Creating a Business Plan

2013 Hartford/ ADGAP Leadership Retreat

Steven Barczi, MD
Director of Geriatric Clinical Operations
Associate Professor of Medicine
Division of Geriatrics & Madison VA GRECC
University of Wisconsin School of Medicine
The Business Planning Process

What are the first things that enter your mind when someone mentions creating a business plan?

Why do you think that is?
In this new era, academic health centers need new types of leaders who can tackle “the business of becoming a business” that is, the people who can apply the disciplines of sound business principles while remaining committed to principles of free inquiry, scholarship, and ethical practice.

We need to be able to communicate to our CEOs, CFOs, COOs in their language when we are “invited to the table.”

Breakout Objectives

• WHAT is business planning?

• HOW do I do it locally?

• A STORY of one Institution

• DISCUSSION
What Language do They speak?

Strategic Planning:
- Evaluate readiness for change
- Identify drivers for change or expansion
- Understand market dynamics
- Complete market analysis
- Assess resources

Business Planning:
- Define stakeholders & their objectives
- Collect program & business data
- Conduct SWOT analysis
- Develop consensus on vision & goals (Retreat)
- Create Document

The “Product”:
- Clear goals
- Well-defined priorities (Key Results Areas-KRAS)
- Infrastructure
- Efficient referrals
- Measureable outcomes
- Deliverables
The Strategic Planning Process

What needs to change?
Is the timing right (Why now)?
Do you really want to do this?
Who will assist in this process?
What is the timeline?
What are the deliverables?
The Business Planning Process or How Do You Tell the Story of Us?

- Get Invited to the Table
- The Document
- The Pitch
- Follow the Timeline
- Deliver the Metrics
- Adapt

Who Can Make It Happen?
- Decision-makers
- Stakeholders (know their objectives)
- Admin Support

What Data is needed?
- Vision & Mission
  - Program Data
  - Fiscal Data
  - SWOT
  - Key Result Areas

How Do You Sustain the Plan?
- Get Invited to the Table
- The Document
  - The Pitch

How Do You Tell the Story?
- Decision-makers
- Stakeholders (know their objectives)
- Admin Support

Who Can Make It Happen?
- Vision & Mission
  - Program Data
  - Fiscal Data
  - SWOT
  - Key Result Areas
Business Plan: The Data *the Way They Want It*

- Program or service line overview
- Proposed service description
- Business environment
- SWOT analysis
- Population served
- Customer value strategy (survey/focus groups)
Business Plan: The Data *the Way They Want It*

- **Competitive strategy**
- **Operational strategy and implementation**
  - Personnel
  - Facilities
  - Equipment
  - Regulations
- **Financial plan**
  - Reimbursement
  - Affiliations
  - Marketing
Multiple versions (audience?)
Focus plan on intended reader
Realistic financial projections
Use non-medical terms
Substantiate with data
Stay flexible
Evaluate and update the plan
The Protagonist

The Barrier

The BHAG*

* Big Hairy Audacious Goal
The Story: The University of Wisconsin Division of Geriatrics
Program Core Faculty
(Shared between GRECC & Division of Geriatrics)

- 28 Staff Geriatricians/Gerontologists
- 5 Geropsychiatrists
- 5 Neuropsychologists
- 8 Geriatric Nurse Practitioners
- 4 Geriatric Social Workers (MSW)
- 165 Research Staff
Madison VA

• GRECC Research
• Geriatric Primary Care
• GEM Evaluation Clinic
• Osteoporosis Clinic
• Geropsychiatry Clinic
• Memory Assessment
• Geriatric Sleep Clinic
• Palliative Care Clinic
• Falls Clinic
• OT Driving Assessment
• Palliative Care Consults
• Geriatric Inpt Consults
• Transitional Care Program
• Home-based Primary Care Program

UW Hospital

• Acute Care for Elders Service
• Inpatient Geriatrics Ward
• UW Home Care VNS

UW School of Medicine and Public Health

• Preclinical Courses
• Geriatrics Interest Group
• Student-Senior Partnership Program
• Schapiro Summer Research Scholars
• Third-yr clerkships
• Fourth-yr elective
• Scholarships to National Meetings

University-based Clinics

• Geriatric Primary Care (4)
• Dementia/ Memory (5)
• Osteoporosis Clinic
• Falls and Mobility Clinic
• Geriatric Sleep Clinic
• Dysphagia Clinic
• Geriatric Oncology Clinic
• Geropsychiatry Clinic

Community Sites

• UW Alzheimer’s Dz Res Ctr
• WI Alzheimer’s Institute
• CoE in Women’s Health
• Oakwood Village Retirement Sites
• Area Nursing Homes
• Enriched Care Program
• Hospice Care Inc.
• Care Wisconsin
Geriatric Business Plan Development
Why were we invited to the table?

- Research productivity
- Successes of ACE program
- Excellent patient satisfaction data
- Several key leaders - parent health crises
- ACA/ACO needs
- Rural partners’ needs
## Business Plan Contributors

### Project Co-Chairs
- Sanjay, Asthana, MD
- Mark Hamilton, VP, UWHC Ambulatory Operations

### Executive Sponsor
- Mark Hamilton, VP, UWHC Ambulatory Operations

### Executive Steering Committee
- Steven Barczi, MD, Geriatrics
- Maria Brenny-Fitzpatrick, RN, CNS
- Julie Christofferson, UWHC Clinics
- Adrienne Cisler, UWHC Emergency Department
- Kelsie Doty, UWMF Finance
- Julie Fagan, MD, Department Of Medicine
- Robert Flannery, UWMF Finance
- Sheri Lawrence, Department Of Medicine
- Joann Wagner Novak, RN, DFM
- Linda Walton, RN, UWHC Medical Nursing
- Rich Welnick, MD, UWMF Medical Director, Ambulatory Clinic Operations

### Model of Care Workgroup
- S. Asthana, MD, Committee Chair
- S. Barczi, MD
- M. Brenny-Fitzpatrick, RN CNS
- J. Christofferson, RN, UWHC Geriatric Clinic Manager
- J. Fagan, MD
- A. Kind, MD
- B. Liegel, RN
- M. O’Connell, UW Health Administrative Fellow
- K. Palmer, UWHC Director Adult Primary Care and Internal Medicine Clinics
- R. Novak, DFM
- L. Walton, RN

### Stakeholder Interviews
- G. Schwersenska, Director, WI Office on Aging, Bureau of Aging and Disability Resources

### Project Management
- Kristi Bartos, Senior Business Operations Specialist
- Mary O’Connell, UW Health Administrative Fellow
- Karen Palmer, UWHC Clinics
- Gillian Schroeder, UWHC Decision Support

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You can’t do this on your own...many different groups should be engaged in the planning process.
## Patient Origin & Access

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>• Dane County/ Ring Counties (70% of referrals internal)</td>
<td>• Dane County/ Ring Counties, UW Statewide partners, new markets via telemedicine outreach</td>
</tr>
<tr>
<td>• 2-3 month backlog for geriatrics primary care</td>
<td>• 30 day access to specialty clinics and geriatric primary care</td>
</tr>
<tr>
<td>• 2-6 month backlog for specialty referrals</td>
<td>• Geriatric triage system to coordinate care across UW Health</td>
</tr>
<tr>
<td>• Lack of dedicated triage system for scheduling into specialty clinics</td>
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Demographic Trends

### 65 Plus Population Projection

<table>
<thead>
<tr>
<th></th>
<th>Pop2005</th>
<th>Pop2010</th>
<th>Pop2015</th>
<th>Pop2020</th>
<th>Pop2025</th>
<th>Pop2030</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dane County</td>
<td>43,146</td>
<td>50,229</td>
<td>63,455</td>
<td>80,641</td>
<td>97,419</td>
<td>112,642</td>
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<tr>
<td>% increase</td>
<td>16%</td>
<td>26%</td>
<td>27%</td>
<td>21%</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Ring Counties</td>
<td>68,779</td>
<td>73,158</td>
<td>82,909</td>
<td>96,471</td>
<td>113,147</td>
<td>128,152</td>
</tr>
<tr>
<td>% increase</td>
<td>6%</td>
<td>13%</td>
<td>16%</td>
<td>17%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>WI Total</td>
<td>726,280</td>
<td>782,810</td>
<td>900,170</td>
<td>1,060,620</td>
<td>1,243,600</td>
<td>1,402,900</td>
</tr>
<tr>
<td>% increase</td>
<td>8%</td>
<td>15%</td>
<td>18%</td>
<td>17%</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>Northern Illinois</td>
<td>66,769</td>
<td>73,294</td>
<td>83,966</td>
<td>98,078</td>
<td>114,367</td>
<td>128,109</td>
</tr>
<tr>
<td>% increase</td>
<td>10%</td>
<td>15%</td>
<td>17%</td>
<td>17%</td>
<td>12%</td>
<td></td>
</tr>
</tbody>
</table>

Source: Wisconsin Department of Administration Demographic Services Center/Illinois Department of Commerce and Economic Opportunities; G. Schroeder
### SWOT Analysis

**Strengths**
- Highly rated programs
- Little direct competition
- Full continuum of care
- Interdisciplinary teams
- Extensive specialty clinics
- Key leader support for geriatrics

**Weaknesses**
- Long wait for specialty clinics
- Poor financial reimbursement
- Higher clinic costs (teams)
- Large volume of calls/care management

**Opportunities**
- Promote cost-avoidance in new UW ACO
- Coordination of continuum of care services/care transitions
- Improve efficiency to optimally use resources
- Promote uniqueness of geriatric care

**Threats**
- Shrinking institutional resources
- Low Medicare reimbursement in FFS model
- Insufficient workforce
- Non-reimbursed care volume
- Silos of care (admin, resources)
- Age-wave overwhelms system
Examples from Patient Focus Group & Phone Interviews

• **Reduced appointment availability** but pts want to wait to see their provider

• **Disappointed about waits** for specialty clinics, but **they prefer to see a Geriatric specialist**

• Appreciate **convenience & efficiency of co-located clinics** and attention to special mobility needs.

• **Scheduling has improved** with EMR

• Prefer to receive **all care and have all records in one place.**

• Feel strongly about **Clear & timely communication** of care plans, medications, test results, visit summaries
The volume of discharges from UWHC has increased by 29% over the past 10 years, with increases in all age categories except for patients ages 18 to 44.

Source: UWHC Decision Support Datamart
# Industry Trends

<table>
<thead>
<tr>
<th>Government &amp; Payor Trends</th>
<th>Clinical &amp; Physician Trends</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medicare Accountable Care Organizations—UW Health ACO 1/1/13</strong></td>
<td><strong>Hospital &amp; Clinic-based consultation model</strong> to support PCPs and inpatient teams</td>
</tr>
<tr>
<td><strong>CMS Innovation Center</strong> to test new payment &amp; care delivery approaches</td>
<td><strong>Team-driven model of primary care- Medical Home Model</strong> implementation 2012-2013</td>
</tr>
<tr>
<td><strong>Healthcare Reform &amp; Medicare changes:</strong> Cuts focus on reducing inefficiency, waste, fraud; greater focus on care coordination and wellness; creates programs aimed at improving quality and cost-effectiveness of care.</td>
<td><strong>Capacity assessment and intervention (CAI) model</strong>- Increasing role of NPs, MAs, PAs &amp; others</td>
</tr>
<tr>
<td><strong>Team-driven model of primary care- Medical Home Model</strong> implementation 2012-2013</td>
<td><strong>Successes in research mission</strong> reduces physician time for clinical work</td>
</tr>
<tr>
<td><strong>Technology Trends</strong></td>
<td><strong>Global Healthcare Trends</strong></td>
</tr>
<tr>
<td><strong>Electronic Health Records</strong></td>
<td><strong>Primary care physicians will take care of the majority of geriatric patients</strong>—supply of Geriatricians cannot accommodate demand</td>
</tr>
<tr>
<td><strong>MyChart/patient &amp; family access</strong> to and interaction with information and providers electronically</td>
<td></td>
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<tr>
<td><strong>Home monitoring equipment</strong> &amp; patient tracking</td>
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<tr>
<td><strong>Telemedicine</strong> infrastructure &amp; services</td>
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</table>
Environmental Assessment
Market Share/ Competitors

• Other programs in state: Aurora (Milwaukee/ Statewide); Medical College of Wisconsin (Milwaukee)

• Locally:
  – No other designated geriatrics programs
  – Competitors (Dean, Physicians Plus, GHC) have geriatric NPs but no specialized geriatric clinics/ geriatricians.
Geriatric Business Plan Executive Summary*

* Abbreviated for ADGAP Presentation
Vision:
The UW Center of Excellence in Geriatrics will lead efforts to ensure that older adults in Wisconsin and beyond receive state-of-the-art *coordinated care that is cost effective and optimizes quality of life, functional independence, and upholds care preferences.*

Mission:
Create a *comprehensive and integrated network of clinical services in partnership with primary care* that incorporates the patient-centered medical home model and provides ready access to geriatric consultation across the care continuum. This will incorporate key principles of chronic disease management, systems-based practice, transitional care, palliative care and health promotion and wellness.
Rationale for the Proposed Plan

- Geriatric population (ages 65+) will increase by at least 30% over the next decade in Dane County.

- Geriatricians cannot provide care for all geriatric patients now or in the future. A change in the care model to provide more efficient consult services to Internal Medicine and Family Medicine physicians is needed.

- Improved services for transitions of care, home care, and coordination of care will be essential to provide effective and efficient care. $3-11 million dollar over five years is at risk at UW Health for decreased CMS reimbursement related to hospital readmissions.

- CMS reimbursement will change with new payment and healthcare delivery system reforms through the ACA/ACO. Changes in geriatric services must reflect better integration of medical services and social supports.
Current Geriatric Services (2011)

**Ambulatory Services**
- FY 10 clinic visits - 7,480
- FY 11 clinic visits – 8,196
- 5.9 FTE MD and 4 NP’s
- Distribution of current clinical practice: 65% Primary Care and 35% Specialty Care

**Inpatient Care**
- ACE consult inpatient program provides assistance to departments caring for geriatric patients to improve LOS, promote patient safety and reduce functional losses
- Shared attending physician coverage of GMED-2 Service

**Long-Term Care**
- Primary care for UW Health nursing home residents
CoE Service Summary

Establish the following new programs:
- Transitions of Care (TOC) Program
- Geriatric Assessment Day Center (GADC)
- Wellness Program (Community & Corporate)
- Tele-Medicine (UW Health & Partner Clinics)

Adapt the following existing programs:
- Outpatient specialty clinics
- Acute Care for Elders into the ED
- Long-term care Program (Re-organize)
Proposed Integrated Network of Aging Services

UW HEALTH GERIATRIC CENTER OF EXCELLENCE

Research and Education outcomes are applied to the clinical care of patients in all aspects of the Geri-Viso model.
Proposed Integrated Network of Aging Services

BHAG="Gerontopoly"

ACE in ED

Transitional Care

Wellness Program

Telemedicine to Rural Partners

Specialty Clinic Access

ACE

Day Treatment Center

Research and Education outcomes are applied to the clinical care of patients in all aspects of the Gerontopoly model.
Geriatric Business Plan Goals

- Decrease hospital and ER admissions & readmissions by 50% by 2015 through the implementation of proposed programs (i.e. Transitions of Care Program and Geriatric Adult Day Treatment Center- GADC).

- Reorganize geriatric clinics to 25% primary care clinics and 75% specialty clinics

- Improve specialty clinic access in areas requested by UW Health primary care MDs (memory, falls, mental health, med management) via an enhanced clinic triage system and new geriatric assessment clinics

- Increase clinic efficiency with increased volume (from 6,480 to 9,736) and improved outpatient appointment template utilization (up to 90%)
Geriatric Business Plan Goals

- **Develop a Geriatric Assessment Day Center (GADC)** to manage frail older adults with acute/sub-acute problems as an alternate to ED/observation/short hospital stays, and enhance post-hospital follow-up care.
- **Streamline the Long Term Care program** across UW Health (Geriatrics, GIM, DFM).
- **Create Community and Corporate Wellness Programs** (Health Span Life Extension) for community-dwelling seniors and employees of area fortune 500 companies.
- **Expand the ACE Inpatient Program** into ED.
- **Implement Geriatric Telemedicine Outreach Services** for UW Health and Partner clinics.
Transitions of Care (TOC) Program

- **Pilot** for hospital adapted from established TOC models (i.e. Coleman, Kind, Jack)
- **Part-time MD, 1.0 NP and 1.0 RN** case manager
- NP pre-discharge visit*, post-discharge RN telephone follow-up and selected NP home visits*
- Focuses on enhanced discharge plan of care, medication reconciliation, red flags, expedited follow-up
- **Bridges care** between hospital & primary care teams
- Outcomes tracked by the Health Innovations Program

* Billable services at time of proposal
Geriatric Assessment Day Center (GADC)

• model adapted from well-established day hospital geriatric programs in UK and Canada

• In 2010, over 15,369 encounters for UC, ED, observation and short stay admits occurred in the 65+ age group

• Overarching objectives of the GADC include:
  • Manage frail older adults with acute/ sub-acute problems as an alternate to ED/ observation/ short hospital stays
  • Enhance post-hospital follow-up care
  • Control costs associated with avoidable ED/ hospital admissions in ACO
GADC: Operational Details

- GADC will serve two major patient groups:

  **Acute/ Reactive/ Unplanned** - patients with sudden change in medical/ mental health status (e.g. CHF exacerbations, outpatient IV antibiotics and diuretics, complicated behaviors in dementia/delirium, failure to thrive)

  **Sub-acute/ Proactive/ Planned** - discharged patients requiring extended medical care outside of the hospital but not needing long term or sub-acute rehabilitation care (e.g. post joint replacement surgery with medical issues, post D/C pneumonia or CHF)

- Duration of care: variable, likely 1-3 days for ~4 hours/day
- Days of operation: 7 days per week
- Staffing: Geriatricians; RNs; part-time SW, PT and Pharmacy
GADC: Advantages

• Projected less costly than inpatient or ED care
• Anticipated reduction in re-admission rates
• Immediate access to specialized geriatric team consultation (enhance quality of care and improve patient/family satisfaction)
• Enhanced care coordination (e.g. outpatient SNF placements, Hospice referrals)
• Planned integration with telemedicine technology
• First program of its kind in the State
Community Wellness Program

Planned Elements to Engage Participants in Substantive Behavior Changes:

1. Evaluation
   - Assessments/Screenings, Health Risk Appraisal, Cognitive/Depression,

2. Behavior Change Pledge Card

3. Specific skill education tailored to patient issues

4. Participant determines/selects where the new skills will be practiced (options reviewed with patient)

5. Regular coaching sessions and participant report outs

6. Outcomes are shared with PCP and incorporated into Patient Care Plan

7. Goal achievement – celebration
Our Key Result Areas (KRAs)

1. Transitional Care
2. Geriatric Assessment Day Center
3. Outpatient Geriatrics Services (Specialty Clinics & Primary Care)
   - Medical Home in Geriatric Primary Care
   - Wellness Programming
4. Inpatient Geriatrics Services (ACE)
5. Long Term Care re-design
### Geriatrics Business Plan Metrics

#### Hospital-Based Services
- ED and Hospital Admission & Readmission Rates
- ACE Program Costs/ Savings
- Drug Utilization Costs
- Joint Commission Safety Measures (e.g. Falls, Adverse Drug Reactions)
- Patient/ Family Satisfaction Surveys (HCAHPS data)

#### Clinic-Based Operations
- Chronic Disease & Prevention Scorecards
- Quarterly Clinic Volume
- Appointment Utilization Reports
- Clinic Financial Statements
- Avatar Results for Clinics
- Kenexa Scores
- Referring Provider Satisfaction Surveys
- Patient-centered goals (care plans and self management indices)
# Geriatrics Business Plan

## Measures & Targets

<table>
<thead>
<tr>
<th></th>
<th>Actual FY11</th>
<th>Actual FY12</th>
<th>Target FY13</th>
<th>Target FY14</th>
<th>Target FY15</th>
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<tbody>
<tr>
<td>Geriatrics Clinic Visits</td>
<td>7,196</td>
<td>8,630</td>
<td>9,736</td>
<td>9,736</td>
<td>9,736</td>
</tr>
<tr>
<td>Geriatrics Clinic Appointment</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Template Utilization</td>
<td>80%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
<td>90%</td>
</tr>
<tr>
<td>Geriatrics Clinic Margin</td>
<td>-163%</td>
<td>-153%</td>
<td>-131%</td>
<td>-130%</td>
<td>-112%</td>
</tr>
<tr>
<td>Geriatrics Clinic % Specialty Care</td>
<td>20%</td>
<td>35%</td>
<td>50%</td>
<td>65%</td>
<td>75%</td>
</tr>
<tr>
<td>UWHC 30 Day Readmissions - Patients Ages 75+ with a Dane County UW Health PCP</td>
<td>15.9%</td>
<td>13.5%</td>
<td>11.5%</td>
<td>10.0%</td>
<td>8.0%</td>
</tr>
<tr>
<td>*UW Health Primary Care Encounters per Patient - Patients Ages 75+</td>
<td>3.3</td>
<td>3.1</td>
<td>2.9</td>
<td>2.7</td>
<td>2.6</td>
</tr>
</tbody>
</table>

*N = 12,823 as of 6/30/11. Measured on primary care panel report 3906, column M divided by column D*
Return on the Investment

Successful implementation of the plan will produce:

• **Reduced 30-day readmission rates** from 15.9% to 8% over 5 years in 65+ patients with avoidance of CMS readmission penalties of ~$3-11 million

• **Avoidance of unnecessary hospitalizations/ ED visits/ observation stays** through improved triage of frail patients to GADC, Acute Home Care and ACE-ED team

• **Enhanced UW Health primary care efficiency** in serving medically complex, high needs older patients through enhanced clinic consultation and co-management

• Expanded UW Health geriatric services to **regional markets & corporate payers**

• Improved geriatric clinics **access, efficiency, utilization and satisfaction** metrics

• Preparation for future **CMS Innovation Grant support** through novel programs such as the GADC and Community Wellness Program
# Phased Implementation of the Business Plan

## Business Planning Process Aug 2010-Dec 2011

<table>
<thead>
<tr>
<th>Phase 1</th>
<th>FY2012</th>
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<tbody>
<tr>
<td></td>
<td>Expand Outpatient Clinic Resources (e.g. new provider support)</td>
</tr>
<tr>
<td></td>
<td>Increase Specialty Clinics (Hire 1.0 MD)</td>
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<tr>
<td></td>
<td>Implement the Transitions of Care Program (Hire 1.0 RN and 1.0 NP)</td>
</tr>
<tr>
<td></td>
<td>Develop the Business and Operational Plan for the GADC</td>
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<thead>
<tr>
<th>Phase 2</th>
<th>FY2013</th>
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<tbody>
<tr>
<td></td>
<td>Continue to Expand All Phase I Initiatives</td>
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<tr>
<td></td>
<td>Implement Pre-admission Triage Program (Hire 1.0 RN) for ACO</td>
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<tr>
<td></td>
<td>Reorganize Long-Term Care within UW Health/ Transitions to LTC</td>
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<td></td>
<td>Hire 1.0 MD FTE for Transitional and ACE-ED programs</td>
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<tr>
<th>Phase 3</th>
<th>FY2014</th>
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<tr>
<td></td>
<td>Continue to Expand All Phase I and II Initiatives</td>
</tr>
<tr>
<td></td>
<td>Hire 1.0 MD FTE &amp; 1.0 NP – GADC/Telemedicine</td>
</tr>
<tr>
<td></td>
<td>Open GADC</td>
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<tr>
<td></td>
<td>Implement the Patient-Centered Medical Home Model in Geriatrics</td>
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<td></td>
<td>Enhance Acute Access to Home Health Services</td>
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<td>Pilot Tele-medicine outreach to Community Partners</td>
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<tr>
<th>Phase 4</th>
<th>FY2015</th>
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<tbody>
<tr>
<td></td>
<td>Continue to Expand All Phase I, II and III Initiatives</td>
</tr>
<tr>
<td></td>
<td>Implement Community and Corporate Wellness Programs</td>
</tr>
<tr>
<td></td>
<td>Expand Geriatrics Involvement into Palliative Care Inpatient &amp; Outpatient Programs</td>
</tr>
</tbody>
</table>
Key Questions:

Is there institutional readiness? Who do you need to persuade?
Who will help you through the process? (local management & finance expertise)
What resources will be leveraged for your efforts? At what cost?
What is your timeline?
A Path to Organizational Transformation

1. Establish a sense of urgency
2. Form a powerful guiding coalition
3. Create a vision
4. Communicate the vision
5. Empower others to act on the vision
6. Plan for and create short-term wins
7. Consolidate improvements and produce still more change
8. Institutionalize new approaches

Questions ?