

Clinical Compensation Alignment of Incentives

By
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Home healthcare providers now find themselves in Stage II of Medicare PPS, the Refinement of 2008. The move to *Value Based Purchasing* (Pay for Performance) for home health care is anticipated to be possibly within two - three years. CMS has already stated that under that refinement, their desire is to:

1. Purchase quality outcomes and not unnecessary costs;
2. Measure quality and comparative results;
3. Increase patient access to care;
4. Increase effective use of technology, especially clinical innovations, and
5. Reward providers with positive and negative incentives to promote its goals.

The major key to successful clinical and financial outcomes will be the alignment of agency incentives for the entire staff, not just for the clinical field staff. Every staff member plays a role in the agency's achievements or lack thereof. All must be pulling together in the same direction, with the same intensity and purpose.

The driving force for success rests with clinical management, supervisors, quality personnel, coders, intake and liaisons. However, without excellent and enthusiastic clinical field staff that respond as a dedicated, cohesive team, the achievement of the desired clinical and financial outcomes will be in question. Today, the shortages in key disciplines make recruitment and retention a challenge. Therefore, the overall compensation package must be designed to both attract interest from a prospective employee, to enlist their enthusiastic commitment after they join the staff, and to incentivize optimum productivity and case management capacity. Management of visit utilization within an episode of care and management of the direct costs per visit by discipline and non-routine medical supply management is critical and should be an integral ingredient.

The clinician caregiver goals for their compensation are:

1. Rewarding "take home" pay with benefits that is commensurate with their work effort;
2. A real sense of patient care accomplishment;
3. A sense of appreciation by clinical management and agency leadership;
4. Feeling of contribution to the agency;
5. A real sense of fairness, and
6. Education and growth opportunities.

If an agency is experiencing actual productivity of less than 5.25 visits per day (often incurring overtime costs as well), management should consider reviewing the current compensation model, case capacity and visit productivity policies to determine the flexibility they may have to apply different compensation approaches.

The review should include the payroll and accounting systems and targeted direct costs per discipline. Any Collective Bargaining Agreement(s) must also be reviewed to determine the potential for a change in compensation methods other than the typical hourly, bi-weekly, non-exempt status. It is extremely important that Senior Management

meet with Clinical Management to identify incentives to align them with those of the agency. Beginning with an examination of the current clinical management model and staff attitude, the review should include:

1. Patient cases managed and staff visits per day productivity, actual versus budget;
2. Consistency of the Plans of Care with agency Standards of Practice;
3. Timeliness and accuracy of OASIS and documentation;
4. Achievement of optimum patient outcomes through Homecare Compare scores including
 - a. Low un-planned re-hospitalization rates
 - b. Low Emergency Departments incidents
5. Very positive patient satisfaction results
6. Spirit of volunteerism and real sense of team

All of these areas are critical to achievement of both clinical and financial outcomes. The biggest issues for most agencies today, are the nurse's and physical therapist's caseload (patients case-managed) and the visits per day productivity of the staff. Generally, this issue is directly related to the compensation models used by the providers. The three most common compensation models are:

1. **Hourly,**

Agencies paying hourly rates usually pay bi-weekly and all staff are considered non-exempt in accordance with federal Fair Labor Standards Act (FLSA). This model represents common acceptance from both the agency and employee perspective with earnings rates well defined directly in accordance with time worked.

This model makes it difficult for the agency to manage the direct cost per visit, visit productivity and case management capacity and requires productivity and utilization management. There is an absence of incentives, including timeliness of documentation. There is an exposure to labor actions within those staffs when dissatisfaction exists. This model does not promote better quality of care, patient education or an incentive to provide any necessary longer visits, or reduce unnecessary visits.

2. **Salaried,**

Agencies that pay salaries often also include a visit productivity bonus and staff may be considered either exempt or non-exempt in accordance with the federal FLSA, depending upon agency policy and the existence of a Collective Bargaining Agreement. The state of California considers all home health nurses non-exempt by statute that overrides the federal law.

The discussion points that relate to the hourly model above also apply to salaried models. Even when bonus provisions are added for visits that exceed a specified threshold and time factor, many, if not most, clinician caregivers do not achieve the desired visit productivity set by the agency. This factor makes managing the costs per visit of salaries and related expenses very difficult, if not impossible. Many agencies have experienced difficulty in getting staff to cover necessary patient admissions and evaluations, despite the apparent available capacity, because of the extra effort required and the lack of real incentives.

Those agencies using either hourly or salaried compensation that are facing problems of visit productivity, patient cases managed, a lack of volunteerism and “sense of team”, and high costs per visit for salaries and related expenses might want to consider investigating a different approach.

3. **Pure Incentives**,

Agencies using a pure incentive model usually include rates for admissions (evaluations), follow-up visits, patient case management and other activities and functions of the position. There are both weekday and weekend (“weekender”) structures and are exempt in accordance with the federal FLSA, but again not in the state of California.

This model requires a pure primary nurse (therapist) care management model that includes admissions (evaluations) most follow-up visits and all discharges (and recertifications). Its design includes payments to compensate clinical staff for each of their activities and functions as specified in the job descriptions. Visit rates are structured by type of visit including virtual (telephone follow-up) visits for patients on telehealth. There is a payment rate for case management. The payment rate for paid days off can be based upon the average daily earnings rate over a rolling period of 24 weeks or two calendar quarters, depending upon the pay period (bi-weekly or semi-monthly). There can be structured bonuses based upon thresholds of either visits or cases managed over 12 weeks or a calendar quarter, or both.

Productive RNs and therapists embrace this concept because their earnings potential is well defined and it is directly related to their productive efforts. This model promotes patient ownership, greater consistency, continuity and coordination of patient care, enhanced quality and timeliness of all documentation and communication, increased volunteerism and greatly enhances morale. Those clinicians that have difficulty maintaining an expected patient caseload, visit productivity and the timely completion of quality documentation may be challenged and have difficulty meeting the higher set of standards that produces the realization of their earnings potential. Overtime compensation will not be available. The key to this model’s success, as well as to the other models, is the strength, knowledge and skills of the team manager’s enforcement of responsibility and accountability and the clinical management oversight. This model fixes the cost per visit of salaries and payroll taxes and interfaces with utilization management based upon patient medical necessity.

The “Weekender” concept is driven by the need to provide consistent and complete weekend nursing service on Saturday and Sunday, as well as facilitating the admission visit burdens that beset many agencies for Friday afternoons. This concept utilizes dedicated staff to partner with weekday staff to share and case manage patients and spread necessary visit frequencies over the seven-day period of a calendar week. This expands capacity of Monday through Friday. There are RNs looking for this type of opportunity. They take care of their children during the week and cannot afford the cost of childcare. However, they have that availability during the weekend period from their spouse or other relatives and friends.

The Weekender Program

is designed to begin on Friday at noon and ends on the following Monday at noon. This program adds additional staff to cover the Friday afternoon admissions and provide to ability to meet all admission and regularly scheduled follow-up visits as if

the weekend days are just like Monday through Friday. This staff absorbs all weekend oncall activity, eliminating rotation by weekday staff who then receive compensatory time off during the week, which reduces weekday capacity. The compensation follows the "Pure Incentives" model including weekend differentials for all visit rates and also includes a payment rate for case management. The position is pro rata to fully fringed including PTO days.

The most successful clinical model to embrace the Pure Incentives compensation model, including a "Weekender" program is Primary Nurse Care Management. Knowing that the vast majority of RNs and PTs prefer to case manage their own patients and have true ownership of their clinical outcomes, agency management should strongly consider employing a Primary Care Management model, if a different model is in place. Strong supervisory staff and quality personnel overseeing this model creates accountability and enforcement of agency clinical processes and procedures produces increased case capacity, productivity, clinical outcomes, increased staff earnings and financial outcomes for the agency.

The primary nurse admits, recertifies and discharges the majority of the patients on their census, unless on weekends and performs most follow-up visits. The primary nurse prepares the plan of care in coordination with the completion of the OASIS and conferences with the primary physician.

Clinician Responsibilities (without Telehealth)

- Clinician manages 25 - 30 patients
- Responsible for entire "episode of care"
- Makes home visits per need/plan
- Consults with ordering physician
- Updates care plan & medication changes as changes occur
- Communicates with all disciplines involved with the patient at least weekly (e-mail, voice mail)
- Designated "high risk" patients are contacted daily
- Completes OASIS within 24 hours of admission
- Documents daily all visits provided, telephone contacts and conferences
- Attends care conferences (remote or face to face) as directed
- Monitors outcomes
- Prevents unnecessary hospitalizations
- Targets interventions for improvement

Clinician Responsibilities with Telehealth

- Clinician manages 30-35 patients
- Reviews tele-monitored vital signs daily
- Makes home visits per need/plan
- Consults with ordering physician
- Makes care plan & medication changes as needed
- Makes telephone Care Call visits on monitored patients with two or less visits per week at least one time weekly

- Communicates with all disciplines involved with the patient at least weekly (e-mail, voice mail)
- High risk patients are contacted daily
- Completes OASIS within 24 hours of admission
- Documents daily all of the provided visits, telephone contacts and conferences
- Attends care conferences (remote or face to face) as directed
- Monitors outcomes
- Prevents unnecessary hospitalizations
- Targets interventions for improvement

It is worth examining creative approaches to compensation that align the incentives for clinical caregiver staff with the goals of the agency for improved recruitment and retention, Homecare Compare scores and financial outcomes. Change can be a challenge, but Value Based Purchasing will be a challenge and the preparation time is for this transition is today.

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