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INSIDE

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Group therapy coding: Clarification creates confusion and controversy

Bottom line: Watch how you bill Medicare for one-on-one time

Start asking questions about the way Medicare wants physical and occupational therapists to code group vs. individual therapy, and you'll get a plethora of contradictory answers and some heated opinions to boot. It's an issue; it's not an issue. It's wrong; it's right. It's confusing; it's clear as can be. It flies in the face of traditional therapy training; it's the way they've always done it. It's a financial blow for providers; it's not a problem at all.

That's if you can get people to talk to you at all. Ever since the Baltimore-based Centers for Medicare & Medicaid Services (CMS) issued Carriers Manual Transmittal 1753 last May, many providers have hesitated to publicly discuss their interpretations of group vs. one-on-one therapy. Behind closed doors, however, it's a hot topic. CMS officials themselves were unwilling to speak on the record to *Rehab Continuum Report*, but their official position can be found on the web site www.cms.hhs.gov/medlearn/therapy, which contains a list — some say a long-awaited list — of frequently asked questions released in January. CMS also held an open-door conference call last September to answer questions on the topic (see an unofficial transcript of the call at www.amrpa.org).

All of this debate stems from Transmittal 1753, which CMS officials say was issued to clarify — not change — the rules. But the effect was to say that many claims for one-on-one therapy actually should be billed as group therapy, which results in significantly lower payment. The transmittal defines group therapy services (code 97150) like this: "pay for outpatient physical therapy services (which includes outpatient speech-language pathology services) and outpatient occupational therapy services provided simultaneously to two or more individuals by a practitioner as group therapy services. The individuals can be, but need not be, performing the same activity. The physician or therapist involved in group therapy services must be in constant attendance, but one-on-one patient contact is not required."

In general, if a therapist is billing for a 15-minute session of a service that is done one on one with the patient, the therapist cannot bill for any other one-on-one or constant attendance service during that same 15 minutes, according to a CMS official. If a therapist treats two or more patients simultaneously, the therapist should use the group code. If the therapist can document the time that he or she worked one on one with each patient, the one-on-one codes may be used as long as the total time billed does not exceed the total time in which services were provided.

"This is a huge issue. CMS' attempt to clarify a definition has really frustrated outpatient therapists," says **Bonnie Breit**, MHSA, OTR, president of BRB Consulting Inc. in Media, PA. "It's not a group in the traditional definition of therapy if you say a group is any two people at any one time doing two different things. For group, therapists generally expect that the patients would be doing the same thing. Imagine what's happening to all the providers. This discussion not only affects the way patients could get treated, but because of the fee schedule, group therapy is considered less skilled, which translates into less reimbursement."

Therapists know when a patient needs undivided attention and when he or she might be encouraged by working alongside another patient, Breit says. "Physical and occupational therapists make those decisions all the time, and they don't need someone else defining if they ever walk out of that room from doing a massage or an ADL, now they have to bill group therapy," she says. "It's a reimbursement issue and a practice issue. This may also reduce access. If therapists are limited to four units per hour, they may not be able to take two patients at a time. They won't be able to afford the decreased reimbursement."

It's hard to argue the point with CMS, though, because if a provider admits to having used a different interpretation of individual or group therapy, they may fear retroactive retribution, Breit says. "Nobody wants to be caught on the wrong side of the definition," she says.

Some providers say they disagree with the notion that a therapist is conducting a group session when he or she moves among patients who are in the office at the same time but who may not have the same diagnosis or be performing the same tasks. Given that the approximate amount paid last year for the group therapy code was $17.74 (which is an untimed code that can only be billed once per day) and the approximate amount paid for the one-on-one therapeutic exercise code (97110) was $26.43 per 15 minutes, it's not hard to see why providers might complain.

HealthSouth blames losses on group code

Perhaps the loudest voice of complaint on this topic comes from HealthSouth Corp., the largest provider of outpatient surgery, diagnostic imaging, and rehabilitation services in the United States. The Birmingham, AL-based company has about 1,800 sites in all 50 states as well as Puerto Rico, Britain, Australia, Saudi Arabia, and Canada. In August, HealthSouth blamed the Medicare group therapy policy when it lowered earning estimates by $175 million. Shareholder lawsuits were filed questioning chairman and

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chief executive officer **Richard Scrushy's** sale of $25 million in HealthSouth stock before the earnings announcement, and the Securities and Exchange Commission is investigating the matter. The company has said an internal review found no wrongdoing.

Scrushy strongly disagrees with CMS' position that Transmittal 1753 did not change the way physical therapists bill for group therapy. He says physical therapists traditionally have moved from patient to patient when clinically appropriate in a practice commonly referred to as "dovetailing."

"When you change the rule from dovetailing, which is what all physical therapists are taught in every school in America and the way they have always worked in every practice in America, you've got a disaster of a rule," Scrushy says. "It's a magnificent waste of resources. Could you imagine telling doctors or dentists that they could only treat one patient at a time? We do practice group therapy when patients have similar problems and are all working on the same thing. But CMS is saying that if you are treating two patients, even if they have completely different problems and need completely different therapies, that if they're laying on a stretcher next to each other and you touch one while the other's stretching, you've got group therapy. It's absolutely ridiculous."

Forcing physical therapists to work with only one patient at a time means they can see only about six patients in one day as opposed to as many as 25, and that has the potential not only to reduce profits but also to reduce patient access to care, Scrushy says. "PTs can do some outstanding work and have some outstanding outcomes working with more than one patient at a time. This is a tragic waste of some really talented people," he says. "I have two daughters who are physical therapists, and they say they're spending a lot of their days now just standing around while Medicare patients are out in the waiting room. It's very inefficient and makes no clinical sense at all. This is going to cost the health care industry billions of dollars."

Scrushy says HealthSouth is complying with the policy 100%, but physical therapists still have a lot of questions about it. "Our PTs are being extremely conservative in our coding. They may have been a little too conservative in their concern that they don't violate any of the rules," he says. "It's a confusing situation."

Another problem Scrushy has with this system is the reimbursement amount itself. The Balanced Budget Act of 1997 required CMS to establish uniform coding for outpatient rehabilitation services, which meant that providers went from cost-based reimbursement to the Medicare Physician Fee Schedule. "When we were under cost-based reimbursement, the reimbursement amount took into account rent and utilities and other overhead," Scrushy says. "Now that we're fee-based, they're using the same amount, but they didn't figure in all those other costs. CMS needs to re-price the fees."

APTA claims codes undervalued by 18%

The fee schedule is perhaps the only area of this argument in which the American Physical Therapy Association (APTA) would agree with Scrushy and HealthSouth. APTA, based in Alexandria, VA, supports CMS' interpretation of the group therapy code, but does have a couple of issues with CMS, including the fee schedule, says **Gayle Lee**, associate director of federal regulatory affairs. "We're working on other areas with respect to this fee schedule. We think the practice expense methodology that CMS uses is flawed," Lee says. "We think it significantly underestimates — by about 18% — the value of the codes in the 97000 series [physical medicine and rehab codes]. We've met with CMS on that issue. We're trying to get the payment increased for all of the codes. If they would go back up on that, it would help a lot with finances."

The 2003 Medicare Physician Fee Schedule final rule, published in the *Federal Register* on Dec. 31, does increase this year's payment to physical therapists by about 2%. But APTA points out that basic flaws with the fee schedule formula more than offset the increased physical therapy values.

On the issue of what constitutes group therapy, APTA agrees with CMS that any outpatient physical therapy services provided simultaneously to two or more patients constitutes group therapy. "We find it very difficult to say that you're one-on-one with more than one patient at the same time," Lee says. "The position CMS has taken is if you're not one-on-one, you can bill for all patients as group or you could go back and forth between the patients and bill for the time that you're one-on-one with each particular patient and aggregate your time. That's always been our understanding. From our understanding, this is not all that new."

APTA is concerned that some providers are having difficulty getting reimbursed if they bill both a group code and a one-on-one code for the same patient on the same day. CMS says you can bill both, but you must use a modifier. "We disagree with that edit," Lee says. "We think you should be able to do both of those services in the same session. We're trying to work with CMS on that. If they're going to advise people to use the group code, then they need to pay for it. There are some implementation issues out there, and we're focusing on those rather than making an argument that you can bill more than one patient at the same time."

Thomas Grissom, director of the Center for Medicare Management, sent a letter (available at www.apta.org/reimbursement/OneonOne_Group/cmsletter) to APTA in November expressing concern with the payment problems reported by APTA. He requested that APTA send specific information about these problems to CMS' division of practitioner services.

'They're throwing therapists to the dogs'

Scrushy of HealthSouth says APTA is making "a tragic mistake" by agreeing with CMS' interpretation of group therapy. He says they like the policy because it will increase the need for physical therapists. "APTA is burying its head in the sand," Scrushy says. "They are letting the industry down. They're throwing therapists to the dogs."

APTA, of course, doesn't see it that way. **Andrew Guccione**, PT, PhD, senior vice president of practice and research for APTA, doesn't buy the argument that this is the way therapists have traditionally worked.

"Traditional doesn't necessarily mean right," Guccione says. "It's done, but APTA has advised against it. It's been a longstanding principle in our code of ethics that you abide by the law, that you represent your services truthfully. If there's a discrepancy, we have the responsibility as a professional organization to advise people how to describe their services appropriately. We'll fight for your reimbursement if we think there has been a capricious denial. We are vigorous in promoting fair payment, but you can't fudge on the description."

Guccione says there's no uniform definition of dovetailing, which could either mean staggering patients' arrival throughout the hour or going back and forth between patients. He says the key is to look at whether the therapist is giving the patient divided or undivided attention. "In order to provide one-on-one services, which is the way many of the CPT codes in the 97000 series are, that means I'm paying attention to you and you alone. That doesn't necessarily mean I will work with you for a half hour straight," Guccione says. "I may work with you for 12-14 minutes — one unit of one-on-one care — then I may ask you to rest or give you an unattended modality, and then I see the next patient, and then I may come back to you. That's different from group. The situation that has arisen is that if I call in three or four patients and I run around the room and speak to everybody, that's the divided attention. That has the characteristics for group. One-on-one is one-on-one and group is not."

This isn't Hollywood

As for the profit issue, Guccione says he's confident that many providers are following CMS' interpretation and doing just fine. "You may not be making money hand over fist," he says. "This isn't Hollywood. If you really want to get paid like a rock star, keep practicing the guitar. There is legitimate profit, but there is not overwhelming profit. It's a human service with an ethical basis. It's not the business to have enormous profits."

What about the issue of potential reduced access for patients? Guccione says it's true that physical therapists have to hustle, but they must continue to put the patients' needs above profits. "There is probably an optimal combination to provide care efficiently and still make money," he says. "But our code of ethics is very clear. You can't put financial gain above the patient. There are cost efficiencies; many clinics are billing this way and still making a profit. If you need to cut costs, look at your square footage, your mix of personnel, whether you've hired too many people, whether your productivity standards are too low. You also have to recognize what a reasonable profit is given your case mix."

The bottom line, Guccione says, is that this is the way it is. "When you enter into a contract with any insurer, you agree to abide by their rules. The rules say please use the CPT codes. That's what you agreed to do. You don't fudge. If you disagree, you argue with it."

Theresa Woodard, PT, director of rehabilitation services for St. Francis Hospital in Greenville, SC, says her institution tries to avoid billing the group code altogether. "Medicare allows it, but it has to be coded with a modifier, and you have

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to make sure the documentation supports it," she says. "Your note has to explain why they needed group and why they needed individual, what the difference was, and what the goal of each was. We try to avoid having to do that. It would be the exception, not the rule, that we would do group and individual on the same day. From a clinical standpoint it's hard to explain the difference in your documentation."

From a compliance standpoint, Woodard says it's just easier not to use the group code. "It's almost like they're asking you to fail," she says. "They've made it so difficult that it's next to impossible to comply. You can bill differently in the private sector, so that's going to complicate things even more. You have to think, 'Is this a Medicare patient?' and it can cause problems to treat them differently from other patients. It's cleaner all the way around to treat all patients the same."

Besides the documentation issue, billing group comes down to simple economics, Woodard says. "If we bill therapeutic exercise, it's something like $26 or $28 every 15 minutes, so if you see a patient for an hour, that's over $100 for the hour that Medicare is going to pay you," Woodard says. "For the group rate, they only pay $13, so you'd have to see six or seven patients in that same hour to get the same amount of money from Medicare. It's really just not cost-effective for us to get $39 for that hour with three patients when we could see just one patient and get $100, and that patient gets more individualized care."

Woodard says the CMS policy doesn't jibe with what she learned in PT school. "We were taught dovetailing where you have two patients at the same time. You might work with two patients at the same time where they're doing different things but they're in close proximity to you," she says. "You could let one rest and then spend a few minutes with the other one. Now, if you have two in the gym at the same time, that's group therapy. We've stopped doing that."

Dovetailing makes sense, Woodard says, because each patient has a different tolerance level. "If you were able to have two or three patients working in the same vicinity, then they could work at their own pace and take rest breaks, and they ultimately could probably do more," she says. "If you are confined to a 45-minute period, then you're going to try to cram everything in and make sure they're busy that whole 45 minutes. If I'm scheduling patients for one-on-one therapy, then if I give them a 15-minute rest break, I don't have anything to do. That's non-billable time for me." ■

The Road to PPS Success

Rehab hospital takes team approach to PPS

Emphasis on staff education, feedback

[Editor's note: January marked a year since the first inpatient rehab facilities began to be reimbursed under the prospective payment system (PPS). Rehab Continuum Report *will take an ongoing look at the challenges and successes of implementing PPS. If you know of a facility that has done a particularly good job in this area, please let us know for possible inclusion in the series. Contact Editor* ***Ellen Dockham*** *by e-mail (edockham@aol.com)].*

When PPS took effect last year, many rehab facilities jumped on the skilled nursing facility bandwagon by naming a PPS coordinator to take charge of the necessary documentation. But Madonna Rehabilitation Hospital in Lincoln, NE, bucked that trend and developed a model for PPS success that relies on a team effort.

"We did not go in the direction of having one PPS coordinator," says **Paul Dongilli**, PhD, vice president of rehabilitation at Madonna. "We did not want to centralize that to one person; we wanted a variety of staff to share the responsibility. We've implemented a structure here that we call 'the Madonna model' where we've formed a triad with the physician, the case manager, and the nurse therapist."

Each member of the team works to collect the information needed for the inpatient rehabilitation facilities patient assessment instrument (IRF-PAI). The case manager on each team, who is usually a social worker, puts all that information together, synthesizes it, and reports the final scores through the IRF-PAI and the software.

"What's unique to us is the whole notion of the case manager having such a strong working relationship with the primary nurse and the same physician," Dongilli says. "We spent a lot of time and energy educating our staff so they were very knowledgeable and could provide the input we needed to complete that document. We thought this would provide us the most flexibility and would result in more than just getting the IRF-PAI done — it would result in good care."

Madonna looked at PPS as more than an onerous new system to learn; the hospital treated it as an opportunity to improve patient care, increase efficiency, and promote better communication among staff members. Looking at the results from the first quarter (July to September 2002) after going on-line with PPS, Madonna appears to be meeting those goals. The hospital's goal for discharging patients to a non-institutional setting is about 80%, and the first quarter rate came in at 79%. Last year in the same quarter, the rate was 75%. Madonna is also keeping a close eye on patient satisfaction rates at 72 hours after discharge and three months after discharge. The scores have remained high since the new system was put into place. "Our new system seems to be effective," Dongilli says. "We're getting people home and we're keeping them happy."

As for the big question — how PPS has affected the hospital's finances — Dongilli was not able to share specific numbers but says Madonna has been able to meet its budget expectations for the financial performance of the program. "There are challenges to the new system, but it has been manageable," he says.

It's harder to quantify Madonna's main goal for the new PPS model — improved staff communication leading to better patient care — but Dongilli says by all accounts the system seems to be working. "We had portions of this team model in place, but we strengthened it in response to PPS requirements and the quick time lines for turnaround of data," he says. "We knew it had to be like a finely oiled machine, that we had to make this happen and we had to decrease the inefficiencies of communication."

One change the hospital made was to house the nurse and the case manager for each team in the same office. They round with the physician each morning, and the team meets daily to share

Expert offers tips for PPS success

Paul Dongilli, PhD, vice president of rehabilitation for Madonna Rehabilitation Hospital in Lincoln, NE, offers the following advice for successful prospective payment system (PPS) implementation:

- **Don't underestimate the importance of having a good, solid plan.** Formulate a logical approach.
- **Invest your staff in the process.** Tell them what you're faced with, base your plan on good patient care, and watch them rise to the occasion.
- **Don't make education a one-time deal.** Make it repetitive, and give staff time to absorb the information. Build PPS into new staff orientation and mentoring.
- **Focus your plan on the front-end clinician.** Don't let PPS responsibility rest on just one person. Get everyone up to speed and make it a team effort.
- **Monitor PPS performance through supervisors, performance appraisals, and your corporate compliance committee.** Recognize good contributions.
- **Measure success, not just financially but also in terms of patient care.** Think about how you will measure progress.
- **Don't skimp on the resources you need to implement PPS successfully.**
- **Provide ongoing feedback on accuracy.** Don't make it punitive, but do help your staff maintain their skill level. People tend to pay attention to things that are monitored. ■

scores and information on their patients. "We wanted to increase the amount of time the team members are interacting so they can bring up issues," Dongilli says.

Another important element of the hospital's PPS effort is staff education. The hospital spent six months getting staff members up to speed on PPS so they would understand not only the IRF-PAI system but also the impact on the industry as a whole. "The education wasn't a one-shot deal; it was repetitive," Dongilli says. "We met in large groups and also in smaller groups with supervisors. We did sample testing and made sure the staff had information related to their respective roles and to the whole coordination of care. Now they have information that is more globally focused."

Much of the education time was spent on guidelines for scoring and how the scores tie back to the case mix group. Dongilli, who also is a surveyor for the Tucson, AZ-based Commission on Accreditation of Rehabilitation Facilities, says the problem with having one PPS coordinator is that the staff members who are providing the functional independence measure (FIM) scores are two steps removed. "Without this team effort, people tend to have only a vague notion of how the FIM score goes into the IRF-PAI. If someone else is responsible for PPS, the other staff members don't really understand how the IRF-PAI drives the determination of payment."

Staff members take ownership of FIM score

Madonna's education effort addresses that issue by making sure staff members take ownership of the FIM score. "It's not just that they are giving a score, but that they are making decisions that drive our reimbursement," Dongilli says. "Now they know that what they are doing is going to impact how we are paid and that it needs to be accurate and timely. They know they can have a huge impact on the resources available to meet the needs of our patients."

The hospital also includes coding staff in its PPS education. "We have concurrent coding by our medical records staff to make sure we're capturing information accurately," Dongilli says. "We analyzed our patient population to see what are the top comorbidities we've seen in the last two years and shared that information with the whole group. Now they have a common framework to be on alert that our patients typically have this profile."

To make sure the PPS model accomplishes its purpose, the hospital has tied documentation to staff performance appraisals. The monitoring effort also is funneled to the corporate compliance committee so the hospital can keep an eye on accuracy. "As part of each performance appraisal, we're looking at each clinical area and looking at FIM scores to make sure there is documentation in the medical record to support the scoring," Dongilli says. "If there are problems, we go right back to the therapist or the nurse and let them know. Then we provide more education to ensure accuracy."

PPS has required a big shift in mindset for rehab professionals, says **Kathy Kuehn**, LCSW, a case manager who has worked at Madonna for 22 years. "In the past, we tended to want to show patients at their best, but now we really need to document what their worst performance is," she says. "We have to make sure the FIM score isn't arbitrary and that we are supporting in the medical record the reason the patient got that score. PPS has forced us to be more efficient."

PPS also has forced clinicians to become more aware of the financial ramifications of their decisions, Kuehn says. "Clinical people were somewhat sheltered from the financial aspects of patient care. But now they have a much greater appreciation for fiscal realities," she says. "We've always worked to make sure patients are getting appropriate levels of service, but now we have to be even more conscious of things like noting comorbidities, rescheduling therapies, and not making decisions based on patients' social concerns. If they're done on Friday, they can't wait until Saturday to leave the hospital just because it's better for their family."

Kuehn says Madonna's PPS model has led to stronger relationships among physicians, nurses, and case managers. "The proximity of being in the same office really helps with team collaboration. It's very effective," she says. ■

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Lift teamwork: MSD injuries drop to zero

When patients need a lift, CNAs page colleagues

It's a common paradox: Employees become injured during patient transfers, while lift equipment sits idle down the hall.

El Camino Hospital in Mountainview, CA, enlisted health care workers themselves to create a better ergonomic climate. They did it — not with lifts, but with teamwork. The Sixth Floor medical unit once had the highest injury rate in the hospital. Since January 2002, there hasn't been a single injury.

"There's a certain amount of pride now on that floor relative to their performance," says **John Deex**, RN, MS, OHNP, COHN-S director of employee health and safety. "It's really cool to tell people, 'We don't have any injuries.'"

Other units, such as the critical care unit, are now launching the same improvement process. Although the action plan may differ, the basic strategy is the same: involving front-line workers in the solution.

Deex also maintains the importance of regular feedback and recognition. The hospital CEO even singled out the Sixth Floor project as an example of excellence.

"The whole idea of prevention is to keep it in the forefront of people's minds," says Deex. "They can't take care of other people until they take care of themselves."

Care plans didn't mention lift needs

The patient lift/transfer program began with an evaluation of current ergonomic compliance. The results were bleak.

On admission, nurses were supposed to assess patients for their risk of falling, their level of dependency, and need for lift assistance on a computerized patient care plan. But most plans made no mention of lift needs. Patients on this medical floor suffer from chronic conditions, including Alzheimer's disease, and are among the weakest and sickest in the hospital.

Employee health nurse practitioner **Beverly Nuchols**, RN, OHNP, PhD, asked certified nurse assistants (CNAs), who were responsible for many lifts and transfers, about the ergonomic equipment.

"Even though they had it there and they had been trained on it five years ago, they didn't have the culture to support that. They didn't have the time to use it," says Nuchols. "They didn't feel comfortable using it because they hadn't used it a lot. Some of them felt the patients would be afraid of it."

The registered nurses knew even less about the lift equipment than the CNAs and didn't encourage its use, Nuchols discovered.

"What we have found is that it really requires an ongoing, motivated program to educate and support people on the floors to use the equipment," Deex says.

Nuchols arranged meetings with workers and managers from each shift. "We would talk about the high-risk scenarios for patients," she says.

For example, the CNAs talked about a common scenario in which a family member wanted the patient moved up in bed or transferred to a chair. They didn't want the CNA to wait for assistance. They wanted to move the patient right away, and they offered to help.

"They end up not doing their part. They pull at a different time," says Nuchols. "People got hurt that way by not having the other person they're working with work as a team."

'Code Bod Squad' brings help

How could the Sixth Floor get quick and safe transfers? They used the pagers carried by all employees on the floor to create a "transfer team page."

"When a CNA wants to move someone up in bed or get someone up in a chair or they're going to transfer someone to a bed or a gurney, they would go to the front desk and say, 'Please get a transfer team to this room,'" says Nuchols. "The people responding to the page know they're only going to be in that room for 30 seconds. The person sending the page has already gotten the room ready."

Sometimes, five people might show up to respond to a page. The person leading the lift can pick her helpers and the rest go back to their tasks, explains Nuchols.

The Sixth Floor has 10 transfer teams of about eight or nine members each, with an equal number of RNs and CNAs. A CNA is the transfer team leader, who trains the others in the use of the equipment.

At the launch of the new program, the teams entered a friendly competition to see who could

be the most successful at reducing injuries. For six weeks leading up to the movie industry's Oscar award show, the teams vied to win Blockbuster gift cards. The team with no injuries would get the cards.

"Because the program was so successful, everybody was a winner," says Deex. "We had no injuries. Not one."

Lifting procedures addressed during reviews

Positive feedback and reinforcement from Nuchols helps keep the teams on track. So does another imperative: Team lift support is now one of the employees' job competencies. Being able to use the lift equipment and responding to the transfer team page will be addressed at annual performance reviews.

Nuchols continues to audit care plans and monitor use of the equipment and transfer team pages. But she also has moved on to other departments.

The Critical Care Unit calls their teamwork system "the Bod Squad." The unit is small, so employees just call out, "Code Bod Squad," and co-workers come to help them.

She's also working with the transporters to track and prioritize calls, and with nurses to help them understand the importance of waiting a few minutes for a safe lift.

Nuchols also is evaluating equipment needs and the purchase of new items.

El Camino expects to save money due to a lower rate of injuries. But that main message of the program involves a safety mindset — and the value of the workers to the hospital, says Deex.

"It's a culture you generate within your institution about how you feel about your employees and what it is you're trying to do," he says. "If you start bringing in the issues of dollars and how much injuries cost, people perceive it's all about money. It's not all about money. It's about preventing people from getting hurt." ■

Employee-centered focus sets Florida system apart

Keys: Recognition, involvement, communication

The lofty vision of Baptist Health Care Corp. of Pensacola, FL, is to be "the best health system in America." The system may be well on its way. According to one authoritative source, Baptist Health may at the very least be the best health care employer in the entire country.

In Fortune magazine's most recent listing of the "100 Best Companies to Work For," Baptist — with six hospitals and 742 beds — ranked 15th on the list.

The next-highest health care employer — there were four in all — ranked 76th.

What sets Baptist apart? For one thing, the system provides a wide range of programs that recognize, reward, support, and involve employees, including recognition of significant anniversary dates and numerous opportunities to present new ideas.

"Fortune said that the No. 1 factor that separates us is that we celebrate so much," says **Celeste Norris**, human resource director. "We have hospitalwide celebrations when we do well, and we thank everyone. We have a sense of pride about our work."

It wasn't too long ago that Baptist didn't have much to celebrate at all.

"In 1995, we needed a boost — a big one," recalls Norris. "We had just been through merger mania, growing from 2,500 to 5,000 employees. We had tried re-engineering, and in the process destroyed morale by shaking up middle management. Our leaders knew we couldn't compete by outspending the competition on equipment, so we decided to compete on service."

It's all about the employees

Leadership recognized early on that it couldn't deliver world-class service consistently unless the work force was behind the effort and every employee was engaged, says Norris.

"We had high turnover, patient satisfaction was in the teens as rated by Press-Ganey, and employee morale was also low as measured by a tool we use from Sperduto & Associates," she notes.

As so often happens with successful change, the process began at the top with the Baptist CEO.

"We made a concerted and sustained effort to change the corporate culture," says Norris. "We republished our values and mission and committed to being No. 1 in patient and employee satisfaction."

Employees were involved from the start in the

visioning process. "One of the first things we did was share the news with employees and ask for their input on how to accomplish our goals," notes Norris. A number of employee teams were formed, including the standards team, which was charged with outlining the behaviors every employee should exhibit in order to provide world-class service. **(The performance standards are outlined on pp. 35-36.)**

"As a result of this process, the employees exhibited a sense of ownership and felt free to express themselves," Norris notes.

At the same time, the CEO sent teams across the country to benchmark other workplaces. A number of these benchmarks were then approved by the CEO and implemented.

Programs that work

The programs at Baptist not only make sense on paper, but they produce results.

"We have a very open culture when it comes to information-sharing," says **Sharon Gaubert**, MPH, program director for occupational health and urgent care. "Every day we review the patients seen and the revenue from the previous day. We also look at month-to-date figures and benchmark them against our revenue goals."

When those goals are exceeded, the department receives a free, catered lunch in the office.

"This helps us keep them fired up," says Gaubert. "It's actually easy to minimize loss of charges and increase accuracy."

Service teams are another key to Baptist's success. Through these teams, front-line employees and leaders work together at enhancing care to all customers.

"For example, one team deals with employee loyalty," notes Norris.

That particular team includes employees from the pharmacy, the wound center, human resources, marketing, and nursing. One project involved one-year certificates given to each employee who reached that milestone. "We celebrate that because we know employees are still at risk for leaving until they've been with an employer for about two years," Norris explains.

However, the certificates cost about $2.95 each to produce, and one coordinator found several of them strewn about.

"The team realized many of these people did not have offices in which to post the certificates, so they didn't value them as highly as they might," Norris explains. "So, they suggested making pins."

The cost of the pins was $1 apiece. The recommendation has now been implemented.

The daily huddle, a practice benchmarked from Ritz-Carlton Hotels, has impressed **Summer Jimmerson**, marketing representative for occupational health.

"I've been here for seven years and never worked on an actual campus," she explains. "With this many employees, its important to continuity to make sure the messages go out. Through the daily huddles, we know where we are, and where we are going."

Cascade learning is another important process, says Norris.

"When leaders go off-site to have instructional training, they are given the tools to waterfall that new knowledge to the staff when they return," she says. "They basically say, 'Thanks for covering for me. Here's what I learned.' With training budgets being cut so only a few people can go, this is a valuable way of extending training dollars."

The 'Bright Ideas' program has impressed Gaubert. It provides a mechanism by which employees' suggestions are taken to appropriate leaders at any level of the organization. "It's really great," she says. "Employees can generate their ideas, take ownership of them, and make them happen."

"When employees submit their ideas and they are implemented, it gets them engaged in the business," adds Norris. "It's great for their self-esteem."

Benefits are apparent

Today, the changes initiated over the past several years have become part of the culture and of everyday procedures at Baptist. For example, the vice president of patient care and the COO meet weekly with the leaders of the service teams.

"That's their forum to get approval," notes Norris.

The numbers don't lie. "We've been in the top percentile in inpatient surveys for four years in a row, and in employee satisfaction surveys we have been ranked 'Best-in-Class' in terms of morale," Norris reports.

The improved morale has also been a plus, says Gaubert. "From our end of the business, we know injury rates tend be lower when employees are happier. When unions are about to go on

strike, for example, injuries are higher."

Norris confirms the positive impact on injuries. "Our workers' comp injuries have declined, and our risk management costs have also declined," she reports.

"It's also reflected in employee turnover, where the numbers are also down," adds Jimmerson.

In fact, Baptist Health Care has been so successful that other organizations are now benchmarking them.

"We now offer a leadership training institute," she reports. "We have had so many requests from executives around the country we have opened it up to the public through our web site [www.ebaptisthealthcare.org]. Once there, people can visit our leadership institute site and learn about the opportunities they have to come here and benchmark." ■

Baptist Health Care's performance standards

'Be truthful and honest in all dealings'

At Baptist Health Care Corp. in Pensacola, FL, the following question is posed to employees: If I'm going to be successful in this culture, how do I need to act?

Performance standards, compiled by employees, are behaviors to be demonstrated by all employees. The standards establish specific expectations that employees are required to practice diligently while on duty. Picking up trash, walking visitors to their destinations, and a courteous smile to all are just a few examples of how employees can meet the expectations set by their co-workers. The following is an excerpt of some of Baptist Health Care Corp.'s standards:

• **Attitude:** Our job is to serve our customers, co-workers, and supervisors and to provide high-quality service with care and courtesy. Always thank the customers for choosing us. Exceed expectations.

• **Appearance:** Be clean and professional. Follow dress code policies and wear your identification badge correctly at all times. Pick up litter and dispose of it properly. Clean up spills and return equipment to its proper place.

• **Call Lights:** All employees are responsible for answering call lights. Acknowledge call lights by the fifth ring and respond to requests within three minutes. Always address the patient by name. Anticipate patients' needs so they will not have to use their call lights. Ensure continuity of care by reporting to relief caregivers before leaving the floor. Return promptly from breaks. Check on patients one hour before shift change to minimize requests during report.

• **Communication:** Listen to customers, co-workers, and supervisors. Be courteous. Don't use jargon. Keep patient information confidential. When someone appears to need direction, escort him to his destination. Know how to operate the telephones in your area. Provide the correct number before transferring a call. Get the caller's permission before putting him on hold and thank the caller for holding. Answer calls within three rings. Identify your department and yourself and ask, "How may I help you?"

• **Commitment to Co-Workers:** Treat co-workers and supervisors as professionals deserving courtesy and respect. Welcome newcomers. Avoid last-minute requests and offer to help fellow employees whenever possible. Cooperate with one another. Don't undermine other people's work. Praise whenever possible. Do not chastise or embarrass fellow employees or leaders in the presence of others. Address problems by going to the appropriate supervisor. Be truthful and honest in all dealings, communications, and record keeping.

• **Customer Waiting:** Educate families about processes and provide a comfortable atmosphere for waiting customers. An acceptable waiting time for scheduled appointments is ten minutes. Offer refreshments and an apology if a wait occurs. Always thank customers for waiting. Update family members periodically while a customer is undergoing a procedure.

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Need More Information?

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• **Elevator Etiquette:** Always smile and speak with fellow passengers. Hold the door open for others. When transporting patients in wheelchairs, always face them toward the door and exit with care. If transporting a patient on a bed or stretcher, politely ask others to wait for another elevator. Pause before entering an elevator so you do not block anyone's exit. Step aside or to the back to make room for others. Walk departing guests to the elevator.

• **Privacy:** Make sure patient information is kept confidential. Never discuss patients and their care in public areas. Knock before entering. Close curtains or doors during exams and procedures. Provide a robe or second gown if the patient is ambulating or in a wheelchair. Make sure all gowns are the right size for the patient.

• **Safety Awareness:** Report all accidents or incidents promptly. Correct or report any safety hazard you see. Use protective clothing, gear, and procedures when appropriate.

• **Sense of Ownership:** Take pride in this organization as if you own it. Accept the responsibilities of your job. Adhere to policies and procedures. Live the values of this o9yrganization.

By incorporating standards in your daily routine teamwork, excellent customer service and our mission of being the best health care system in the country will be achieved.

Baptist Health Care 'Pillars of Excellence'

Our core strategies are used to develop annual goals and action plans and are aligned with our five pillars of operational excellence. Our five pillars of operational excellence are:

1. Best People: Strive to become employer of choice in the market area by emphasizing values-based recruitment, employee and physician satisfaction, retention, and leadership development.

2. Best Service: Provide compassionate care and service to all customers at a level that continues to set the highest standards in the health care industry.

3. High Quality: Pursue continuous improvement in the quality and efficacy of services provided by all affiliated providers.

4. Low Cost: Become the market area's low-cost provider, while optimizing reimbursement for services provided and improving operational efficiency.

5. Growth: Continue to achieve growth in scope of services provided, service volumes, and market share. ■