ah HA! News and Updates from

HOSPICE analytics

Research and Analytics to Improve Hospice Care

Spring 2015

In This Issue

Join Our Mailing List!

Quick Links

- Our Web site home
- National Hospice Locator
- InfoMAX
- InfoMAX pricing and order form
- Products & Services
- Resources for Opposing Physician-Assisted Suicide
- About Us
- Contact Us

FREE InfoMAX Demo Webinar, May 12

Attend a **FREE, half-hour** webinar to learn more about the power of data in your management and planning processes. **This month, we'll explore Discipline Visit Number and Discipline Visit Length**--what can

Our new logo and Web site design are done! Check it out **here**. It's not just window-dressing -- we hope we've made our products and services more accessible and clear. A number of the changes were made because you asked . . . including a new feature in the newsletter called, ***"Since you asked . . ."*** which we hope will shed some light on interesting aspects of using and understanding data in hospice care. Let us know what you think!

--Cordt, Jennifer, Cathy, and Joy

Registration Now Open for Hospice Analytics "Basecamp," July 31 in Denver!

Hospice Analytics is offering a **day-long, hands-on "basecamp" for hospice leaders and staff** working directly with our data or wanting to learn more about it. In a lively workshop format, we'll walk through how to access, understand, manipulate, and report essential data. Sessions will focus on utilizing data for **financial and strategic planning, marketing, advocacy, and clinical services.**

Earlybird registration is available until June 1, at only $375.00, which includes your hotel stay over the night of July 30 at the luxurious **Woolley's Classic Suites**, breakfast and lunch on the conference day, all conference materials, complimentary reception the evening of July 30, and free transportation to and from Denver International Airport.
Register now
Space is limited!

Opportunities to Help Hospitals with Readmission Penalties

Reducing readmissions of patients to hospitals within 30 days of discharge is a top priority in healthcare reform,

these data tell you about your program vs. others in your area, utilization of resources, clinical service model, and compliance?

May 12, 3:00PM EST (12:00PM Pacific).

To register, send an email to **Jennifer Ballentine**

Hospice Analytics Info

Our Mission

Hospice Analytics is an information-sharing research organization whose mission is to **improve hospice utilization and access to quality end-of-life care through analysis of Medicare and other national datasets.**

Collaboration with State Hospice Orgs

More than 50 percent of the State Hospice Organizations participate in Hospice Analytics' Market Reports Project. These State Hospice Organizations represent over 60% of the hospices serving over 70% of the hospice patients in the country. Substantial revenue is shared with participating non-profit State Hospice organizations.

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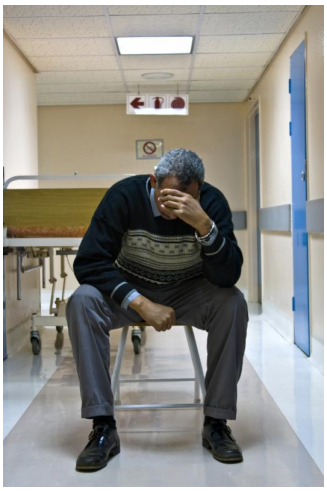
both to improve quality of care and to reduce costs. Since 2012, hundreds of hospitals across almost all 50 states have been financially penalized for high rates of readmissions. Many facilities and systems have been working to develop patient discharge and transition interventions to decrease readmissions, especially among high-risk, high-intensity (and thus high-cost) patient populations. **There is an opportunity here for hospice and palliative care programs.**



Factors contributing to readmission

Nationally, the average readmission rate is 24.10%, and many systems have made successful efforts to reduce rates. Study data and conclusions vary; however, a meta-analysis[i] of 34 studies showed that a **median 27% of hospital readmissions are preventable** (range 5% to 79%). Factors contributing to 30-day readmissions include

- premature discharge or inadequate post-discharge support;
- insufficient follow-up;
- failed handoffs to primary care providers;
- complications from procedures;
- infections, pressure ulcers, and patient falls; and
- therapeutic errors, many involving medications.

In particular, polypharmacy, certain high-risk medications (including narcotics, antipsychotics, and antidepressants), more than six comorbid chronic conditions, and specific clinical conditions (including COPD, heart failure, cancer, and stroke) have been identified as high risk factors for readmission.

Interventions

No one reliably successful intervention to reduce readmissions has been found, but the **most effective programs are multifaceted, complex, and geared toward supporting patient self-care,** according to the authors of the meta-analysis. The best models often combine nurse-led care coordination with telephonic support and frequent home visits.

Opportunities for hospice and palliative care

Looking at these risk factors, hospice and, in particular,

Hear What Our Clients Are Saying!

We have really come to appreciate you and the service you provide. It's been invaluable to our work!
--Hospice CEO (TX)

This is really wonderful data! The report . . . has really helped our Board to picture where we are and where we need to go as an organization.
--Hospice Executive Director (NY)

I like your reports and find them invaluable to our business development work. Keep up the good work!
--Hospice Business Development Manager (WA)

Speaking & Teaching by Hospice Analytics

Hospice Analytics has offered workshops and plenary sessions on data analysis and utilization, strategic planning, and other topics at numerous state and national conferences. To arrange an engagement in your state or agency, contact ***Jennifer Ballentine*** .

May 20
Hospice Federation of Massachusetts Annual Meeting
Jennifer Ballentine

May 21
Hospice & Palliative Care Association of New York State Annual **Interdisciplinary Seminar and Meeting**
Cordt Kassner

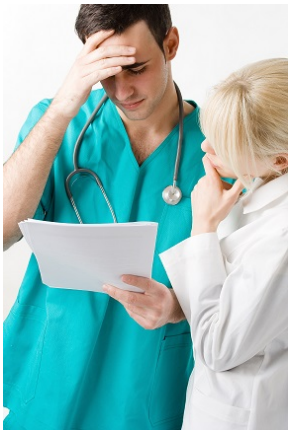
community-based palliative care programs are ideally suited to helping hospitals with their readmissions challenge. **Hospice and palliative care (HPC) programs can position themselves to receive high-risk, high-intensity patients** with multiple or advanced illness, for instance, by

- specializing in care of patients with COPD, heart failure, or cancer;
- partnering with hospitals to provide or participate in palliative consults; and
- arranging post-discharge transfer to an HPC program. HPC can then fully coordinate care for these complex patients.

HPC medical directors can review medication lists, focusing on those most essential for symptom control and comfort, and nurses can assist with patient education and support patient self-care and caregiving.

How InfoMAX Can Help

Premier InfoMAX subscribers can find several reports to that will help identify opportunities: Hospital, home health, and skilled nursing facility admissions diagnoses reports can identify patient populations at risk for readmission. The Hospital Palliative Care report identifies hospitals that are doing palliative care consults--which can often lead to a hospice referral. It can also identify hospitals that are not doing palliative care consults--which provides an opportunity for hospice help build a consult option. As the pressure mounts on hospitals and systems to further reduce readmission, HPC can thus be valuable partners in improving patient care and reducing costs.



[i] Alper, E., O'Malley, T.A., & Greenwald, J. (2014). Hospital discharge and readmission. Up To Date report. http://www.uptodate.com/contents/hospital-discharge-and-readmission

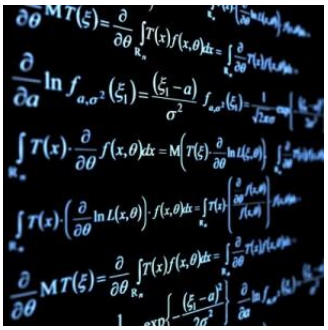
"Since You Asked . . . "

The Hospice Analytics team is available to answer questions at any time. It's occurred to us that your questions--and our answers--might be interesting to others in the field. So we're adding this new feature to our newsletter. Each month we'll share a question and an answer. Let us know what you think!

How is average length of stay calculated?

You wouldn't think this would be a stumper, but it is. Hospices (and payers and FIs) calculate mean length of stay (LOS) at least a dozen different ways. Here are some examples:

1. Hospice Analytics uses calendar year Medicare hospice claims for all beneficiaries, which equals **the total days of care divided by the total number of beneficiarie**s. We can then use this method for a beneficiary, a hospice, a county, a state, or the country. This allows us to compare changes in LOS across different calendar years.
2. MedPAC first narrows their sample to only Medicare beneficiaries who have died, then looks across the **lifetime total days of hospice care per beneficiary.**



3. **NHPCO reports using a combination of National Data Set results and Medicare claims.** More recently it appears they rely more on NDS results; so LOS as self-reported by 12% of hospices nationally who complete the survey.
4. Some hospices **pick a month and divide days of care by beneficiaries served.**
5. Some hospices will **track all patients admitted in January through discharge, and average their days.**
6. Some hospices will **only include patients who died in their program during the calendar year,** and do the calculation.

All of these methods are "right" as long as the numerator and denominator are clearly defined. If your LOS calculation is different from someone else's, double-check how LOS was defined.

Opportunities and Announcements

Sarah Bealles to lead innovative merger of three palliative and end-of-life care providers

If you attended our Evidence-based Leadership Summit in January, you'll remember that Sarah Bealles, then CEO of JourneyCare in Illinois, discussed how she has used InfoMAX data to understand opportunities for mergers and acquisitions. Recently, it was announced that JourneyCare is joining Horizon Hospice & Palliative Care and Midwest Palliative & Hospice CareCenter to form the largest nonprofit palliative, supportive and end-of-life care provider in Illinois. Altogether,

the new entity will comprise 800+ employees and care for thousands of patients in Chicago and 10 surrounding counties. Sarah will serve as President and CEO of the new, yet-to-be named organization. More information this exciting development can be found **here**.

IOM Releases PSA About Having a Conversation on End-of-Life Care

More than a quarter of all adults have given little or no thought to the care they would want to receive if seriously ill or nearing the end of life. **The Institute of Medicine has created a new public service announcement and website** on when and how to start that conversation with friends, family, and care providers. The 30-second PSA can be viewed at **www.iom.edu/theconversation**, which also lists resources for having a conversation about end-of-life values, goals, and preferences.

Resources to Oppose Physician-Assisted Suicide

Physician-assisted suicide (aka "physician aid in dying," "physician-assisted death") bills have been introduced in **14 states: California, Connecticut, Colorado, Iowa, Kansas, Missouri, Maryland, Massachusetts, Montana, New Jersey, New York, Oklahoma, Utah, and Wyoming**. The Colorado bill was defeated in committee and the Wyoming and Montana bills have been tabled. Several other states have proposals or drafts in process, and lawsuits challenging laws prohibiting PAS have been filed in New York and California. **If it hasn't already, this issue will soon come to you,** and every hospice professional and agency will be called upon to provide accurate information, distinguish hospice from assisted death, and reassure patients and families that relief of suffering is both our specialty and our top priority. **Hospice Analytics has been following this issue very closely** and has assembled copious fact-based information as well as model position statements and legislative recommendations. Because there appears to be no national clearinghouse or centralized organization opposing PAS, we have **assembled opposition resources on our Web site.** For more information, contact **Jennifer Ballentine**, 303-521-4111.

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