

**MAHC 29th Annual Meeting
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**Aligned Incentive Compensation
Requires the Right Clinical and
Case Conferencing Models**

Pat Laff, CPA, Managing Principal Kathy Sgro, DNP, MBA, RN
President
Alterna-Care Home Health System




HHPPS 2011

CMS' Final Rule –November 17, 2010

- Reduction of Base Rate by \$120.87 from \$2,312.94 to \$2,192.07 = 5.226%
- Reduction in the Rural Add-on by 5.226%
- Reduction of LUP rates = 3.44%
- Additional therapy assessments required on the 13th and 19th visits

NAHC Medicare Cost Report Study reflected that the more profitable agencies had lower costs per visit, not higher case weights!

HHPPS 2012-2013

- Anticipate similar net rate reductions
- Increased costs related to "Face to Face" and the additional therapy evaluations
- Increased costs related to contemporaneous compliance

In other words: ***Significant financial challenges***

Let **Operational & Profitability Goals 2011 and Beyond**

- Increase Revenues by Increasing Referrals
- Increase Clinical Staff Case Capacity by Increasing Productivity and Efficiency
- Achieve Optimum Outcomes and HHCAPs
- Manage and Control the Cost per Visit by Discipline and Cost per Episode
- Manage and Control the Utilization and Cost per Episode of Non-routine Medical Supplies

Will your Agency's Culture Fit These Goals?

Let **Incentive Based Compensation**

The Change from Managing Productivity To Real-time Clinical Case Management

- Controls the Cost per Visit and the Cost per Episode
- Eliminates management of visits per day
- Eliminates the search for clinicians to:
 - Cover visits
 - Admit patients
- Reduces and eliminates delinquent documentation
- Improves team chemistry
- Improves communication between the Supervisor and the Clinical Case Manager in the field

Let **Managers Must Know**

Home Care Management (including Supervisors) must have a solid understanding of:

- Clinical Management and Episode Management
 - OASIS-C Process Measures
 - Case Weight
 - Timeliness of RAP Submission
 - OASIS Errors by Clinician
 - OASIS Corrections Completed
 - Cases Managed per Clinician
 - Average # of Therapy Visits per Episode
 - Average Visits per Episode
 - Productivity by Discipline – *Actual*
 - Outcomes Improvement
 - Patient Declines

Let EXCELLENCE
**Clinicians and Finance...
 Work WITH your People!**

How much effort is required for your clinical staff spend:


- In the field making visits?
- At patient staff meetings to learn and understand the ongoing care planning process?
- Completing OASIS C? **IT IS ADVANCED ROCKET SCIENCE!**
- Documenting and conferencing with other disciplines and the physician?
 - Point of Care technology?
- Traveling

Let EXCELLENCE
**Financial Impact of
 Clinical Operations**

- Differences in the type of visits (and OASIS C) effect per visit costs
 - Admission
 - Follow-up
 - Resumption
- Recertification
- Discharge
- How different diagnoses effect the length of a visit and the documentation requirements
- Visit frequency factors and diagnostically specific standards of practice effect productivity, efficiency and costs per visit and episode of care


Let EXCELLENCE
**Provide the Right Tools
 "Point of Care"**

- Clinician laptops should have Wireless feature and "Air cards" to facilitate remote syncing to system
 - Access by all disciplines to most recent documentation
 - Email and team communications
 - Transmission of patient Admission information
- Facilitates Clinical Case Conferencing
 - Clinician and supervisor (team leader) referring to same patient records
- Provides complete up to date patient records for oncall
- Ordering non-routine medical supplies directly from vendor

 **Compensate Fairly
Incentive Based**

Pure Incentives (Per Visit Rates -- Exempt) – Field Clinicians

- Visit Rates
 - Structured by Type and Weight of Visit, including Telephone Follow-up Visits and Meetings
- Case Management Fee for Cases Managed (RN, PT & ST) in a Calendar Month
- Paid Days Off Based Upon Average Daily Earnings for the Previous Quarter (or Six Months)
- Compensation Floor at 80% of Average Projected Earnings, if Advantageous
- Implementation test period(s) – staff compensated under current method with bonus payment(s) for positive differences under the new plan

 **Compensate Fairly
Incentive Based**

Pure Incentives (Per Visit Rates -- Exempt) – Field Clinicians

- Visit Productive Incentive, at \$ X.00 per visit for exceeding Threshold in a Calendar Quarter
- Episodic Incentive, Layered up to 5% of Quarterly Earnings, Based Upon Threshold of Cases Managed in a Calendar Quarter
- Clinical Outcomes Incentive, Layered up to 5% of Quarterly Earnings, Based Upon Threshold of Targeted Outcome Achievement in a Calendar Quarter
 - OASIS C measurements (real-time) & Home Health Compare scores
 - HHCHAPS results

 **Compensate Fairly
Incentive Based**

Incentives – Clinical Supervisors (Team Leaders, etc.)

- Bonus Incentives of Visit Productivity, Cases Managed and Outcomes achieved that mirror those for their staff
- Additional Incentives for team achievements could include thresholds for:
 - Admissions within 24 hours
 - Timeliness of submitted documentation
 - Reduction of corrections required for OASIS
 - HHCHAPS results

Let QUALITY
COMMUNITY CARE

Questions Often Asked

- Recommended Clinical Model:
 Primary Nurse – Care Management
- Productivity and Case Capacity
 - RNs: minimum 25 – 27 visits (hands on) / week
 25 – 30 Patients (without Telemedicine)
 - PTs & OTs: minimum 27 – 30 visits (hands on) / week

Let QUALITY
COMMUNITY CARE

Questions Often Asked

- Visit weighting – Based the Requirements and Complexities of completing OASIS C
 - Admission (evaluation) visit 1.90
 - Resumption visit 1.30
 - Recertification Visit 1.20
 - Discharge Visit 1.25
 - Follow-up Visit 1.00
 - Virtual Telephone Visit (Telehealth) 0.25

Let QUALITY
COMMUNITY CARE

Questions Often Asked
 (Visit Weight – Time Equivalents Based upon OASIS C)

Visits per Day	Follow-up	Admission	Resumption	Recert.	Discharge
Visit Value	1.00	1.90	1.30	1.20	1.25
5.00	96 minutes 1hr 36min	182.4 minutes 3 hrs 2min	124.8 minutes 2 hrs 5min	115.2 minutes 1 hr 55min	120.0 minutes 2 hrs
5.25	91.4 minutes 1hr 31 min	173.7 minutes 2hrs 54min	118.9 minutes 1hr 59min	109.7 minutes 1hr 50min	114.3 minutes 1hr 54min
5.50	87.3 minutes 1hr 27min	165.8 minutes 2hrs 46min	113.5 minutes 1hr 53min	104.7 minutes 1hr 45min	109.9 minutes 1hr 49min
5.75	83.5 minutes 1hr 23min	158.6 minutes 2hrs 39min	108.5 minutes 1hr 49min	100.2 minutes 1hr 40min	104.4 minutes 1hr 44min
6.00	80 minutes 1hr 20min	152 minutes 2hrs 32min	104 minutes 1hr 44min	96 minutes 1hr 36min	100 minutes 1hr 40min

All times include hands-on, documentation, travel, conference and case management time

 **Compensate Fairly
Align Incentives for all Agency Staff**


Consider a Comprehensive Agency-wide Incentive That Will Enhance Teamwork

- ❑ Improved Clinical Outcomes
 - Homecare Compare Scores
 - Outside Benchmarking
 - Reduced Non-planned Re-hospitalizations and Emergency Department Incidents
 - High Risk Patients
 - OASIS Timeliness and Accuracy
 - Development of Disease Management Standards of Practice Adopting "State of the Art" Clinical Technology
- ❑ Patient Satisfaction
- ❑ Admission Within 24 Hours of Referral

 **Compensate Fairly
Align Incentives for all Agency Staff**

Consider a Comprehensive Agency-wide Incentive That Will Enhance Teamwork

- ❑ Administrative and Financial Outcomes
 - Timeliness of OASIS Submissions, RAPs, Signed Orders, End of Episode Billing (no recoupments)
 - Achieving Planned Costs per Unit of Service
 - Achieving Planned Process Productivity
 - Reduced Absenteeism – Sick Days
- ❑ Increased Referrals
 - New Referral Sources
 - Additional Referrals from Existing Sources

 **Goals of Aligned Incentives**

"Provide the right amount of care efficiently and effectively to achieve anticipated or desired patient & financial outcomes"

Let's EXCELLENCE
IN THE CARE OF OUR PATIENTS

**ALTERNA-CARE
HOME HEALTH SYSTEM**

**INCENTIVE COMPENSATION PROGRAM
PREPARATION, IMPLEMENTATION, RESULTS**

KATHLEEN SGRO, DNP, MBA, RN

Let's EXCELLENCE
IN THE CARE OF OUR PATIENTS

Alterna-Care Home Health Agency

- Located in Central Illinois
- Main office located in Springfield, IL with branches in Jacksonville, and Litchfield, IL
- Serves over 2000 patients annually in 31 contiguous counties
- Free-standing for profit agency
- Over 50 employees

Let's EXCELLENCE
IN THE CARE OF OUR PATIENTS

Meeting with Our Consultant


- We brought in our consultant and involved the staff
- Selected three types of nurse employees to meet with our consultant
 - Early adapter
 - Late adapter
 - Resister
 - Initially the nurses understood the nature of pay per visit before it was implemented

Let's **Multiple Meetings**

- Announce to staff there will be a change in the method of payment
- Conduct pay per visit analysis to determine rates
- Continue to conduct education meetings to review pay per visit rates, incentive bonus payment system, supervisor incentive bonus
- Purpose was to increase productivity, the number of cases managed, timeliness of documentation, and improve outcomes


Let's **Conduct Additional Staff Meetings**

- Conduct final meeting with staff to answer questions and concerns
- Implement pay per visit
- Conduct first meeting after implementation to alleviate anxiety




Let's **Many Internal Changes**


- Changes in accounting
- Changes in payroll
- Tracking for management
- Everyday is a batch. 1 note missing the entire day is not accepted. This is legal in the state of Illinois
- Eliminates conflict and animosity between clinician and back office
- One test month

 **Prepare Accounting Department**

- Set up pay codes for various rates
 - New Admission
 - Follow-up or routine visit
 - High tech visit
 - Telehealth phone contact
 - Case management
 - Meetings and in-service
 - Vacation and sick


 **Develop Tracking Tools**

- Track number of various visits to report to payroll
- Track number of case management fees per nurse to be paid. (based on completion of all requirements)
- Track number of telehealth calls
- Track quarterly outcomes per nurse


 **Average Patient Caseload
2009 vs. 2010**

- 2009 -7.5 nurses with an average monthly case load of 36.3 (unduplicated patients)
- 2010 -6.5 nurses with an average monthly case load of 44.9 (unduplicated patients)


(excludes PT only patients)

 **Home Health Compare**

Higher Percentages are Better	2009	2010
Improvement in mgt. oral meds	46	44
Improvement in dyspnea	70	67
Discharged to Community	65	74
Improvement in status of Surgical Wounds	61	81
Lower are Better		
Acute Care Hosp	31	24
Emergent Care without Hosp	27	1.5
Emergent care due to wound deterioration	2	.5

 **Clinical Manager**

- Nurses are assigned patients by their clinical manager.
- Frequency of visits are discussed based on the appropriateness of the patient needs
- Telehealth needs are identified by the clinical manager

 **Nurses Participate in Case Management Payment**

- Monthly SBAR completed
- Timely follow-up on labs / orders
- Insurance follow-up completed
- Medication follow-up
- Skilled need documented on every visit
- Teaching documented on every visit
- Oxygen attribute, order, clause completed
- Everything Medicare requires to be completed

Let's CONNECT
COMMUNITY CARE

Case Conferences

- Occur every 14 days
- The clinical model changed to improve primary care nursing model
- Responsible for everything related to the case management of each patient
- Nurses now have control over utilization and outcomes

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Telehealth


- Telehealth monitors are used on diabetic and cardiac patients and those identified as needing close monitoring
- Daily vital sign monitoring
- Agency has 65 monitors
- Each nurse is able to view their own patients who are on monitors
- An office nurse reviews the daily transmissions to double check on patients with vital signs outside the norm
- Monitor patients 7 days a week

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Point of Care

- Nurses use point of care for patient documentation
- Nurses have air cards so they can transmit while in the field
- Air cards allow access to Telehealth and lab results
- Allows nurses to schedule their own patients




 **Benefits of Incentive Compensation**


- We actually lost a nurse and didn't have to replace her
- Improved communication with nurses and supervisor
- Documentation is timely and better quality
- Telehealth is being used and follow up calls are rewarded
- Incentive compensation has improved ER and Hospital outcomes

 **Results**


- Nursing productivity increased
- Timeliness of documentation improved. For the first time anyone can remember, all nurses notes were completed within 24 hours.
- MD verbal orders and recertifications were completed on time
- Visit frequency orders were accurate
- Case loads increased per nurse
- Nurses made more visits per day and made more money
- Monitors were in patient homes and no longer on the shelves

 **Results**

- Nurses did not complain
- Comments:
 - I'm really working hard
 - It's difficult to get your paperwork done with this many patients
 - But, I'm not complaining
 - Supervisor states nurses are content
 - No problem getting nurses to see patients on weekends!!!
 - No push back when given a new admission in their territory!

 **Average Nurse 11 Month Salary**

- 2009 - Average 11 month comp. was \$ 38,412
- 2010 - Average 11 month comp. was \$ 46,362
Increase of \$ 7,950 = 20.69%
- 2009 - Total Per Diem comp was \$ 31,022
- 2010 - Total Per Diem comp was \$ 10,119
Reduction of \$ 20,903 = 67.38%
- 2009 - Direct Cost per Nursing Visit - \$ 79.71
- 2010 - Direct Cost per Nursing Visit - \$ 63.90
Reduction of \$ 15.81 = 19.83%

 **Conclusion**

- Incentive compensation increased efficiency throughout the entire organization
- Patient quality of care was not negatively impacted
- Accounting department is able to bill timely
- Clinical staff are rewarded for their hard work
- Telehealth is being utilized to its fullest capabilities
- Communication with clinical managers improved
- Incentive Compensation is a win-win

Contact Information

Pat Laff, CPA
Laff Associates
Consultants in Home Care & Hospice
Phone: (843) 671-4170
Email: plaff@laffassociates.com
Website: www.laffassociates.com

Kathy Sgro, DNP, MBA, RN
President
Alterna-Care Home Health System
Phone: (217) 525-3733
Email: kathysgro@alterna-care.com

