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INSIDE

Special Report
Countdown to PPS:
Is Your Agency Ready?

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Supplies still an issue as home health care prepares to embrace new PPS

Here are strategies you can use to weather the transition

Months after the Health Care Financing Administration (HCFA) released its final rule for the new prospective payment system (PPS), the supply picture doesn't look any brighter. Supply problems — including the lack of case-mix adjustment and confusion over which supplies home health agencies are required to provide — remain the thorniest issue with HCFA over the new payment system, says **William Dombi**, Esq., vice president for law at the National Association for Home Care (NAHC) in Washington, DC.

The final rule, released June 28, has some welcome changes from the previous proposed rule, including measures to address serious cash-flow concerns. As a result, initial payments for the first episode of care beginning Oct. 1 are expected to be larger and come more quickly. But agencies continue to worry about the impact of HCFA's decision to bundle supply costs into the episode rate and to require agencies to take responsibility for more nonroutine supplies, even those unrelated to the reason home care is being provided.

Countdown to PPS: Is Your Agency Ready?

Ruth Constant, RN, MSN, EdD, CHCE, president of Ruth Constant & Associates of Victoria, TX, worries about the impact of the new payment system on cases such as wound care patients, for whom supply costs can mount.

H. Kenneth McNulty, vice president for finance for the Visiting Nurses Association of Boston, foresees possible conflicts between providers and suppliers over supply charges Medicare will refuse to reimburse. "This is going to be a major, major problem," he says.

Dombi describes HCFA's stance on supply questions raised by NAHC as "evolving."

"When we're using specific illustrations of supplies, some HCFA officials seem to be backing off. Their position is not absolutely set in stone.

Tell us about your experiences with PPS

As *Homecare Quality Management* continues to follow the rollout of the prospective payment system, we want to know how PPS is affecting you. Were there aspects that caught you unprepared? Have you made quality improvements that have eased the transition? Do you have unanswered questions about the payment system?

Contact *HQM* writer Suzanne Koziatek at (618) 398-5555 or by e-mail at koziatek@intertek.net. We'll use your responses in a follow-up story later this year. ■

When we try to nail them down specifically, we get something else."

He says home health agencies are likely to see some relief in this area in the form of changes to the rule and possible congressional action. Unfortunately, neither is expected to come before the Oct. 1 start date for PPS.

How do you prepare to deal with bundled supplies, not to mention possible cash-flow difficulties and the long-term ramifications of PPS? The message from our panel of experts, many of whom earned their stripes by participating in the PPS demonstration project, is this: Be prepared, and be flexible.

"There is a way to do it, although it's going to be a different way than we've been doing it under cost reimbursement," says **Lucy Lee**, RN, MHA, CHCE, owner of Lee Health Care Inc. in Hamilton, TX. People with the right attitude — "I'm here to meet the challenge, and I can make it work" — are going to be more successful, she says.

Who pays for what?

Dombi sees the final PPS rule as expanding home health agencies' supply responsibilities past the point of reason or legality. "For Medicare to now say, 'We're going to pay you an amount equivalent to what we were on average paying for supplies before, but we're going to expand the level of supplies that you have responsibility for,' is simply not appropriate," he says.

And it's still hard to pin down the extent of that responsibility. As an example, Dombi points to the use of adult diapers. "The response we get back is, 'Of course we don't intend the agencies to pay for those,' but what distinguishes those supplies from other nonroutine supplies?" he says.

McNulty foresees problems when suppliers attempt to bill Medicare and are rebuffed, then come to agencies seeking reimbursement.

"I think providers are simply going to say, 'I'm not paying. I didn't order it, and I had nothing to do with it, and the patient didn't need it while we were taking care of them, so I'm not paying.'"

To avoid any misunderstanding, Dombi advises a thorough inventory on admission of all supplies a patient is using, even those that don't relate to the particular diagnosis for which he or she may be receiving home care.

"The agency should give a very specific notice to this patient, explaining that they are getting a bundled service and supplies benefit," he says. "Should they go outside of that benefit to secure either services or supplies, either they or the supplier is at risk."

Comparison shopping for supplies

Dombi says HCFA may be willing to change the scope of the responsibility for nonroutine supplies. In addition, he says, HCFA officials have indicated they wouldn't oppose a change in the law allowing supply costs to be taken out of the base rate and reimbursed on a fee basis.

Those changes could take months. In the meantime, he advises agencies to get control of their own supply costs. "They need to start looking to how they can most efficiently manage it. Where are they going to buy the supplies? Where can they get the best product at the best price?"

He says agencies may get to the point where they ask suppliers to accept payment on a capitated basis, just as they are doing.

Cathy Nielsen, RN, CPHQ, corporate compliance officer and vice president for clinical services for In Home Health Inc. in Minnetonka, MN, says the new supply rules will put the burden on clinicians to be more creative and flexible in the supplies they use.

"Typically in the past, nurses would just take a catheter they felt comfortable in using," she says. "Now, they're going to have to understand the financial ramifications of a particular catheter.

Maybe the outcome for that catheter means it has to be replaced more often. I think our clinicians are going to have to become much more astute in the financial management of the patient."

Most agree HCFA went a long way in its final rule in trying to address cash-flow issues raised by home health agencies.

It increased the upfront payment for the first episode of care to 60% (previously 50%) and erased the 14-day waiting period for Medicare to pay on a request for anticipated payment (RAP).

"There's still these technical hoops to jump through, but agencies will make some adjustments, I'm sure, pretty easily, to meet those standards."

Dombi says the RAP must have the detail necessary to be the equivalent of a plan of care. "You have to have a detailed verbal order that's recorded and a written care plan that's sent to the physician before the RAP can be filed," he says. "There's still these technical hoops to jump through, but agencies will make some adjustments, I'm sure, pretty easily, to meet those standards."

To avoid creating a new form for staff to contend with, Lee's agency is considering changing its admissions assessment form to provide a place for the nurses to attest that they have the verbal orders.

"I think the big thing is you have to be ready to do the billing, to send in the RAP, just as soon as possible," she says.

Dombi agrees, noting that switching from periodic billing to a daily billing system is probably a more efficient way of spreading the workload, as well. But he and others note that the improvements in the final rule, as helpful as they are, won't ensure smooth cash flow for every agency.

The following are some potential problems that might arise:

1. **Loss of PIP payments.** Dombi says agencies dependent on periodic interim payments (PIPs) could start to see a real crunch early on.

"Yes, they will get a check probably in the second week of October, in addition to whatever payment they get on that Oct. 1 episode of care," he says. "But . . . two weeks after that, they're not going to get another PIP payment. Then, they're into the same cash-flow concerns that other agencies might have, and their obligations may be six weeks ahead of those payments."

2. **Delays in payments.** The fiscal intermediary (FI) can deny a request for anticipated payment if it believes the agency has a history of invalid claims. Agencies subject to medical review on their claims also could see slowdowns.

"It's impossible to predict what's going to happen there, but we're telling agencies: Do not expect that the day after you submit a claim, you're going to receive a RAP," he says. "If you are, you might be extremely disappointed."

Are the intermediaries ready to deal with the new system? "All I can look to is the history we had with the FIs in the demonstration," Lee says. "They had specific people trained to handle these 45 agencies [that were part of the demonstration],

Prospective payment system final rule at a glance

Here are some of the major components of the final prospective payment system rule, published in June:

- ✔ The national standardized base rate: $2,115.30 per episode, up nearly 4% from the proposed rate. There also are increases in the per visit rates for low utilization payment adjustments.
- ✔ Initial payment: 60% at the start of the first 60-day episode of care; 40% at the end. For each successive episode, the split is 50-50.
- ✔ The Health Care Financing Administration will allow use of a verbal order for the initial billing. The request for anticipated payment (RAP) must contain the detail necessary to be equivalent to a plan of care.
- ✔ There is no 14-day waiting period before Medicare will pay on the RAP.
- ✔ Medical supplies are not case-mix adjusted but are included in the base rate.
- ✔ There is no adjustment in the base rate based on the presence or absence of a caregiver in the home.
- ✔ Partial episode payments will be prorated based on the number of days of care.

Sources

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and they couldn't get it done. Now we have the whole group of employees being trained on how to implement this prospective payment system for every agency they have. It scares me to death."

Dombi says that in the event there are complications, he's optimistic that HCFA's mindset will be to help, rather than to give providers a hard time. "We at least have an attitude at HCFA which will create an environment for protecting the providers as quickly as possible, whether it's through accelerated payment or some other means," he says.

3. **Charge-backs for LUPAs and PEPs.** McNulty predicts that the bigger cash-flow problem will come not at the start of PPS, but several months down the road, when agencies must return overpayments for cases in which there were low utilization payment adjustments (LUPAs) and partial episode payments (PEPs).

"Agencies need to be thinking about coming up with some ways to build their reserves for the end of their fiscal year, especially if their fiscal year is a calendar year," McNulty says, "so that by Dec. 31, they have reserves in their financial statements to cover the charge-backs that are going to occur, so they don't end up distorting two different years' financial statements."

Dombi says that won't be a major problem. The charge-backs will be for money the agencies were overpaid to begin with, he says. "If they're counting on overpayments to ensure good cash flow, then they have real problems."

He says agencies should try to figure out as soon as possible which patients will be LUPAs or PEPs and refrain from submitting RAPs in those cases. He agrees with McNulty on the importance of cash reserves, lines of credit, and other fall-back systems. Dombi says agencies should have their financial records in good shape so they can quickly pull together a request for accelerated payment, if necessary.

Long-term strategy: Be creative

Constant, whose company owns and operates three Texas home health agencies, says this is a time when a home health operator's best friend is the local banker.

"To be prepared, you need to keep a good relationship with your banker, someone who knows your history and trusts you," she says. "You need to educate the banker so he knows what's coming down the pike in case the cash flow gets tight."

Once home health agencies weather the immediate effects of PPS, some more permanent changes in how care is offered are inevitable. The final rule, which does not adjust for the presence or absence of a caregiver in the home, for example, could lead agencies to look very carefully at a client who has no caregiver.

Constant notes that it's safer to carefully screen patients at admission than to discharge them later and be accused of abandonment. "I know we're going to be more cautious," she says.

Lee says assessments should be much more thorough to assure that a patient is a good fit for home care. "I'm not going to make it a condition of admission that they have an available caregiver. I do think we'll find that we may be very careful and assess very well on admission what the abilities of the patient are and what the prognosis of the patient is for their getting to a higher level of independence."

Nielsen says the long-term impact of PPS will be to force agencies to become more creative and efficient, perhaps by relying more often on specialists or by taking advantage of technologies such as telemedicine.

"Agencies need to have a better understanding of their patient population and the services they're providing," she explains. "They need to see if there's any other way of providing that same service via telemedicine, via phone calls, or other types of services." ■

OASIS proficiency key to surviving transition

Let staff suggest ways to adapt to PPS changes

In the month before the start-up of the prospective payment system (PPS), improving Outcome and Assessment Information Set (OASIS) data is job one, say those who have been studying the ramifications of the final PPS rule.

"The first thing [home health agencies] absolutely need to do is make sure the clinical staff know how to do OASIS in a completely accurate and consistent fashion," explains **William Dombi**, Esq., vice president for law at the National Association for Home Care in Washington, DC. "The care plan and the daily record of care must be consistent with the findings in OASIS. You don't have a diagnosis on the OASIS that's not shown in any relationship to the plan of care."

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At the VNA of Boston, there are plans to update training on OASIS to ensure that assessments are being carried out consistently among nurses and other clinicians, says **H. Kenneth McNulty**, vice president for finance at the VNA.

"You don't want some clinicians being tougher than others," McNulty says. "The thing everybody is talking about is consistency between the physical therapists vs. nurses doing admissions."

But OASIS isn't the only key to surviving — and even thriving — in this rocky transition period, as everybody adjusts to the new system. **Lucy Lee**, RN, MHA, CHCE, owner of Lee Health Care Inc. in Hamilton, TX, says an agency's leadership is key to its success in handling the changes.

"People who are very knowledgeable and who have plans are going to be better able to handle it than people who just try to wing it from a management perspective," Lee says.

Many agencies have special PPS committees in place, some of which have been operating for months to foresee problem areas and devise solutions. Companies that were part of the PPS demonstration project, such as In Home Health Inc. in Minnetonka, MN, have been using their experiences under that system to prepare for the real thing.

In addition to PPS committees at individual agencies, In Home Health has a corporate committee with several subgroups examining specific issues related to the final rule, says **Cathy Nielsen**, RN, CPHQ, corporate compliance officer and vice president for clinical services.

"Clinical management is looking at revising our nursing care plan," she explains. "Operations is looking at revisions to referral forms. There are several subgroups working on individual projects and then bringing them back to the table."

Calling all willing participants

Ruth Constant, RN, MSN, EdD, CHCE, president of Ruth Constant & Associates of Victoria, TX, owns and operates three Texas home health agencies. Representatives of the agencies have come together for years in a director's committee, which recently has been focusing on the transition from the interim payment system to PPS.

Lee says her agency's PPS committee, which has swung into action since the final rule was published, comprises "anybody who wants to be on it. We've got clerical people, nursing supervisors — I think we have about 15 people so far who've said they wanted to be on it. By starting with people who indicate an interest on their own, [we can] develop a process that they're willing to implement.

"Probably, we'll get more done that way than setting up the process and telling them what to do," she predicts.

Timing is everything

Here are five other keys to navigating the first few months of PPS:

1. **Know the timetable.** All patients have a new start date of Oct. 1. For this episode, Dombi says, agencies have the option of using an OASIS assessment performed any time in September for that Oct. 1 patient.

"Patients whose last OASIS was before Sept. 1 would have to have a new OASIS before Oct. 1, but that OASIS could be prepared anywhere from Sept. 1 to Sept. 30," Dombi explains.

The arrangement eases the burden at the start of PPS, but agencies should anticipate a real bottleneck a few months later, at the end of the first episode of care, Lee says.

"It's going to be a huge mess. Everybody we

have who hasn't been discharged will come up for recertification on Nov. 29 — Happy Thanksgiving!" she says wryly.

2. **Educate staff.** Nielsen says it's important that employees, especially clinical staff, understand the financial ramifications of PPS. "As part of inservicing, you should be looking at the financials as well as operational and clinical issues that are involved with that care."

> **"I have always said that employees can turn on a dime, and they do, because they want the patients to be happy and well cared for."**

For example, when explaining OASIS, nurses should understand the financial consequences of an incomplete or incorrect assessment, Lee says. "We need to be telling them how important it is that they answer these 23 questions correctly and what are the ramifications if they don't," she explains. "These are the ones that impact our payment, and the impact on our payment then impacts the resources available to take care of the patient."

3. **Educate physicians.** Dombi suggests that home health agencies prepare physicians for the care plans they'll receive in September, which will run through Nov. 29, the end of the first episode.

"That's a one-time approach to care planning so they can get everybody into the 60-day episode cycle," he says. "Doctors may look at that and say, 'We don't usually do plans like that' or 'This patient doesn't have a need for service through the 29th.'"

At In Home Health, "we've already started educating physicians," Nielsen says. "We've been providing them with some written materials to give them a heads-up on what this entails."

The company is recommending that its individual agencies work with doctors on-site or through one-on-one discussions.

Beyond the initial start-up, physicians should be prepared for other aspects of home health care to change as agencies become more efficient, Dombi suggests. He says home health agencies will have more flexibility to use technological advances such as telemedicine to provide care more economically.

4. **Remain flexible.** As PPS gets under way, unforeseen problems will arise, and the Health Care Financing Administration in Oakbrook Terrace, IL, may continue to make changes to deal with them.

What employees learn today may change tomorrow, and they need to be prepared to deal with the changes as smoothly as possible, Lee says. Mostly, she says, it's a matter of attitude, and that attitude needs to come from the top.

"I have always said that employees can turn on a dime, and they do, because they want to please and they want the patients to be happy and well cared for," Lee says. "They are willing and able to change quickly, just given guidance and direction and information."

Eyes on the goal: Good care

Nielsen says one lesson from her company's participation in the PPS demonstration was to watch carefully to make sure the new emphasis on financial considerations didn't get out of hand.

"We saw some of our managers [being] a little too aggressive at first in cutting back on visits and putting some pressure on the clinicians," she explains. "We were able to alleviate that by doing some training with the operations people to say the goal is not to reduce visits but to provide appropriate, efficient patient care."

Signals to watch for may include an immediate, dramatic decrease in visits or an increase in patient complaints. Nielsen suggests calling patients directly for feedback to check for potential problems.

5. **Fight for change.** Even while learning how to use the new prospective payment system, agencies can keep trying to change it.

It's important for agencies to keep lobbying, both through professional associations and directly with their congressmen.

"I think people need to still be very aggressive with their local, state, and national government and associations," Nielsen says.

"The fact that we've got the final rule doesn't mean that we should stop here. I would encourage people to remain really involved with organizations to keep this issue in the limelight," she says. ■

Take a breather from PPS: Assess staff morale

Agency creates team-building QI project

Morale was low among the home care staffs of Upper Chesapeake and St. Joseph hospitals in Baltimore as the two systems prepared for a merger that took place in early 1999.

"Of course, anytime you're thinking about a merger, everybody is worried about their jobs and how is it going to affect them," says **Debbie Chisholm**, BSN, RN, CRNH, quality and staff development manager of Upper Chesapeake/St. Joseph Home Care in Baltimore.

"You could hear people talking about rumors, and then we started to lose staff," Chisholm adds. "So we decided that we would look at staff satisfaction quantitatively before and after the merger and use that data to implement changes."

The pre-merger survey demonstrated a very low staff morale and identified several major problem areas, including a lack of trust in management. Chisholm grouped the survey results according to job title and found that nurses had among the lowest morale scores, with an average of 1.93 out of a possible 5.00.

Seven-step model

Chisholm and the quality council formed a process action team that was carried over to the newly merged home care agency as well. The team's purpose was to investigate how to enhance team-building skills among the joined staffs, brainstorm about problems and possible solutions, and then implement improvements.

A year later, the team repeated the staff satisfaction survey and found a 29.3% improvement in overall staff satisfaction. That included job satisfaction, staff morale, and the effectiveness of supervisors as coaches.

The team-building quality improvement project followed a seven-step model. Chisholm outlines what the agency did for each step:

1. **Identify the process that needs improvement.** The proposed merger and managers' observations of how negative staff were about the merger made it simple for the quality council to identify the problem. Also, the agency had a number of negative rumors to deal with, and staff retention was becoming an issue.

2. **Organize the team.** The quality council selected representative employees from all the different disciplines to form the action team. Typically, the action team would include people whose jobs are affected by the process that needs to be improved. In this case, staff morale affected everyone.

"We chose people who are problem solvers," Chisholm says. "We didn't want people on the team who had an ax to grind and would grumble and complain; we wanted people who would give constructive criticism."

3. **Analyze and understand the process.** The action team brainstormed, listing problems. Then they created a flowchart of the process from beginning to end. "That was very difficult in this situation because the problem is so subjective," Chisholm notes. "This is not a black and white issue; it involves feelings, experiences, and was difficult to flowchart."

Still, the team worked on analyzing the process and came up with a flowchart that helped identify the opportunities for improvement. "As you define the process, it becomes very evident where the problems are and where we're falling down," she says. **(See story on the agency's morale problems and how it solved them, p. 104.)**

Once all of the problems were listed, the team voted on each as a way to reduce the list to a manageable number of priorities. That helped the team focus on the key issues.

4. **Identify recommended improvements.** Once the team came up with the priority list of problems, team members suggested improvements. "We came up with ideas to solve the problems we were having, and then we made recommendations," Chisholm says.

Then she brought the lists of problems and potential solutions to the quality council, which would determine the financial impact of each suggestion. "On the action team, you could have grandiose ideas, but are they fiscally feasible?" she says. "That's why it has to go to the quality council for approval."

5. **Plan the improvements.** This step simply involved having the team plan who would be responsible for each improvement approved by the quality council. So each recommendation was

assigned to a team member to assure follow-through and accountability.

6. **Implement the improvements.** The people in charge of implementing improvements got to work. The implementation process started in December 1999 and ended in February 2000.

7. **Check the results.** The team distributed the post-merger staff satisfaction survey in April 2000 and compared its results with the results of the pre-merger survey of one year earlier. Besides looking for overall satisfaction and staff morale results, the team looked at results in specific areas. If outcomes did not improve significantly, the team concluded the changes were not as effectual as hoped. In those cases, the team analyzed the process again and continued to strive for improvements. ■

Morale-challenged? Take these extra steps

Promote relationships, control rumors

The merger that created Upper Chesapeake/St. Joseph Home Care in Baltimore contributed to so many staff satisfaction issues that the agency felt it had to include the entire staff in its staff morale quality improvement (QI) process.

The action team, formed as part of the QI process, sent a survey to all employees, asking them to prioritize the problems the action team had identified. There were more than 30 items on the list.

"We said, 'Help us identify which of these are truly problems,'" says **Debbie Chisholm**, BSN, RN, CRNH, quality and staff development manager for the hospital-based agency that serves three counties in the Baltimore area.

The query served two important purposes. One, it helped the action team further narrow the list of potential problems, and two, it encouraged the staff to invest in the quality improvement process. Nearly 60% of the staff responded.

"By going back to the entire staff, there's a feeling that you're getting their buy-in because you care enough to listen to what they have to say," Chisholm explains.

Each of the problems listed on the survey fell into one of four categories: orientation process, relationships, satellite offices, and issues with compensation and performance.

The action team decided to consider any problem listed on the survey a top priority if the problem was cited by at least 30% of the staff who completed the survey. Those would be the problems the team would attack.

That effort narrowed the 30-plus items to 10 problem areas, listed here:

- poor and/or mixed communications;
- lack of clear directives;
- inappropriate and negative communication;
- rumors, lies, and gossip;
- lack of follow-up after meetings and conferences;
- withholding of information from lower-level staff;
- lack of trust among team members, administration, and staff;
- staff's perception that they volunteered a lot of their time;
- rate of pay;
- feeling demeaned as a professional.

The action team found that the problem areas most important to the staff were not in the categories of the satellite offices or orientation process. In fact, nearly all of the problems fell into the category of relationships.

'Kudos' for staff excellence

After mulling over these top 10 problem areas, the action team came up with a variety of potential solutions, including one solution that has turned out to have the biggest impact. The team developed a "kudos" program that bridges all levels — managers giving kudos to staff, staff giving kudos to managers, and staff giving kudos to each other.

"We thought it would help build relationships and increase the overall bond team members have with one another," Chisholm says. "We thought it also would help to overcome the feeling of isolation that some staff members have."

Anyone who would like to give kudos to another employee only has to fill out a postcard that has the kudos graphic and the words, "Kudos to you because . . . ." The employee who receives the postcard can save it and turn it in at a staff meeting for a chance to win a prize. Prizes include such items as free lunches, gift certificates, decorative candles, and movie tickets.

"You wouldn't imagine the response we've gotten from this and the number of employees

sending these to one another," Chisholm says. "The staff say these little cards mean the world to them, and to receive one makes a difference in their day."

Kudos recognition is handed out for many different reasons, such as when a therapist or nurse goes above and beyond for a patient, or when one employee fills in for another during a vacation. Some months, prizes are given to the holder of the postcard that touches the heart the most. One winning example read, "You light up the room every time you show up for work."

The kudos notes are an easy way to make the staff feel better about their jobs and themselves, Chisholm says. It is important for the staff to get that kind of recognition for what they might think is an unnoticed kindness, she adds. "That program has made a big difference in relationships and building trust between administration and staff."

Another solution was to add a new column to the monthly newsletter, featuring stories about different team members as a means of introducing the staff to one another.

"In each newsletter, we profile several different team members, discussing who they are and what are their hobbies and interests," Chisholm says. "This way, employees can identify common interests such as sailing, and then they have a common ground where they [can] approach one another."

Managers get communication clues

The action team and quality council worked on the problem of poor communication between staff and managers through coaching sessions with managers whose scores on the staff's satisfaction survey indicated the need. They also had a speaker talk to managers about open and honest communication techniques and ways to improve communication and build trust.

"He was a dynamic speaker and did a great job," Chisholm recalls. "He used different tools to identify what kind of communicators we were and then showed us our weaknesses and ways to overcome those weaknesses."

The action team also suggested that the agency stop holding separate field staff and office staff meetings because this was divisive, she says. Now there's a combined meeting. Instead of having some of the same issues brought up and discussed at separate meetings, they can be discussed at one meeting and solutions can be found that pertain to both field and office staff. The combined meeting also has improved communication between the field and office staff, eliminating misperceptions about what might have been said at one meeting and not at the other.

"We publish the minutes of that combined meeting and make the minutes accessible on the computer system so everyone has access to them," Chisholm adds.

Keeping gossip in check

Another solution involved forming a rumor control hotline on voice mail that staff could call anonymously about any rumors, such as a rumor that the agency would close or one that management was receiving a huge raise while hourly workers were not.

The hotline number is listed at the top of the staff employee phone list for easy access. Employees merely call and leave a message describing the rumor they have heard circulating. Then the agency's president, Shawn McNamara, MSN, RN, CRNH, tells the entire staff the truth. For example, one rumor was that the president was looking for a new job.

McNamara responded to the rumor with a staff e-mail that dispelled the myth and reiterated that he had every intention of staying at the agency.

A final solution to poor communication and lack of trust was to implement an open-door policy among top management. As a result, the president keeps his door propped open so any employee with a concern can walk in and ask if the president has a minute to discuss concerns. The door is only closed during confidential meetings.

"It's good to have a leader who is easily accessible and encourages communication," Chisholm says. ■

Source

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Streamline PI program to cut costs, improve quality

Agency did a PI project on its PI program

Sometimes the best performance improvement (PI) program is one that revamps the entire PI process. At least that's the philosophy this year at MCH Services / Pediatric Nursing Specialists in Indianapolis.

The agency, which serves central Indiana, regularly has PI projects on customer satisfaction, infection control, risk management, and safety. But what managers really wanted to know in 2000 was whether those PI projects were using the most efficient PI process to obtain better quality, or could the process be sliced and diced and still achieve all its goals?

"We found that we were spending a lot of time in meetings and not getting a lot accomplished. So we tried to streamline it because in home care, we need to do more with less."

"We found that we were spending a lot of time in meetings and not getting a lot accomplished," says **Shari Paige**, RN, director. "So we tried to streamline it because in home care, we need to do more with less."

The agency has had to make administrative and field staff cuts, as have many others in recent years, so all remaining employees have been forced to become more efficient, spending time wisely. Unnecessary meetings did not appear to be a good use of their time.

Managers began by looking at the agency's PI goals and the task forces established to help meet those goals. There was a task force for each PI project area, and each task force met separately. Some met monthly, and others quarterly. Still others used focus groups within the task forces, and those also met separately.

"Some of these were very long meetings, and we felt too much time was spent in meetings," Paige says.

Managers met with the task force chairpersons, and together they decided to merge the various task forces into one committee. Each person on the committee would be responsible for monitoring one of the special PI projects. That task involves other staff when necessary, reporting to the committee about problems and progress and discussing improvements that need to be made.

Staff didn't mind PI process changes

"The change was a relief to some of the chairs because they all had jobs other than this particular project, and they also were feeling stressed," Paige recalls. "We wanted a good PI program and have put a lot of effort into it, but it took away from the other jobs they had to do."

To make sure there were no hurt feelings over the change, committee members told staff the committee didn't want to take away their involvement in PI projects but needed to be sensitive to their time constraints with regard to patient visits and other duties. As a solution, staff who help out with PI projects are not required to attend PI meetings. Instead, they are represented by the committee members at the meetings.

"We said that we would no longer require regular PI meetings of all the staff involved," Paige says. "There might be a brief meeting, but not a routine committee requirement."

Committee named 'hot topics' for 2000

Here's how the agency developed the new, streamlined PI process:

1. **Identify PI ideas.** "We started by identifying the ideas we wanted to monitor for 2000 and any specific incidents in those areas," Paige says.

They came up with five distinct PI project areas to address:

• **Recruitment and retention:** The committee tracks the number of hours it takes to recruit and train employees.

"We're tracking our new hires as relates to the ads we put in the paper, and we track our percentage of new hires compared to the number of people who responded to that ad," Paige says. "So if 20 people called, and we hired five people, why is that?"

The committee also tracks turnover costs and the turnover percentage and continually tries to identify ways to recruit and retain nurses.

There's even a formula the agency uses to estimate turnover costs. The formula, obtained from a human relations agency, enables the agency to keep track of the cost per new hire in terms of the orientation cost, and the cost of replacement when that employee leaves.

• **Safety:** This year, the committee decided it wanted to focus on durable medical equipment (DME) in its safety project. The committee monitors the agency's DME program to check on preventative maintenance, staff and caregiver education on using the equipment, and any incidents that occur with DME use.

• **Risk management:** The committee tracks all incidents related to medication errors and any other risk problems, including patient falls or injuries.

• **Staff development:** "We're monitoring to assure competency assessments for staff nurses," Paige says. "It was identified in our customer satisfaction survey with staff nurses that they needed more inservice opportunities." As a result, the committee developed an inservice program and has tracked participation in it.

• **Infection control:** The committee tracks any patient infections that are related to the patient's hospitalization or cross-contamination within home care, although the latter occurrence is very rare.

2. **Discuss committee members' duties.** The committee has one person monitoring each PI area, except for recruitment and retention, which has two people assigned to it.

Committee members are expected to meet at the beginning of each year to discuss the PI projects, their accomplishments, and any necessary changes. They also discuss the specific items they want to monitor. Each member is responsible for writing a plan about the particular PI area to which he or she is assigned. The plans include information about data collection from the field

CE objectives

After reading each issue of *Homecare Quality Management*, the quality manager will be able to do the following:

1. Identify particular clinical, ethical, legal, or social issues pertinent to home health care management.
2. Describe how those issues affect nurses, patients, and the home care industry in general.
3. Cite practical solutions to the problems that their profession encounters in home care and integrate them into their daily practices. ■

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staff, tracking tools to be used, areas that need improvement, and the additional staff needed to make any improvements.

"They can recruit staff to help them, but we generally don't obtain an ongoing commitment from additional people," Paige says.

Monitoring staff, customer satisfaction

Then committee members survey the staff about the PI plan and the tools they've been using and ask for feedback on how they might improve.

At quarterly meetings, committee members discuss how their PI program is doing and any problems or trends they've discovered.

3. **Keep customer satisfaction in mind at all times.** Committee members continually are reminded that everything they do, including each PI project, must maintain high customer satisfaction.

"So we specifically monitor patient satisfaction or the satisfaction of the parents of the children we care for," Paige says, "and we monitor referral source satisfaction and field staff nurse satisfaction."

Easing nurses' time constraints

Since the nursing shortage began within the past year, the agency has focused a great deal on nursing satisfaction, which is the reason the agency added a PI project for recruitment and retention, Paige adds.

The revamped PI program has definitely served its purpose of cutting down on staff time, she says.

"It gives us a little more focus. Before, when we had so many people involved, while it was great to get that input, everybody had their own way of doing things, which caused us to get a little out of control. So the new committee has helped in that regard." ■

Source

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