to in the car to redeem “windshield time.” Also, any course worth its salt has a written manual to common-ize the material.

2. Tell – The Why & How

Have your WOW! Teacher of the Visit teach the Visit. Clinical Managers also must MASTER teaching the Visit Structure (or they will destroy your whole system later and confuse clinicians). The WHY always has to be explained for EACH of the steps of the Visit Structure as well as the over-arching principles. If the WHY is not taught, Best Known Practices tend to disappear over time. We recommend using an array of positive as well as negative examples to stress points.

3. Show (Visual)

85-93% of communication is non-verbal. Images are more powerful than words. “Still” images as well as video are used to communicate Visit Steps as well as “excellent” and “horrid” visits because showing negative visits has proved to be extremely effective as clinicians say to themselves: “I don’t want to be THAT clinician!”



4. Test (Evaluate Learning)

If a clinician can't do a visit intellectually, they can't do a visit! A clinician must know your Visit Structure intellectually. All testing is done to Pass/Fail or 100%. Anything less creates knowledge deficits within an organization. We administer 3 tests, a multiple-choice exam which tests knowledge of the philosophical reasons or the WHY behind the Visit Structure, a Timed 5-Minute Test where the clinician must fill-in the Visit Steps IN SEQUENCE, and a CAHPS Test so that clinicians will understand what is on the CAHPS survey. A typical clinician can complete the Timed 5-Minute test in 4 minutes. This creates a "stress condition" which will tell at Teacher how well the clinician knows the material.

5. Practice (Demonstrate)

After passing the 2 written tests, clinicians are ready for lab work. Don't even waste time on clinicians in the lab if they can't pass both written tests. Lab work can be viewed as 3 phases:

- 1) **Steps**
- 2) **Feeling**
- 3) **Escalation**

We recommend you use Pre-Recorded Visit Scenarios and limited use of Role-Playing. Hospice's have been "role-playing" for decades. How has that worked out? Role Playing, though effective on a limited scale, fails on many levels including inefficiently, demands huge expenditure of Teacher or actor's Energy, is non-repeatable/variability of performances and it compromises the objectivity of the Teacher, if he or she has to "perform" and then evaluate the clinician's performance. The sheer efficiency of using Pre-Recorded Scenarios cannot be overemphasized as 50-60 visits a day can be run with ease as well as NOT wiping out your Teacher! With Pre-Recorded Scenarios, the iPod or iPad does the work and the Teacher controls the interaction. MVI has stock Pre-Recorded Visit Scenarios for clients, but organizations can make their own with great ease using our templates! All teaching as well as all visits are a type of performance. This "performance mindset" must be explained and be understood. In addition, the clinician doing a visit normally directs the visit in reality as the caregivers and patients respond to the clinician while he or she goes about their work. Clinicians quickly get over the mechanical aspect of the Pre-Recorded Scenarios and learn to interact and perform.

Steps – Using easy, non-complicated scenarios, have clinicians walk-through the Visit Structure by simply calling out the names of each Step. The clinicians can use the IRMs during all lab work so they can form Habits and become dependent upon them. If you are using MVI Pre-Recorded Visit Scenarios, we recommend using #1 and/or #3 or #9. Normally, after only a few runs, a clinician will pass this phase.

Feelings – The next thing the Teacher wants to know after the Steps phase is: "Can the clinician do a visit with a warm and compassionate Feel?" We are Feeling creatures and Feelings are the foundation of all memory and recall. All caregivers and patients will remember



is how we made them Feel. In this phase, the clinician interacts with the manikins as they would speak with caregivers and patients. Normally, we recommend staying with the now familiar, non-complex visit scenarios like MVI's #1 and/or #3 or #9. Normally, this can be accomplished in 3-5 runs in the lab.

Escalation – After the Feeling of the visit has been evaluated and is done to the satisfaction of the Teacher, we introduce increasingly complex scenarios, which we call Escalation. These complex scenarios include: 1) Service Failures (#4) Reluctant Caregiver (#8), Caregiver Refusal to Participate (#10), the Visit from Hell (#5), which includes inappropriate advances, threats and such. Clinicians learn WHEN and HOW to terminate a visit.

6. Evaluate Practice (Test)

Have clinicians watch videos of themselves and their peers. Video is one the BEST Teachers! Video is one of the most important aspects of teaching great visits. Clinicians see the “objective self” and what others see rather than only the “perceived self” of how a clinician sees themselves. Posture, verbal ticks, body language and such are almost automatically improved as clinicians become aware of what others see and experience. This is especially important because 85-93% of communication is non-verbal. Just like professional athletes, an organization's clinicians learn by watching themselves. Normally this lessens the expenditure of Energy of the Teacher as clinician's self-correct and are far more critical of themselves than the Teacher would ever be! We recommend the clinician be allowed to watch their initial videos by themselves so they can make significant self-adjustments. Subsequence visits can be viewed by all the Students in the class. This peer review introduces a degree of Accountability. Later, the “final” video of the clinician will be sent to the Team Manager and the Team they will be assigned to for review so the team can see the quality of the clinician which fellow team members will be reliant upon as an interdisciplinary team.

7. Certify (On-Boarding, Annually)

Though the clinician's confidence must be high, the Teacher's confidence in the Student must be high as well! A Teacher must have high Standards and not allow any clinician to get through the training that can't do the Visit Structure under stress conditions. An organization's reputation is on the line with every visit!

Train your clinicians in the lab until YOU are confident in them!

Now, all of this is great. BUT if your Clinical Mangers are not trained to 100% of the Visit Structure, they will undo all of your hard work. Your Clinician Managers have to be certified in the Visit Structure as well as running the Synthetic Lab!



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Class Sizes and Who to Train First?

We like class sizes for these 2 (or sometimes 3) half-day sessions between 4-6 clinicians. This is a very workable number. Who to train first?

The WOW! Teacher is, of course, the “seed” so he or she must know the Visit Structure cold and on a profound level. It is also a great thing if the CEO (the Chief Teaching Officer) knows it too! This gets the CEO points and buy-in with staff! Then it comes to training your staff.

- 1) Train your Clinical Managers – They are the replicators!
- 2) Train your Top clinicians – They are easier to train and normally have great attitudes. They will also tell other clinicians how great it is!
- 3) Train your lesser skilled clinicians.

Preservation of the Negative

One master teaching concept is the Preservation of the Negative. This master teaching concept is rarely recognized as it flies in the face of many academics. Yet it is used by the most powerful teachers that have walked the Earth. As human beings are essentially driven by FEELINGS and the avoidance of negative feelings or emotions is a powerful motivator. Negative or painful feelings register in the psyche more powerfully than positive feelings or emotions. The fact that negative or threatening emotions are remembered or register more powerfully than positive feelings or emotions is perhaps due to our primal instincts from millions of years of evolution as there is survival value in the ability to detect harmful or life-threatening things and avoid them. Those without such instincts tend not to live long... The Master Teacher understands this pattern of Nature and accepts it and uses it to teach. The master teacher most often employs this via the use of vivid examples. Here is a summation of this point:



A Master Teacher uses negative examples because they are remembered more than positive examples.

To illustrate, when I teach the Perfect Visit, I use an actual story of a negative example called the Driveway Manners step where a careless RN dripped 2 or 3 drops of oil on a patient's pristine driveway. It meant a great deal to the patient because his expectation was that his house be sold for top dollar after his passing. Those few drops of oil from the careless RN's vehicle were enough to cause the man to suffer for the remaining 2 weeks of his life... When I tell this story to a room full of clinicians, what does each think to themselves? "I don't want to be that person!" And thus, they think about it when they park at a patient's home. The negative thought comes to mind easily.

Another illustration would be in the Teach Back step. The Teach Back step impacts more CAHPS scores than any other. I use an example of a prideful or fearful caregiver that refuses to administer medications for breakthrough pain. The dialogue might go like this... *"I know that this is new to you, but there is no point in your Dad suffering for an hour or so, unnecessarily, when you could handle this in 1-minute. I've been doing this work for a long time, and you are perfectly capable! I remember a caregiver who didn't think she should have to give her Dad the medications herself...only to have to watch him suffer when he had severe breakthrough pain at 2 a.m.... He lay there in pain for an hour and a half until the RN came... In her heart, she knew she had blown off the nurse who and tried to teach her... When the RN arrived, she realized how easy it would have been if she had only been willing... Let's just try this together! You and I can do it together! Plus you always have us to call for support!"*

Negative examples are especially powerful when training clinicians in Synthetic labs. You might want to find the juiciest-awful examples for each step in your Perfect Visit teaching and include them in your Self-Learning Modules! Once a negative story is memorialized via a Self-Learning Modules, you see how these negative stories MASSIVELY improve your clinician's adherence to your Standards.

Once I was invited to speak at a large health system which had adopted the Model and was launching it at a big event. It was an academic health system and had plenty of "smart people" around. I kicked off the event and then took my seat as the professional teachers took over... All was orchestrated beautifully as they presented the system of care...and then it hit me... They had taken out all the negative examples of service failures, tortured patients and families, complaints, documentation mishaps and such because they wanted the experience to be completely positive. Like most large health systems, care is quite lousy and their quality scores were poor. Finally, with my IQ of 40, I politely stood up and said, "Where are the negative examples?" Did we not learn the significance of preserving the negative? Our teaching of clinicians as well as ourselves and patients and caregivers will not be nearly as effective as it could be. We have outsmarted ourselves I believe..." Of course, you don't get invited back...but the point was made directly.



The Four Mindsets that have to be Destroyed when teaching the Visit

When Teaching the Visit, You must Destroy these **4 Mindsets**

1. It is OK to not do a Standard Visit
2. That longer visits = more quality
3. That it is OK to make unnecessary visits – “We are guests”
4. That it is Ok not to document in the home or point of service Use the time-stamps in your EMR to track)

These points MUST be completely understood by clinicians intellectually and emotionally.



These points have to be taught “multiple” times throughout the onboarding process as well as by Clinical Managers.



Visit Design Preparation/Work

Model Your BEST!

Who are the top performers at Sunny Day? Who is simply GREAT at what they do? Some will be inclined to say that “everyone is great,” but that is simply not true. If this were true, why would there be a preference for some clinicians over others? The point is that there are “epitomes of excellence” walking in your halls. Often they are not even aware of their excellence because it comes so naturally to them. These are the clinicians that one wishes they could replicate. The quickest and perhaps the most effective way to start is to identify your ideal clinicians and create a Model based on their examples.

You have to be a producer and “draw-out” how they do it!

Identify Your BEST Based on these Three Things!

There are three criteria that should be looked at when choosing whom to Model. They are:

- Attitude
- Productivity
- Documentation

If you have someone that does ALL of them well, Model them! If you can't identify ANYONE, then you will have to build a “composite” visit based on your ideas. You should incorporate “ideals” regardless of whether a single person embodies all of the characteristics.

Attitude – Who is upbeat? Who lifts the spirits of all they encounter? Who is ready for a challenge? Who is excited about QAPI and the opportunity to make things better? A great attitude carries a person a long way in the pursuit of a World-Class Hospice.

Productivity – Who consistently performs a high number of weekly visits within defined work hours? Who is highly organized and efficiently uses their time? Also, be aware that there is a level of Energy associated with productivity. If a person lacks sufficient Energy, low productivity will result.

Documentation – Who documents well? Who can do it as succinctly as possible and still paint a true picture of the patient's condition? Who documents to the diagnosis? Whose charts are “consistent” among the various disciplines involved with the patient/family? Clinicians that cannot document well are of no use to a Hospice. The Hospice will eventually cease to exist if documentation is poor. ADRs, Focused Review, and other forms of payment delays and



denials will eventually force a Hospice that does not document well out of business... even if great care is being provided.

Other Considerations – The Look, Voice and Smell

How a person looks, speaks, smells and dresses all are factors to be considered when constructing ideal visit interactions. The more professional and inviting a person can look and conduct themselves, the more confidence will be conveyed to patients and families. If a person speaks well, it is easier for patients and family members to communicate their wants and needs. Also within a few sentences, people can make relatively accurate assessments regarding a person's level of education and Intelligence as well as level of enthusiasm for their work or Hospice. Smell is also an important consideration. Many people that do not smoke DO NOT want to be around smokers nor do they want people that smoke in their house. The smell of a person that smokes is highly detectable. Upon referral or admission, it should be assessed whether or not a clinician that smokes can visit a home. Non-smoking clinicians are not as limited as clinicians that smoke. If a Hospice employs clinicians that smoke, it should explore ways to reduce or eliminate the smell. In addition, patients and families should have the express right to request clinicians that do not smell of cigarette smoke.

The Deterioration Rate of Documentation

You can compare the deterioration rate of a French fry to clinical documentation. Award winning fast food providers understand that French fries start to deteriorate within milliseconds after they leave the fryer. A similar thing could be stated about clinical documentation or for that matter, taking notes on anything. One of the Hospice patient management vendors did a study a while back and discovered that 70% of the important details of a visit were lost after only 6 hours!

Avoiding “Death by Committee”

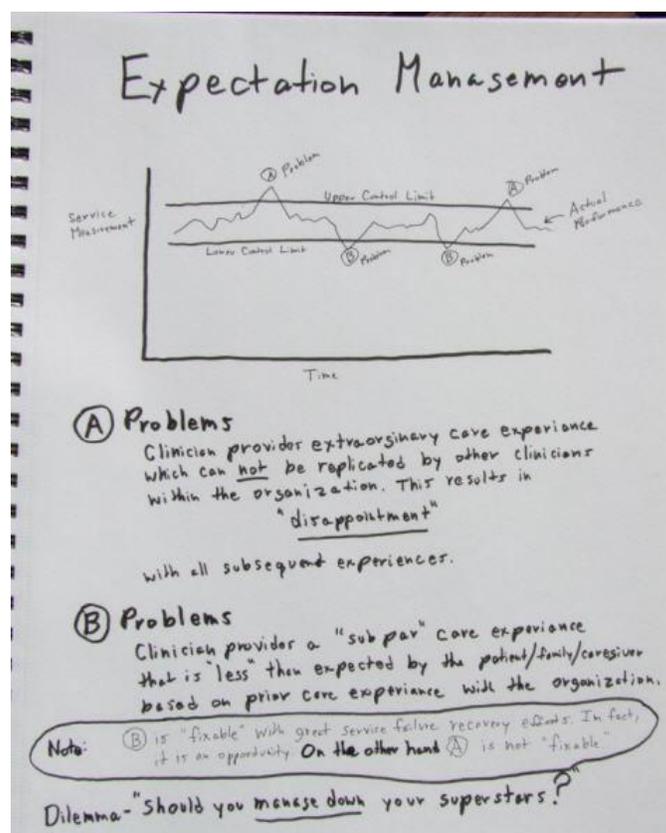
To avoid “Death by Committee” appoint an individual to lead the Visit Design effort. This person can and should use the input of others but also craft the visit the way the trusted and appointed individual thinks is best. It is this person's duty to construct the ideal visit for his or her discipline WITH the input of others. It has been said that there is a certain wisdom in crowds. Also, know that it has been said that “committees are often the voice of mediocrity,” as great ideas are compromised when concessions are made to gain consensus rather than what is best or ideal. Although avoiding the dreaded “Death by Committee” situation is critical in the Visit Design effort, understand IDG members are justifiably skeptical when non-clinical people, or people far from the front lines, start tampering with visit design. Put the right person in



charge and then quickly involve at least one representative from each discipline; failure to do so can be the kiss of death. Mixing line staff with Managers is great and don't automatically assume that the Manager needs to be the one in charge. Regardless of the mix, select individuals that have these characteristics:

- Willingness to speak up
- Excellent problem solving skills
- Ability to see the big picture
- Respect of team members (for the right things!)
- Comfort with tackling the productivity issue head on—if you think that you can tiptoe around it at the beginning and then add it on later, dream on

Are Your Top Performers Setting Other Clinicians Up for Failure?



Any clinician that provides services beyond what is *Standard* sets all other clinicians up for failure. Why? Anything that does not meet or exceed a client's expectations results in disappointment. Therefore, a *Standard* visit must be done in all cases. We do not use phrases



like “Go the extra Mile” as this FEELS good, but care create great customer dissatisfaction as the next clinician may not be able to replicate the experience. Also, if some Clinicians are doing more than others, the Clinician may be “requested” by patients and families. This is NOT good and it points that the Upper Control Limit has not been addressed

A MUST...use

Pre-Recorded Visit Scenarios

***to reduce variability, conserve Teacher Energy,
and not damage your reputation by “training”
clinicians with actual patients/families... Clinicians
can't do a Visit or even answer the phone until they
are certified via demonstration in the lab...***

***Role Playing is weakand is used
sparingly...***



Creating the Synthetic Training Space

The synthetic training space is one of the most powerful teaching environments, perhaps only followed by actual visits. It is the space where clinicians (as well as support staff) physically demonstrate technical competence and skills. Hospices have spent millions on administrative buildings and IPUs and have overlooked the most important space that needs to be designed if “People are really our most important asset.” Here are some recommendations about creating such a space at your Hospice:

1. **The Size of the Space** - The space doesn't have to be very large. Hospices have converted really small spaces into learning labs. I have seen literally a closet work or where Clinical Managers just place a couple blow-up dolls in the corner of their office! You must have enough space for the student and the teacher as well as a patient and caregiver. If space is extremely tight, paint it to somehow delineate the patient or caregiver on the wall like a mural! We have found that the easiest way to teach is to simply have the Teacher sit in a chair (next to the props) in the room. This allows the Teacher to correct and offer recommendations immediately. Optimally, you could also have some space for the storing of your “props” in the synthetic space for easy access.
2. **Colors** – Red, Orange and Yellow are stimulating colors and give life. You can also use many colors (maybe a different color on each wall). Bright Green, Blue and Purple are also good colors. The point is that you want the training space to stand out as “special” and sacred. The color needs to stimulate! Pure white can be attractive as well! AVOID tans, browns and neutral colors. Wood and natural textures are also very good as they are unique and inviting AND are a fresh contrast in most corporate environments.
3. **Avoid the Basement!** – Having the “sacred” training space in the basement is not very inspirational. If your training area is indeed “the center of the universe” then put it in your prime real estate! Put it in your most visible place! Convert your atrium into the lab with see-through windows so that visitors can “awe” at your dedication and esteem for People Development. Often, people will donate quite liberally to educational initiatives.
4. **A Simulated Car and Car Box?** – Make a half-car on the wall, where a clinician can simulate the Pre-Visit Phase. You might have an “Onstage and Offstage” sign in the car just to place emphasis on the performance aspects of the visit. If you use a simulated car situation, you will want to place a video camera in the area to capture this phase of the visit.
5. **Make the Entrance Like an Outside Door!** – This adds a more realistic dimension to the visit and makes the lab stand out even more.
6. **The Threshold!** – Make the threshold of the entry door special. Make it RED or colored with the words, “I am a Guest” or “I am Creating an Experience” or something that inspires and reminds students of an important thing to keep in mind during the visit.



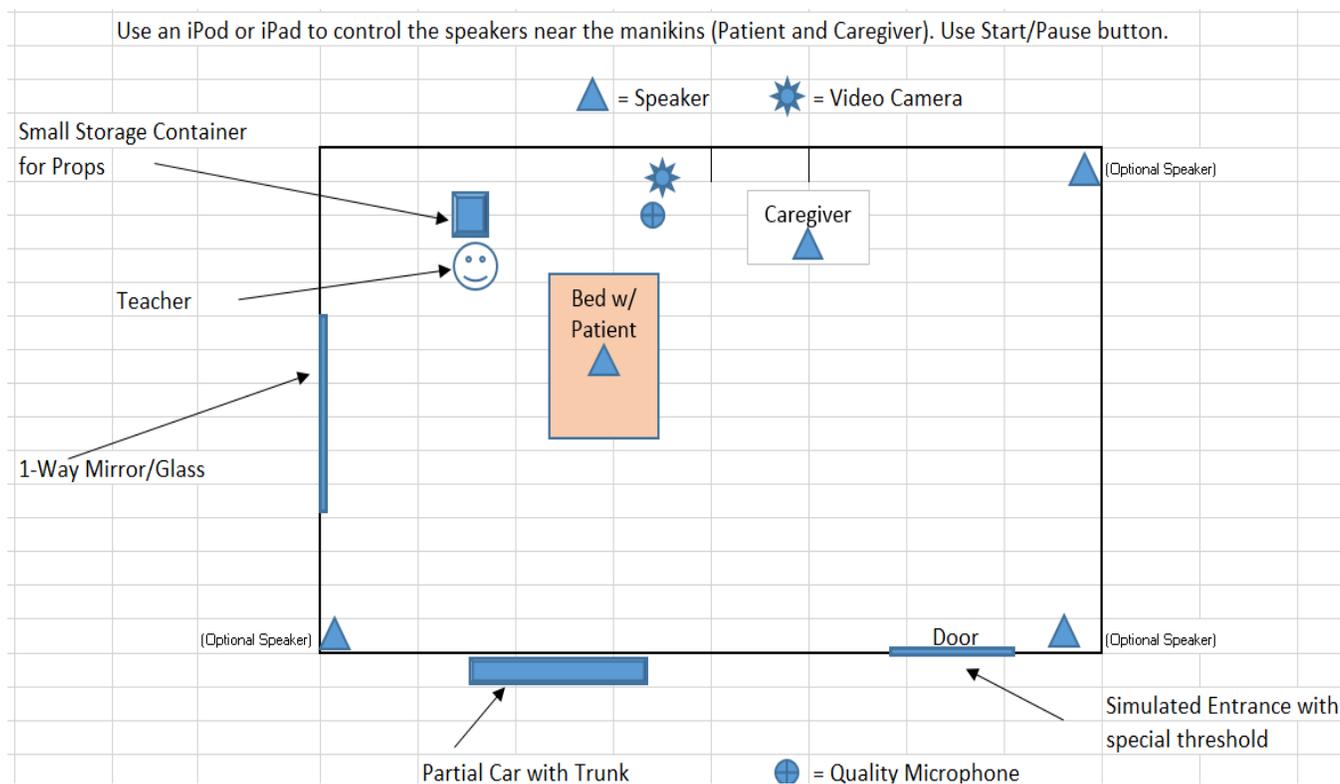
7. Furnishings - I would have simulated stoves, fridge and other furnishings. These can be cardboard, painted wood (a good project for the Boy Scouts) or the real items! A table and chair as well as a bed are also needed if space allows.
8. Props – You will need various props to create different settings (unless you can afford to have dedicated rooms for each type of interaction, which is NOT recommended). It would be very convenient if you have a storage closet close to the lab for easy access to props. What props will you need? You might have fake puke, turds and perhaps a rodent or two. Be imaginative. By slightly altering the environment between visits, you can test clinicians’ observational and perception skills.
9. Pull Down Scenes – If you want to get fancy, have pull down screens near the walls so that you can simulate several different environments within the same room.
10. The Patient and Caregiver – You want to simulate people. This can be accomplished with manikins, dummies, cardboard cutouts or even painted people on the walls! What you want to keep in mind is that you will place a small speaker near the head or general area of the figure or image. Sounds come from directions in real life and you want to simulate language and sounds coming from the patient, caregiver and even from other sources. These sounds and dialogue will be controlled from your iPod or iPad by pressing the Start or Pause buttons! We simply record the scenario following the Visit Structure (since that is what you are teaching) and then “split” the voices with the Patient on the right channel and the Caregiver on the left channel!
11. Video the Visit – You will capture each synthetic visit on video. Therefore, in a corner of the room you will position a camera. This will be one of the most important training tools in your People Development System. People normally do not like to see themselves on video. But forcing people to watch themselves is one of the most powerful and EFFICIENT ways to train. Most people are VERY critical of themselves and will autocorrect when they become aware of bad habits or poor performance. You, as a Teacher, will also be on the lookout for Best Known Practices. Often, most top clinicians are not aware that they are doing a Best Practice or are performing their work at extraordinary levels. The job of the observers is to notice these practices so they can be incorporated into the Hospice’s system of care. By videoing these practices, a BEST of the BEST compilation video of the Visit can be created and shown to students. This gives recognition to star performers and also gives the Hospice yet another very powerful teaching tool.
12. Spend Extra Money on a High-Quality Microphone – Use a high-quality microphone to record the audio of synthetic visits. Since people will be reviewing the videos, make them sound good. It is painful to have to listen to harsh, tin can recordings. Plus, you want to make a BEST of the BEST audio CD that can be used in the car as well! WOW! Two training tools in one!
13. Place High-Quality Speakers in Every Corner – Like the speakers near the heads or in the general direction of your simulated patient and caregiver, speakers in the corners gives you further flexibility as you can add background noises, other people, other voices and unexpected things that could happen during a visit! These sounds would



require an additional speaker system and iPod or iPad, but it would give the Teacher more scenario options.

14. A one-way mirror or glass should be used if you want to really impress the public and create more learning options in your lab. This allows observers and other students to be able to see the actions of the student in the lab. I like to locate this one-way mirror off of the formal teaching space! This naturally connects the learning environment and facilitates learning even more!
15. The use of pre-recorded scenarios and sounds is **CRITICAL** to minimize the variability of the teaching environment. Role playing with live people is **HIGHLY** variable and is **NOT** sustainable. There is **NO** way that role playing will teach as well as a pre-recorded scenarios when teaching “structure.” You will never be able to get actors to say the things that need to be said and with the Energy required. Use pre-recorded scenarios and sounds!!!!!! I cannot overemphasize this. In order to use this type of training environment, you will have to create scenarios. You may create 5 typical visit scenarios and then, **WHAM**, hit the student with the “unexpected” and “edgy” visits in scenarios 6-10. Teachers and observers should pay special attention to the perceived **CONFIDENCE** levels of students. If you have taught to a sound conceptual visit framework, the student should be able to recognize the situation and adapt confidently. The point is that you want to minimize the variability of training experience by using pre-programmed visit scenarios. **DO NOT EXPECT ACTORS TO PLAY THE PART OF PATIENTS AND FAMILIES ON A REGULAR BASIS.** Though real people can occasionally play the role of patients and family members **OR** students may play the part of patients and caregivers, it is not a consistent method of training.





Use an iPad, iPod or PC to control the Scenarios!



Synthetic Labs



A Synthetic Lab for the Final Test-Out!



Running a Synthetic Clinical Lab

A Synthetic Lab is the most effective and efficient method known for teaching the “structure” of a clinical visit. It is effective because it involves physicality which can take learning to a 100% level with repetition! It is efficient in that you can run 50-60 visits in a day!

Key Teaching Points to Get Clinicians Sold!

Pride normally keeps clinicians from accepting a “visit structure.” They are not bad clinicians because of this lack of humility. Lack of humility has plagued humankind throughout history as people tend to fight against nearly all breakthroughs and Best Known Practices! In this case, the good clinician simply does not understand the value of a structure. If taught well, an Integrous clinician will see the value of such a Visit Structure and its enormous benefit to themselves as well as those the clinician serves. The truth is that each clinician who has been doing Hospice or Homecare work for some time already has a structure. It’s just that if you have 15 clinicians, you probably have 15 Visit Structures! A good Teacher makes “the pill” small and makes the idea of a Visit Structure exciting and interesting! Even Spiritual!

Here are some important things:

- The Structure of a Visit is NOT clinical; rather, it is more about the creation of a FEELING or the experience of the patient/caregiver. This structure provides an overall coherent flavor or branding of your care which, in itself, provides comfort through predictability. Clinical skills are taught in focused skill lab settings and with other MVI People System methods.
- Only 30% of a Visit Structure is prescriptive! The remaining 70% is up to the professional judgment of the clinician. This helps clinicians realize that their professional judgment is respected and is expected to be fully utilized! Since most Hospice and Homecare work is done autonomously, we MUST only hire clinicians with fantastic personal and professional judgment!
- We do NOT use the word “script.” All Master Teachers and your Students must learn several ways of saying the same thing to effectively communicate with caregivers/patients of various socioeconomic backgrounds. This is an important statement to repeatedly emphasize with your Students as you do NOT want robotic visits.
- Roleplaying, though effective in various situations, is neither reliable nor efficient when teaching Visit Structures as actors can’t replicate each visit or even a single visit! Nor do they have the energy to act-out 30-60 visit performances at the same intensity level in a day. Therefore, pre-recorded scenarios are the primary mode of visit practice.



- The clinician is to learn the Visit Structure so *well* that it “liberates” the person’s personality!
- Use IRMs. Image Recall Mechanisms are simply “cues” or “triggers” that are strategically positioned in the care environment to prompt a clinician (1) what to do and (2) when with very little effort. This makes learning the Visit Structure, as well as doing work, much easier as little has to be memorized.
- The Visit Structure will improve a clinician’s life as visits become EASIER to do, leaving nothing to worry about later! When a visit is done, it is DONE! This means that all visits are performed to 100% of the visit *Standards* and nothing is missed or incomplete!

The point is that organizations that use these visit practices along with strong Accountability linked to SuperPay! can increase their quality to a level that is almost unbelievable, going “months” or “thousands of visits” between complaints, service failures or documentation errors. With multi-location Hospices or Homecare organizations, it is fun to see how many days or months each site can maintain this level of quality! It becomes a competition among a peer group with incredibly high Standards!

A Roller Chair, iPad, Smartphones and Box of Props

When I run a lab,

1. I like to just sit in a roller chair with the patient manikin and caregiver manikin. Try to get manikins you can adjust to a standing or sitting position easily for Eye-Level, Lean-In practice. The roller chair allows me to move around easily. This face-to-face, close proximity makes it easy to interact with the Student. As the Teacher, I can also do limited role playing if needed to make a point. It is easy to coach the Student in this environment as you can “pause, teach and replay” any part of the pre-recorded visit scenario!
2. I have my iPad in hand (or iPod) with the scenario text on my clipboard. Though we don’t use the word “script,” it is helpful for the Teacher to have a visual to know when to pause or start during a scenario. These especially help when the Teacher becomes a bit tired.
3. I keep my “box of props” next to me so I can alter the scenario environment quickly.



Critique and Self-Critique of Video

All visits are videoed! And the video camera is one of your SUPER POWER tools as it is largely mechanical and shows the objective-self rather than the perceived-self. Since the Teacher is in the lab, a lot of critiquing is actually done immediately! I have each clinician watch themselves in private as well as with the group. There are extreme benefits from viewing in both settings. The magic of “Video as a Teacher” comes in full force as the Students are far more critical of themselves than the Teacher would ever be! I have the Student self-critique themselves using a form that guides them through the specific steps of the Visit Structure.

Points to Notice when Reviewing Video or Live Performances

When reviewing videos or live performances from Students, here are some things to be aware of:

1. What is the immediate IMPACT of the person on you Emotionally/Energetically?
(Positive, Neutral or Negative)
2. Did you like the person?
3. Was the teaching effective?
4. Did you find the teaching and/or topic interesting?
5. Was there enough or not enough movement?
6. Was the person confident?
 - a. Arrogant/Off-Putting
 - b. Unconvincing
 - c. Confident but Humble
 - d. Average
 - e. Commanding!



Synthetic Lab Equipment Recommendations

[Visit Scenario/Synthetic Lab Hardware Setup & Instructions](#)

Materials: Ulanzi iPhone Mount (MVI Bundle) iPhone SE -64 GB (MVI Bundle) Deity V-Mic D3 Pro (MVI Bundle) Amazon Basics Tripod (MVI Bundle) Mackie CR5BT Speakers (MVI Bundle) HDMI Cable (MVI Bundle) Ipad (MVI Bundle or Purchased Separately) Mannequin (caretaker) - Purchased Separately M...

Multi-View Inc.

1611 Asheville Hwy,
Hendersonville, NC 28791

Filming Accessory Package

Date

10/1/2019

Ship date

TBA

Ship via

Amazon

Terms

Shipping & payment terms

Vendor

Name
Amazon

Item #	Description	Qty	Unit price	Total price
1	Amazon Basics Tripod	1	\$20.77	\$20.77
2	Camera/Phone Mount	1	\$15.95	\$15.95
3	Microphone	1	\$200.00	\$200.00
4	Apple TV	1	\$179.00	\$179.00
5	iPhone - GSM (Unlocked)	1	\$143.99	\$143.99
6	iPad Air - Renewed	1	\$113.00	\$113.00
7	HDMI Cable	1	\$8.96	\$8.96
8	Bluetooth Speakers	1	\$249.00	\$249.00

Subtotal **\$930.67**

Shipping & handling N/A

Sales tax N/A

Total Before Tax & Shipping: \$930.67



Multi-View Incorporated Systems
PO Box 2327
Hendersonville, NC 28793
828-698-5885 or multiviewinc.com



Materials:

- Ulanzi iPhone Mount (MVI Bundle)
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- Deity V-Mic D3 Pro (MVI Bundle)
- Amazon Basics Tripod (MVI Bundle)
- Mackie CR5BT Speakers (MVI Bundle)
- HDMI Cable (MVI Bundle)
- Ipad (MVI Bundle or Purchased Separately)
- Mannequin (caretaker) - Purchased Separately
- Medical Dummy (Patient) - Purchased Separately
- Speaker Wire (16 AWG gauge, found at any Hardware/Electronics Store)

Setup:

Phase 1 Placement

1. Determine if the powered speaker is left or right. The Switch is on the rear of the powered speaker.*
2. Choose speaker location typically hidden behind the Mannequin and the Dummy. Keeping out of sight helps reduce synthetic feel.
3. Patient is always the **Right Speaker**.
4. Caregiver is always the **Left Speaker**.
5. Place Camera where you want to capture the training.

**This will be determined by the location of the power outlet and the placement of the lab.*

Phase 2 Speaker Connectivity

6. Connect main speaker to power outlet.
7. Connect main Speaker to other speaker with speaker wire.
8. Turn Speaker on.

Phase 3 iPad connection to speaker

9. Press Home Button to start from Home Screen.
10. Swipe up from bottom of screen and choose blue tooth symbol to turn on Bluetooth.
11. Go to Settings => Bluetooth and scroll down to devices.
12. Go to power speaker and hold Bluetooth button.
13. Locate on iPad under devices and touch "CR5BT." This will connect the speakers and iPad. **
14. You may now run the training scenarios from iTunes.

***If iPad is not connecting. You may connect a 1/8" to 1/8" audio cable to the front aux port (bottom left) of the powered speaker. These are the aux cables that you typically would connect and iPod to a vehicle's stereo system.*



iPhone Camera Setup:

1. Loosen top screw on Ulenzi Mount
2. Place iPhone in mount and tighten (Not too tight; snug)
3. Set up Microphone
4. Attach Ulanzi Mount to Amazon Basics Tripod

1) For Mounting DEITY

- 1) Loosen the bottom round dial on mic.
- 2) Slide the base of microphone in slot on top on Ulenzi Mount.
- 3) Tighten bottom round dial to secure the microphone mount (Not too tight; snug).

2) For Connecting DEITY to iPhone.

- 1) Plug the headphone cable into the DEITY and into the headphone jack on the iPhone.
- 2) Your microphone is now connected. All settings for the microphone are on the back of the mic.

Recommended settings for DEITY

- 1) The dial on the back of the microphone has a white line on its side. This indicates your input level. We recommend setting this between 6 and 7. When reviewing the video and you find it to be quiet feel free to turn it higher. If your audio is too loud you will want to turn this dial down
- 2) You will also see two numbered buttons on the side with a slanted line. This is called a “high-pass filter”. We recommend keeping this set at “75” indoors; if outdoors, “150”. To select one of these numbers, press the button until the blue light appears next to the desired number
- 3) This unit operates by a rechargeable battery within the mic. Be sure to charge your microphone with the provided USB cable before & after use

Attaching Ulanzi Mount to Tripod

- 1) Separate tripod mount base from legs.
- 2) Screw base to bottom of mount, then reattach to tripod legs

You may now record the training scenario!

For presenting your finished videos to a Large monitor/TV, we recommend using the “airplay” function of an Apple TV for ease of use. Watch this YouTube Video for more instructions:

Apple TV Setup (see Apple manual or instructions).



Visit Scenarios from MVI

MVI has trained hundreds of Clinical Managers and People Development staff using pre-recorded iPod/iPad/MP3 Visit Scenarios when we are teaching how to run an effective clinical lab. **These are available for download by MVI Network clients from our website.**

When using Visit Scenarios, you are entering the world of the “Outlier” by focusing on the most important strategic direction for any organization... People Development! The use of simulation labs is a practice of the 90th percentile as an organization can teach its proprietary “visit-ology” methods as well as other practices in a safe setting that minimizes reputation damaging errors and maximizes experiential learning on both an intellectual and an emotional level. With each scenario are:

- An audio file (MP3, iTunes or other format).
- The script in Microsoft Word format for customization and editing.

Both of the files for each scenario will have a similar title for easy identification.

Using the files:

1. Load the audio file(s) onto an iPad, iPod or other MP3 player.
2. Edit the Word script if necessary using the names for your visit steps.
3. Print the Word script and place it on a clipboard or some non-obstructive stand (like a light-weight sheet music stand).
4. Using a stereo speaker set, place the LEFT speaker next to the Caregiver and RIGHT speaker near the Patient (both manikins). All MVI Visit Scenarios use the same LEFT/RIGHT convention.
5. Control the visit scenario by simply using the PLAY and STOP/PAUSE button! There is a 1.75 second space between all voice segments. Press STOP or PAUSE to allow the Student (clinician) to respond. Then press PLAY to resume the scenario!

For more information regarding Visits, see the MVI website!



Self-Critique of Visit

As clinicians complete their visits in the lab, they also should critique themselves. This is a powerful learning technique! It also provides clinicians something to do when they are not in the lab! Flash cards are another good thing to have Students doing when they are not in the lab!

#	Visit Element	Done Yes or No	Confidence Level 3 = High	Comments
	Back Stage			
1	The Dumpster Principle	Y/N	1 2 3	
2	Tune-In	Y/N	1 2 3	
3	Drive Way Manners	Y/N	1 2 3	
4	Update Brain Container	Y/N	1 2 3	
5	Vibrate On!	Y/N	1 2 3	
6	"Center Yourself"	Y/N	1 2 3	
7	"I Am a Teacher"	Y/N	1 2 3	
8	Everything I Need	Y/N	1 2 3	
	Entrance			
9	Project Warmth	Y/N	1 2 3	
10	Perceive	Y/N	1 2 3	
11	Bag Mat	Y/N	1 2 3	
12	Sanitize Hands	Y/N	1 2 3	
13	Eye-Level, Lean-In	Y/N	1 2 3	
14	Biggest Concern	Y/N	1 2 3	
15	Presence	Y/N	1 2 3	
16	Validate for Comfort	Y/N	1 2 3	
17	Manage Expectations	Y/N	1 2 3	
18	Introducing Mr. Gates	Y/N	1 2 3	
	Professional Judgment			
19	Hands On	Y/N	1 2 3	
20	Reconcile Meds	Y/N	1 2 3	
21	Rock the Doc	Y/N	1 2 3	
22	Med Refill & Thrill	Y/N	1 2 3	
23	Teach Rather than Do	Y/N	1 2 3	
24	Teach Back	Y/N	1 2 3	
25	Crystal Ball	Y/N	1 2 3	
	Document for Comfort			



#	Visit Element	Done Yes or No	Confidence Level 3 = High	Comments
26	Check and order supplies	Y/N	1 2 3	
27	DMEase	Y/N	1 2 3	
28	Verify Visit Frequency	Y/N	1 2 3	
29	Tell me how Grim it is Graphically and as a Team!	Y/N	1 2 3	
	Exit			
30	"I've watched what you're doing and..."	Y/N	1 2 3	
31	"You have everything you need"	Y/N	1 2 3	
32	Number in View	Y/N	1 2 3	
33	"Is there anything else I can help you with?"	Y/N	1 2 3	
34	Presence	Y/N	1 2 3	
35	Assure and Build Confidence as a Compassionate Teacher	Y/N	1 2 3	
36	Express Gratitude	Y/N	1 2 3	
	Off Stage		1 2 3	
37	"I've Just Got to Get a Message to You"	Y/N	1 2 3	
38	Sync Device	Y/N	1 2 3	
39	Release	Y/N	1 2 3	
40	You have just made a difference in the world!	Y/N	1 2 3	



The Visit Structure

The Nursing Visit Structure is where MVI advises to begin. This is because a Hospice or Homecare organization usually has a fair number of this discipline so there is an increased likelihood of already having Superstars to model. It is key to the support of the clinical paradigm, which Medicare is myopically focused. What an organization will discover is that the phases of the visit remain the same for all disciplines except Professional Judgment. This is normally the only one where the elements or steps can change for the discipline. But even with this, the changes are usually minor. Other phases might also have small changes, but they are minor. This means that an organization can train to basically ONE Visit Structure. This makes it easier to teach and minimizes confusion between disciplines. It also helps all disciplines understand what other disciplines are doing on visits.

Usually the basic Visit Structure for Nurses can be used for All disciplines with only minor changes...and these changes are normally in the Professional Judgment phase.

MVI recommends that you simply adopt this structure and implement it. This way important elements will not be removed. After an organization gets more experience, THEN modify.



Inpatient Units & the Model

Example Visit Structure

1 Backstage <i>Time Est: 5 minutes</i>		2 Entrance <i>Time Est: 5 minutes</i>		3 Professional Judgment <i>Time Est: 15 minutes</i>		4 Document for Comfort <i>Time Est: 20 minutes</i>		5 Exit <i>Time Est: 5 minutes</i>		6 Off Stage <i>Time Est: 10 minutes</i>	
11 Clean Behind the Scene Q6 <i>Grass Bag</i>	2.1 Project Warmth Q11 Q12 <i>Car Bag</i>	3.1 Hands On Q15 Q21 Q22 Q24 Q26 Q27 Q28 <i>Leop/Dance Stairclimber</i>	4.1 French Fries <i>Leop/Dance Stairclimber</i>	5.1 "I've watched what you are doing and..." <i>Pill Bag</i>	6.1 "I've Just Got to Get a Message to You" <i>Duckweed IRM</i>						
12 Ask for Divine Help (800) <i>Duckweed IRM</i>	2.2 Perceive <i>Car Bag</i>	3.2 Meds, Beds & Supplies <i>Leop/Dance Stairclimber</i>	4.2 Tell Me How Grim it is! <i>Leop/Dance Stairclimber</i>	5.2 "You have Everything You Need" <i>Pill Bag</i>	6.2 Let Go (800) <i>Duckweed IRM</i>						
13 Drive Way Manners <i>Duckweed IRM</i>	2.3 Bag Mat - One Detail <i>Bag Mat</i>	3.3 Rock the Doc <i>Leop/Dance Stairclimber</i>	4.3 Verify Visit Frequency <i>Leop/Dance Stairclimber</i>	5.3 Number in View <i>Pill Bag</i>							
14 One Detail Q10 <i>Duckweed IRM</i>	2.4 Sanitize <i>Bag Mat</i>		That's Important! Great Point Comfort Tools with IRMs 0 Visor or Dashboard IRM	5.4 "Is there anything else I can help with? I have time." on <i>Hopsc Place</i>	You have just made a difference in the world!!!						
15 Vibrate On! <i>Yur</i>	2.5 Eye-Level Learn-In <i>Santizer Sticker</i>	3.4 Teach Rather than Do Teach Back	1 Green Bag IRM 2 PCH-Pad IRM 3 Bag/Luggage Tag IRM 4 Perfect Clear Carbox IRM 5 Bag Mat IRM	5.5 Zen Listening Q14 Q35 <i>Dear Tracker</i>	Windshield Time Enjoy the Scenery						
16 "Breathe" I am a Teacher <i>Yur</i>	2.6 Biggest Concern Q13 <i>Santizer Sticker</i>	Q3 Q8 Q9 Q16 Q17 Q18 Q19 Q20 Q23 Q24 Q25 Q29 Q30 <i>Covertop Chickster</i>	6 Sanitizer w/ sticker IRM 7 Clipboard/Checklist IRM 8 Hospice Companion IRM 9 Caregiver Quick Guide IRM 10 Hospice Menu IRM 11 Diagnosis Guides IRM 12 "Not Today" Door Hanger	5.6 Validate & Match Q11 Q36 Q37 Q38	The 4 Bs Relax Retool Refuel Redeem						
17 Everything I Need <i>Car Bag</i>	2.7 Zen Listening Q14 Q35 2.8 Validate & Match Q11 Q36 Q37 Q38 2.9 Manage Expectations Q9 Q31 Q36 <i>Hopsc Place</i>	3.5 Crystal Ball <i>Covertop Chickster</i>		5.7 Express Gratitude Last visit with sensitivity. *This survey means a lot to me.							
2.10 Introducing Mr. Gates <i>Leop/Dance Stairclimber</i>											

Total Direct Time (Including Perfect Documentation): 60 minutes / *Travel Time Excluded*

Sunny Day 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!



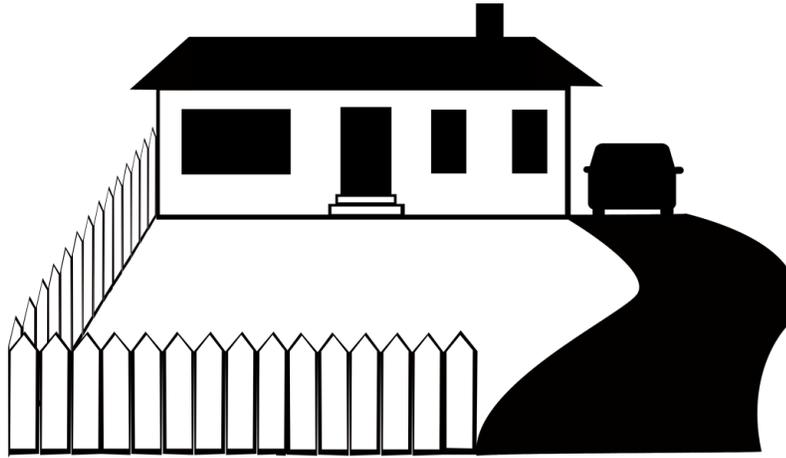
Visit IRMs – They can be Words or Images



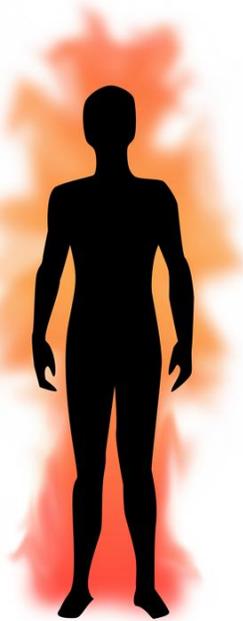


IRM - Vibrate On!





IRM - Drive Way Manners



IRM - Perceive



Example - Teaching the Visit Structure

Here are some ideas about the art of teaching the Visit:

Train Managers FIRST!!!!!! If the Clinical Manager is not trained, most of the formal training will be undone in a very short period of time. 70% of the development of an employee comes from the immediate Manager!

A Few Days before Class

1. Provide Students (minimum 7 days before class, maximum 14 days before the first day of class) [As much as 50% of formal learning may take place in this phase]
 - Pre-Test/Study Guide
 - **Issue Self-Learning Module**
 - Video(s)
 - Audio (MP3/CD)
 - Manual

Half-Day 1

1. **Tell:** Dress the Part – You want the Teacher to look and act like the discipline they are modeling. This includes the roller bag, bag mat and any other equipment.
2. Grab a random clinician and have them explain the visit to the class. This is a demonstration that the organization actually practices what it preaches and that everyone truly understands the Visit.
3. Explain why the structure of the visit and the specific tasks within each phase are important and what it means to the Students personally. Call out Students by name to explain why the Visit structure is necessary. Highlight the teaching aspects of our proprietary visit design and how master teaching methods are gracefully incorporated.
4. **Show:** Show the Short Version of the Visit Structure via video (12-15 minutes).
5. Solicit feedback from the group and point out subtleties. Answer questions and call out individual Students by name to explain aspects of the visit.
6. Show the Long Version of the Visit that explains the “why” behind each phase and action. Use Pause Points to stop the video so you can explain points further and answer questions that Students may have while the questions are fresh.
7. Solicit feedback and answer questions. Call-Out individual Students by name to explain aspects of the visits. Perhaps use Standup Call-Outs as well to further build confidence and help Students overcome fear.
8. Show the IRM Slide Show of the Visit Structure.
9. **Test:** Test and grade the Students on the Visit. Students must get 100% in order to start practice in the synthetic lab.



10. Introduce Flashcards so that Students can be occupied with learning activities while other Student are in the synthetic lab.
11. **Practice:** Start Students in lab with basic scenarios focusing on Steps first and Feeling second. You will probably not have enough time to move to Escalation.
12. **Evaluate Practice:** Students review themselves on video using a Self-Critique Sheet.
13. Let Students re-do Scenarios if needed.
14. Review these videos as a group on a large TV or project on large surface. Discuss during this exercise.
15. Run other basic scenarios.
16. Self-Review with Critique Sheet.
17. Run Scenario #3.
18. Review with Group.
19. A second time through the written tests on the Visit Structure for further deepening.

Half-Day 2

1. Test and grade the Students again on the Visit. All Students must score 100%.
2. Further explanation, clarification, repetition of important points. Perhaps a few Call-Outs or Standup Call-Outs to give Students teaching opportunities and to build confidence (overcome fear).
3. Show the Slide Show IRMs.
4. Delve into the Methods of Master Teachers and how they directly apply to doing an Extraordinary Sunny Day visit!
 - a. Body position, voice, tone
 - b. Listen, Listen, Listen, observe, prioritize (quick assessment of caregiver – confidence, how does this person learn and his or her capacity at this time)
 - c. Teach rather than do.
 - d. Use and learn to teach to the available materials
5. Run Escalation scenarios.
6. Self-Review with Critique Sheet.
7. Run additional scenarios if needed. Vary Self and Group review.
8. Solicit feedback and answer questions. Call out individual Students by name to explain aspects of the visit.
9. **Certify:** Certify and Annual Re-Certify. Record in tracking system with date.

Possible Scenarios

- #1 – A completely *Standard* visit
- #2 – A *Standard* visit with plastic puke in the corner and an anxiety-filled caregiver
- #3 – A visit that tests boundary issues and requests for a cell number
- #4 – A pre-death visit
- #5 – A post-death visit
- #6 – A visit where there is a real or perceived customer service failure



- #7 – An overly talkative caregiver
- #8 – A cancer patient visit
- #9 – A dementia patient visit
- #10 – The Visit from Hell

Don't Let Clinicians Pass Until Your Confidence in them is High!

It is about YOUR LEVEL OF CONFIDENCE! Train until YOU are satisfied!

Visit Teacher:

Teach Clinical Managers until YOU have **confidence** they KNOW the Visit Structure and can effectively teach it and run a synthetic lab at their site.

Clinical Managers:

Make-sure all clinicians on your team know the Visit Structure and can teach effectively by putting them through the written test and your own synth lab. Teach until YOU have **confidence** they can do the Visit to 100% of the Standards. Do ride-alongs after this.

All clinicians receive at least 1 ride-along every 2 months.



Video!!!!

Let's put it bluntly. ***The video camera is your most influential Teacher and teaching tool.*** Video allows you to DRASTICALLY reduce training time as it is a fairly mechanical activity. However, the fact is that Students will learn far more from having to watch themselves than from any other teaching method. People are naturally self-critical and are self-conscious. This objective tool allows them to see themselves as they really are and not how they perceive themselves. Video personalized the learning experience. IT will teach Students many things beyond what is taught in class. Though painful, it WILL improve behavior quickly.

Video is also a very powerful Accountability tool as it forces a Student to demonstrate what they have learned. Ideally, you want Students to have a *command* of the material. When Students know that they will be videoed, and that the "performance" will be viewed by others, and perhaps their peer group, they will concentrate and put extra effort into learning the material. They know they will be held Accountable for the investment in their development. In addition, the videos can be shown to Clinical teams BEFORE a new hire joins it. This helps a team know the talent and quality of the new person. And there is more! Annually it is great for other team member to see each other's videos so that they can have increased CONFIDENCE that Perfect Visits with Perfect Documentation are being done since an interdisciplinary team is completely dependent upon each person doing his or her job to Standard.

There are multiple ways that video can be employed in the teaching environment. Obviously it can be used to teach Students. Playing a short film clip or DVD can greatly enhance learning. But as stated in the prior paragraph, the greatest use of video for a Teacher is to watch yourself teaching.

To be a truly great Teacher, you MUST be self-critical. Videoing yourself teaching is one of the most brutal and honest personal evaluation methods available. Study yourself on video. Unless you do this, you are only seeing yourself from the inside. Video forces you to see yourself from the outside. This "self-awareness" is vital. Learn to be aware of how you look, how you sound, how you move and what kind of an impression you are making on your audience. It is only when you recognize the good points as well as the bad points that you can improve as a Teacher.



The video camera is your best teaching tool... And pain is your best Teacher...

The video experience works only because it is painful. People don't want to do it...and it is for THAT reason that it is effective! It is stressful. It makes us self-conscious. It is objective. Even though the video camera is your most effective Teacher for many things, most Teachers do not want to see themselves on video. Watching yourself teach is:

- Extraordinarily painful
- Extraordinarily helpful

Here are things you may find:

- You will find it is easy to be theatrical, but not be memorable
- Gestures, body language of Students and Teacher tell much about the effectiveness of the teaching
- The utter importance of non-verbal communication
- Posture
- Facial expressions such as smiling or frowning
- The impact of your physical look, dress and state of health
- Your energy level
- The speed of your delivery
- Your confidence level

Do you practice what you preach? Video reveals the real you...the objective you. You may find that you actually enjoy watching yourself teach if you're good at it! This is good and not bad. This means that you like yourself and this will give you confidence. Sometimes people feel it is



“uncool” or “self-absorbed” to actually like to watch yourself teach. I think it is good, for it is only when you critically assess yourself that you improve...and this takes actually watching yourself. So it might as well be a positive experience! I hate to watch myself teach. But has proven to be the best Teacher!

We recommend the use of a Smart Phone for visit lab work and a regular video camera for capturing teaching sessions. We also have seen where Hospices have placed small “mirrors” on your training space walls where Smart Phones will be used so you can change the angle with ease!

The Training of Professional Athletes

In our Hospice work, there are no “redos.” When we blow it, we can NEVER make it right...and our mistakes can haunt and cause suffering for caregivers and family for the remainder of their lives. This brings great gravity to the seriousness of our work. However, Hospices use amateur methods of training and Accountability and this has created problems for our movement. Consider the training of professional athletes. How do they learn? Well, one of the ways they learn and improve is watching themselves on video! They see the objective self rather than the perceived themselves in hope of correcting or improving performance. Hospices should do the same. Missing a tackle or a jump shot is insignificant compared to a person in the process of dying and the impact on that family! Why would we have less Standards? I think that we should have HIGHER Standards than those of professional athletes! And the point is, we CAN do this NOW!

The Teacher’s Speech Habits

Speech habits of Teachers are also revealed by video (which normally records the audio as well visual). This is a difficult task for many Teachers as it can be very painful to hear ourselves. However, it is essential to develop and evolve your teaching. Here are points that a Teacher can work on:

- Get Rid of “you know” or “umms”
- Verbal tics
- Talk in complete sentences
- Walk among the Students and look them in the eyes
- When speaking, Students need to “feel” the end of paragraphs. This helps with ideas, and when taking notes. It is an organizational part of language.

Since June 16, 1996, MVI has employed the use of audio messages. This came about due to my recording and music background and the sheer need to multiply my efforts. CEOs and



Hospice Managers used these messages with their respective staffs and listened to them on their way to and from work. This same technique can be used by Hospices.

I listen and re-listen to messages from long ago and realize that I have evolved. I am a better Teacher now than I was then as I have a basis to evaluate my teaching. However, sometimes I also notice things that I've lost or forgotten. My passion for certain subjects is now much less. Passion is greater for other topics. The number of topics I can teach on have greatly increased as I have increased via personal experience and from practice. I think you will discover the same things as you record yourself as review after many years.

The Use of Video in the Development of Clinical Managers

If we don't want all the hard work of developing clinicians to be undone from an initial on-boarding and if we recognize that 70% of the development of a clinician will come directly from the immediate Manager, then we will FOCUS on Clinical Managers rather than focusing on front-line clinicians. We would view the development of the Clinical Manager as the primary MEANS of developing clinicians and increasing QUALITY. Video (Smartphones) would be used as one of the primary tools to develop true professional Managers. 7 videos would be required for each Manager.



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**



Annual Clinician Skills Recertification

RN/LPN Observation of Skills *Nurse*

Name: _____ Date of Hire: _____ Position: _____	Check One: <input type="checkbox"/> New Hire <input type="checkbox"/> Other _____	Evaluator: _____ Date Completed: _____
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Self-Evaluation Columns Please Use Proficiency Level Key: D=Daily, W=Weekly, O=Occasionally, N=Never



SKILL SET	EXPERIENCE WITHIN 12 MONTHS (Self-Evaluation Use Proficiency Level Key)	METHOD USED ➤ Observation ➤ Simulation ➤ Chart Audit ➤ Testing	COMMENT
Subcutaneous Therapy			
<ul style="list-style-type: none"> • Obtain MD order for SQ Therapy • Assemble Supplies • Verifies patient identity and explains procedure • Wash Hands • Prepare infusion set, pump, tubing if applicable • Choose and prepare injection site using aseptic technique • Insert and secure the needle • Start infusion if applicable • Document initiation of SQ Therapy • Able to state policy for site monitoring • Able to state signs/symptoms of site complications • Able to state policy for site/tubing change 			
G-Tube Therapy			



<ul style="list-style-type: none"> • Obtain MD order for G-tube Therapy • Assemble Supplies • Verifies patient identity and explains procedure • Wash Hands • Assess the area for abnormalities • Cleanse and prepare area • Remove tube • Insert tube • Verify placement • Document care performed • Flushes before and after medications • Initiate infusion if applicable 			
<p>Coagucheck Therapy</p>			
<ul style="list-style-type: none"> • Obtain MD order for PT/INR • Assemble Supplies • Verifies patient identity and explains procedure • Wash Hands • Prepare meter, lancet, or syringe if applicable • Obtains blood sample correctly • Applies blood correctly • Document care performed • Properly discards used strips and supplies 			
<p>Trach Therapy</p>			



<ul style="list-style-type: none"> • Obtain MD order for trach therapy • Assemble Supplies • Verifies patient identity and explains procedure • Wash Hands • Prepares new trach tube • Remove and insert new tube • Remove obturator and secure • Properly dispose of supplies • Document care performed 			
<p>Chest Tube Therapy</p>			
<ul style="list-style-type: none"> • Obtain MD order for CT Therapy • Assemble Supplies • Verifies patient identity and explains procedure • Wash Hands • Prepare the supplies in the drainage kit using sterile technique • Connect the drainage bottle • Drain the fluid • Secure the catheter • Document care performed • Properly discards used bottles and supplies 			



13 Documentation Design

1. Why?
 - a. Documentation is the means by which we organize our care. It is the basis for a Hospice's claim to be an interdisciplinary team.
 - b. Without excellent documentation, a Hospice CAN'T be high-quality for how can excellent coordinated care be provided if team members don't know or understand what each discipline/person is doing?
 - c. Documentation is the basis of payment which enables us to serve now and in the future. It is the means by which each person is compensated in order to explore life and provide for those we love.
 - d. Clinicians must become "comfortable" documenting SLOW decline. Long LOS is better Hospice care.
2. Practice I: Documentation
 - a. Teach the 3 reasons Why we document in the best sequence. With we "care enough" as a major point.
 - b. Point of Care Documentation Why? 70% Rule.
 - c. It is not just what I did or do. It is about eligibility.
 - d. Describe, explain with an image, paint a mental picture. Be graphic!
 - e. It is about truly understanding the illness/disease progression and not just "moments" but "trends." Graphs that show – 1) Crash, 2) Stair Step Decline, 3) Surge The decline could be over a week, month, quarter, year "How are they different than they were a year ago?" A "Periodic Plateaus" based on a declining condition.
 - f. Describe How to Get Documentation to 100%.
 - g. "Would you be surprised if the patient would die within a year?"
 - h. Use of precise language including No No Words and Phrases.



The Sequence for Teaching Documentation

It is important that documentation is taught in a specific sequence with

1. Coordination of the Care Experience *always* being referenced 1st
2. Financial Implications *always* being referenced 2nd

Why?

We must always stress that the care experience is our first and foremost concern. It is absolute necessary. The fact that it is also the means by which we are paid is secondary, but essential the continuation of the organization's fulfillment of the mission.

- 1. The chart is our basis of any real claim of being a true interdisciplinary team. We document because the chart IS our basis of communication and coordination of the care experience. Without great documentation it is impossible to create a high-quality care experience. We “care enough” to document well.**
- 2. Because it enables us to be paid and continue fulfilling the mission.**

Never say that a clinician is a “good” clinician if there any problems with his or her documentation. They are NOT a good clinician and should be removed from the Hospice as they are NOT a team player and put the organization at risk.

The Deterioration Rate of Documentation

You can compare the deterioration rate of a French fry to clinical documentation. Award winning fast food providers understand that French fries start to deteriorate within milliseconds after they leave the fryer. A similar thing could be stated about clinical documentation or for that matter, taking notes on anything. Allscripts, one of the major Hospice patient management vendors did a study a while back and discovered that 70% of the important details of a visit were lost after only 6 hours! Therefore, documentation MUST be done at the time of the visit.



70% of the important details of a visit are lost after only 6 hours!

French Fries...



This is an example of an IRM (Image Recall Mechanism). We use this image to convey the deterioration rate of documentation. It works because it is interesting, relatable and appeals to the senses. Most important, people remember it!

Failure to Document Induces PAIN in Patients and Families

If our Hospice has explained that our computers and devices are used to coordinate our care and 4 clinicians use them during the visit and the 5th does NOT, PAIN IS INDUCED by the careless clinician. This is a form of non-physical pain. In this situation, the patient and family members see “non-Standard” practice. This leads to thoughts of worry and wondering “How will the rest of the team know what is going on?” If our Hospice claims that “You don’t have to retell your story over and over” or “We don’t ask the same questions again and again like other healthcare organizations” and a clinician does, we have BROKEN the promise...we have BROKEN the system...we have LOST credibility...and it will take as much as 10x the energy and effort to FIX the disappointment, if it can really even be fixed...

Failure to Document Induces PAIN!

Clinicians that don’t Document Don’t Really Care

If a clinician does not think that documentation is important or even complains about it, one has to question the degree that they even really care about patients and families. These clinicians are more concerned about themselves than the patient. To be blunt, they are selfish and self-absorbed...

If a clinician fails to document according to Standard, the clinician does not really care enough or love the patients and families enough to be part of the Hospice.

These “low caring” and “spiritually lacking” clinicians need to go work elsewhere.



Changing the Paradigm of How a Clinician Documents

It is a new world in Hospice regarding documentation. **Eligibility IS what we document.** The old paradigm of “I did this” or “I did that” on a visit must be replaced with a long-term view of the patient’s illness progression and decline.

Recognize Patient Plateaus

A common phenomena in the dying process is that patients “plateau” at some point. There is little decline or their can even be an improvement of the situation. However, the question must be asked “Is has the patient declined over the last month, 3 months or 6 months?” “Is the patient unable to do things they did previously?” “Can they still do the things they did previously, but now it requires much more effort?” These all indicate decline.

Prognostic Uncertainty

Medicare CMS and MACs/FIs don’t give Hospices many tools to determine eligibility. We have the LCDs (Local Coverage Determination), but they are quite vague. Therefore, we must be creative and determine our own methods as NO one has really mastered prognosis of time in the dying process. This is due to the VAST number of factors and interplay among factors such as:

- Genetics
- Socio-economic
- Life Style
- Medications
- Use of Medications
- Will to Live
- Divine Forces

If 100 light bulbs representing 100 identical patients were displayed over time, we do not have a good idea which particular bulbs will burn out first. Perhaps a few will burn out in the first few days. A few more after a week. A few more after a month. This will continue till there are few bulbs left burning. And some of these keep going, and going, and going... Why? We do not know, but they are Outliers. This principle applies to many, many things and situations in the human experience.



Medicare and FIs have somewhat misguided expectations of Hospices in the prognosis area. Example: Coroners are unable to determine cause of death for 1/3 of all deaths in the United States. This is AFTER a person has already died. Yet, Hospices are not allowed to use “unspecified” as a death description? Coroners have the benefit of performing their examinations after the death has occurred. Yet, Hospices are expected to anticipate or know this before the death. Hmmm.....

Measure

Most things have a central tendency...and average, median or mode. Each clinical must have measuring tape and other measurement devices and be trained on what an average healthy person’s measurements are for nearly all parts of the body. What is the average circumference of an arm or leg? The average humorous is 22cm. So if a patient has a 14cm (average weight, age, etc.) then decline is happening.

Up to 90% of the Assessment Process is Observation

This may seem like a huge percentage, but this is the consensus of many clinicians. This observation can and should (if possible) involve measurement. But our observations often go beyond measurement in order to accurately represent the patient/family situation. Things to be aware of or “observe” might include:

1. Significant Pain
2. Weight Loss
3. Sleeplessness
4. Emotional Distress
5. Breathlessness
6. Forgetfulness
7. Many Doctors, Emergency Visits
8. Fatigue
9. Loss of Mobility
10. Caregiver Stress



Demand the Use of Precise Language in Documentation

Master Teachers do not allow the use of sloppy language. Sloppy language mean that the thinking is also sloppy. This concept particularly applies to documentation. You must determine what words or phrases can be used as well as the words or phrases that are OUTLAWED at your Hospice.

List the Words & Phrases that are OUTLAWED at your Hospice.

Documentation Language	
No No Words & Phrases	Model Words & Phrases
Stable	Patient has definitely declined over the last 2 months
No Change	Patient cannot do activities done previously Example: Knitting
Not able to assess	Patient has great difficulty knitting
Patient doing great, fine, well...	Patient has lost desire to knit
Good Day	Patient experiencing a short-term plateau in decline
Patient Sleeping	Patient environment has deteriorated
Patient Oriented/Patient Alert	Patient experiencing a brief respite.



Make the Review Process Ridiculously Easy to Determine Eligibility for Medicare FI Reviewers

A reviewer at Palmetto, NGS or CGS will spend 2 minutes reviewing a chart. They are quick in their assessment of eligibility. They are not playing too much attention to the LCDs but rather, they are looking for decline.

When you document, you want to get the message of decline across quickly. You want a short story filled with facts and observations. Do not make reviewers “work” to see decline. Make it easy for chart reviewers to see it. Imagine sitting in a cubicle for 8-hours a day with stacks of charts to review along with 500 other reviewers. You get good at reviewing. You learn which Hospices are good at documentation and which Hospices are poor at documentation. You identify which ones you want to work with as well as which ones you dislike working with. So organize your chart so it is easy for reviewers and help them LIKE you! Forget “fancy cover letters” and tell a short story with facts.

If Your Hospice Does NOT Have A Fair Number of ADRs, You Are Probably Far Smaller than You Could Be

Some Hospices pat themselves on the back because they don't receive many ADRs (Additional Data Requests). This is foolish. It usually means that the Hospice is ultra-conservative in its clinical practices and your Hospice's census is FAR SMALLER than it should be. Your Hospice should be pressing a MAC/FI's measures of central tendencies (averages, medians and modes). This will trigger ADRs. But in this case, it is OK...IF YOUR DOCUMENTATION IS GOOD!

If your documentation practices are good, then a Hospice can have a larger census.

Great documentation translates into higher census.

The Hospice Medicare Benefit is an UNLIMITED benefit. It is OK to keep long living patients as long as you can demonstrate decline over time. Do not let the 6-months or less mindset cause you to discharge patients. A better way of presenting it would be



Would you be surprised if the patient died within a year?

50% of all prognostications are WRONG. That is, if a physician says that a patient has 6 months to live, statistically they will live HALF of this or 3 months. If a patient is certified to have 1 month to live, they will statistically live 2 weeks.

Great Documentation Will Grow a Census

Look at your Discharge and UR Process. The picture in the charts dictate whether we keep or discharge a patient. If your Hospice has a limited view of what a Hospice patient looks like, you will probably discharge patients you don't need to.

Most often the picture of the Hospice patient is too conservative. This often is the natural reaction after a Hospice has some ADRs or other scrutiny. It also can just come from a "too uptight" Compliance department! So look at who you have performing this function! You don't want too loose and you don't want too tight.... Just right does it!

- The discharge rate should only be around 5%. It can go higher if you are super aggressive in admitting patients.
- Are you discharging due to poor documentation? Could you keep more patients if your clinicians learned to document better?
- Your clinical educator could add to your census and bottom-line if they were doing a better job teaching documentation.

Inoculation of the Fear Bug

This is a Best Known Practice that can add tons of patients to census and has made millions of dollars for its users. Whenever a bunch of ADRs or other scrutiny occurs, most humans will react with caution. Clinicians as well as Clinical Managers will become much more conservative fearing negative consequences. The result is a big "dip" or "divot" in census. It can take "years" to recover for these scares. It is like being infected with a "fear bug."

What is the remedy? Inoculate it with vitamin C which is CONFIDENCE! As soon as ADRs or scrutiny happen, as a protocol, dispatch your confident documentation teaching specialists! Nip the fear in the bud before it becomes an operating norm! This is eliminate the "divot" or at least make it very small!



How to get Documentation to 100% of Standard

Some Hospices do not believe that clinical documentation can be done to a 100% Standard. Here is how it can be done.

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 REMOVED from their duties.
5. If any 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 has fix the issue if possible and complete the Self-Learning Module within 1 day.
7. In addition, the Standards Bonus pay is revoked. Normally this is 5-10% for 1 pay cycle.



The Model™
Balancing Purpose and Profit...

I have found that a Hospice can do different variations of this and get good results. However, by far the most powerful component to get documentation to 100% is the automatic compensation piece. This will fix documentation overnight. But let's break down this sequence.

1. **Documentation Standards are Defined** – An exact picture or example(s) of documentation must be provided to clinicians (Students). This means that a perfect example of ideal documentation is provided for all major diagnosis groups, especially



difficult situations. This would include the words and phrases that are used as well as the words and phrases that are outlawed! This Perfect Documentation would be not too long and not too short. These are your documentation *Standards*. Normally we want Perfect Documentation examples of COPD, CHF, Dementia and a “generic” Cancer.

2. **Self-Learning Modules are Created** – Students must have access to learning materials before they are taught in a formal setting. These Self-Learning Modules are used further to reinforce learning when needed. They can be easily linked to emails when documentation defects are identified.
3. **Compliance/QI Samples (Audits) Charts to a 90% Confidence Interval** – This is a REVOLUTIONARY paradigm shift for most organizations! It is with this Best Known Practice that an organization can REMOVE the duty to monitor clinical documentation from the Clinical Manager’s job description! They don’t have to do it anymore, thus FREEING up more time for the Clinician Manager to do the 1st Duty, which is to teach and coach their Students! On a periodic basis (usually weekly), the Compliance/QI department samples and audits clinical charts. Thus, every clinician is sampled on the same frequency over time. A good rule-of-thumb is that all clinicians should be sampled at least 6 times a year.
4. **If ANY non-Standard (defect) documentation is identified, the Clinician, the Clinical Manager and Payroll are notified** – This is normally through an email. The clinician knows what is wrong (immediately, so they can self-correct) and the Clinical Manager is aware that he or she has a teaching/coach task to get the clinician’s documentation to *Standard*. In addition, Payroll is alerted.
5. **The Clinician has 1 day to correct the documentation defect (if possible) and complete the Self-Learning Model** – This step has several objectives: 1) to correct the documentation (if possible, as all documentation issues are not possible to fix), 2) to teach the clinician how to document to *Standard* and 3) to cause the clinician to experience a degree of pain. There is great value in an appropriate amount of pain when there is non-Standard performance or behavior. Master Teachers know that much of our deep learning comes via pain. This is Accountability plain and simple.
6. **The Standards Pay Portion of the Clinician’s Compensation is Removed in the Next Pay Period** - This is a bit beyond the scope of these steps, but in the MVI way of compensation (SUPERPAY), all positions reconstituted with 90% being an employee’s normal salary or hourly rate and 10% is structured like a bonus and is called *Standards Bonus*. This 90% plus 10% brings an employee to 100% of what they are currently making. Everyone is expected to receive their Standards Bonus every pay period! To receive *Standards Bonus*, all an employee needs to do is do their job to *Standard*! There are no goals or stretch involved. Just do the *Standards* of the company! It is that simple! HOWEVER, if a clinician or any employee doesn’t do the *Standards*, this portion can be removed for non-*Standard* performance or behavior. Of course we include 3 *additional* ways employees can make more money (more than competitors or other healthcare entities pay), but the *Standards* must be done! This is the quickest way for an organization to become a healthy, integrated whole and to bust down silos. In addition, the clinician FEELS a very small amount of pain from the one-period removal



of the *Standards Bonus*, which is not enough to disrupt anyone's life-style, but enough to get the clinician's attention! The truth is that it is not the removal of pay that corrects the behavior, but rather the Emotional pain that one FEELS that causes the positive change in one's performance or behavior. If an organization can't get the compensation system reworked to Model methods of compensation (SUPERPAY) due to timing or it just doesn't have the guts to do it, then optionally *Incident Reports with an Essay* can be used for Accountability.

If an organization wants 100% documentation, this is what you do! All top-run organization have high Accountability. Why would a clinician at a hospital never even think of leaving for the day without documenting?



How to Solve Short Length of Stay (LOS)

Most problems in the Hospice world have ALREADY been solved by people in our Movement... Yet, at the open mic during the MLC CEO Forum, Hospice leaders line up to complain about the same issues year after year it seems... Short Length of Stay (LOS) is one of those issues... Short LOS is a QUALITY issue! Is it better to have a patient for 4 months or 4 days? In which case could a Hospice do a better job? Low quality Hospice is Brink of Death care... LOS is important! So let's solve it!

There are at least 3 ways to address short Length of Stay (all which are within your influence):

- **Expand the Paradigm** – Change the picture of what a Hospice patient looks like and train your staff accordingly.
- **Learn to be a True Managed Care Organization** – Become an expert at managing cost with capitated reimbursement and management of risk.
- **Increase Confidence in Documentation** - Use documentation as a mechanism of transformation of LOS.

Historically, from 14- 16% of all Hospices have excessive LOS as evidenced by aggregate CAP overages. It is an obvious fact that some folks have the long LOS thing worked out, or at least they're hovering around CAP boundaries. How can this be? Do they not operate in the same world? The better questions are the ones that indicate your beliefs and attitudes about Hospices with long LOS. Do you have an immediate negative reaction to those that exceed CAP thinking, *"They're admitting patients that don't meet criteria?"* or *"They are bad Hospices..."* Maybe the truth is that these Hospices are willing to assume more risk...and take the "grays." Maybe they are willing to trust a physician, a physician who has had a 30year relationship with a patient and who may see something we don't? Maybe you are limiting LOS because of narrow and limited ideas of what a Hospice patient looks like...and have trained the referring community by virtue of the patients you have either admitted or (more importantly) not admitted...

Note: MVI advises and operates Hospices at approximately 80% of CAP, leaving a 20% "screw-up" factor for errors or performance issues.

Note: A Hospice using the Stream-Lined Method is worth millions more than Hospices under the Proportional Method. Never, never, never select the Proportional Method given an option for CAP.

LOS is an Inside Job!

One of my Mothers in Hospice, Deborah Dailey, would normally increase LOS at each Hospice where she was CEO, sometimes by 25+ days. This included Hospice of Ashland, Hospice of



Winston-Salem, Hospice of Palm Beach County, VistaCare (central region) and Hospice of Dayton. Why did LOS increase overall in each case? The answer is simple... Change the paradigm of what a Hospice patient looks like in the minds of staff and this paradigm outflows to the referring community and the community at large. All Hospices train the community and the referring community by virtue of the patients that are admitted or not admitted. The patients we do not admit tend to HURT referrers and change their attitudes about Hospice or a particular Hospice. And many Hospices are “very very, very” conservative. Especially Not-for-Profits. In fact, Compliance, or as we say Business Prevention Units, often boast that they don’t receive ADRs or very few. These Hospices are far smaller than they should be. Any Hospice that is aggressive will be pushing the FI or MACs measures of central tendency for LOS and thus be subject to ADRs and edits. So ADRs are part of doing business! They are not something to run away from if we are conscious of quality (Again, 4 days or 4 months...Hmmm....).

Of course, you need CASH to be able to push LOS to the extremities as you may not get paid for 6-9 months as you go through the appeal process. This leads us back to becoming an extraordinary well-managed organization with 6-9 months of cash/near-cash reserves! What I am basically saying is that LOS comes out of your ideas about Hospice. We were “designed” to take the grays. This is why we have a recertification process. Our LOS is manufactured by us and our thinking. Our LOS has more to do with our views and beliefs than it does with the external world. Certainly the external world impacts us, but not to the extent that most people in Hospice place blame for short LOS.

Learn to Work with Managed Care Organizations & Health Systems by Speaking their Language

I have worked with a lot of Managed Care Organizations. We cut deals with them... In fact, we ask them to only refer to Hospices “Doing the Model” well. MVI was formed around the idea of Managed Care...EXPERT at managing costs with capitated reimbursement. Hospices ARE Managed Care Organizations, or at least that was the intention behind our reimbursement structure. We must be EXPERT at the management of risk. But most Hospices do not have costing systems in place to know costs by diagnosis, payor, clinical team, clinician, referral source, time-slice or other demographic...even though MVI has provided an easy process to get these views for 20 years. Obtaining these very accurate views of costs can be accomplished in minutes if a Hospice benchmarks with MVI and has a decent EMR. (See our *videos and training materials on How to Know Your Costs by Diagnosis, etc.*). MVI is an **expert organization** regarding the knowledge of cost, cost behavior and cost-views, which are the foundation of a MCO. We encourage you to use MVI more in this capacity.

MCOs have the ability to dump tons of patients, long-living patients, into your Hospice. They want cost avoidance. And your Hospice can be part of alleviating this frustration. In this case,



you have a hard time keeping Length of Stay down! I speak with Hospice CEOs nearly every week about too long of LOS. “Andrew, how can we get more short LOS patients?” These Hospices are working BIG TIME with MCOs and health systems. How do you get in with MCOs and health systems? Money!!! That is the language they speak... Show them savings! I helped cut a deal with a mega MCO recently and showed with ease how they’d save \$1,700,000 next year alone if they would use a particular Hospice and its IPU. They agreed in moments... In addition, their patients would receive extraordinary care that the system could feel good about as they use the Model well. “Win, Win, Win” for all involved! Except maybe for the competing Hospices... But the pain from loss of market share is exactly what is needed to get the other Hospices to improve their management and quality! Competition increases quality in most all cases! In fact, we NEED competition to help us grow so we don’t get complacent. This is the system of the natural as well as the spiritual world which we emulate... Whoa!!!

Increase Your Confidence in Documentation

I go to Hospice after Hospice and ask “Can you show me a perfect chart?” They can’t...not even a generic Cancer, Dementia, COPD, CHF...nothing... How in the world can an organization expect clinicians to do great documentation when they don’t even have an example of a great chart? When MVI does a Magic! deal, one of the first places we address is documentation because if it is horrid, the whole place can come down! We also know that quality care is not possible because poor documentation is the basis of a true interdisciplinary team. Documentation is the ONLY way a cohesive, coordinated and integrated experience can be created.

What clinicians need to be taught is 1) it is OK/NORMAL when patients live 4-8 months and 2) how to document slow decline. Hospices with short LOS often have clinicians who feel “uncomfortable” with patients that live for months instead of weeks or days. This should be an ABNORMAL feeling. If clinicians feel a 10-day LOS is normal, they have become “conditioned” to short LOS.

Note: Clinicians have to believe that 4-6 months is normal. Basically admit any patient where there is a plausibility the patient might die within 1 year. This is because prognostications of death are usually off by 50% statistically. If you are told you are going to die in 4 months, you will probably die in 2 months as physicians often view death as defeat.

When MVI does Magic! with a Hospice, where we engage in the People Development department of an organization, documentation is the bedrock. It is the foundation of everything so it is one of the first thing we address and get to Perfect (Perfect = To the organization’s high Standards).

What we have learned from a 90th percentile Hospice is that you can transform a Hospice using documentation as the instrument!



Confidence in documentation WILL increase LOS.

(Confidence is a self-assessed state.)

Make it EASY for folks at the FI/MAC to look at your charts, see decline and stamp them “approved!” Extreme CONFIDENCE must be built into your Hospice’s documentation so clinicians are comfortable with long LOS patients. Will you receive ADRs or be subject to edits or reviews? Probably, as you will inherently deviate from the FI/MAC’s measures of central tendency regarding LOS, BUT you WILL get paid normally on 98% of your claims! You will get paid in 6-9 months on these claims, and therefore need to have 6-9 months of cash/near-cash in reserve so that you can continue to pay your bills and make payroll. If your Hospice does NOT have this level of reserves, you normally can NOT have long LOS patients for obvious reasons.

So there it is! I know this will not be a very popular piece as it flies in the face of the Herd. But the fact is that a Hospice has much more to do with LOS than it may believe... Take responsibility and own your LOS rather than blaming the outside world! You can SO do this!



Understanding the COPs

Extraordinary Managers know the COPs (Conditions of Participation). Nothing will make you look more ineffective than not knowing the rules. An *Extraordinary Manager* will get more respect from staff knowing and being able to quote them, not to even mention surveyors, nursing home people, hospitals etc. This includes documentation!

NHPCO Top 10 Hospice Survey Documentation Deficiencies

http://www.google.com/url?sa=t&rct=j&q=&esrc=s&source=web&cd=4&cad=rja&uact=8&ved=0CEIQFjAD&url=http%3A%2F%2Fwww.nhpc.org%2Fsites%2Fdefault%2Ffiles%2Fpublic%2Fregulatory%2FCMS_TopTenHospiceSurveyDeficiencies.pdf&ei=nwCOVLHJJYKmgwTW6oH4Ag&usg=AFQjCNGwXaV1Mek3dHc25I01Gr6M3bifkA&sig2=mpKXcdG3G8GEo4rbkMDzBA

1. Medicare Hospice Standard: Plan of care

Hospice failed to follow the plan of care or there was no plan of care

2. Medicare Hospice Standard: Supervision of Hospice aides at least every 14 days

The Hospice nurse visits the home at least every 14 days to assess the quality of care and services provided by the Hospice aide and to ensure that services ordered by the Hospice interdisciplinary group meet the patient's needs.

3. Medicare Hospice Standard: Content of the plan of care

Hospices failed to develop an individualized, written, plan of care for each patient that included all services necessary for the management of the terminal illness and related conditions. For example, oxygen use identified as a goal on initial visit, but oxygen therapy was not implemented until two months after the initial assessment. Facilitation to have oxygen removed from home per patient's request was coordinated by spiritual counselor without notification/ coordination with RN/ physician.

4. Medicare Hospice Standard: Drug profile

Hospices failed to ensure a review of medications on the initial comprehensive assessment. For example, an RN recommended Benadryl and cortisone lotion yet as of 11 days later no mention on the drug profile.

5. Medicare Hospice Standard: Coordination of Services

For example: A patient residing in an ALF did not receive two medications in accordance with the plan of care. The patient was on automatic drug refills with the pharmacy but because there were temporary changes to the dosages the auto refills were placed on hold. The patient went without these meds for approximately one month.

6. Medicare Hospice Standard: Nursing Services

Example: No documented measurements of wounds. A Hospice aide was changing the dressings to a patient's neck and around the feeding tube on a regular basis. The RN



was aware of this practice although the RN never instructed her to do this. These dressing changes were outside the scope of the Hospice aides practice. There was also no evidence in the clinical record that the RN provided any wound care or assessment. LPN's noted performing care outside their scope of practice.

7. Medicare Hospice Standard: Review of the plan of care

The plan of care is reviewed by the interdisciplinary team no less than every 15 calendar days and documented on the patient's clinical record.

8. Medicare Hospice Standard: Counseling services- Bereavement counseling

No documented evidence that families were contacted to offer and/or determine need for Bereavement services following the patient's death.

9. Medicare Hospice Standard: Competency Evaluation

The Hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.

10. Medicare Hospice Standard: Timeframe for completion of the comprehensive assessment

The interdisciplinary group, in consultation with the individual's attending physician, completes the comprehensive assessment within five calendar days of the effective date of the Notice of election.

If you need help with documentation

Weatherbee Resources, Inc.

Contact: Heather Wilson

These folks have done a great job in the compliance and documentation areas. They are great people, high integrity and have never disappointed in our book.

Phone: 866.969.7124

Web: www.weatherbeeresources.com

MVI INSIGHT:



A Hospice that can provide a narrower scope of services and products can actually have more satisfied patients/families/referral sources due to better expectation management.



Ideas that Must be Effectively Communicated

Here are ideas that must be stressed when teaching the Visit Structure.

We are not paying you to provide the care! We are paying you to Teach!

We are NOT making robots with our Visit Design! We are not using “scripts!” We want you to learn our Visit Structure so well that it liberates your personality to shine while doing 100% of the *Standards.*

Have each Student tell you explicitly (using precise language) WHY we strictly adhere to our Visit Design.

Care enough as a Teacher that no Student “gets out alive” without knowing the visit perfectly. The Teacher needs to be more of a drill sergeant personality rather than a soft, weak-willed person.



15 Creative Compensation

Your Most Powerful IPU Accountability Tool

People behave the way they are paid. Compensation can take the form of financial or non-financial rewards such as emotional satisfaction or an increased inner sense of wellness. However, here the focus is financial. Before I came to Hospice, I worked for a company that specialized in compensation systems. In my first Hospice CFO experience, we implemented a performance-based compensation system for clinical staff (The reason we didn't do it for non-clinical and Leadership is because we didn't know how to do it well at that time). The result was a 100% increase in productivity for all disciplines (except Spiritual Care – only a 50% increase) and a 100% increase in the timeliness and quality of documentation. I've seen similar results at ANY Hospice that has a well-thought-through, SIMPLE performance compensation system. I have implemented compensation systems in different settings and have increased performance as much as 400%. Complicated, stingy or infrequent systems don't work well. Compensation is the fastest way out of financial trouble and the fastest way to create a healthy Hospice culture. Why not let every paycheck become an automatic report card?

Compensation is a tool that many organizations fear. Why? Because it works. It works in that people and organizations change behavior based on how they are paid. When Medicare changes how Hospices are paid, does everyone keep doing things the same way and not comply? Of course not. Hospices react almost immediately. Human behavior is greatly influenced by compensation in all of its forms. The statement,

People behave the way they are paid

is one of the most fundamental truths known by humankind. It takes us back to our survival instincts that have been created over a LONG period of time. We are automatically wired to “get paid” or benefit from our efforts. Almost every human activity is focused on the payoff (a key point when establishing habits).

Of course, compensation is not the most important reason or motivational force in our work, or at least it should not be. However, it is a major consideration for all of us as money does impact so many aspects of how we live and how we spend our time. The phrase “incentive compensation” itself is a bit stupid as ALL compensation is used to incentivize people. This is



why we use the phrase “performance compensation.” So, if performance compensation works, it seems to make sense to get beyond our fear of it and learn to use it! Be positive about it!
[There is an MVI audio CD devoted to this specific subject called Compensation & the Model which may be helpful.]

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

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

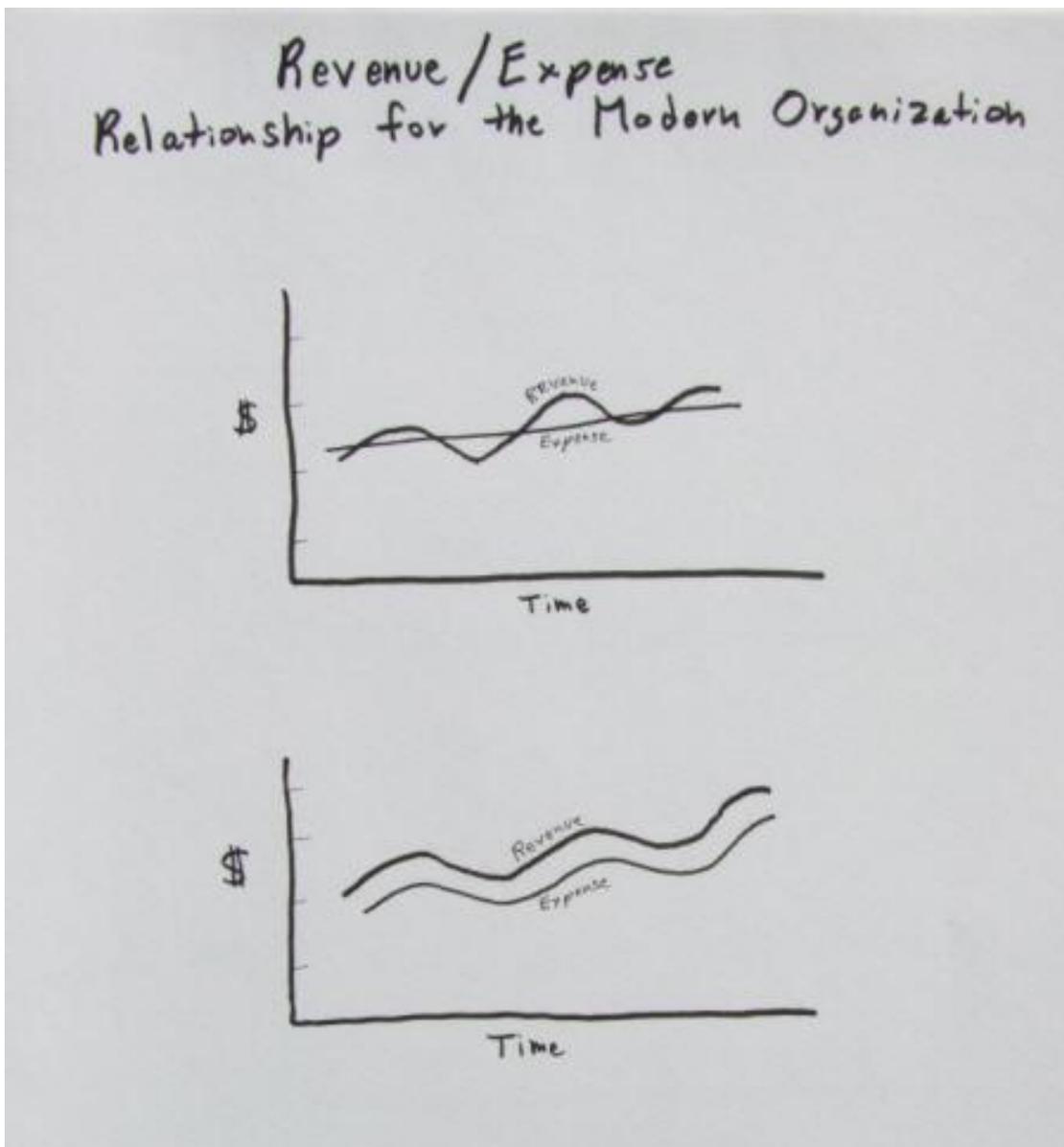
Even the Volunteer gets paid...



Also, let me add this comment. Tying compensation to Model performance will *supercharge* its implementation and impact. In fact, if I am working with a Hospice that is facing bankruptcy, performance compensation is one of my first moves because it is so *devastatingly* effective.

If we could create an ideal organization in terms of the relationship of revenues and expense, it might look like the latter graph in this illustration.





When one examines the cost composition of a typical Hospice as a percentage of Net Patient Revenue, approximately 63% of Hospice costs are related to labor (Direct 41% and Indirect 22%) and Patient-Related accounts for 18%, for a total of 81% of total costs. So 81% of a Hospice's costs can be tied to census volume. Ideally, it would seem to be a good idea to engineer and structure costs that vary with fluctuations of patient census/revenue. This can only be accomplished through structuring labor costs as variable. This would be a structure that would well serve a Hospice in the future facing rapid changes.



Key Ideas:

There are a couple of key overall ideas regarding compensation that we should consider. They are:

- Leaders and staff should be stakeholders. We want owners and not renters.
- Confidence in the organization, as well as self-confidence, needs to be high. You want people with enough confidence in the organization and their own abilities that they are willing to bet on themselves and the organization.

In our respective organizations, it is highly desirable for everyone working at the Hospice to view and feel that they are stakeholders and owners of the Hospice. There is a big difference in the care with which we conduct our activities when we feel that it's "our" company. People with pride of ownership notice stains on the carpeting and if something needs to be fixed. You want owners rather than renters.

In addition, you want confident people in all areas of the Hospice. It is perhaps the most important result of a successful Model implementation. Confidence will be transmitted through Leaders via the principle of replication. Therefore, Leaders need to be very confident.

These statements should be pondered:

Confident people render confident service. Unconfident people render unconfident service.

The fact is, people can't give what they don't have. You can't get \$1,000,000 from a person that doesn't have it. A loveless person can't give much love. You get the idea. The same holds true with confidence. Unconfident people will NEVER provide confident service. This hits home in Hospiceland because unconfident clinicians will NEVER render a satisfactory or confident patient/family experience. People can't give what they don't have.

The fact that we measure confidence in our FEHC scores (a very disliked measurement by unconfident Hospices) further demonstrates the importance of confidence. LACK OF CONFIDENCE induces PAIN and SUFFERING in patients and families. Therefore, our Hospices can't have unconfident people, period. This point has been stressed in most Model workbooks and media, but it is especially applicable in the context of performance compensation.



Use Compensation as a Tool to Find People with Confidence and to Smoke out People who Lack Confidence

The role of confidence has been discussed numerous times and is a major benefit of implementing and using a Model approach to Hospice management. However, most Hospices that “do the Model” don’t have the guts to address compensation. A Hospice should be highly confident in what it does if everyone understands the Model and if your Model is believed to be executed near-flawlessly. Since confidence is such an important attribute of Leadership, why not use performance compensation to determine if your Leaders are confident?

By tying compensation to performance, you find out if people are willing to bet on themselves and the organization.

With this move, you immediately find out if Leaders have confidence in their own abilities to meet their objectives as well as the organization’s objectives. This move will “smoke out” unconfident Leaders.

Use Compensation to Attract and Retain Completely Committed People that Believe in Creating an Extraordinary Experience

Completely committed people is what we desire at our Hospices. How do you get truly committed people? By casting a captivating vision, by leading with a powerful example and there are probably many other things. However, compensation commits people. It is why an employee shows up more consistently for work than perhaps volunteers (sadly, this isn’t always the case!). This is why FP Hospices are more creative and astute in managing their Hospices. It is their livelihood. Their home was used as collateral for the business. Their money is on the table. Giving your team skin in the game commits them. Skin in the game is a nearly automatic financial and emotional stake in the organization. Since money is highly emotional, it does both.



Compensation and the Hospice Medicare Advantage Carve-In

With the **Hospice Medicare Advantage Carve-In**, how an organization intentionally structures its costs is a big deal. Of course, your labor costs are by far your **BIGGEST** cost so it is critical they are structured so you can be profitable when census is up or down, where you **WIN** in either direction. This is achieved by structuring compensation so that it goes up when census goes up and it goes down when census goes down. But you can't do this if you are paying your people using tradition salary and hourly methods. With Managed Care, it is especially important to structure your labor costs to fluctuation with patient-volume as once these entities realize how much cost avoidance is possible, they can dump huge volumes of patients into a Hospice in short periods of time. To take much of the "sting" out of sudden census increases, you want an automatic system where your clinicians are paid more, in direct proportion to the increased demands placed upon them. So structuring labor costs to increase automatically is important when census is increasing rapidly. However, you also need it on the backside. Once a privately administered Medicare provider has you "hooked" or "addicted" to patient-volume on a certain level, they can control you by simply turning the referral spigot (faucet) on or off, or something in between. If they dial referrals back or stop referring and you have hired more people and increased Indirect costs and have **NOT** structured your costs to fluctuate with patient-volume, you will **IMPALE** yourself on your costs! On the other hand, if your labor costs fluctuate naturally with census, you have "walk away" power as it will not **KILL** you...and you will still be profitable without the MA deal.



Individual, Team and Organizational Compensation within the Model

The Model lends itself beautifully to performance compensation for **Individual**, **Team** as well as **Organizational** performance simultaneously... so three levels of compensation are combined in an ideal situation. This multi-dimensional approach is important as you don't want to foster silos nor do you want hard-working and high achievers to go unrewarded. You can have all three levels working for you.

We pay people for the performance of a function needed or desired by the organization. There are two essential questions that are linked to functional performance:

- 1. Is the cost of the fulfillment of the function acceptable? [Cost]**
- 2. Is the function being done well? [Quality]**

For performance compensation to be paid out, the financial performance Standard has to be met FIRST. If there is no gain, there is nothing to pay out. The first question is answered by the Model very effectively, especially for Managers. Your Hospice's monthly benchmarking shows the financial performance of each area of your Hospice, expressed as a percentage of NPR (Net Patient Revenue). These NPR%s would then be compared to your Model or the MVI Model. ANYTHING that exceeds the Standard is unacceptable. A performance compensation structure will be discussed in a subsequent section that is constructed around these ideas.

The second question involves a Hospice setting clear and well-defined performance/quality expectations for each functional area. Most Hospices *already* have "something" established in the area of quality. If not, I'd say there is a problem. *The quality measures that are already established can stay intact when the Model is implemented, unless they are too complicated or are weak.* The Model or performance compensation does not change these Quality Standards. However, if quality/performance measures need to be bolstered, then this needs to be done regardless of whether you're using the Model or not. The question of whether a function is being performed well can become quite involved and MVI has suggestions. If functions or the basis for functional evaluation is not established at your Hospice, we advise that you do so as soon as practical.



SuperPay! The 5-Ways-to-Get-Paid Approach to Accountability Compensation

In the SuperPay! approach to compensation, a person gets paid on an Individual, Team and Organization basis. The 5 ways are:

1. *Base Pay* - Salary or Hourly Rate - 100% or 90-95% of current pay unless it is excessive) – Semi-Monthly
2. *Standards Bonus* (5-10%) (10-20% for Managers) – Semi-Monthly
3. *Individual Pay* – Semi-Monthly
4. *Team or Manager Pay* – Monthly (Based on Savings)
5. *Organizational Pay* – Quarterly (Based on Savings)

SuperPay! (Brand your Comp System!)

1. Base Pay - Salary or Hourly

- 100% or 90-95% of current pay UNLESS comp is excessive

2. Standards Bonus

- “Just Doing Your Job” Pay (5-10%) (Managers 10-20%)

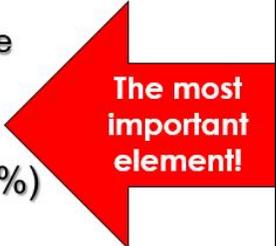
3. Individual Pay (For above Standard Productivity)

4. Team or Manager Pay (Based on Savings) Monthly

5. Organizational Pay (Based on Savings) Quarterly

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.”



The most important element!



The Model™
Balancing Purpose and Profit...



This methodology can be applied to clinical teams as well as to Indirect areas such as Finance, HR and IT.

Base Pay

Base Pay is similar the pay in a traditional Compensation System. It is usually either a salary or an hourly rate. It is used in this system to help get people past the “fear barrier” by providing them something that is very familiar. Care should be given NOT to set *Base Pay* too high or at very comfortable levels or you will rob the other pay categories of their power.

Most organizations have compensation systems where salary or hourly rates are set for each employee. However, within a system such as *SuperPay!!*, a static amount can be set by position and not by employee. This simplifies payroll and eliminates the assumption of a raise or COLA increase every year. Since we do not encourage typical annual reviews, this relieves the burden of having the awkward conversation with an employee expectation of additional pay. However, when implementing a compensation system, adjusting everyone’s pay to the same rate can be **emotionally jolting**. Therefore, I would recommend that you leave people at their present compensation (adding the 5% Standards Bonus to their present pay or adjusted to 90% Base and 10% Standards Bonus) and subsequently all new employees come in at a standard rate by position. The point is that everyone will be making great money! And you want people to become highly dependent upon the “additions” to their Base and Standards compensation from Individual, Team and Organizational Pay!



Standards Pay or Standards Bonus

Standards Pay is one of the most revolutionary concepts in compensation practice. It is structured as a bonus. We expect you to receive 100% of your *Standards Bonus* every pay period for just doing your job. We aren't asking anything unreasonable or outrageous. There are no goals or stretches with *Standards Bonus*! *Standards Bonus* should be taxed as regular pay and not as bonus pay.

NOTE: Up to 75% of the value of an Accountability pay system will come, not from increased pay, but rather from *Standards Pay*!!!

This is one of your most EFFECTIVE pay components. It is rarely used, but is wildly powerful. The thought of not receiving a mere 5-10% of a regular paycheck for just “doing your job” will motivate people to action. **It is not a reduction or taking away pay.** There are legal implications with “taking away” people’s pay, so the wording and communication of *Standards Pay/Bonus* is important. It must not be presented or communicated as a dig, ding, reduction, take away, removal, deduction, etc. It is rather “a bonus or extra pay we expect you to receive every pay cycle for just doing your job!” The 5-10% *Standards Bonus* is a big motivator! Most people can handle a little less in their paycheck for a week or two. This is not the main reason *Standards Bonus* works. Rather it is the thought of failure...a slight rejection from the group. *Standards Bonus* impacts self-concept and how a person FEELS emotionally about him or herself. *Standards Bonus* involves pain. And humans LEARN from pain, perhaps more so than from pleasure or gain. I know the idea of using pain is a difficult concept for most people as it flies in the face of mainstream ideas about management and being a caring person. Yet, most of us can personally testify that we learn more from our painful life experiences than our positive ones. We want to avoid pain almost at all costs. We would often forsake the potential for tremendous gains if our present comfort is threaten. Pain is a motivator. People will do



most anything to avoid or relieve pain. *Standards Bonus* is a method of recognizing how human beings behave in reality and structuring a system to flow with this reality.

We have discovered through Magic! implementations of compensation systems that 5% usually works, as well as 10%, for the Standards Bonus. What “moves” people is the emotional aspect and not the dollar amount so much. With Managers, you will want to use a larger percentage, perhaps 10-20% because they are the replicators of your Model and are responsible for 70% of the development of their team members. You also want your Compensation System to cause poor Managers to quit so you don’t have to fire them. When we can, we recommend 20% for Managers. One of the most harmful things an organization can do is keep failing Managers who will replicate poor performance and bad results in the employees they lead.

The Additive Approach to Implementation of the Standards Component

There are different scenarios to consider when implementing the Standards Bonus.

- If wage levels are not excessive, an organization can simply ADD the 5% Standard Bonus (again structured as a Bonus) and this will provide the organization with the Accountability tool it needs. You will not see your overall labor costs shoot up (except for maybe the first month) as you will see an immediate impact on the QUALITY and quality will decrease your overall costs. This is called the Additive Approach.
- If wage levels are excessive (you are paying people a lot of money to do very little), then you have a real problem. It will be difficult to ask people to do more for less. You will lose people. But you still need to bite the bullet and do it... This is called the Subtractive Approach.

Once you have your Standards Bonus structure in place, you can start with easy Standards like meeting promptness, dress, professional development modules, etc. Then once clinicians get used to this, you can go do Perfect Visit and Perfect Documentation Standards. This is a nice progression that has moved Hospices to 100% compliance regarding all the important Standards!

Also, when implementing the Standards Bonus, we pilot it with a team that is already winning! We show the Clinical Manager what they are presently making as compared with what they will be making in the “new comp system” if they just do what they are already doing! The entire team wins and soon nearly all of the other Clinical Managers want to be on the system!



Eliminate the Need for Annual Evaluations

If *Standards Pay* is employed there is no real need for annual evaluations. The fact that a person is still employed at your organization means that they are doing their jobs to Standard. Their pay checks tell them if they are in Standard or not as your systems would detect any deviation from Standard in all important areas such as documentation, productivity and quality.

Remove 4 HUGE Duties from Clinical Managers!

There are 3 duties that can be removed from Clinical Managers with a Compensation System linked to Standards. They are the need to:

- Monitor Documentation
- Monitor Productivity
- Annual Evaluations
- Need to Fire People

All 4 of these things can be eliminated! It is almost hard to believe! The question that comes to most people's mind is "If the Manager isn't doing these things, who is?" The answer is, "Your systems!" Part of the design of a great Compensation System is that all supporting systems are "sensitized" to detect any deviation from Standard. You want your systems to do the work for you. This includes getting rid of negative aspects of Management.

The purpose of removing these duties is to free up time to do the *1st Duty* of a Manager, the duty to teach as all quality comes from the quality of our people. The *Extraordinary Manager* will devote most of his or her time to teaching. Therefore, we design *structures and systems* in the Model that remove common and often unpleasant tasks of management and work where possible.

Sensitize Your Systems

As part of the Compensation System, several Indirect and Supportive areas will change the way they operate. There are really only 3 things that will be monitored and apply to all clinical disciplines in all areas. They are 1) Documentation, 2) Productivity and 3) Quality. If you can't get the Quality component, you can do it with only the first two! However, normally there is something in the EMR that be pulled in report form that can easily indicate Quality.

Compliance/QA – Compliance samples charts on a weekly basis to a 90% statistical confidence interval. This is a surprising small number of charts. It randomly picks charts like an auditor would and reviews it. If ANY element of the chart is not to Standard:



1. A code with the date are placed on a simple manual employee list, denoting a deviation from a Standard. This will be turned into Payroll before the next payroll run.
2. A Standardized email is sent to the individual with a link to the Documentation Self-Learning Module and the Manager is copied on the email. The clinician has 1 day to complete the self-learning module. The Manager at this point has awareness of an area to teach and coach providing an opportunity for “ride-a-longs” or other teaching.
3. *Standards Pay* is not paid. This is structured as a bonus of 10%, a bonus that is paid for simply doing one’s job with no stretch or goals.

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											
	Pay Period	Period	Period	Period	Period	Period	Period	Period	Period	Period	Period	Period	Period
1	Doe, Jane	3/19 A	2	3	4	5	6	7	8	9	10	11	12
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													

For this sequence to happen, ideal charts must be created for the most prevalent diagnosis groups.

IT – Creates or modifies output reports from the EMR for 1) Productivity and 2) Quality, which could be Average Pain Scores, satisfaction scores or any other indication of satisfaction with services. They key is that it must be EASY to access in the EMR. An “exception report” is recommended that isolates only clinicians that are not at Standard in Productivity or Quality. These reports would be run by Payroll immediately before a payroll run. Any person that is below Standard:

1. A checkmark would be put next to the employee’s name.
2. A Standardized email is sent to the individual with a link to the Productivity or Standards Self-Learning Module and the Manager is copied on the email. The clinician has 1 day to complete the self-learning module. The Manager at this point has awareness of an area to teach and coach providing an opportunity for “ride-a-longs” or other teaching.
3. *Standards Bonus* is not paid. This is structured as a bonus of 10%, a bonus that is paid for simply doing one’s job with no stretch or goals.



Finance – Finance is involved with the calculation of payouts based on “Savings” from performance that is LESS than Team or Department Standard of Net Patient Revenue (NPR). This calculation normally comes from the MVI Comprehensive and Team/Location Reports. Finance must denominate this “Savings” difference in dollars, where it is distributed in the established proportions to the Manager and on an FTE basis. This is why the NPR Standards are not “ratcheted” down too tight. Many think that the 38% Direct Labor or 17% Patient-Related amounts are difficult. The truth is that the 38% is only 3% less than the median Hospice! And the 17% is only 1.5% less than the median! These means that with a little effort and the adoption of a few “best known practices,” a Hospice Clinical Manager can MASSIVELY outperform the MVI Model! Direct Labor can be driven down to 32%! And by just using Wise Hospice Options (Grant F.) Patient-Relateds can drop to 14%! This opens up tremendous bonuses based on SAVINGS! There are no other words to describe it! These savings are calculated and bonuses are cut out on a monthly basis after the financial reports are run (which should be by the 3rd week of the month). It is literally that simple! The discipline that is involved is DON'T GET GREEDY! Even though you know that Clinical Managers can beat the Model, don't change it! Settle for the CUMULATIVE 14%!

Payroll – Before a payroll run, the person (as it only takes ONE person for even thousands of employees) reviews the lists and reports. Anyone with a check, the Standard Pay is not given. It is that simple...

This small disappointment in Self...does the work for the organization. The denial of *Standards Pay* (a bonus for just “doing your job”) is not enough to materially impact a person's Life...but it may be enough to rethink Starbucks the next week! The impact is normally an EMOTIONAL impact as we all want to FEEL we are doing our job! The slightest idea we are somehow “isolated” or “let down” the group, even for a brief period, is enough to motivate most people to do the Standards of the organization! *Standards Bonus* is a form of pain...and there is HIGH value in pain. It is a slight pinch that helps our organizations become WORLD-CLASS! It is Accountability! A trait of all top-rung organizations! And it requires little expenditure of Energy!

The Reduction of Indirect Costs

Many Indirect costs are the result of “hiring people to make sure clinicians do their jobs.” This is a waste of resources. If *Standards Pay* is in place, an organization simply does not need a lot of FTEs as everyone is doing their jobs! Thus, Indirect Salaries plummet. They can shrink as low as 15% instead of the typical 22-23% for median Hospice! This is HUGE! Then imagine that 7-8% of NPR being distributed to the Indirect staff as well as front-line clinical staff! All of this is enabled by the use of *Standards Bonus* and people actually just doing the basics of their jobs!



Why Such Emphasis on Documentation?

Documentation is the basis for any Hospice to have a claim of being an interdisciplinary team. It is the **ONLY** practical way to orchestrate a coherent, integrated care experience. We would document even if we didn't receive a dime from Medicare as we are not telepathic (Although this may be debatable on some level!).

1. The first reason we document the way we do is **BECAUSE WE CARE** enough for patients and families as well as our co-workers, as each clinician is dependent upon each other. Each clinician needs to be able to depend upon the other as a true interdisciplinary team. A team based upon mutual reliance.
2. The second reason we document is because it is the way we are paid! However, the former reason is the most significant as it is based in LOVE and COMPASSION, but the latter is important as the mission and capacity to LOVE in this way is compromised if funding is compromised...

The Standards Bonus is the KEY to This Entire System!

Sometimes an organization will spend tons of time and Energy creating Standards...only to waste it or get a diminished result by going weak when it comes to implementing the Standards Bonus component. Why? There is FEAR people will quit or that they won't be able to attract clinicians. We understand this human phenomena. However, the truth is that the people you want to keep WON'T quit if it is explained (Taught) well and people see the personal benefit for them from such as system! Your weak people **NEED** to go as they will destroy your reputation as an organization as well as a CEO if they are allowed to remain. Even if your staff have to work short for a short period of time or even if you have to pull back in census temporarily, you will be positioning your organization for GROWTH through a radical increase in quality! **You can't get the quality we are shooting for without strong Accountability structures** that required little Energy on the part of Managers, especially Clinical Managers where 70% of your strength will come from! It is easy to miss the utter importance of Accountability after the creation of Standards. Often when this failure to pull the trigger on Standards Bonus happens right at the point of implementation and most of the time the CEO doesn't understand the enormous benefits they are giving up by NOT implementing Standards Bonus.

What is an organization giving up by NOT doing Standards Bonus?

- **You can't offer a "Life-Style" to clinicians where you remove 8-5 work hours and treat them as a true professional.** You can't provide front-lines this flexibility because your systems won't be doing the Accountability. This needless burden will fall on the



Clinical Managers. Hospices have been doing this for decades. How well do most Clinical Managers hold their people Accountable? Point settled...

- **You can't remove the duty to monitor documentation, productive or quality from Clinical Managers.** It can't be done! Therefore, they will NOT have the time to teach and coach.
- **Decreased Attraction of Talented People.** You will have a difficult time recruiting TOP RUNG Clinicians and Talent as the quality of the organization will not be attractive to these people.
- **Your quality will NOT be what it could be...** And your organization will pay an ENORMOUS price everyday with service failures, broken Standards and average to poor documentation.

There is perhaps ONE thing that all World-Class organizations have...and that is strong Accountability! Anytime an organization does not get the results it wants from the Model or any serious initiative, it almost always comes down to weak Accountability.

If you don't do the Standards Bonus where your "systems" do the work and monitoring for you, how then are you planning to do Accountability?



The hard truth is that most Managers don't want, and are thus reluctant, to truly hold their people Accountable. It is flat-out unpleasant. Your compensation system can do this job for them and thus remove some of the most negative aspects of being a Manager.

If your organization does not do Standards Pay or a Standard Bonus, what are your options? It means that you will have to rely upon the same Accountability methods which most organizations use...which are NOT effective.

- You can't offer "No 8-5 Lifestyle" flexible work routine to employees
- You have to do hard-ass, management.
- Your Clinician Managers have a much tougher job.
- Your quality will never be as high as it could be.
- Your economics will never be as good as they could be.

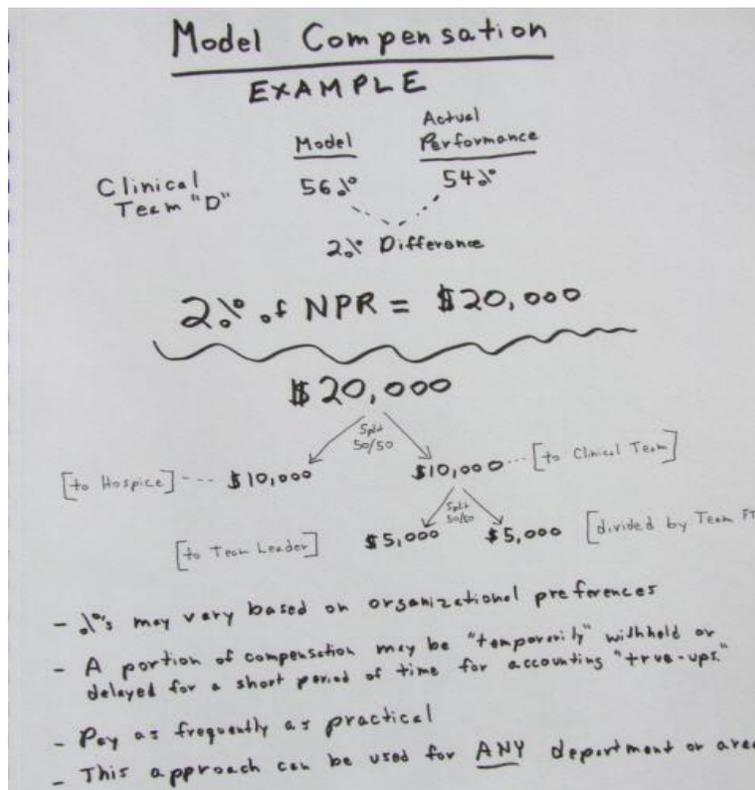
The pragmatist recognizes that doing the same things will get one the same results.



Team Pay or Manager Pay

Team Pay or Manager Pay is one of the most powerful aspects of this approach to compensation. It gets all Managers in the game! This move alone can change a Hospice culture without doing anything else! So it is a good place to start the discussion since the methodology employed is the primary driver of the system. Here is how it can work for any team or area of the Hospice from clinical teams to HR and IT. **The most important position that needs incentive is the Manager** as 70% of the development, retention and morale will come from the immediate supervisor. The Manager has to be incentivized to MANAGE. Therefore, the incentive has to be “enough” to motivate! In fact, the entire Manager Compensation Package has to be substantially **BASED ON RESULTS**. In the example below, a “split” of the savings from beating the Contribution Margin is shown going to clinicians as well as the Manager. But we have found a more direct way of doing this through Individual Pay. This frees up more money to put into the pockets of the Clinical Manager, thus making the position more desirable. We will call the two options the 1) Split and the 2) No-Split methods. One or both can be used. For example: Clinical Teams can use a No-Split Method and Indirect departments can use the Split Method. The point is you have options!

Here is a clinical team example that includes the Splits method between the Clinical Manager and clinicians:



In this example we have Clinical Team D. The Model for a clinical team is a contribution margin of 56% of NPR. The team was able to beat the Model by 2%, which results in a savings of \$20,000 for the month. In this case, 50% (\$10,000) of the savings would be kept by the Hospice. The remaining 50% (\$10,000) would be distributed to the team with 50% (\$5,000) going to the Clinical Manager and 50% (\$5,000) being distributed by FTE to the members of the team. So if there were 5 FTEs, then each would receive a check for \$1,000 for the month in addition to their regular pay. However, if the Quality Standards were not met, then ANY Accountability performance compensation would be revoked.

A Better Way of Doing Team Pay or Manager Pay – Tie Individual Pay to the Contribution Margin of the Team

MVI is now recommending a more powerful way of doing Team or Manager Pay. In order to INCREASE the percentage of the savings “split” between the organization and the Manager, the portion that goes to clinicians is eliminated. However, to provide incentive for clinicians to “care enough” about the performance of the overall team to perform at high levels, the amount of Individual Pay is REDUCED IF the Contribution Margin Standard is not achieved for the team. This method is superior as it is more DIRECT. Normally, the more direct the relationship between pay and performance is, the stronger the compensation method. For example, if a clinician merits Individual Pay due to beating the Productivity Standard, but the team’s Contribution Margin is less than Standard, then the amount of Individual Pay is 50% of what it normally would be. This provides STRONG and DIRECT incentive for the entire team to be winning! It also helps to eliminate clinicians from “gaming” the system by switching patients unnecessarily in order to get more Individual Pay.

FOCUS on Contribution Margin

Team Pay is where the driver of the compensation of Managers, especially Clinical Managers, takes place. **Managing by NPR (Net Patient Revenue) percentages is the “governor” of your entire organization’s costs and guards against losses or mismanagement.** This is why when the Additive Approach is used to implement the Standards Bonus, the organization need not fear that the added 5% will increase costs. It won’t because the Manager will learn to manage their people more efficiently out of self-interest and discover that there is usually VAST inefficiencies and capacities within teams.

Contribution Margin is a RESULT. Elegant organizational systems use simple and direct measurement and standards that impact many others. Contribution Margin is a great example of a single measurement, which would naturally and automatically drive a multitude of other



metrics to the levels desired by the organization. Managers learn to manage to a result. This result creates increased FOCUS and eliminates directional confusion.

Determining the Contribution Margin - Market Adjusted Contribution Margin

In some CBSAs there can be a mismatch of average wage levels and Medicare reimbursement, especially in areas that cross state lines. Hospice per diem rates can vary by 30% with the average wages being about the same in both. This brings up the question of what the Contribution Margins should be as you want the fairest system you can use at those sites with lower reimbursement and a similar wage base will have a more difficult time meeting the Contribution Margin Standard. The preferred way to do this is to use one Standard Contribution margin across the entire country. This is easiest to teach and does not confuse people. A single Standard Contribution Margin is possible, if there is “enough” tolerance in your Standards. MVI often uses the 17% Patient-Related NPR% even though most Hospices can achieve this as it provides some cushion for specific areas that are more expensive in a market. However, perhaps a better system would be what we will call the Market Adjusted Contribution Margin.

To me it is a bit too complex, and though it is helpful when you start to develop different Contribution Margin Standards. After a while, you just start to adjust by 2 or 3 percent only for sites that there is a “known disparity” between the Tier I rate and local clinical wages.

Here is how it might be calculated:

This is where we take the base CMS Tier 1 Per Diem Rate for the nation and compute the percentage difference for each site and then decrease this percentage by 75% and apply the calculated percentage to the Contribution Margin percentage.



Market Adjusted Contribution Margin

	Tier 1 Per Diem	Difference in Dollars	Converted to %	Proportionalize 25% of %	Market Adjusted Contribution Margin	Rounding
CMS Base	195.65				50%	
Site 1 - TX	169.28	26.37	13.5%	1.7%	48.3%	48%
Site 2 - OR	222.05	(26.40)	-13.5%	-1.7%	51.7%	52%
Site 3 - San Fran	280.00	(84.35)	-43.1%	-5.4%	55.4%	55%
Site 4 - IA	140.00	55.65	28.4%	3.6%	46.4%	46%

Example:

- 1) Determine the Difference from Base
 $195.65 - 169.28 = 26.37$
- 2) Convert into a % of Base
 $26.37 \text{ divided by } 195.65 = 13.5\%$
- 3) Proportionalize Using a %
 $13.5\% \times 25\% = 1.7\%$
- 4) Add or Subtract from Standard CM
 $1.7\% - 50\% \text{ Contribution Margin} = 48.3\% \text{ Market Adjusted Contribution Margin}$

This provides some relief for sites with lower reimbursement and causes those with more favorable reimbursement to contribute more. The Proportionalized Factor is arbitrary based on your professional judgment.

An Indirect Example – A Finance Team using the Splits Approach

Let's say the Finance Team Model percentage is 2.25% of NPR (Net Patient Revenue) at your Hospice. Suppose that the Finance Team actually performed at 2% of NPR for a month resulting in a savings to the Hospice of \$10,000. In this case, we would recommend that 50% of the savings (\$5,000) is kept by the Hospice. The remaining 50% of the savings (\$5,000) would be given to the CFO and the Finance team with \$2,500 going to the CFO and the remaining \$2,500 being distributed evenly to the other four FTEs in finance area. This compensation is IN ADDITION to their regular pay! Let's look at another example and take it farther:



Sunny Day Hospice - Compensation Structure

The 4-Ways-to-Get-Paid Approach

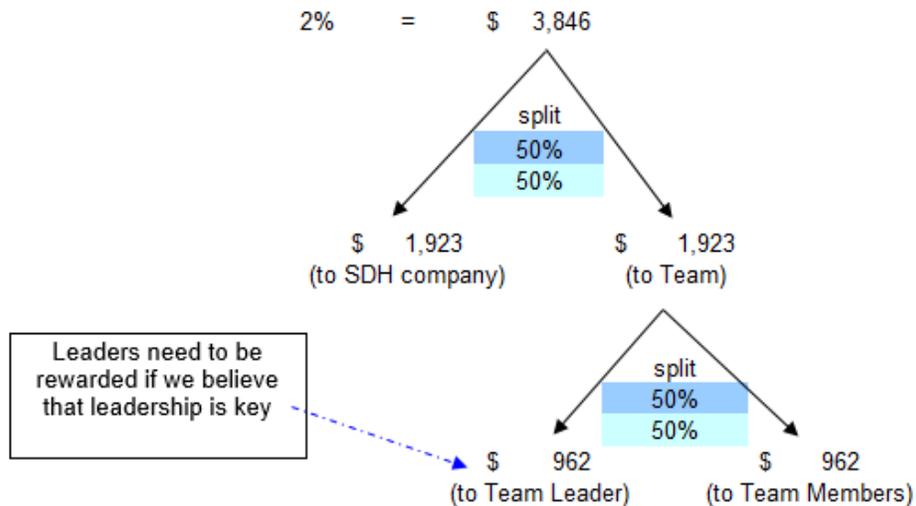
Version 3.1

Total NPR = 5,000,000
 1 % of NPR = \$ 1,923 for a two-week period (26 periods)

Example Area	Actual Performance	NPR% Model	Difference	Frequency
--------------	--------------------	------------	------------	-----------

Clinical Team A

- | | | | | |
|--------------------------------------|-----|-----|-----|----------------------------|
| 1) Base Salaries (lower than market) | | | | Per Pay Period |
| 2) Individual Excellent Bonus | | | | Per Pay Period |
| 2) Team Bonus | 48% | 50% | -2% | Per Pay Period |
| 4) Organizational Bonus | | | | Quarterly or Semi-Annually |



In this example, Clinical Team A beat the Model by 2% of NPR. The Model contribution margin was set at 50% and the team performed at 48% of NPR. 2% converted to dollars is \$3,856. Thus, \$3,856 is divided between the Hospice and the team, each receiving 50%. Both the team and the Hospice receive \$1,923 (50%). In this case, the Clinical Leader would receive a check (in addition to regular pay) for \$962. The remaining \$962 would be distributed by FTE to the team members.

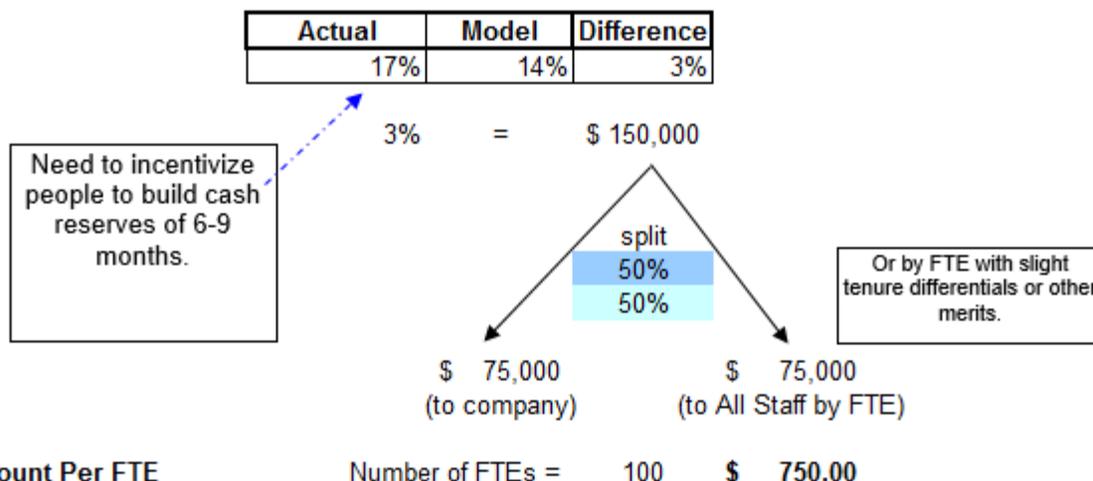
In the prior examples, the team portion is split 50/50 between the Clinical Manager (or area leader) and the team members. This is an example of Team compensation, though it is also the Manager's individual Performance Pay as the leader's performance is based on the team's performance. The 50/50 split is an arbitrary determination. It could be 70/30, 60/40 or whatever your Hospice wants. However, it must be perceived as fair, it must be sustainable over the long-term, work must be done that meets or exceeds the Quality Standards and it has to be "enough" to motivate.



Organizational Pay

Now let's apply the same principle to compensation for the overall organization.

Overall Company Compensation



Let's add an element for overall Organizational performance. Let's say the Hospice as a whole beats the Model by 3% and it represents a savings of \$150,000 for the quarter (Usually Organizational Pay would be distributed every quarter – annually is too long!) Using the same methodology, 50% of the savings would remain with the Hospice (\$75,000). The remaining 50% (\$75,000) would be distributed among the staff according to the number of FTEs. In this case, if there were 100 employees, simply divide the \$75,000 by the number of employees. Each FTE would receive a check for \$750 (less taxes and other deductions of course). So every full-time Nurse, Hospice Aide, SW, IT person, Finance person as well as the CEO and other Managers would receive a check for the quarter for \$750.00. For some people, this might mean more to than others. For many Hospice Aides and others, it would be a much welcomed addition. Heck, it would be nice for anyone!

We have had situations where *Organizational Pay* has been consciously omitted. In the case with some For-Profit situations where some shareholders or owners have different ideas or commitments or need “room” for significant shareholder changes, it might be fine to leave this pay category out. If an organization (NFP or FP) faces circumstances that are quite uncertain (extraordinary and non-reoccurring items) where the company will have large or material payouts, a company might not choose to have *Organizational Pay*. We think *Organizational Pay* is a good idea, even with such events as pay is a communication tool of the overall health



of the company. **If an organization does not have 6-9 months of financial reserves, we usually don't recommend the use of Organizational Pay.**

What about when Census goes Down?

You may be thinking, "This all sounds good when census is high as it makes hitting the NPR percentages easier, but what about when census decreases?" Is the Accountability or Empowerment Pay system going to penalize me in the same proportion? Here's our advice (this is where the Base and Flex components of *Individual Pay* come into play for Managers):

If an area is less than the Model NPR percentage (even .01%), the Manager (and only the Manager of the area) would not receive his or her *Standards Pay* (normally 10% of *Position Pay*). **Others in the department would not be impacted other than not receiving the Team Pay component.** This slight pinch automatically sensitizes the Manager that there is a financial problem. In this case, the "system" is working for you, sending the message that the Manager is "out of the Model."

This approach can be used for a clinical team as well as for any Indirect area. If the Blue Team beats the Model and the Red Team doesn't, then only the Blue Team gets its *Team Pay*. If both teams beat the Model, both receive their *Team Pay*. In fact, when using this type of approach, EVERY area could hit their marks and it would still result in overall savings for the Hospice! Many bonus plans almost bankrupt companies if everyone hits their marks (In fact, they count on everyone NOT hitting their targets). Because this is based on savings, we want every department to be within the Model. Also, if the 50/50 split is too rich for you or is not enough, adjust it. Remember that you are always dealing with savings or beating the Model. I would advise that you not go beyond a 30/70 split with 30% of the savings remaining with the Hospice.

You may argue with this example methodology and say that Marketing and Admissions has more to do with achieving NPR percentages than a Manager of a Team or area. The truth is that BOTH impact NPR percentages! A Manager is responsible for the costs that he or she can control within his or her respective department. This is internal and is the responsibility of the leader of the area. They are paid to manage, right? An area is also impacted by external forces and the Manager has to adjust for that reality as well. So it is both internal and external. ALL Managers should be acutely concerned with census and have a mindset of improving it. EVERYONE IS RESPONSIBLE FOR CENSUS. In this system, perhaps we will be more motivated to give marketing and outreach a hand?

Too many times in a Hospice, census decreases and people sit around and complain. This can go on for months. The low census can even be welcomed by staff members. In fact, they get used to low caseloads and after a few months of low census Managers begin to say, "I think I'll



knock off at 3:30 today... not much happening here.” This is dangerous thinking! Then when census finally starts to climb, people will complain that they are “overworked” even if the census is just increasing back to normal levels. Why does this happen? **Because the Managers are not personally and immediately impacted by the decreased census. Managers need to FEEL the sting of low census... they also need to be rewarded when they are working hard during times of growth.** Everyone needs to FEEL the sting of low census and the more immediate the sting is, the more rapidly the organization will respond. You might say that all staff members should FEEL the pain of low census and not just the Managers. Perhaps. But I see low census as a Management problem.

This heightened sensitivity to census or cost problems can be analogized to the human body, a highly integrated system. When pain is felt, it immediately causes a reaction and sends signals that there is a problem along with the compulsion to alleviate the problem/pain... as soon as possible. This methodology does a similar thing organizationally. When there is an injury or problem, the rest of the body is alerted via the nervous system. *Money is the nervous system of your Hospice.* As a CEO, you don't have to spend Energy putting out a memo or holding a meeting about the low census. Everyone knows it! The structure saves you the effort... and the structure will rescue you as well! By directly linking compensation in this way, the collective consciousness of growth and profitability is automatically increased on an individual and team level and an overall organizational level. The organization really becomes a much healthier, unified system. Again, just as the human body works as a unified whole and is impacted by what happens to each part of the body, a similar thing happens to each part of the Hospice as well.

Is Marketing in the “Hot Seat?”

The “hot seat” in this type of Compensation System would normally be perceived as the Manager of Marketing. However, this is too narrow of a view. There are many players including the Manager of Admissions, Education (especially Documentation Education), the head of the UR committee, Team Managers, etc. Marketing is everyone's job, but the Manager of Marketing is supposed to be the expert.

What if Marketing needs more resources which would likely increase Net Patient Revenue? Whenever the Model needs to be changed, it is a decision that needs to be pondered. The CEO is always the Gatekeeper of the Model and must make the final decision regarding Resource Allocation. If one area is increased, another has to be decreased or the profit level will be reduced. If overall NPR would increase as a result, most Managers are going to say “yes” to the request for more resources for Marketing!



Individual Pay

Individual compensation can be the most complicated of all the pay types. And we know that complicated doesn't work well, if at all. Clinical disciplines are the easiest to apply performance compensation to since they perform similar tasks. Supporting areas are more difficult because you have many people doing different tasks. However, if you think enough of a function to pay money for a position, then certainly Standards of productivity for the position should be created.

Individual Clinical Pay

Clinicians are normally paid a salary or an hourly rate. Some Hospices can start the implementation of their Accountability or Empowerment Compensation System without changing what clinicians are already making (except for changing 5% as Standards Bonus) and the individual performance aspects are treated more like a bonus or additional pay. *However, if current salaries and wages are too high, then adjustments must be made.* This is a difficult thing to do. It is ultimately about ROI. If you are going to pay a super wage, then you better be getting super results!

The basic measurements of productivity for clinicians per pay period are:

(1) **Number of Patients Visited** and (2) **Visits**. A Hospice can use either or both (we will discuss the quality measures later). This is especially important in SuperPay! as productivity is where Individual Pay is earned.

The point is to incentivize the behaviors you want. When it comes to Individual Pay, the point is not just to give clinicians more money, but to get a result.

For example, Visits as a way of paying Hospice Aides and sometimes LPNs works as this is the type of productivity you want to encourage. It is more task-oriented type of work. Visits also encourage more efficient visits as "work expands to fill the time allotted" when there is an hourly emphasis. Visits, however, are NOT a good idea for RNs/SWs/PCs mainly because the idea of a managed care organization is to "professionally manage the care experience. Visits are certainly part of this, but phone interactions, POC coordination and other professional assessments/interventions are part of this job.



Here is why you don't make Visits the primary productivity measure for Individual Pay RNs, SWs and PCs. I will mainly focus on the RN, but keep in mind that much of this can apply to SWs and PCs as well!

- The best RNs do less visits, as they are effective Teachers. People aren't freaking out when changes happen. Encouraging or incentivizing more visits defeats this. It will defeat your best RNs.
- We want to encourage more telecommunicative interactions and skills as these can be BETTER from a patient/family perspective than a visit. Sometimes a visit from a clinician is inconvenient!
- Historically, an RN paid by the visit can blow out your financials, if the amount is set too high. I have implemented these before and got killed when clinicians started doing 7-9 visits a day! Plus if Nursing Homes and ALFs are in play, then HUGE numbers of visits can be done! This is NOT what you want! A Hospice Aide visit is much less "elastic" than an RN visit. This is a physical limiter of how many Hospice Aide visits can be done in a day. A unit of Average Caseload or Number of Patients would be a higher Individual Pay amount than a Visit in most cases.
- Hospice is a Managed Care Organization. It is not about "doing visits." We are paid by Medicare to "professionally manage" the care.
- If Visits are used, more Energy will be used by Clinical Managers to monitor "who is being visited" as clinicians can fall into "favorite patient" syndromes and start making unnecessary visits.
- Cranking out visits FEELS very production-oriented, whereas Average Caseload or Number of Patients FEELS more appropriate for a "professional." We want to respect the position.

Number of Patients Visited Per Pay Period for RN, SW and PC Productivity

Average Caseload can be a difficult thing to get in some EMRs. A simpler alternative can be **Number of Patients Visited Per Pay Period**. This is simply running reports that contain the clinician and the patients that they have visited in a pay period. **This number will be a bit larger than Average Caseload, but will work EVEN BETTER because it takes some acuity into account as a clinician with a lot of new patients and deaths would have a higher patient count!** If an RN or other clinician helps out another clinician by doing a visit, this would also be counted in the person's Number of Patients Visited. Normally, the dollar amounts for Number of Patients will be slightly lower than Average Caseload because there are more! You can "stress" or test your Individual Pay amounts easily using the Model Teaching Tool Version 18.2 or 18.3 as you want to assume that 100% of your employees are receiving additional Individual Pay based on productivity that exceeds the Excellent threshold. Average Caseload is inherently difficult to calculate as it involves knowing the number of patients each day and doing an average calculation. Number of Patients Per Pay Period is



vastly easier as it only requires knowing what patients have been assigned to clinicians over the period of the pay cycle.

Number of Patients Visited Per Pay Period as the unit for Individual Pay also solves a couple of other issues.

- It easily allows both the IPU as well as a clinician to be paid for patients they share. You don't want to penalize Homecare clinicians that refer their patients to the IPU. In fact, you want to incentivize it! This solves that with ease!
- It is easier to communicate than Average Caseload. The number of patients is the Number of Patients served in a pay period! Number of Patients is a type of Caseload for a pay period.
- Though we sometimes suggest an Average Visits Per Patient Per Week or minimum number of visits as secondary productivity measures when Average Caseload is used, this is NOT necessary when Number of Patients is used as you can simply run reports of most EMRs that show ANY patient, which the visits are not conforming to the POC (Plan of Care). Failure to adhere to the POC is what will really harm an organization. Wouldn't it be fantastic just to know that 100% of your clinicians are adhering to the POC!
- IF the number of visits is unacceptable or low at your organization, then add a Minimum Number of Visits as a secondary productivity measure. Number of Patients and Minimum Visits are quite easy to get from most EMRs!

Average Visits Per Patient Per Week within a range as a secondary productivity/quality measure is still a very, very good practice. I think it is a high quality measure. However, if it is hard to produce, this can be replaced with your EMR reports that show if visit frequency complies with the POC. Minimum Visits per pay period is another alternative secondary measure.

“What if a clinician visits a patient assigned to another clinician or on another team?”

We pay the clinician just as they would be, if the patient were assigned to them.

- This makes it easy to determine the number of patients made as visit reports are common in EMRs.
- It encourages visits, but not excessive visits.
- It encourages clinicians to help out fellow clinicians.
- It encourages clinicians to refer to the IPU as visiting the IPU by the Homecare clinicians is a great practice, unless the IPU is a great distance away.



Individual Pay is Decreased if the Contribution Margin of the Team is NOT to Standard

This links back to the concept of Team Pay. As stated earlier, there are two options for administering Team Pay the 1) Split and the 2) No-Split methods. One or both can be used. However, MVI is now recommending that the clinician portion of Team Pay is eliminated and that Individual Pay be linked to Team Contribution. If a Clinical Team is not meeting the Contribution Margin Standard, then the rate of Individual Pay is DECREASED by 50%. This is more powerful as it is a more direct communication that the Team is not healthy. This also discourages “gaming” Individual Pay by seeing other clinician’s patients when it is not necessary in order to jack up their pay.

This direct impact on Individual Pay provides incentive for clinicians to “care enough” about the performance of the overall team to perform at high levels. This method is superior as it is more DIRECT. Normally, the more direct the relationship between pay and performance is, the stronger the compensation method. For example, if a clinician merits Individual Pay due to beating the Productivity Standard, but the team’s Contribution Margin is less than Standard, then the amount of Individual Pay is 50% of what it normally would be. This provides STRONG and DIRECT incentive for the entire team to be winning!

This also helps INCREASE the percentage of the savings “split” between the organization and the Manager, the portion that goes to clinicians is eliminated.

A Clinical Manager needs to try to prevent clinicians from “swapping patients” to game the Compensation System. This would negatively impact Contribution Margin, which directly impacts the compensation of the Clinical Manager.



Here is an example of Individual Pay based on the *Number of Patients Visited in a Pay Period*:

Example of Individual Pay For RNs, SW, Spiritual Care			
<i>Semi-Monthly Pay Period: 9/1/18 to 9/15/18</i>			
Clinician #1			
Caseload/Number of Patients			
Patient 1			
Patient 2	Transitioned		
Patient 3			
Patient 4			
Patient 5	Transitioned		
Patient 6			
Patient 7			
Patient 8			
Patient 9			
Patient 10	Transitioned		
Patient 11			
Patient 12		Minium	
Patient 13	Added		
Patient 14	Added	Excellent = \$75.00 per Patient	
Patient 15	Added		
Patient 16	Added	Total \$225.00 Individual Pay Bonus	



There are many ways of doing Individual Pay

Clinician compensation can be done a number of ways. Going into many of these methods is beyond the scope of this program and is better addressed in the [Compensation & the Model Program](#). But here are a few general methods. These titles aren't fancy, but you can get an idea of the variety that can be used!

1. Salary or Hourly – Business as usual in Hospice. This will produce the SAME results we are now achieving.
2. *Base Pay* (with a Flex component) – This adds a great deal of muscle to Accountability as 100% of the Standards must be met to receive the Flex component.
3. *Base Pay* (with a Flex component) and a set amount if the Excellent threshold is met. Example: \$150 if the Excellent threshold is equaled or exceeded. This takes a bit of the sting out of working harder, especially when census is down.
4. *Base Pay* (with a Flex component) and an amount for each patient served while maintaining the Standard average number of visits per patient. This flexes well with upward shifts in census.
5. Average Visits Per Patient Per Week/Number of Patients – This method is simple and holds a great deal of promise as compensation is directly related to performance and quality. This ideally fluctuates with patient volume.
6. ABC: Activity-Based Compensation – In this system, every activity has a compensation rate from routine visits to meetings. It is the first one I used at my first Hospice.
7. Pay per Visit – This incentivizes visits and not caseloads.
8. Average Caseload – This incentivizes larger caseloads, but are patients being seen? Average can be hard to get.
9. Number of Patients is an excellent measure! Or just run a POC visit report for visits outside of the POC!

Overtime

Overtime is a no-no and should be discouraged. If the employee is owed overtime, the organization by law must pay it. However, the Manager needs to have a conversation and train the clinician on time management as all work is designed to be sustainable and done in an 8-hour day.

If overtime is paid, then for each hour of overtime 1 unit of Individual Pay is removed. Examples: If 2 hours of overtime is paid to an RN, then 2 patients are subtracted from the Number of Patients Visited above the Excellent Standard. If 3 hours of overtime is paid to a Hospice Aide, then 3 visits are subtracted from the Number of Visits above the Excellent Standard.

The point is, you can't be working overtime and expect to get additional bonuses as well.



Establishing Clear Standards

When creating your Model, you are creating “Standards” which include financial as well as clinical Standards. The Model advises the use of Model Cards that are issued to every employee to remove any excuse that a person in the organization has for not knowing the Standards. Normally, the section of the Model Cards for clinical Standards looks like this:

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

Note that there is a Minimum and an Excellent for each category. The Minimum is what needs to be done to keep your job. A minimum is a minimum for an FTE. The Excellent is where the Individual Pay comes into play. If a person meets or exceeds the Excellent measure, he or she receives additional pay. It may be \$50, \$100 or \$200. It does not have to be a huge amount but it must be enough that it motivates. When establishing the Minimum and Excellent amounts it is extremely important to keep the gap between them minimal. Example: If you want Nurses to perform 22 visits a week as your Minimum, set the Excellent at 24... which is only modestly more. Why? You want this to be a motivator and not a de-motivator. If the gap



between the Minimum and Excellent is too large, it will become a de-motivator. You want your staff to say “I can do that! I can meet the excellent with a bit of work!” The Standards have to be sustainable over the long-term, like a decade! You don’t want to be changing the Standards and jerking people around by ratcheting up the Standards annually. This type of system helps reward clinicians when they are working hard, especially when census is high or is growing rapidly.

I would advise a Hospice to select a Standard or Standards that incorporate both caseloads and visits for all disciplines except for perhaps Hospice Aides. However, even this position could be done the same way!



Quality Measures

All of this is good for the financial Standards, but what about the Quality Standards? Here is what we would advise:

The Same Measures Can be Used for Virtually All Clinical Positions

Quality Measures for Clinical Positions

Version 20.0

Position	Quality Measure	Choose Only One if Possible!	Choose Only One if Possible!	
		(1) Documentation	(2) Productivity	(3) Quality
Clinical - Direct Labor				
RN		1) Documentation to Standard, 2) <u># of Patients Visited</u> and to 100% of the POC	3) <u>No Complaints/Gifts</u> , Avg Pain Scores	
LPN		1) Documentation to Standard, 2) # of Patients Visited, <u>Visits</u> , Minimum Visits, 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
Aide		1) Documentation to Standard, 2) # of Patients Visited, <u>Visits</u> , Minimum Visits, 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
SW		1) Documentation to Standard, 2) <u># of Patients Visited</u> and to 100% of the POC	3) <u>No Complaints/Gifts</u> , Avg Pain Scores	
Chaplain (PC)		1) Documentation to Standard, 2) <u># of Patients Visited</u> and to 100% of the POC	3) <u>No Complaints/Gifts</u> , Avg Pain Scores	
Admissions RN		1) Documentation to Standard, 2) # of Patients Visited, <u>Visits</u> , Minimum Visits, 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
Advanced Practice Nurse		1) Documentation to Standard, 2) <u># of Patients Visited</u> and to 100% of the POC	3) <u>No Complaints/Gifts</u> , Avg Pain Scores	
On-Call RN		1) Documentation to Standard, 2) <u># of Patients Visited</u> and to 100% of the POC	3) <u>No Complaints/Gifts</u> , Avg Pain Scores	
Occupational Therapist		1) Documentation to Standard, 2) # of Patients Visited, <u>Visits</u> , Minimum Visits, 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
Physical Therapist		1) Documentation to Standard, 2) # of Patients Visited, <u>Visits</u> , Minimum Visits, 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
Speech Therapist		1) Documentation to Standard, 2) # of Patients Visited, <u>Visits</u> , Minimum Visits, 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
Physician/NP		1) Documentation to Standard, 2) <u># of Patients Visited</u> and to 100% of the POC	3) <u>No Complaints/Gifts</u> , Avg Pain Scores	
Homemaker		1) Documentation to Standard, 2) # of Patients Visited, <u>Visits</u> , Minimum Visits, 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
Inpatient Unit				
RN		1) Documentation to Standard, 2) <u>Unit Census</u> , 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
LPN		1) Documentation to Standard, 2) <u>Unit Census</u> , 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
Aide		1) Documentation to Standard, 2) <u>Unit Census</u> , 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		
Charge Nurse		1) Documentation to Standard, 2) <u>Unit Census</u> , 3) <u>No Complaints/Gifts</u> , Avg Pain Scores		

MVI Suggestion in RED

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

MVI suggests RN, SW and PC disciplines 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!



There are 3 Standards of great concern for a Hospice, (1) Documentation, (2) Productivity and (3) Quality. All three would be part of an ideal Compensation System. However, if you can just get Documentation and Productivity you are still in a better place than any traditional pay system!!!

Rather than having tons of quality measures for disciplines, use the SAME or SIMILAR ones for all clinicians. Yes, for the Productivity Standard you may use Caseloads for Nurses and Social Work and Visits for Hospice Aides and LPNs, but the Quality Standards may be the same. You want to make it EASY! Easy for clinicians to remember and easy for you to administer!

1. **Documentation** is the very basis of our existence. It is the only practical way to orchestrate a coordinated, coherent interdisciplinary experience. We would use a written chart to common-ize this communication even if we weren't paid a dime for it! So this is the first and most important reason. The second reason for documentation is it IS how we get paid! Documentation needs to be perfect and at 100% of the Standards on a day-to-day basis. Anything less than 100% is not acceptable. And this is doable. If you set your Standard at 90% your Hospice is going to be in trouble as even a 10% knowledge deficit results in an exponentially high screw-up rate when multiplied by the number of employees at your organization!
2. **Productivity** is an objective measurement in the concrete world. It is needed to gain perspective. What is being done which we can perceptively see impacting the world? Normally this is denominated in Number of Patients Visited in a Pay Period, Caseloads, Visits, Time, etc. Our recommended method is Number of Patients Visited Per Pay Period as it is relatively easy to get from most EMRs and takes acuity into account. We also recommend that all visits are 100% to the POC. If that is done, normally is good! And EMRs are normally configured to show any deviation from the Plan of Care in terms of visits! Just run your EMR reports before every payroll! If any are outside the POC, BAM! No Standards Bonus!
3. **Quality can be No Complaints/Gifts or Average Pain Scores or Patient/Family Satisfaction/Confidence Scores.** We recommend No Complaints or Gifts. We want people to be happy with our services and products. Happiness is a FEELING. The only thing a person will remember ultimately is how he or she FELT! The measurement of all things relating to FEELINGS and emotional Energy are subjective. But we should not be troubled by this as if we consistently measure the subjective it become increasingly objective! CAHPS gives a Hospice some insight, but it is a bit dated when it gets back to a Hospice. The measurement of pain is in nearly every EMR! Therefore, could be one that is used. There are also newer technologies and apps where patients and families can give almost immediate feedback for things such as pain and their happiness with the experience they are receiving. Many Hospices have or are developing these apps.



Inpatient Units & the Model

Why not use these Quality Measures before every payroll run to evaluate clinicians' performance?

If ANY clinician does not meet the Standards, any Individual Pay compensation as well as *Standards Bonus* is not given. People have to FEEL the sting of not meeting Standards. This helps to ensure Accountability.



What about Quality Measures for Managers of Clinical Teams?

Quality measures need to be in place for Clinical Managers. Why? Because a Team's NPR percentages can be great and yet, there can be large numbers of clinician's whose documentation or productivity or quality is not to the Standards of the organization. Here is how we handle this for each payroll run:

1 Grace Clinician - A Clinical Manager can have 1 clinician out of Standard without any impact. This "grace" clinician helps because it is impossible for a Team to operate indefinitely without an issue. Sometimes a problem clinician can be out of Standard in 2 or more areas simultaneously! If the Clinical Manager is "pinched" for a single clinician, it can negatively impact Energy and motivation.

2% of the Clinical Manager's Standards Bonus is removed for each additional clinician that is out of Standard up to 10% - This means that a Clinical Manager will feel a 2% reduction of their Standards Bonus for each clinician that is out of Standard beyond 1. In addition, if the Clinician Manager has 5 clinicians (the Grace Clinician plus 4) out of Standard in a pay period, the Clinical Manager's Team Pay is removed for the month. That is, the Clinical Manager can't hit 10%. Thus, they can only have a total of 5 and still get their Team Pay. It is a good idea to keep the same methodology in place regardless of team size. If a Clinical Manager can effectively manage more clinicians, then they have opportunity to earn more. It can be illustrated like this:

Clinical Manager's Standards Bonus

Based on the Number of Clinicians Out of Standard

FTE Number	% Decrease	Standards Bonus
1	Free	10%
2	-2%	8%
3	-4%	6%
4	-6%	4%
5	-8%	2%
6	-10%	No Bonus

- 1) Documentation to Standard, All to the Plan of Care
- 2) Productivity to Standard
- 3) Quality to Standard - No Gifts/High CAHPS Scores

RESULT/OUTCOME

You want large teams, and you want it to be fair...so it needs to be proportional.

FTE % Based on ADC	% Decrease	Standards Bonus	Standards Bonus
10% or 1	Free	10%	20%
11-14%	-2%	8%	16%
15-18%	-4%	6%	12%
19-22%	-6%	4%	8%
23%-29%	-8%	2%	4%
30% >	-10%	No Bonus	No Bonus

- Can I win as a Clinical Manager? Is this achievable?
Is it reasonable? Is it fair?
Is it easy to do?



Your Clinical Managers will Struggle at First as they Grow in Capability

Many Clinical Managers will struggle at first with the Compensation System as they are used to being told what to do and if they can have additional staff or use a particular medication practice. In SuperPay!, Clinical Managers have great latitude and are given lots of room for creativity within the Standards. They are managing to a Contribution Margin and not cost line items. It is up to them and to figure out how to get there. They just can't cross that NPR% line. They also will struggle with perhaps the #1 topic, Accountability and Professional Judgment. The Compensation System will administer the Accountability and report non-standard performance to the clinician and the Clinical Manager. Then the Clinical Manager's job is to work with the clinician to understand the true meaning of Accountability.

Clinicians new to the Compensation System may initially complain and be a bit hurt if their Standards Bonus of 5% is not given in a pay period. They will say it is unfair... It is the Clinical Manager's job to intervene and "teach" Accountability so that the clinician is OK with it and that he or she should use this "pain" or "hurt" to learn rather than feeling like a "victim" of the system.

Standards are not unreasonable. They are not difficult. There are not goals in the Standards. If a Standard is unfair or unreasonable, it should be called out and corrected. But most Standards are completely sustainable and are able to be done in an 8-hour day with no overtime. The Standards are "just doing your basic job" with no stretch.

When a clinician, especially initially, feels hurt that he or she did not receive their Standards Bonus it is the Clinical Manager's job to help them interpret and learn from the event. Sometimes clinicians still view not receiving their Standards Bonus as a "takeaway" and not an additional amount. They feel entitled to it. This is an immature view and it is the signal to the Clinical Manager that you have a Student that needs help.

"Karen, why do we have Standards?"

"What happens to patients and families when the Visit Structure is not consistent or when documentation is not to Standard?"

"What does it mean to be Accountable?"

"When we start a meeting with: "What day is it?" What is the meaning behind this statement?"

Questions asked in a calm and benign spirit will help the clinician learn. They will start to answer their own questions and integrate their negative emotions about Standards into something positive.



Quality Scores for Indirect Areas

Indirect Teams could be done simply as follows:

Indirect Labor - A simple and effective system that fosters a culture of service.

Administration	Overall Satisfaction Score Rating (1-10) from Clinical Leaders
Clinical Management	Overall Satisfaction Score Rating (1-10) from Clinical Leaders
Finance	Overall Satisfaction Score Rating (1-10) from Clinical Leaders
HR	Overall Satisfaction Score Rating (1-10) from Clinical Leaders
IT	Overall Satisfaction Score Rating (1-10) from Clinical Leaders
Marketing	Overall Satisfaction Score Rating (1-10) from Clinical Leaders
Education	Overall Satisfaction Score Rating (1-10) from Clinical Leaders
Compliance/PI	Overall Satisfaction Score Rating (1-10) from Clinical Leaders

On a scale from 1-10 (using a tool like Survey Monkey), all Clinical Managers score Indirect areas on their overall satisfaction with the area. Any average score less than a 7 would constitute a revocation of the Team's and Manager's Standard Bonus. Does this sound harsh? In the MVI playbook,

Indirect areas live to serve the Clinical Manager.

Why is this? Isn't our purpose to serve patients and families? Yes. However, all clinicians at the front lines of care take their behavioral cues from their immediate leader. Clinical Managers REPLICATE what they are and influence clinical practice more than anything or anyone else. If Clinical Managers are not served well, it harms what they are able to do with their teams. The job of Indirect areas is to serve the Clinical Managers by making it easier to do their demanding jobs, including the *1st Duty* which is to develop or teach the people they lead. If they are given untimely, difficult to use and inaccurate reports from Finance, a disservice is being done.

What we want is a service culture!

If IT is not responsive, Clinical Managers have a voice. If HR is not providing great candidates that fit the culture, Clinical Managers have a voice. If new staff are not being trained well during the on-boarding process, Clinical Managers have a voice.

An exception might be Compliance as this is a critical watchdog function. You want this area to be as objective as it can be. So Compliance might be excluded from this system. There may be a way to do this area, but we have not seen it... yet!

OPTION: Due to the nature of Compliance, sometimes the rating of this department is done by the CEO and Executive Management. This is a professional judgment. I personally do not favor this.



Team members within Indirect areas of course will receive the Team component of Team or Individual Pay. This is probably sufficient. However, if needed, other measures can be created to foster the behaviors you want. But if it is complicated, it will probably fail.

So with this simple approach, Managers as well as individuals are incentivized. Of course, if quality factors or other performance measures are not met, you could have Accountability compensation withheld or reduced as needed. Using a Finance example, if AR (Accounts Receivable) is beyond 48 days or if financial reports are not accurately completed by the 24th of the month for the prior period, no bonus!

Cross-Training Should be Included as Part of an Indirect Manager's Compensation

MVI advises that all Indirect personnel work for 2 noncontiguous months per year in another Indirect area. This practice helps an organization in many ways including:

- Cross-Training each Indirect position so that if something happens where a person with specialized knowledge or skills can't do their job another person can step in.
- It develops teaching skills in Indirect staff just like clinicians doing the Model. The paradigm of the Model is that we are a Teaching Organization rather than a Provider of Care.
- It forces the documentation of process in most cases. A written document common-izes knowledge and makes it more transferable.
- It helps an organization detect fraud. This makes fraud and irregularities much more difficult.
- Innovations are more likely when "fresh eyes" look at a work situation.

In the case where an organization uses this method of cross-training, there should be no allocation of the person's cost to the department or position they are temporarily working in. Why? Because it is not material and it is difficult. It is just a cost of doing business this way.

Likewise, if a person helps another area or department, the cost should not be allocated because it is not material. Many accountants just get way too anal-retentive about this type of thing. If the amount of time is extreme or material, then go ahead and allocate. But only do this if it is indeed enough to skew management decisions. It is a matter of professional judgment.

Compliance may monitor cross-training and maintain a log of each person's area of cross-training as well as make sure that those employees work the position at least 2 non-consecutive months a year. The Standards Bonus of the Indirect Manager should be removed if cross-training is not done or not to Standard.



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	Overall Satisfaction Score Rating (1-10) from Clinical Managers
Clinical Management	Overall Satisfaction Score Rating (1-10) from Clinical Managers
Finance	Overall Satisfaction Score Rating (1-10) from Clinical Managers
HR	Overall Satisfaction Score Rating (1-10) from Clinical Managers
IT	Overall Satisfaction Score Rating (1-10) from Clinical Managers
Marketing	Overall Satisfaction Score Rating (1-10) from Clinical Managers
Education	Overall Satisfaction Score Rating (1-10) from Clinical Managers
Compliance/PI	Overall Satisfaction Score Rating (1-10) from Clinical Managers

The question is "Overall, as a Clinical Manager, rate your satisfaction with IT on a scale of 1-10, 10 being Excellent!"
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

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.



The Model™
Balancing Purpose and Profit



What Happens when a Manager does not Meet the NPR% Standard?

What if a Manager's
**NPR% exceeds the
Standard?**

**The Manager's Standards Pay is removed. The
Team Pay is also not given as there is nothing to
bonus to the team.**



Inpatient Unit (IPU) Staff

Why Use the Overall GIP Census Level as a Component of IPU Pay? We specifically link this to GIP as you DON'T want Residential patients or patients at a Routine level of care or even Respite. Routine level should NEVER exceed 10% of a unit's census (*See the Inpatient Unit & the Model manual for specifics regarding this.*)

The reason behind this is because census of an IPU is everyone's job. You WANT everyone at the IPU to be CONCERNED. You want to foster a sense of urgency to fill up the unit, to get new patients admitted. CENUS IS THE BIG DEAL IN AN IPU!

In addition, you don't want IPU staff bitching when the unit is full. By tying census to pay, you pretty much wipe out this "bitch factor."

This also creates a healthy flexing of costs of an IPU. When the IPU census is down, you aren't paying out as much. This is a structural tool to keep an IPU full.

This also puts a bit of pressure on an IPU Manager to fill a unit. So, not only are they being paid on the performance of an IPU (Just like any Clinical Team Manager using SuperPay!) on a percentage of savings based NPR (Net Patient Revenue), but they know that their team will suffer if they don't fill the unit. YOU WANT THIS PRESSURE.

So what would the structure look like?

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	
	Base	Semi Monthly	Pay Period	Percentages of Position Pay									
	40,000.00	24	1,666.67	0%	10%	20%	30%	40%	50%	60%	70%	80%	90%
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	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, a 10% Dig is deducted from the pay period.

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

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

As you can see from this template, nothing extra is given for any census level below the "Magic Number" (one above breakeven). However, once that number is reached, the



incentives increase dramatically. Of course, the “magic” number is different for every IPU and it must be calculated independently. Here is a section from the *Hospice Inpatient Units & the Model Workbook* regarding the Magic Number.

- **The Magic Number.** Many clients know that I refer to the “Magic Number” regarding units. This is the one additional bed average that is expected to be filled annually ABOVE breakeven. The Magic Number has to be discovered... and discovered in the planning stages. Some Hospices have built units that were one bed short and as a result, they lose money all the time or struggle at best. Let’s face it, once a unit is built you just can’t snap your fingers and add a room. This is a “structural” problem. The Magic Number has to be found. The difference that one additional ongoing occupied bed can make is tremendous. I did a pro forma the other day and the Magic Bed moved the model from a loss of \$35,000 per year to a gain of \$150,000. Now, which would you rather have? I suggest that MVI clients look hard at the [IPU and Continuous Care Management and Costing Model](#) and discover the Magic Number. Within a few minutes or hours, you can know your “Magic Number.” This number is burned into the brain of the IPU Manager.

Provide Incentives for Homecare Clinicians to Refer Patients

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* as well as in the IPU census. That is, the patient is counted on both censuses at the same time. We have constructed RN, SW and PC compensation around the *Number of Patients* as a performance metric. If clinicians are able to count referred patients to the IPU as part of their “census,” it causes clinicians to refer more as most of the care at that point will be performed by IPU staff. This translates to less work and expenditure of Energy by the clinician and the ability to have a higher *Number of Patients*. If Homecare clinicians are receiving an extra \$50, \$75 or \$100 for each additional patient above or equal to Excellent level, having 1 or 2 patients in the IPU is a great deal financially! In addition, the IPU staff is paid more when the IPU census is high.



Continuous Care

Continuous Care (Crisis Care) is a function of time. It lends itself to hourly rates, which you want to avoid if possible. This is a more difficult area than others. Since a Crisis Care program is much like a “floating” IPU, it can be done much like a Hospice Inpatient Unit, with a *Base Pay* component and a component that is tied to census.

Part-Time Employees

A True Professional Hospice Manager would never staff with full-time people! In a business where census naturally rises and falls within very short periods of time, would a True Professional Manager ever staff 100% with full-time people? The answer is of course no.

An *Extraordinary Manager* is a true Manager of resources. He or she has the Integrity to reduce costs when the revenue is not there. The *Extraordinary Manager* also does not build profits on the backs of overworked staff when the census surges! To manage well, means to adjust costs according to revenues as expediently as practical.

An *Extraordinary Manager* can manage costs at less than or equal to the organization’s NPR percentages within an acceptable range of census fluctuation. The MVI recommendation is 10% plus or minus. This means that ALL Managers (Direct as well as Indirect) need to be able to manage the costs their area(s) at or below this organization’s Model percentages of NPR (Net Patient Revenue).

To illustrate this, we will refer to a Clinician Manager we will refer to as Alan. For over 10 years, Alan set most MVI benchmarks including high profits, high quality and low low low turnover. Alan grew any clinical team he was given (I watched Alan in multiple settings over those years). He was a “star of stars” Clinical Manager. I sat with him one day and he explained how he operated. Regarding his phenomenal financial performance he said,

“I always maintain 20% of my staff as flex or part-time so I can ramp up or cut back as needed when census goes up or down. That 20% is the toughest part of the job as they have to be trained and held to the same *standards* as everyone else, but you have to do it in this business.”

NOTE: Alan also had virtually a ZERO turnover rate! And his teams worked hard and were the most productive in the company! The only turnover Alan experienced was when a spouse situation dictated it, illness or retirement. Why was Alan so successful? It is because Alan changed your Life! It was a privilege to work for such a fine human being! This highly Spiritual man (he was a Chaplain by trade) created a tangible atmosphere of Love, Compassion and Accountability. He had some of the highest *Standards* I have ever seen... and his staff responded to this!



Some Managers are hampered greatly in managing fluctuations of patient-volume due to “structural” issues such as completely “fixed” compensation systems. It is not even logical to pay people an entirely “fixed” or set amount in a business where there can be significant fluctuations of patient volume. Compensation systems need to work for us based on the realities of human behavior and not against us by promoting unwanted behavior. Paying PRN staff MORE than your regular staff is a poor practice as it incentivizes PRN employees!

Example: H&R Block

H&R Block’s business model intentionally relies on seasonal labor during tax season (Jan – April). Seasonal employees are then laid off and rehired during the next tax season, rather than retaining employees the entire year, in which case they would be paying them salary and benefits during unproductive months. They offer no guarantees that laid-off employees will be re-hired the next tax season, but as an example from 2008 to 2012, H&R Block rehired 268,804 of its tax preparers. Of former employees reapplying for their positions, it only chose not to rehire approximately 20,357 or about 7%. H&R Block employs around 10,000 full-time year-round employees, and while that number climbs to 137,000 during the tax season, they only employ about 7% of their employees year-round while turnover of seasonal employees runs about 50%.

The secret to their success: employees are eligible to collect unemployment or work other jobs during the off-season. Thus, employees (some not all) value the freedom to work only four months of the year. Thus, H&R Block has high rates of employees returning to work for H&R Block the next tax season. For some people’s Lifestyle it just works.

2014 Operating Margin = **26.64%**

2014 S&P500 Operating Margin = **13.65%**

Takeaway Points

- H&R Block manages expectations and spells this out up front in their employment agreement.
- They build their high unemployment insurance cost into their economic model.
- Done correctly, this “model” works! The benefits to working only part of the year and not the rest of the year work, or they wouldn’t have so many employees return to work each year.
- **Bottom Line:** Without a flexible staffing *model*, there is no **Model**. How can you commit to a Standard, i.e. 38% of NPR for Direct Labor, if you don’t have a plan for the changes in census that are virtually guaranteed in Hospice?



Physicians and NPs

Trying to manage Physicians is nearly impossible due to many factors... with strong ego many times being involved. The one structure that seems to work is MONEY. *Most Physicians will work to understand every detail of how they are paid.* They get this and will employ their brains to drive the great car and live in the big house... the images that drive so many Docs' behavior. Yes, they are smart and will learn how to maximize their financial situation. I don't know another more effective way to get Physicians productive.

I favor a Compensation System for Physicians based on VALUE. They also should be impacted by ADC, LOS, creating new business and Pharmacy & Therapy costs. They are also impacted by *Standards Pay* to ensure Accountability in documentation. NEVER use pure salary for Physicians or NPs. I have seen systems where Performance Pay was used and then after the Docs complained, they yielded to a salary based system only to see performance dramatically drop. The use of contract or hourly community Physicians is still a good way of doing Hospice, but not nearly as good as a system based on VALUE. Right now it is en vogue to hire full-time Physicians. There are certainly benefits from this! However, using community Docs still works! Perhaps the full-time Physician is the quarterback of community Docs is the winning formula! Anyway, it is something to consider.

NOTE: When I address Physicians, this includes Nurse Practitioners or Advanced Practice Nurses (NPs) as this discipline is an "extension" of the Physician function.

Billing for 180-Day Recertifications

I have seen Hospices bill for 80% of recertifications. This is what I recommend. My understanding is that CMS presumed that Hospices would bill for these visits when the mandate was given. The fact that Hospices serve the "sickest" patients in the world and that the average healthy person in the US visits a Physician 3 times a year would provide pretty solid ground that there would be "some" medical reason for a visit besides the 180-Day Recertification.



Physician Value and Paying Docs!!!

Regarding Physicians and NPs... I don't believe in a lot of visits. I look at Physicians' VALUE differently than many and it is not about doing visits, except in a Hospice IPU where visits are critical to substantiate the GIP level of care. (In a 16 bed IPU, rounding should take about 4 hours.).

The VALUE of MDs/NPs (NPs are an extension of the Physician function just like all support staff) is not in visits except for the 180-day F2F recert visit and when an actual visit is needed. A phone call from a MD works better in many situations and is a surprise to patients and families in itself! But Docs don't like that idea normally.

Value of MDs (Prioritized)

1. Documentation, Recertifications and LOS - The job is to help the Hospice keep patients. And 80% of these F2F visits should be billable! Yes, we are dealing with the sickest people and if we can't come up with a reason to visit other than the recert, something is wrong!
2. Education (Don't call it Marketing) - Docs like to talk to Docs. Opening up referrals sources translates into big money! This is how you get ROI way beyond their compensation! This takes a personality, Integrity and technical competence.
3. Positive Cost Effective Influence – This is the influence of clinical practice (getting patients off expensive treatments coming from hospital and other settings).
4. **Routine Clinical Visits are the least valuable component.** Hospice did just fine without such extended use of MDs before. I would rather have a Doc make 25 phone calls a day than do 4 or 5 visits! Spread the value over more patients!

Paying Your Docs and NPs

Obviously, we want to link our Compensation System to these prioritized value points for Physicians and NPs. You want to make Compensation Systems simple and therefore EASY to do. Physician and NP compensation actually poses more complexity than others due to the “marketing/educational” component. Here are some thoughts:

The “overall” net effect of the costs of Physicians, NPs and direct staff supporting this function as well as the costs of pharmacy and therapies can be the responsibility of the person that is leading the Physicians and NPs which we will call the Physician Manager. Much of this has to do with how a Hospice has setup the Accountability structure of a clinical team. Sometimes the Physician and NP costs are the responsibility of the team Clinical Manager. Either way, the line of Accountability must be DIRECT, meaning “You have one boss!” with no ambiguity. This



monthly evaluation of performance is done just like any Manager using Model compensation methods. The Team/Location or Comprehensive Model Report is run and performance is EASILY compared to your proprietary Direct Labor Standards (Model) which is normally 2% of NPR (net of Physician billings) and 1.25% for the Medical Director portion. Physician/NP Labor Costs are either “in or out” of your Standards. If these costs are “out”, the Physician Manager’s *Standards Pay* is not given, which is normally 10% of Base Pay for a 2-week period. If the Physician costs are lower than the Standards (Model), the Physician Manager gets 25% of the savings which can be substantial! In addition, each Physician and NP that is 100% in Standard gets a portion of an additional 25% share as well! Because this “opportunity for savings” can be tremendous, I do NOT recommend a large salary or *Base Pay* component.

The cost of pharmacy and therapies (combined) are really the responsibility of each Physician/NP or Clinical Manager. **We highly recommend that these are linked to the Standards Pay of the Physician rather than Clinical Managers.** This is where the Accountability really resides. The Accountability must lie with only ONE person, clearly defined, unambiguous (see below, *Point #3, for more on this*).

1. Documentation, Recertifications and LOS - This is accomplished through *Standards Pay*. This universal compensation structure works with all clinical disciplines. *Standards Pay* is normally 10% of *Base Pay* (or some increment of it) and is setup as a bonus structurally as you can’t be jerking base salaries around. All clinicians are expected to receive 100% of their *Standards Pay*. Performing F2F recertification visits is part of *Standards Pay* (just doing your job!). It is not a basis for “extra” pay. 80% of F2F recertification visits should be billable. If a Physician can’t come up with a reason to bill on a F2F for the sickest people in the world, you have a problem!
2. Education/Marketing – This would be setup much like a Marketer’s pay and be based on the volume of admissions from each account or number of new accounts. Not all Physicians are effective Marketers. Those that are not suited to expanding the business can be compensated easily via productivity (visits, documentation and Medical Director function to 100% of Standard).
3. Positive Cost Effective Influence of Clinical Practice – This is the “management” part of being a Physician or NP. This is compensated via *Standards Pay* as well (the 10% portion a person receives just for doing the job to the basic Standards of the organization). Reports can easily be run for the Docs assigned to clinical teams that tell whether pharmacy and therapy costs are “in or out” of the Model. If these costs are “out,” the Doc’s *Standards Pay* is not given. If the cost of pharmacy and therapies (combined) are below the Model, the Doc gets a proportion of the savings! These savings could also be distributed to others such as the Clinical Manager and Clinicians as well depending upon how you structure it. Note: Most patients are overmedicated in the USA so there is a lot of room in this area!
4. Routine Clinical Visits – This is easily determined by a Hospice and is best measured via collections rather than visit counts or billing for the Physician function. If the *Base Pay* is substantial, then the minimum number of visits must be done to stay in Standard.



Inpatient Units & the Model

If performance is not up to Standard, *Standards Pay* is removed. YOU DO NOT WANT TO INCENTIVIZE ROUTINE PHYSICIAN VISITS! Virtually 100% of these visits should be billable.

Here is the way I would structure Physician Pay:

Physician Performance Pay							
<u>Physician VALUE Pay</u>							
			Rate				
Per Pay Period F2F Visits			75.00	10	10	20	25
Education/New Accounts tied to %s below				0	1	2	3
				Percentages of Position Pay			
Base	Semi Monthly	Pay Period	5%	5%	5%	5%	
130,000.00	24	5,416.67	270.83	270.83	270.83	270.83	
Individual Pay (Based on New Accounts)			-	6,500.00	13,000.00	19,500.00	
F2F Visits			18,000.00	18,000.00	36,000.00	45,000.00	
Pharmacy & Therapies - Based on Savings			27,375.00	54,750.00	-	41,062.50	
Position Pay			130,000.00	130,000.00	130,000.00	130,000.00	
Total Compensation			175,375.00	209,250.00	179,000.00	235,562.50	
Pharmacy & Therapies Calculations							
ADC			200	200	200	200	
Standard			5.0%				
Actual Performance			4.0%	3.0%	5.0%	3.5%	
MCR Rate			150.00				
Percentage of Savings to Physician			25%				
* 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.							
*** Note: Pharmacy & Therapies is dependent upon ADC.							

ADC becomes a major factor in the Pharmacy & Therapies component as a higher ADC (which includes LOS) is desirable. This also encourages F2Fs. Education/New Accounts is a HUGE value that an MD can influence with “Doc to Doc” talk. And of course, the Physician/NP Standards Pay means that they have Perfect Documentation as the auditing of chart by Compliance will detect deviations from Standard.



Here are other ways it could be done:

<u>Base Plus Per-Activity</u>			
		Minimum	
Weekly Visits		20	5 8 10 12
	Rate	100.00	
Weekly Cert Visits		All	0 0 0 0
	Rate	-	
Phone Calls		40	5 7 10 20
		25.00	

Base	Semi Monthly	Pay Period	Minimum	Compensation			
130,000.00	24	5,416.67		625.00	975.00	1,250.00	1,700.00
Individual Pay				15,000.00	23,400.00	30,000.00	40,800.00
Position Pay				130,000.00	130,000.00	130,000.00	130,000.00
Total Compensation				145,000.00	153,400.00	160,000.00	170,800.00

* 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.

I really don't like a Physician paid with Visits. Yet, many Hospices do. Therefore, it might look like this:

<u>As a Percentage of Salary</u>						
Weekly Visits			24 28 32 36			
Base	Semi Monthly	Pay Period	Percentages of Position Pay			
130,000.00	24	5,416.67	10%	20%	30%	40%
			541.67	1,083.33	1,625.00	2,166.67
Individual Pay			13,000.00	26,000.00	39,000.00	52,000.00
Position Pay			130,000.00	130,000.00	130,000.00	130,000.00
Total Compensation			143,000.00	156,000.00	169,000.00	182,000.00

* 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.



Link Physician Compensation to Collections and NOT Visits

If you decide that visits are what you value, the better thing to do with Physicians is to link their compensation to Physician collections and not visits. Why? Because if they can do a visit with crappy documentation and still get paid, they will. If getting paid is DIRECTLY tied to collections, they get this... Post public graphs on this if you need to!



15 Conclusion

As the Manager of an IPU, you are essentially a mini-CEO. I encourage you to run the unit like it is your own business. This means that you are concerned about the look, the feel, the behaviors of your staff AND the financial results. It is a balance and it takes creativity and innovation.

The Hospice herd, in general, does not do a great job managing IPUs. This is an opportunity to shine. I encourage you to use this FACT as a motivator to be an outlier and live in the 90th percentile. Most of your success or lack of success will come from your people management skills and, to a lesser extent, management of things. Your *1st Duty* is that of a Teacher... a Teacher that understands Standards, Self-Control and how habits are formed. These, along with a great understanding how costs behave at your IPU, are the tools you will use to

Be an Outlier!

I encourage you to develop your own methods and approaches and use these materials and ideas as guides.

The Hospice World desperately needs extraordinary IPUs Managers... You can be one if you want to. It's your choice...



Appendix 1

Management Evaluation Form

Name:	Excellent	Fair	Poor
Leads by Example Is the individual respected as people see them "walking the talk?"	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Technical Competence Is the person able to effectively perform the duties of their position?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Humble/Confidence – Hungry to Learn Is the person always eager to learn more and become better?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Level of Energy Does the person have the "juice" to get the job done?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Inspire and Motivate Is the person an inspiration?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Attractiveness Factor Does the individual attract people? Do people want to work for this individual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Creates a Positive Atmosphere Does this person bring a positive atmosphere with them?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Integrity/High Trust Is this individual HIGHLY trusted?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to Fire People Can this person fire people that do not meet minimum expectations or violate values?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Comments and Thoughts:

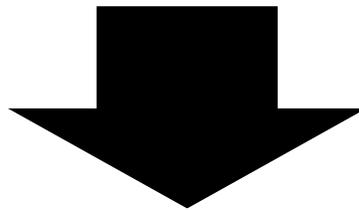


The 3 Characteristics You Want in All Managers

Intelligence

Energy

Integrity



Self-Control



Appendix 2

Hospice Finance 101

1. List the 4 primary reimbursement forms (levels of care) of the Hospice Medicare Benefit.

1) Routine Home Care

2) General Inpatient Care

3) Continuous Care

4) Respite Care

2. Respite Care can be used a maximum of _____ days per episode. [5].

3. Continuous Care must be at least _____ hours and _____% must be _____. [8, 50%, nursing]

4. A Continuous Care day starts from _____ a.m. and ends at _____ p.m. [12:00, 11:59].

5. The Hospice Medicare Benefit is part of Medicare Part _____. [A]

6. Attending Physicians continue to bill Medicare Part _____. [B]

7. The Hospice Medical Director bills Medicare part _____. This is a per-visit fee and it is in addition to the normal level of care billing. [A]

8. Consulting Physician Services are billing to Medicare Part _____ and are billed by the Hospice on behalf of the physician. A _____ needs to be in place for Consulting Physician Services. The reason this is billed through the Hospice is that it is the Hospice's responsibility to _____. [A, contract, professionally manage the care]

9. The Hospice Medicare Benefit is divided into periods. Patients are reviewed for appropriateness and either recertified or discharged during the Utilization Review process. The number of days in the first periods are:



Period 1) 90

Period 2) 90

Period 3) 60

Period 4) 60

10. When a patient is in a hospital for Inpatient care, the Hospice must have a _____ with the hospital. The _____ is paid for the day of discharge/death as contrasted with the way hospitals are normally paid on the day of discharge/death. [contract, Hospice]
11. Medicare FIs (fiscal intermediaries) pay the _____ of the billed amount and the rate set by CMS. If you bill less than the rate set by CMS, you will receive what you billed and the FI is under _____ obligation to pay a Hospice the difference. [lesser, no]
12. One of the biggest problems in Hospice billing is late or incorrect _____ of _____ information. [level, care]
13. To alert a Medicare FI that a patient has elected Hospice, a _____ is sent. [NOE or 81A]
14. To elect the Hospice Medicare Benefit, what needs to occur?

1) A physician needs to sign a certification of terminal illness (6 months or less)

2) The patient needs to sign a consent statement or election statement

15. _____ is a prospective payment system option for Hospices and allows a Hospice to receive a set amount per month based on forecasted Medicare revenue. It is used by few Hospices, but it can be useful for cash flow management. [PIP]
16. The acronym ADR means _____. [Additional Data Request or Additional Development Request]
17. _____ billing is where the Hospice must get paid for the previous Medicare invoices before subsequent invoices can be paid. All invoices must be paid in order. [Sequential]



Physician Billing

18. A physician rounding in a Hospice inpatient unit can bill for acute patients usually _____ a day depending upon the patient's need and the Hospice's ideals of care. **[once]**

CAP

19. The Hospice Medicare Benefit has two CAPs, _____ and _____. **[Aggregate, Inpatient]**
20. The _____ CAP limits the number of Medicare GIP days to _____%. **[Inpatient, 20%]**
21. The _____ CAP limits the total amount that a Hospice can receive from the Medicare system within a year. It is computed by taking an amount set by CMS and multiplying it by the number of Medicare _____. This CAP period runs from _____ to _____ and is based on the cash payments made by the FI. The Medicare Admission period is not the same and runs from _____ to _____. **[Aggregate, Admissions, November 1st, October 31st, September 28th, September 27th]**

Cost Report

22. The Hospice Medicare Cost Report is due _____ months after your fiscal year-end. Hospices are required to be on the _____ basis of accounting. **[5, accrual]**



Appendix 3 IPU Construction Points

Here are some thoughts to ponder when building a Hospice Inpatient Unit:

- Design your pods with the “walk” distance in mind. Quality care comes from human beings. If clinical staff have a hard time physically getting to patient rooms, quality care cannot be provided. With long “walk” distances you will tire out your staff and not be able to share staff efficiently when necessary. Ultimately you will lose good people due to the physical demands and patients will suffer as you are unable to get to their rooms in a timely manner.
- IF the nursing stations can be “hidden” or less in view the better! You don’t want to have an “institutional” feel if at all possible.
- People Development Space – If you have a fantastic formal training space and synthetic lab at your Hospice great. If not, it is the MOST VALUABLE REAL ESTATE at any Hospice. Therefore, the IPU represents a place where this can be located.
- Invest in good looking, stain resistant, non-skid flooring. Flooring is one of the most important things to consider. You will be spilling and torturing the floor over time. It has to be tough and safe. You can reduce your liability by choosing a modern flooring that is specifically built for clinical situations.
- Invest in wall materials that minimize sounds. Patient cries can be disturbing. We can do more than just put up sheetrock and little wood and insulation. Noise reduction should be considered.
- Keep size of “pods” in the 6-8 range (7 seems ideal to MVI, remember the difference a single additional bed can make financially – See Inpatient Thoughts Doc)
- Stagger the entrances to rooms so that a person looking out from a patient room will not see into another patient room.
- Don’t put a bunch of shelves in rooms.
- Entrance needs to be impressive but “fit” the community.
- Bring patients in through the front, but have them leave through the back.
- Most patients and families do not use the private patios. There are lots issues, left open and let bugs in, security issues, patients disappearing, maintenance issues, etc. Instead, have a common outside area that connects to walkways and paths. Usually there are only a few patients and family members that use them at a time.
- Chapel areas are usually not utilized very much...however, I believe they are needed and need to be accessible for patients!



The Short List

We often get requests from Hospices for names of experts in areas outside the scope of MVI, including patient-management vendors, service organizations, consultants, utility software and other Hospice-focused entities. We can provide lots of names, but all are not equal in our eyes. Here is our “short” list of experts who we recommend to our clients. Our reputation is at stake when we endorse individuals and organizations, therefore, we do not do this lightly. An individual or organization does not get on the **Short List** unless they have demonstrated excellence in customer service and quality of services. A track record is needed as we believe that past performance is indicative of future performance. Here is our list of the most trusted individuals and companies that truly can help a Hospice in their respective areas of expertise:

The Watershed Group **Contact: Patti Moore**
Clinical Review & Documentation, CONs, Organizational Work
Phone: 352-495-2800
Email: pattimoore@thewatershedgroup.com
thewatershedgroup.com

Wise Hospice Options **Contact: Grant Faubion**
Pharmacy: A boutique pharmacy benefit Manager (PBM Network) designed specifically for Hospice to improve drug utilization and reduce costs. Median clients has pharmacy costs of 4% of NPR. Fantastic customer experience! One of MVI's most trusted vendors.
Durable Medical Equipment: a web based medical equipment software for ordering, tracking and billing WHO will also help negotiate contracts
Phone: 405-590-5280
Email: gfaubion@wiseop.com

Blackmore CPA **Contact: Aaron Blackmore, CPA**
Accounting Services for Hospices: This accounting service was formerly MVI Partners and became its own entity when MVI decided it wanted to FOCUS on Best Practices and Benchmarking only! Blackmore CPA uses MVI practices and they work in the same building as MVI! This service is a well-oiled machine and they know the Hospice business. They work on an interim basis as well as form long-term relationships, many for more than a decade. They are also some of the finest people you could ever work with.
Phone: 828-233-1180
Email: aaron@blackmorcpa.com
Web: <http://blackmorcpa.com>

Donor Express **Contact: Bob Holder**
Donor Tracking Software: Great value, initiative and does virtually everything a Hospice needs. It is also great for cash receipts as well! Super service!
Phone: 828-264-2577
Email: bob@donorexpress.com
Website: JarredZuccari@HamiltonInsurance.comonorexpress.com

Hamilton Insurance **Contact: Jarred Zuccari**
Brief summary- Hamilton Insurance Agency (HIA) is a full service, nationally licensed brokerage and risk management firm that specializes in insuring healthcare companies. Independently owned and operated since 1982, HIA is small enough to deliver personalized service but large enough to influence carriers and secure preferential treatment for its clients. Dynamic and innovative, HIA strives to be much more than a vendor but rather a partner that wants our client's businesses and industries to succeed. These are NOT people that will be



taking you to play golf! Rather, they focus on bringing you VALUE! These folks are doing for the Hospice movement what they have done in the Nursing Home space!

Phone: (571-239-7149)

Email: JarredZuccari@HamiltonInsurance.com

Hartman Value Profile – Steve Byrum Method **Contact: Will Brown**

This system zeroes in on people's judgment rather than providing a personality categorization system. In Hospice, we must have people with extraordinary personal judgment as so much of our work is done independently and is decentralized operationally. This is the system we recommend for determining cultural fit. This is a specifically adapted version of Hartman unlike any other. Used by the Mayo Clinic, the Citadel and many other prestigious organizations. This system provides an immediate payoff!

Phone: (423) 505-2580

Email: will@browngrouptn.com

Hilliard Lyons – The SPG Group **Contact: Peter Shanahan**

Investment Experts. Far different from any of the other major brokers or even other Hilliard Lyons groups, the SPG Group incorporates practices that have 30-year audited returns that exceed the S&P by 8% on average! They also have the ability to get out of markets in 20 minutes in order to preserve assets during massive downward upheavals. They will go to *any* asset class that works including stocks, bonds, currencies, commodities and other...even to cash if cash is the best place to be. Other brokers don't play like this! Phone: 828-233-1906

Email: PShanahan@hilliard.com

Website: hilliard.com

ZipScan **Contact: Alan Jones**

When people attend our Tough Training events, they often ask about our grading scanner and system because we process exams so quickly. Our secret vendor is ZipScan! The ZipScan unit is tough as a tank, easy to use and is incredibly accurate. We can grade 80 CLP attendees, each with 4 answer forms (with 200 questions each), in less than an hour! If education is a big deal at your Hospice, this is the system. Objective, tough, easy-to-use and fast!

Phone: 801.947.0490

Email: allen@zip-scan.com

Asheville Color & Imaging **Contact: Jeff Jones or Maria Petersen**

If you want **Workbooks** printed (as no true People Development is done without manuals!) or **Model Cards** (tri-fold) these are the folks we TRUST! They have never failed on an order and we expect perfect! They are a comprehensive printing company! We use these guys all over the country whether in California or Maine! All of our training materials are produced here. And they have MVI templates! Whoa! Slam Dunk!

Phone: 828.774.5040

Email: jjones@goaciprint.com or mpetersen@goaciprint.com

Weatherbee Resources, Inc. **Contact: Heather Wilson**

These folks have done a great job in the compliance and documentation areas. They are great people, high Integrity and have never disappointed in our book.

Phone: 866.969.7124

Web: www.weatherbeeresources.com

These people/organizations come without big egos. They are salt of the earth types who actually produce results and above all, do what they say they're going to do. There are a lot of people who would like to be on this list and there are probably some who we should add. But these are our most trusted ones. There are 3 things you normally want from Vendors: 1) Quality, 2) Cost 3) Service (Timeliness). You may expect to pay slightly more for quality, but it is worth it... It is non-integrus to pay any vendor, employee or anyone less than he or she is owed and is to the detriment of, even if the contract or agreement states otherwise...



The Presenter



Andrew Reed, CEO & Chief Teaching Officer System Analyst/CPA

Andrew is best known for his song, *If All the World Were Right* and *Strangers* - but he is also one of the most influential people in the United States regarding the operations of Hospice and Homecare organizations. He has worked with over 1,000 organizations in the United States and abroad over the past 27 years. He is perhaps best known for “the Model” - a modern approach to Hospice and Homecare management which creates a high-quality, predictable experience that is financially balanced. Through humility and openness, he has helped organizations quantify, become aware of and implement innovations in management that have created some of the most successful platforms in the history of the movement, resulting in some of the highest valuations and quality scores accompanied by phenomenal economic performance. These results have been achieved by bringing meticulous FOCUS to virtually every aspect of the care experience, including perfect phone interactions, perfect visit structures and, if a Hospice, revolutionary bereavement. All are designed to create a high-quality, predictable experience for every patient, every time. Andrew has been the CFO for many Hospices and Homecare entities and has served on many boards of directors and has as well been the interim CEO during turnarounds. Andrew formed Multi-View Incorporated (MVI) in 1996 to help organizations become “transformative” for all touched through dedication to the highest quality and ideals in the human experience. Since then, MVI has multiplied into several different companies including MVI, MVI Systems, MVI Benchmarking, and MVI Media. Andrew has personally visited hundreds and hundreds of Hospices and Homecare organizations. He also has produced top Billboard records and worked with Grammy-winning artists and nominees. *If All the World Were Right* was an international hit at #15 Global Top 50 Adult Contemporary Airplay Chart, #31 Billboard Mainstream Top 40, #32 Global Top 50 Rock Airplay Chart and #1 for 10 weeks on the Indie US Radio Chart. *Cure My Mind* also topped the charts in a similar way. *Strangers* reached #15 on the Billboard Adult Contemporary Chart, #5 on the NMW Hot 100 and #6 on the Top 40. It was also #1 on the Indie Top 40 for 10 weeks.

What is MVI in 167 Words...

Perhaps no other organization has meticulously considered and cared enough about the Hospice and Homecare experience to breakdown and systematize everything from phone interactions to clinical visits to revolutionary bereavement to enormous utilization of volunteers to the economic welfare of the mission. After working with over 1,000 Hospices and Homecare entities, MVI starts with Benchmarking for professional perspective and guides an organization all the way through the Model with its establishment of 1) Clear, 2) Impressive and 3) Sustainable Standards. Then via extraordinary People Development, an organization with near-flawless quality is created, where it can go days, sometimes weeks, and even “thousands of visits” between complaints, service failures or documentation errors. Economic results are often 200% above average and are a natural byproduct of radically increased quality. This is the reality in the Hospice and Homecare world IF the practices of the 90th are adopted. In a healthcare world that is falling apart, there can be something that actually works... This can and should be your organization!



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Evaluation Form

Thank you for participating in this program! We would like to know your thoughts. Feel free to comment on any aspect. Write on the back of this form or attach additional sheets if more space is required for you to fully express yourself.

May we use this evaluation form to help spread the word about this program? YES NO

Name _____ Dates _____

Hospice _____

Place _____



Multi-View Incorporated Systems
PO Box 2327
Hendersonville, NC 28793
828-698-5885 or multiviewinc.com



Evaluation

Please rank the following aspects of the program. Place an “X” or check in the box that corresponds to your answers.

	Excellent 5	Good 4	Average 3	Below Average 2	Poor 1
Were the stated learning objectives met? Objectives:					
(1) Gain Perspective on current Hospice IPU financial results.					
(2) Learn the Primary Factors of Hospice IPU success.					
(3) Discover the best known practices regarding IPU profitability.					
If applicable, were the prerequisite requirements appropriate and sufficient?					
Were the program materials accurate?					
Were the program materials relevant and contributed to the achievement of the learning objectives?					
Was the time allotted to the learning activity appropriate?					
If applicable, were the individual instructor(s) effective?					
Were the facilities and technical equipment appropriate?					
Were the handouts or advance preparation materials satisfactory?					
If applicable, were the audio and video materials effective?					
<u>Are you more confident in your role than when you arrived?</u>					
Please evaluate the teaching of each presenter individually. Were the individual instructors effective?					
Andrew Reed					

Thank you!

