Transcript: Part Two - The Future of Hospice: How HOPE Will Transform Reimbursement & Care

Jeff Haffner: 00:01

Welcome to TCNtalks, and Anatomy of Leadership. We continue the conversation in Part Two —The Future of Hospice: How Hope Will Transform Reimbursement and Care. With our guests, Raianne Melton and Andrea Hale. And now, here's Chris Comeaux.

Chris Comeaux: 00:22

Well, as we go into our next segment, I want you guys, we've alluded to in the first segment about that hope is going to be able to enable us to go into value-based reimbursement. I'd like both of you to talk about that just a little bit more. I think sometimes anymore we hear value-based reimbursement and people kind of check out, been there got the t-shirt. But doesn't value-based reimbursement just mean that it's pay for performance? It's it's ensuring quality ultimately aligns with reimbursement. And so I'd love to hear each of you kind of talk a little bit more how you might see that hope will help get us there and maybe how it'll actually work out. So, Brian, do you want to go first?

Raianne Melton: 01:02

Sure. So it'll take a minute to talk about what CMS did with home health. And basically they came up with three categories of measures. One was OASIS, one was claim-based, and what's one was the CAP survey. So what they what they've done is they've been refining it over the years now, is um, you know, usually dysphia, treatment of dysphnea is one of the oasis-based questions. And they have a couple of areas where they combine OASIS answers into categories. For claim-based, they're looking at uh re-hospitalization and ED visits. And then for CAPS, they've whittled down to just would recommend and uh overall rating. So, if I put my, you know, get out my crystal ball, uh knowing that I have no talent at all for forecasting, you know, what I think what we're gonna be faced with is the hope questions will replace whatever the OASIS uh questions are. Um and you know, they'll be looking at symptom impact. And it's gonna be interesting to see where we go with this because hope is only now in the first 30 days, whether for patients who are on 60 180 days, what that's gonna look like as we progress. So it'll have hope, but it will have claims-based measures. And you may think, what is a claim-based measure for hospice? You know, I really was looking at Bertisson discharges in the uh hospice care index. There's two categories for uh Bertis and discharges, and but now with that new SSDI where they're really trying to target that out of the hospice Medicare spend, that may that's gonna be interesting to see how that plays out.

Andrea Hale: 03:05

Andrew, what would you like to add? No, uh you got me thinking I was um several months, well, probably six months back, I was trying to think of that trifecta that was similar to home health. And this is the difference than then um we're in the same three places, hope and the cap score. But I was wondering with the claim based if there would be something around acuity, because they've been having us submit diagnosis, all the diagnosis that are related to the terminal prognosis for a long time. And I've wondered, is that how they're going to give us an acuity index? Because if you're submitting a patient for the claims and you have two diagnoses, but what they're asking for is every IDT to update that. So UTIs, respirator infections, any, you know, any symptoms in addition to diagnosis, then I was wondering if that was going to paint, complete the trifecta and give the acuity measure. Because the acuity of the patients that we're caring for, I was just wondering if that was the other claim based.

Raianne Melton: 04:06

Yeah, and I and I'm not sure how they would measure that in terms of it's so easy because the claim based in home health comes directly from Medicare billing.

Andrea Hale: 04:17

We yeah, we submit it. We have to submit all the diagnosis. And not everybody's doing it this, you know. That's why I said never take that lightly. Like if Medicare is asking for something, there's a reason. Just like come out, they're gonna look back at it and look at behaviors and it could predict your payment. So I'm like, we have taken the sickest of the sick. You know, we have our acuity is very high. And so how do you, you know, if if visits are similar, it's still not representing the acuity, maybe. Um, and visits could be the way they're gonna do it. But I just always wondered about um the diagnosis because if you don't have somebody that that is painting a picture.

Chris Comeaux: 04:55

Well, you two are the experts, but it is interesting when we're at a conference together, Andrea. A couple of CEOs started sharing with me that they are now doing HCC scoring on hospice patients. And we know that, you know, on the MA side, that's the language of MA, which is really kind of a comprehensive way of almost creating like a case miss case mix index acuity. So there is that. I mean, you have HCC, you've not we've not done it in the hospice space. Um, it'd be a huge kind of learning curve for many of our organizations. The other thing, listening to Raianne, um, you know, re-hospitalizations, and we also know because of um it wasn't SSVI, but it was maybe it was actually I had did a podcast with Kim Brandt, who is the chief vibrant officer of CMS, they're looking at those discharges of actual um hospices. Because we know some of the um ones have not been doing the right thing, you know, the collegiality, ends at criminality stuff, lord, lords discharge rates. And so you could see maybe a combination maybe of all of that. I don't know if that provoked some thoughts on either one of your part.

Raianne Melton: 05:58

Yeah.

Raianne Melton: 05:58

So when I was looking at the hospice care index, and uh, this is something I'm also surprised at, you know, we all know that we want to be 10, but very few people actually look at I found in my experience, very few people can really speak to what items are actually on them. And that um burdisome discharge, you know, where somebody is discharged. Number the first one is discharged to go and they're in the hospital or ED, and they return to hospice and then die in hospice is different from the second level where they're discharged from hospice, go to the hospital, and die while they're in the hospital off of hospice care. So I think that that's really low-hanging fruit, especially, you know, when we're looking at what are is it like 23, 25% national discharge, live discharge rate right now? So low-hanging fruit. And um so, you know, recommendation to all of you hospice leaders out there, understand where you're at on the uh hospice care index and which each item is.

Chris Comeaux: 07:06

That's well said. We did a podcast earlier this year with um burdisome discharge and the gang on the measures that matter, and he talked quite a bit about some of those key measures. So listening to you both, I w I worry now about how bad the data is gonna be, you know, garbage in, garbage out. And so, and that may just be kind of the way it rolls, like maybe OASIS wasn't so good earlier on. So, can you just both speak to that? That um, we're gonna see a wide level of variability. I mean, just listening to you, I wonder how many people are really taking the time to go through those different chapters and define what do you mean um by like you were talking about dyspnea earlier. Are you concerned that the data is gonna be all over the place and is that gonna harm us as a whole? Or that's CMS is just used to that and they just keep on trucking going forward?

Raianne Melton: 07:56

That's a loaded question, isn't it?

Andrea Hale: 07:59

I think right now they're just focused on showing up. Um, you know, getting that, making sure they they show up for that symptom follow-up visit, their HUV visits, making sure they're submitting the data. And then that I think the biggest area of risk, and Raianne, you can weigh in is um how that symptom impact is gonna play out as far as consistency. I think that's gonna be everything else is straightforward, but I really think that's gonna be telling as to even within the same organization, how people are answering those questions um would be thought on that. What would you add, Ray?

Raianne Melton: 08:41

You know what, I would add it, I think Andrea and I talked about this in our in our first meeting. Um, one of my big fears from the beginning as a nurse myself and um a nurse for many, many years, and working with a lot of different hospice nurses across the board is there's my concern was the underrating of symptom impact to avoid the creation of the HUV. And um, you know, people often dismiss me uh saying that hospice nurses are too prof too professional ever to do that. But the reality is, is they're overworked, no work-life balance, you know, being a hospice nurse is not the easiest uh route to take in nursing. It's maybe the most rewarding, but it's certainly not easy. And even, you know, having a subconscious bias to underrate that, and I am convinced that CMS is gonna look at HUV utilization, and that's one thing that's gonna get, you know, from a survey point of view, is going to be a problem for people. So uh I would say that there's gonna be data is gonna be over all over the place because there are gonna be people who are treating hope as a form. There are gonna be a group of people that have a lot of resources, our larger organizations who have the resources to really train staff, uh do the data analysis, be singularly focused on the outcomes, they're gonna have better data. So um, and I think that CMS loves it when we provide incomplete and poor data because it gives them an opportunity to make changes that are not always in the benefit of the industry, but might benefit in terms of reducing reimbursement.

Andrea Hale: 10:41

So we should get really good at submitting the data then to prevent that. Chris, I hate to interrupt. Can I add one thing? And it's around specifically pain. And we are taught Margot McCaffrey, pain is what the patient says it is. When you look at symptom impact, my dad is an example. If this pain was a 10 out of 10, he could be riding a tractor because he was so stoic and he was an iron worker and he endured pain all the time. So if you asked a couple of questions, how's it impacting your sleep? How's it and my dad's gonna say he's just gonna it doesn't because that's but his pain is still a 10, then that wouldn't trip that visit. And I've I was concerned about that. Yeah. You know, because then it takes away the pain is what the patient says it is if the impact isn't there. And I just I've been thinking about that a lot in with new nurses that, well, when you get into spaces of somebody has taken a lot of of opioids in the past and you know, they're not responding like they're in pain. Well, there's reasons for that, and you're not experienced yet to understand that. So don't dismiss that and not address the pain because the impact doesn't seem to be there. So that specifically around pain, and that's the cornerstone of what we do. That was that I'm glad you brought that up. That's where I want us to just keep working with CMS. I mean, this is our opportunity to work with them and provide them feedback. They've been very, you know, get on their website and you can provide feedback to things and be part of this, you know, help create this tool that's gonna provide better end of life care for everybody who receives it when they do their quality.

Chris Comeaux: 12:14

Andrea and Raianne, I'll send this to you and follow up. I was just listening to you, Andrea. There was an article that Cordt and I had highlighted in top news stories of the month earlier this year, because in in Europe, they use a red, red, yellow light, maybe orange. It was red, orange, yellow, whereas the patient's perspective of where they want to be. I know, like we may say, okay, Chris, what's your a tolerable pain level? But there was some wisdom in actually how they used the actual kind of, it wasn't a stoplight because it was, I think, green, orange, and yellow. I'll forward that article. I'm not sure if either one of you are familiar with that, but I found that kind of fascinating because it's from the patient's perspective that's making the clinician look at not just like we're trying to hit some measure that, you know, your pain went from a seven down to a two. Well, what is the what is their perspective in in it and where they want to be?

Andrea Hale: 13:02

And that's perfect because that is part of a complete pain assessment. But when you do not do a complete and you just ask them their number, but you don't say what is your acceptable? Because you can have a pen of pain of 10, but your acceptable level is six because you want to be more alert and you want to be able to communicate, then that's the goal. That's the goal. And it still might be in that moderate level, but it's what the patients, like you said. So, but some pain assessments aren't complete. And that's my that like it has to be complete, the type, their goal, and you know, those conversations. So, yes, that is a main point in your pain assessment is understanding from their perspective what's acceptable.

Chris Comeaux: 13:44

Raianne, let me ask you, what gaps do you maybe concern you on the technology side? I mean, you it's interesting to ask you, you work in a technology company, but the fact that you were teaching all last year on this, yeah, where do you see those gaps that are maybe going to prevent or create friction for people to accurately capture the hope data?

Raianne Melton: 14:03

Yeah. So I think that the biggest gap isn't the collection of the data. I think it's making it actionable in real time. Um if you're if your staff is not doing point of surface documentation so that everybody is everybody on the team is aware what those hope scores are, especially around symptom impact, you know, you're you're not you're failing the patient. So I'm just gonna say, you know, whatever tool you use for documentation needs to have the ability for your team to do point of service documentation. So not only is it more accurate, um, it also, you know, informs, it's gonna inform the plan of care, but it's also gonna improve your nurses' work-life balance. Um, you know, I always said don't if you're not doing point of service documentation, don't talk to me about your work-life balance because it's gonna be more accurate if you're there in the home. You know, also you need to have hopefully access to data analytics that is gonna show you how you're trending. And I think that's gonna be super important as as people move forward. Having the assessment as part of the embedded in the visit as part of the normal workflow is essential. So that just to make it happen and make it happen accurately. And having that data link uh to easily update the plan of care while you're there, you know, where one of the questions, you know, we're always asked by surveyors, they'll ask the patient, Did you participate in development of your plan of care? If you're updating your plan of care at the visit and you say, We're gonna update your plan of care now, um, you're gonna have improved scores. So um I I would say that um if you're using an electronic medical record, hopefully you are. If you are, make sure you're using it to its full potential and that and that you haven't created workarounds because you don't understand how it functions properly, because that's the delays that delays to everybody and um you're not gonna get the accurate data from it.

Chris Comeaux: 16:29

Thank you. Andrea, what would you add?

Andrea Hale: 16:33

Um, agree. Point of care documentation. With that said, the clinicians' barriers to point of care documentation are thick. If you open up your laptop, you're trying to sync, you have cumbersome little text boxes that you're supposed to go in and out of and engage with the patient we're asking too much. It's I go back to this, Raianne. 22 years ago, I had one piece of paper to do my physical assessment on, and admission was a trifold. People are dying the same way they were 22 years ago. Their meds that we're using and how we're doing it are pretty similar, but we have complicated this so much at the point of care, and we want them to do more and more. And how many fire extinguishers and this and that? And it has to become less burdensome for them because there's enough pressure to be there with this family that and they're losing their loved one and all the stress. So I challenge the EMRs, make it so easy at the point of care. Like I have a notebook, and that just like I have that one page, like that's still the way we assess the patient. But now it's 18 pages, 18 pages of an admission assessment. And I'm saying, for what? And you want us to sit in there and do these 18 pages. How do we make it so user-friendly that they feel like they're not burdening the family on admission, especially two hours of their precious time and still getting that information? And I don't know that we've solved that. And we're we're in Suncoast, and I talk to colleagues all over the country. Is how do we make that so easy for them, I'll say.

Raianne Melton: 18:17

I've got to say seamless.

Andrea Hale: 18:18

Seamless, because before I retire, my goal is to not have any citations for care plans. Because they they're just out there disconnected, you're in there doing your thing, you're managing the plan of care, but they'll get it one way or the other. You're gonna get a citation because they're just disconnected. So how do we make that so seamless for them? And that's the word, that it's possible. It's really possible.

Raianne Melton: 18:43

I've been um, we're just about to launch at Axxess, our ambient listening model, and I'm really very excited about this. I think it's gonna require quite a bit of retraining because as we're asking the questions to the patient, the the um the ambient listener, which, you know, even though I work for a technology company, I I don't have a lot to do with technology, is going to be frightening, isn't it? Um what we're gonna be doing is it's gonna be pulling out that essential data and automatically entering it in for you. And then it will also create the narrative. Now, you know, it's always gotta be human forward, right? Human and head in charge. So, you know, the nurse will have to go through and, you know, uh check, you know, validate that it's correct. But I think that probably ampne listening is gonna be the one thing that is gonna uh really support that accurate documentation and and timeliness and make us feel that we uh we've done it in we've done it quickly because if it's ke we don't have to just talk it and then write it, it's all happening at the same time.

Chris Comeaux: 20:04

And write it in 20 different places. You're it's actually listening and trying to put it in that way.

Andrea Hale: 20:09

Of all the things that we've talked about in AI, AI ambient listening is when I've went that if we can figure that out in a way that supports these clinicians at the bedside, that they feel confident that all that's being captured, it will lighten them so much. So that it you nailed it, like that is the space of figuring that out. Um, you get accuracy, you get work-life balance, and and I think that's that's a main part of the solution. Sorry, I didn't mean to interrupt Chris, but I was excited that you talked about that.

Chris Comeaux: 20:46

Let me let me ask you guys one final question and then give you the opportunity for a final thought. If either one of you was advising a hospice CEO today, how are they and how should they balance these near-term financial pressures like you know, the wage index stuff that we just started, especially if you got areas where you're getting a wage decrease from due to the CBSA when you got inflationary expense pressures? But then you also need these longer-term investments required to be able to compete in a hope-enabled value-based environment. What would be your recommendations to them? So, An Andrea, would you like to go first?

Andrea Hale: 21:23

What I've been uh focusing on is, you know, there's a lot of distractions right now, more so than I've ever seen in 22 years. Like all these predictions of what might be and what needs to be, and you just kind of get frozen in it all. But when you stay focused on your mission and your organization and you start digging into the areas, the um mission support areas, right? The the places in MVI where you can look at your net patient revenue and make sure that you're lean and all of those places. And if you need support in those places to figure that out now and get lean and make sure you can invest in your clinical support at the bedside to be able to, you know, provide the caseloads for these clinicians, that it's possible for them to show up every time they need to show up and um get their caseloads down so they can have work-like balance. Because if we can't continue with a consistent workforce and start teaching the next generation, it doesn't matter. So the more lean you can be on those mission support services and all those areas and your operating margin, um that's where I've been trying to focus with all this going on and quality and just doubling down on that. That would be my suggestion.

Chris Comeaux: 22:42

Perfect Raianne.

Raianne Melton: 22:45

Well I I don't think it's an either or problem. It's a sequencing problem. And you know if if you look at the short term um goal of cost control for instance that's going to buy you time, you you're not gonna want to shrink you don't want to shrink your organization into irrelevant. You know what this you need to be very targeted. You know, protect more clinical talent and quality infrastructure. And then at the same time be aggressively attacking variation inefficiency and non-strategic spend. That's so important. And you're looking at productivity and standardizations, not blanket cuts, which is in the long run is gonna hurt you. And at the same time you need to be investing in things for your future that are going to make a difference. You know what EMR what EMR are you using? The the cheapest is not always the the best it'll work for you but how do you you know get that the tool that is going to really support your growth be compliant and meet all the regulatory components as well as support your your team in better work life balance. So um what you the few non-negotiables are clean reliable clinical data consistent care pathways and engaged clinicians who understand outcomes not just visit. So that would be my takeaway.

Chris Comeaux: 24:20

That's well said I I did a podcast a couple weeks ago and um originally Andrea knows this we had done research and came to the conclusion there are eight challenges facing all hospice empowered care programs and I was working on it one night and my wife said what are you doing and I told her and she goes that's depressing. She goes you got to give people hope and so long story short we came up with this really kind of sticky sticky kind of prescription it's just broad categories. You should grow you should know you know you need to sew and you need to flow um and so those four category areas and you really hit upon all of them in what you just said Raianne well for I want to give each of you the opportunity because we really have you covered a lot of territory in this and it's going to be so interesting to see where hope is going but again why I wanted both of you is you are so foresightful. I always kind of make the joke that you know the sentence for Medicare and Medicaid innovation, they're doing great work but CMS is not exactly all that innovative you just look at what they've done to other parts of healthcare i.e home health they're gonna do it to us at some point in time which is obviously a lot of the premise of this so what final thoughts would you would each of you like to share?

Chris Comeaux: 25:28

You've got the year of hospice and power to care leaders um you're both incredibly knowledgeable about this area. So, what are your final thoughts? Raianne would you go first.

Raianne Melton: 25:38

When I step back and look at my 20 years in hospice I always thought home health nurses were the if I was in school they were the preppy kids and the hospice nurses were the were the hippie kids which really worked well for me because I've always thought of myself as kind of a hippie. And now we we've always thought that our reputation and clinical instinct were the most important things. And and that's not disappearing but it's no longer enough on its own. And we the future buyers of hospice, you know, whether it's Medicare Advantage, health system, um patients they they're going to expect hospices to prove their value, not just assert it and for a long time because what we've done, we've just said, you know, we're the we're the cool kids and we do it well and we know what we're doing but we never really provided the data we didn't always provide the data to support that. And I think that moving forward we need to think about how we message that we're still the cool kids providing a specialized kind of care but we have data to support it.

Chris Comeaux: 26:48

That is very well said, Andrea?

Andrea Hale: 26:54

Similar to how I was going to sum it up you know now um imagine that the data comes first you know the data comes first um understanding it comes next and then the payment is going to follow and if we can get comfortable with you know now we have the data. We've always had the stories right we've always had the stories in the communities the community support is a cherry on the top that they just come forward with gifts of philanthropy because they love the care that they received and they want us to do more of it. So if we just get more comfortable that yes we got to give a little bit more data. We've always done it and now it's just this is a tool to help us do it. And then we'll understand it and when we need to pivot, we'll pivot and then we're gonna get paid based on how wonderfully we've do and have done. And the only thing that I would add then is you know we've talked about the value-based care and taking risks and I've thought about and I've had this conversation with Chris we're really the OGs on taking risks when you look at hospice because we were given let's just make it a $4,000 a month of care for somebody and you take them on and then they may add treatments to their plane of care that are beyond that $4,000. We're managing risks all the time. Then when you became open access, trilogies, millrenone, TPN, all these expensive this types of treatment came about, we're managing that and we're not sharing in any savings. So we've always done this. We've always not full risk because we're not responsible for hospitalization and everything, but we are managing risk all the time. And I think when you are a nonprofit and you're taking the highest acuity and you're saying yes to every patient that comes to your doorstep that be confident and you've been doing that and now you just need to take it to the next level. Taking it to the next level. It's not like we need to throw out the baby with the bathwater. We've been doing it we just haven't been calling it that you know and especially when they said virtually all diagnosis related to the term prognosis and you but you are covering everything but maybe some glaucoma. So all of those meds and all of those treatments that this is where we're at and now we're gonna get paid for the quality. So it's exciting and terrifying in the same sentence but I think it's it's necessary and and we're in this together. So and I love having partners like Raianne who will help us solve those problems like you know charting at the bedside because this next generation isn't going to have it. They're not gonna even if they could document it nine o'clock at night, they're not and I applaud them for that.

Chris Comeaux: 29:40

That's well said. And rea I'm just reflecting on what you're saying because I know you well enough that I mean you know that we're not getting the penalty but what you're saying is we've been saving the money when you actually look at it. Even the studies that included mediocre even horrible hospices still saved a lot of money and that it shouldn't it shouldn't worry us that we're gonna be at risk. If anything just listen to both of you and I mean thinking about it like getting it dialed in in the education you should then be in the top tiers and if you're in the top tiers that's where typically Medicare say congratulations we're gonna give you an add-on if you're mediocre we get whatever the national rate is you're with your CBSA. But if you're below the 50th percentile guess what we're gonna take money back and the organizations that should be fearing that are not even thinking in terms of what you've been weaving throughout this whole conversation. So kudos again to both of you and Rand I love what you said I just finished this weekend. It was actually through a good friend that Andrew introduced me to had him on the podcast last year Dave Mastovich with No BS Marketing he had a meeting with our TCN network and he said you guys should go and read the whole story which is about Whole Foods which is so fascinating because I I totally get now we were spoken this you know Whole Foods were the hippies about the like the whole healthy eating kind of movement. And now everybody wants a Whole Foods in their community and this is where Andrea comes in Andrea said for me for a long time Chris the baby boomers going to want the best of the best we've created a beautiful model of care. We have to talk about it differently so they realize like what I'm thinking is listening to you two is we need to create the Whole Foods brand that they realize this is the best of the best but when it comes to serious illness care, this is the type of organization you need to get care from which is what Whole Foods did for healthy aging. We need to do that for the serious ill space.

Andrea Hale: 31:32

I don't know I know I told you final thoughts but if that provokes anything from either one of you any final uh comments from either one of you just you don't need to put on the podcast Chris but with that baby boomers and my brother my big brother's 18 years older than me so he tells his friends when they need hospice he has this bucket list that you know he'll go you ask them their star rating and if they don't have one go no thank you. And then you ask them if they have a care center and what do you do if your loved one can't be managed at home and they have a crisis do you have a then if you don't have a care center do you have a contract with your local hospitals to provide that what happens um and what's the third one he has a third one so he has his own little baby boomers like checklist for his friends that they know that his sister does hospice so then they'll ask him but I gotta figure but that's it like boiling it down to them to wait out because they'll have all these providers coming to them but what what is quality?

Chris Comeaux: 32:26

How do you know we're getting the best of the best ladies thank you for both of you you just did a tremendous job and yet we could go two hours um you know I should probably do long forum podcasting just very few people will listen to the full two hours but you two could keep going for for two hours.

Chris Comeaux: 32:41

Thank you for the work that you're each doing and to our listeners we thank you at the end of each episode we share a quote a visual the idea is to create a brain bookmark a thought prouder about our podcast subject to further your learning and growth and thereby your leadership. We're hoping it sticks like a brain tattoo. Be sure to subscribe to our channel we don't want you to miss an episode. Check out if you're interested in my book The Anatomy of Leadership you know it's easy for us to rail against the world and be frustrated by things let's be the change that we wish to see in the world. So thanks for listening to our podcast and here's our brain bookmark to close today's show.

Jeff Haffner: 33:14

"Hope becomes the shared clinical language that drives real time decisions." By Raianne Melton.

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