

TRANSCRIPT: The Future of Hospice: How HOPE Will Transform Reimbursement & Care | Part One

Leadership Rooted In Purpose

Melody King 0:00

Everything rises and falls on leadership. The ability to lead well is fueled by living your cause and purpose. This podcast will equip you with the tools to do just that. Live and lead with cause and purpose. And now, author of the book, *The Anatomy of Leadership*, and our host, Chris Comeaux.

Chris Comeaux 0:22

Hello and welcome. I'm so excited today. We have two special guests with us today. We have Andrea Hale, who's the CEO of Valley Hospice, and Raianne Melton, who's the Director of Clinical Services for Professional Services for Access. Welcome, ladies. It's so good to have you both. Thank you. Happy to be here. All right. Well, let me introduce you just a little bit further, and then we're going to jump in because we're going to be talking about Hope today. This is actually a podcast I've been wanting to do for quite a while, and we actually had scheduled it in this time of the year, knowing that the uh preliminary wage index for 2027 would be out. So let me introduce Raianne first. So Raianne is the director of clinical services for professional services for access. In this role, she serves as a subject matter expert in hospice and powered care, assisting in the creation of training and certification courses for these specialties. Raianne also supports patient engagement as a consultant for Access as CAP Solution. And she is an ANCC lead nurse planner and is a member of the Alliance for Education Workgroup, the Emerging Models and Innovative Care Workgroup, and is an Alliance Grassroots Ambassador. She is the recipient for McKnight's 2026 Pinnacle Marketplace Influencer Award. That's pretty awesome, Raianne. And she has 20 years of experience in hospice care with various companies. And one of her most recent roles, she served as the Director of Clinical Strategy for Banner Health, where she was responsible for developing strategic education to support current and future business opportunities and redefining the delivery model for powder care programming to improve patient outcomes. And so, Raianne, again, it's so great to have you. Um, I tell you about I'm gonna ask you this now. What's your superpower?

Raianne Melton 2:05

Well, this was a kind of a tough one for me because I don't always think of myself as having a superpower. But after a lot of consultation with my family and colleagues, I think that my superpower is that I just care. I care about patient outcomes. I care about the services that people deliver. Um, I care so much it it moves me to action. So I guess caring is my superpower.

Chris Comeaux 2:37

I love that, Rianne. And I'm so glad I just keep asking this question because, you know, I'm I'm not a very bright guy. I just get to interview amazing people like both you ladies. And then I asked that question and I could see it in action. Um, in fact, let me introduce Andrea, and then I'm gonna tie together why I just reacted in that way, because the first time I got you two together, it was like kind of combustible passion and caring all over the place, actually. So, Andrea Hale, she's an RN, MBA. She's the chief executive officer of Valley Hospice, a mission-driven nonprofit serving the Ohio Valley for more than 40 years. She has over two decades of experience from bedside nursing to executive leadership. She brings a grounded clinical perspective to the future of both powdered care and hospice. Andrea's passionate, and I'll put passionate capital exclamation point, about defining what is truly exceptional, five-star care. What does that look like across the continuum with a focus on the holistic expertise and competencies required to care for the seriously ill and dying? She's a strong advocate for advancing palliative care while protecting hospice as the holistic clinical specialty for the final stages of life, ensuring each remains distinct, purposeful, and rooted in clinical excellence. As healthcare shifts towards value-based care, she believes innovation and payment must never disrupt the core fundamentals that created the expertise of caring for the dying, which is also going to be a great segue to what we're going to be talking about. So, Andrea, what is your superpower?

Andrea Hale 4:06

Well, we've done these exercises a couple of times and it keeps coming forward that uh storytelling. So I love to tell stories in a way when things are complex or there's a lot of data and I see like question marks in people's eyes, then I take that data and I can tell a story that kind of helps them understand it. And from a patient care perspective, you know, if we've had a situation where maybe we should have done a little differently or being able to look at it through the eyes of the patients and the families, then I can tell a story from that perspective. But I do, um, underneath all of that, uh, my mother taught me to come from a place of love. So as passionate as I am, and you know, I do uh share that passion, and I like to have conversations around different topics. I try to ground that always in love.

Wage Index Signals And County Risk

Chris Comeaux 4:54

Um That's well said. And again, to mirror that back to you, I could so see that. And there were some cool little breadcrumb breadcrumbs in your bio, just being very passionate. Um, hospice is a brilliant model of care, the competency is by the bedside. And so the first time you two got together, I I can't remember exactly what the catalyst was, other than I think it was me being kind of a little bit of a pest that as I normally am with people like, hey, I'd like to get you on a call. And um, Andrea, you were certainly very influential over me about, hey, do you really understand hope and where it's going? And I'm like, honestly, I don't, certainly not to the extent that you do. And you're like, you know, you should go find an expert for hope. And then lo and behold, the Access team connected me with Rianne, set up a call with both of you. I think it was early this year or right before Christmas. And it was like just explosive energy, caring and love, but passionate around what hope is and where hope is going, which is really like, you know, uh, probably starting last year, I just felt like we needed to do a show around hope. You know, we talked with Judi Lund Person and uh Ned Kaiser last year just about the mechanics of it. But both of you had been kind of planting some seeds with me since I've got to know you about do you understand the chassis that this is? And so finally got you two together, and here we are. So are we ready to jump in? Absolutely. Yes. So last year's home health wage index, there were some changes in there that caught a lot of providers, I'll say, off guard. When you look at hospice today, what signals in that home health wage index that maybe you believe a similar recalibration is coming for hospice? And maybe where do you think leaders are underestimating the impact of that?

Rianne Melton 6:39

Well, I can go ahead and speak to that. Um, you know, one thing that I think that we need to be very cautious about is thinking that the headline of the wage index is really what we need to be focused on as leaders. That is not the case. And when you really dive into the 2027 hospice proposed rule, what we're seeing is that um the 2.4 applies to national payment. Where they really are gonna get us is the in the CBSAs those at the county level. And it's really amazing um how we are going to how many counties are targeted for the full 5% decrease. So, you know, I live in Arizona. I my county, the state of Rhode Island would fit into my county. So most hospices serve one county. When I worked in Springfield, Illinois, we service like 15 counties. And if you're an organization that is servicing a multi-county radius, you may be getting several levels of reimbursement based on the county. So you're as a leader, you're really gonna need to focus on um what model your care over what the actual reimbursement is gonna be based on the CBSA. Andrea, would you like to respond as well?

Andrea Hale 8:07

Oh, I agree with everything that Raianne said. And I think it was it wasn't one change, it was a stacking effect that people underestimated. Um they updated a wage index, um, they recalibrated the case mix, you know, there were several things stacked in there. Like you said, if you just looked at the headline, then you put all those things together and in your net and in your margin, you were shocked. And I'll take it back um when I look at this year's change with home health, you know, I take it all the way back to ninety-nine in the OASI when I was in home care and we were part of the beta for OASIS and our home care. And so when you look back there, and as soon as they said hope, I'm like, this looks like smells like Oasis. I mean, it just does. And and so that was on paper, and that's the difference. That that assessment was on paper, so it was easier for us to implement. It still wasn't easy as far as the changes and the that we're looking at outcomes, but you then you saw that game, and then you looked at the case mix and reimbursement followed with the outcomes. And so as soon as hope hit um center stage and we were a pre-alpha and alpha, you know, it was just very clear that we were the last one standing, and we were going to evolve the way that the OASIS did, and now you see this last update, and you know, that's just that's just gonna be the progression, you know, our future moving forward.

Chris Comeaux 9:31

So, Andrea, you uh we didn't I didn't mention that in your bio, but you were in home health when Oasis came about. And then didn't your hospice, weren't you guys part of the um demo of hope? Is that did I misremember that?

Andrea Hale 9:45

Yeah, we were the pre-alpha and alpha for hope in our hospice, and then it was during COVID, so we were almost gonna, you know, it's unlike unusual to do the beta, but we just couldn't because of staffing. And we just, you know, they listened, we provided a lot of input, our staff leaned into it, and um, you know, I'm really impressed with what CMS produced through that, the thoughtfulness that they put into it and how to move us into this space. And that was our experience with doing the pre-alpha and alpha with the hope tool.

Chris Comeaux 10:16

Well, let's jump into it. So maybe some of our listeners, you know, for someone who hasn't na maybe been living and breathing this, how would you explain the hope tool? What is it, what is it designed to do, and why does it matter for the future of hospitals?

Andrea Hale 10:30

Well, yes, it it basically is an assessment tool, right? It's an assessment tool that's replacing the HISS for the HQRP data, um, quality data, and it's going to in real time look at symptom management, responsiveness, and the outcomes ultimately of our patient's experience. Right now we have the CAP score, which if you ask my brothers and I what m are where our parents both had Valley Hospice, what our perception of their care was, that's through our eyes. But what the hope's gonna do for the first time is gonna give real-time data and assessment of the patient's perception of their symptoms being in manage the responsiveness when they're able, those answers will become from the patient. So you know, it's um that's what it's gonna bring to the hospice finally uh what are our outcomes? What what do our patients experience? Um and I think that's a good thing. I think that it that is the next step. Um, and right now it's just a process. You know, they're really tiptoeing it's into this, and that's different from Oasis, where we're just like all of the things we had to do at once. Like right now it's just a process. Did you show up? Did you identify that they have symptom impact? And did you show up? That's all we're monitoring. And then the next phase is then we're gonna look at the outcomes.

Chris Comeaux 11:55

Um that's my you think that's why some people maybe um miss uh miss think about it. Like it surprises me. You and I are at some conferences sometimes, and we're surprised by other than the initial kickoff last year, certainly got some airtime, but it doesn't seem like it's getting the airtime as much as you would expect because of where you and others believe it's going. Do you think that's kind of because it's just focused on process right now, that why people might be miscalculating its its future impact?

Andrea Hale 12:26

I wonder that. And because of our, you know, being pre-alpha and alpha, and I have my uh hope manual that's 1.00, but they already have 1.02. And I watch the outcomes, the objectives very, very closely, and it talks about the standardized data. That's number one. Number two, to inform future payment and quality improvement. So they're saying it in their objectives, in their hope manual. They've given us uh this information, but there's so much out there that's changing in our world that maybe that's just not, and if you haven't been through OASIS and maybe you're just not looking at this is the way to position us as value-based care. It it really is. Rai, and I don't know if you'd like to.

Chris Comeaux 13:09

What would you like to add to all this about how would you explain it, what is designed to do, and maybe where it's going?

Raienne Melton 13:15

I well, I think you're gonna hear Anthony and I uh say over and over, you're gonna hear the term value-based care. Um, and I think that you as a hospice leader, if you care about what your future is gonna look like, you need to be really looking into this and embracing it. So um this is not uh CMS's first rodeo. And, you know, we know, as uh my good friend Jennifer Kennedy from CHAPTER, you know, hospice is always at the caboose at the home health train. And so, you know, it took 20 years for uh value-based purchasing in home health from the uh when they initiated the OASIS assessment to when they implemented uh value-based purchasing. You know what? They're not gonna take that time with hospice guys. You need to be prepared. That is gonna happen very, very quickly. And I yes, we are just in the process stage of hope, which I think will only benefit all hospices because we're finally documenting in a in a um systematic and uh uh regulated way about how what the symptoms are, what the impact is to the patient, and what we're gonna do. So that's only gonna help us. But I think that you know, we need to be prepared that this is all about that uh future payment changes. And as hospices, we're gonna need to be more aware of data. We're it's you know, we're we're the kind of the feeling business, right? You know, we do a lot of things based on gut reaction. We're gonna have to be a little bit more analytical and data forward as we proceed forward with uh hope.

How To Measure A Good Death

Chris Comeaux 15:25

This is so good. I think I'd shared this with Andrea before, but um I read a book about Socrates. It was kind of fascinating. And so Socrates coined a term. I'm not gonna butcher it's a Latin word, but it's about euid e M A Euidema? I don't know if this is the right way to say it. But basically, Socrates was talking about, and this is like 500 years before Christ, about what is the measure of a good life. I think this is part of our problem right in hospice, is that you know, there's some people say, well, you know, you guys have been talking about quality forever and you still don't have a good measure. Well, the caps, to your point, is like post-experience of the patient and family or the most involved caregiver. But how do you measure for the one who's experiencing the care? And when we tell these beautiful mission moment stories about beautiful closure, maybe even beautiful family reconciliation before someone passed away. Yes, good pain symptom management. Like, how do you put that in a measure? And I I think that's where we've wrestled. Like, how do you measure the end of a good life that we help facilitate that? But yet we're at a time, right, where we just can't throw our hands up to that anymore. And the the other thing that strikes me, Raianne, just listening to you, is that it took quite a while for home health to get there in value-based payment. We're not gonna have that luxury of that much of a runway. Okay, I thought that's what you're alluding to.

Raienne Melton 16:48

We are not gonna have that runway. I will be surprised. Uh, I don't have a crystal ball, but I will be surprised if we don't have some kind of value-based care by 2030, definitely by 2035, but I will be shocked because they're um they're clearly not only on the road to um you know, having more data around outcomes, they're also on a mission to reducing out of the hospice benefit Medicare spending, which is just astronomical. \$1.9 billion was spent um last year in out of hosp out of the hospice Medicare with hospice beneficiaries that were spent outside of that benefit.

Preparing For Value Based Hospice

Chris Comeaux 17:41

Gotcha. Yeah. The the non what we call the non-hospice spending. Exactly. Well, here's a good segue question question then. So if hospice is going to experience this similar shift that home health has seen, what are the first order financial consequences, or maybe better, maybe said a better way, what should the CEOs and leaders be doing right now to prepare and mitigate the risk? Because we know, right, when you look back every time Medicare does something like this, the per unit revenue goes down. Like, right, the outcome of OASIS was not that they got more money necessarily. Although you can make your argument, well, the ones who are doing the best of the best, maybe they did, but overall, maybe the poor portion of the pie maybe shrunk via the OASIS. So that may be what they're trying to do is create more quality, but also maybe shrink how much expenditures, and hopefully maybe that'll be for the ones that um are not doing such a good job. But what do you guys think?

Andrea Hale 18:42

I think it we just need to double down on quality, Chris. And this is what we do. For the hospices that are focused on aggressive symptom management and their bar and case managers are trained that way, you know, we don't let people sit in pain, severe, moderate pain. You know, we we that if it's we make changes, then we call that night. And if it's not better, then we go the next day. That's what we do. So to double down on your quality and just look at this like, and this is what we talked about here, we just need to right now practice like the expectation, and it's already our expectation, is severe to moderate symptoms should be managed in 48 hours. Like, who would want to not have their severe to moderate symptoms? That's the cornerstone of who we are. Then you can move to the mind-body spirit, right? If your physical symptoms aren't managed aggressively and you don't have, you know, median length of stay, ours is around 11 days, you're not able to face those psychosocial, emotional, and spiritual issues if you're brathing in pain. So I just would say look at that as this is double, doubling down on that

quality and showing the industry that yes, we've been doing it. Now we're just getting measured on it. And we welcome that opportunity to show the, you know, the the those that are going to influence our payment, um, that there are great providers out there. And I also believe that our system, as we know, per diem is set up that people can game that system. And there isn't the accountability on outcomes. There is an accountability on you get paid whether you go or not, and the whole per diem system has set up some profiteering that has just been um forlited uh uh over our industry. And now we've seen the shift of of the market. And so this is another opportunity that now, you know, you have to be there. You have to show up, you have to show that you've managed symptoms and there's accountability around being a hospice provider that is needed.

Raienne Melton 20:49

Well, you know, uh I love Andrea's response. I I think that uh we can't think of hope as a form to be completed. It needs to be thought of as a care management tool, and that we really need as leaders to oper operationalize documentation into care management and you know, really look at how we're providing care, how f how quickly we're providing care, and where where is that spot where we're missing the mark? Like one of the things as a hospice uh administrator or clinical director that would make me crazy is a call for supplies from a family on the weekend, or um a visit for a symptom that should have been handled during a regular visit. So, how do we identify those misses and make sure that we're really tightening up how we do the work, how we focus on that, and how we really think of That uh care in the in a manner of we're we're the managers. And I know we have I know we have case managers, but how many case managers get real treat uh training and how to be a case manager? I not all hospices provide that. And how do we how do we use Hope to manage the entire uh episode, including and really drive that uh planet care?

Andrea Hale 22:29

Oh my gosh, Raienne, I love that because you are so right. We're on the next generation of RN case managers. I mean Valley's been in existence for over 40 years. So I've been in it 22 and I'm seeing them retire, and the new ones are coming on, and the census is growing. So having that that basic that fundamental, what does it mean to be an RN case manager? It's back to the basics, right? It is back to the basics, and when you teach that from that foundation, and you know, the assessment, and I say I would add to pull in that pharmacist. You know, I was trained that every admission, you went out, you gave this beautiful assessment to your pharm D, they that's when the magic happened. They would come in and you'd work on the system symptoms until you had a med for every symptom or non-pharmacologic intervention, and then the physician completed the trifecta. When you do that and you prep and you teach that, then you aggressively manage that

symptom from a place of depth. And I just that just reminded me, double down on the basics, go back to the basic.

Raianne Melton 23:29

Absolutely. And I'm just gonna say that when you I'm sorry, sorry, Chris. It's the it's the Rick Hand and Andrew. This is what I knew was gonna happen, just getting you two together. No, listen, when you have standardized protocols for each symptoms that everybody follows the same way, everybody, you know, in uh concert with your pharmd, everything I learned about hospice medication, I learned from my PBM. I learned from my pharmacist, everything. And so having standardized protocols for dyspnea, nausea, pain, neuropathic pain, all kinds of pain that everybody follows the same way is setting up the entire team as well as the patient and family for success.

Andrea Hale 24:18

And that's it, and that expertise. So, Dr. Byock, you know how I love Dr. Byock and his four strategies and pathways forward. And that one that I think is first and foremost is is um defining our expertise and what that looks like and what it takes. And the certification for CHPN, we are focusing on that and we are ensuring that everybody that's been here two years gets that certification. And when you do that and your nurses become more confident and competent, then when they're speaking to the physicians, they were speaking to families, it comes from a place of expertise, not a model of care that's 40 years old. This model of care has been, you know, sharpened and perfected. And, you know, we yes, it was started with cancer. And look what NPHI has even done with all the non-cancer diagnosis. Dr. Muir's work on, you know, American Heart Association, Lung Association, now we have drilled it down into those places where the studies show when you have hospice and some diagnosis, you live longer because of what we do, the symptom management, the quality of life. So then it's like putting that stake in the ground that it's it's not just by chance that that happens with the expertise.

Chris Comeaux 25:27

Well, let me ask this question. This is kind of a segue, but I think it's gonna maybe have you answer what you just did, maybe a slightly different way. I do think a lot of people are treating hope as the next his. You've suggested it's much more than that, it's a broader chassis. So what fundamentally changes in how an organization operates if they take that perspective more seriously than, oh yeah, we've been there, we got the his t-shirt. This is just an ex iteration of that.

Raianne Melton 25:56

Well, I'll start off by saying hope becomes the shared clinical language that drives real-time decisions.

Chris Comeaux 26:06

What does that mean?

Raianne Melton 26:07

What that means is that we're all instead of speaking a dialect, we're all speaking this the same words. All words that we're speaking in regards to hope mean the same thing to all of the stakeholders. And you know, what I found, I taught I was at, I think about 15 state and national conferences last year speaking about hope. And I'm gonna tell you the thing that startled me most that everybody told their t taught their trained their team how to use the hope tool within the EMR, but no one shared what are the how do we correctly answer them?

Andrea Hale 26:49

That's that that's what yes. Right? Right, that's it. You're speech you're speechless, but it's true.

Raianne Melton 26:57

I'm speechless. I asked them to raise their hand, raise your hand if you've taught your team how to accurately score the hope questions. Not a hand in the room fifteen, fifteen different conferences, not a hand in the room went up. So we gotta go there, you know, make sure that we're all the answers to the questions all mean the same thing to the same to the people who are filling them in. Otherwise, you're gonna get all kinds of confusing and contradictory answers.

Andrea Hale 27:39

Oh, you're giving me flashback. So in Oasis, what happened was because we were the beta there, we understood the content and the context. So if you didn't, if your admission nurse did not answer the questions at the lowest level of the patient's care, so say they needed um two assists, but that admission nurse said one assist, you weren't showing the progression of the outcome. So same thing with hope. If we don't understand and I'll answer the same way, we're not gonna show the outcomes consistently, and that's not gonna be good for the organization or the industry. So totally agree.

Training Teams To Score The Same

Chris Comeaux 28:14

Um, gosh, d I love your both of your answers. And I'm trained as an accountant and we experience this on the accounting level. Like, you know, if we let's say you call a category marketing, but if you don't put a definition of what you mean by that, you've got different invoices being coded to different things. And so this is the wisdom of a taxonomy. So, Andrea, I know we always joke like more than once you've showed me your hope uh manual that you have. Is the hope manual like, how do they know that right taxonomy? There you go. If the our viewers could see Andrea just put up her manual. So so how do they know the right taxonomy? What's do they need to print the manual? And then is that what you were kind of teaching from Rian, or what would you say?

Raienne Melton 28:55

I would say that um you need to have a a good educator and um you need to go section by section that for those areas that are going to impact um each group. So, you know, the administrative section is different than the clinical section that is different from, you know, section Z. So, you know, for those clinical questions, I would go one section at a time. You know, I think it's a great IDG activity. You bring the you've got the team together. Today we're gonna go over, you know, uh dyspnea. Today we're gonna go over the pain assessment and just make sure that everybody knows that for a lot of the hope questions, you're checking all that apply. You know, and if you don't if they don't know that you're checking all that apply, they're not gonna do it. So in my mind, it's also engaging, find out who's doing it well, which clinicians are doing them well. And they're usually the informal leaders and bring them in and uh, you know, to lead the charge and and to demonstrate where they're good.

Andrea Hale 30:14

Um, I would agree with that. And I think those sections on the assessment of uh symptom management, what tripped us up a little bit was severe, moderate, and mild. And the who ladder teaches us that in pain. But what they're looking at is the impact, and that's where the subjectivity lies. The impact of the if it's severe, moderate, and mild. And so spending time talking about that and and looking at the intent and answering and giving scenarios. You know, we had several training sessions that gave real patient um case studies so that we're sitting in a group and go, okay, what would, and just like Raienne says, what would you say this impact is, severe, moderate, or this, what would you say? And then talking that through, so it gives them time to process all this because that's the next step. And the more you talk it through and weed out all the subjectivity and comes an understanding, then when it's time, it's just a very natural thing of what we do. You know, we're just saying it the same way now. But it does take a little bit of time because when we did that, we found that there were three different opinions at the table. Because that's not something we were taught. We weren't taught about the impact of a symptom and what means severe, moderate, and mild. So then let's look in the manual and let's see what

they're talking about. And so that was one of the most helpful exercises we did with uh through Leading Age Ohio. Um, they started that with us and they gave us the tools, and then we took it back and we talked it through. Um yeah, that's that's very important.

Part Two Preview

Chris Comeaux 31:48

This is so good. So I I knew I'd learned a bunch just listening to both of you. But you know, one of the things always strikes me, one of my nursing mentors, when I grew up in hospice, which is over 30 years ago, would talk about how hospice was so much art. But every part of medicine, you have to have an art and a science. And the problem is when we treat all art, right? There's so much, there's so much kind of latitude for variance. And that's the problem today, is now we have so much variance throughout America. So when I'm listening to you, I could see where you can really get your, well, it's Andrew's words earlier, just get your quality just really dialed in, very much more precise, and and not as much left to chance, where yeah, we just hire a lot of caring, compassionate people, and they just do caring compassionate stuff, just seeing where they bring more of the science into this.

Jeff Haffner 32:34

Don't miss part two of this episode coming this Friday.