91 IDEAS FOR REDUCING COSTS, ENHANCING REVENUE, AND MAINTAINING QUALITY IN NURSING HOMES

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INTRODUCTION

This document is a tool. Just like a socket wrench or a can opener, it is a tool developed for a specific purpose. This tool was developed to help nursing home staff do their job -- to help them provide high quality care to those in their facility. It is a tool for individuals who are working in nursing homes and are concerned about the quality of care that they provide. It is a tool for those who want to understand how to reduce costs or increase revenues without affecting the quality of care that they provide. It is a tool for those who are uninterested in reducing total costs but are nonetheless seeking ways of "freeing up" or generating funds to support innovations in care. It is a tool based on interviews with facility staff in six nursing homes in New York City that were identified as higher quality facilities.

The manual offers ***91 examples*** of how these facilities tried to reduce expenses or enhance revenues without adversely affecting the quality of care that they provide (see Chapter 3). It offers ***5 lessons*** in how cost containment and quality monitoring should be done to effectively deal with financial issues while still meeting residents' needs (see Chapter 1). It offers ***7 case studies*** of how cost reduction lead to better quality of care in our study facilities (see Chapter 2).

Two of these 91 specific ideas, or two dozen of them, may be applicable to any individual facility. It doesn't really matter. What does matter is that those reading this manual develop a certain perspective on cost and quality issues. That perspective is a simple one – ***Providing high quality care is the primary goal, and quality of care is not always directly tied to the cost of care. Better quality can mean higher costs. It can also mean no change in costs. It can also mean lower costs.***

The examples in this manual are a testament to that perspective. They are not a testament provided accountants, consultants, or regulators. Instead, they are a testament that comes from those with the everyday responsibility of caring for the frail and disabled in nursing facilities.

CHAPTER 1:

ADMINISTRATIVE AND FINANCIAL

"BEST PRACTICES"

In the early days of industrial development in this country, the emphasis in management was on finding the "one best way" to do each task. Managers quickly discovered that even in the smallest matters of industrial production there simply was no one best way to complete a task. In the production of a complex "product" like good quality of care in nursing homes, that reality is even more evident. In the course of our site visits, we did not come upon the "one best way" to maintain quality in an environment where resources are becoming more scarce. We did learn a great deal about the variety of ways that higher quality facilities are responding to the challenge of shrinking resources. We also learned how critical it is for facilities to assure that residents' needs are constantly considered in any attempt to deal with these financial issues. Finally, we learned that facilities must constantly monitor and evaluate the effects of all changes on the quality of care and quality of life in the facility.

In this section, we offer a picture of what might be considered "best practices" in dealing with this new environment. These practices represent our distillation, aggregation, and recombination of what members of the research team observed in the site visits. In some sense, this section contains the lessons that we believe we learned from our discussions with facility staff.

LESSON #1: REDUCING COSTS DOES NOT REQUIRE ONE TO REDUCE QUALITY OF CARE

In Chapter 2 of this manual, we provide a number of examples of instances in which reducing costs or enhancing revenue led to better quality of care. These examples counter the conventional wisdom that quality can only be enhanced through increased costs. The relationship between costs and quality is not always

so straightforward. Our examples imply that there may be many opportunities for cost reduction that do not reduce quality of care. In fact, some expense reduction efforts actually result in better quality of care. The relationship between costs and quality is not fixed. Instead, it depends on the expense reduction strategy under consideration and the ability of the facility to monitor and evaluate the effects of any innovation on quality of care.

LESSON #2: FOCUS EXPENSE REDUCTION EFFORTS BROADLY

The first tendency in expense control is to focus on the largest items in the budget. This, of course, means looking at staffing. More specifically, it means looking at staffing in those areas with some of the largest staffing costs, such as nursing, dietary services, and housekeeping.

This focus means seeking savings in areas that are extraordinarily closely related to residents' quality of care and quality of life in the facility. It is true that facilities often make changes in these areas that seem benign in their impäct on quality. Some cross-training and manipulation of staffing patterns may even enhance quality. However, these are expense areas, because of their direct bearing on resident care, in which it is always dangerous to tread. Such changes must be monitored very closely.

A broader focus in expense control means also looking into indirect expense areas for savings. In most instances, reductions in these areas pose less of a potential threat to quality. For example, we saw facilities generate major savings through reducing administrative costs, joining purchasing alliances, through self-insuring, or through the use of private workers' compensation insurance programs. None of these changes seemed to present even the remotest threat to residents' quality care or life.

LESSON #3: MAKE YOUR EXPENSE REDUCTION EFFORTS SYSTEMATIC

Those facilities that seemed to be the most successful in controlling costs were those that approached expense control in a systematic, institution-wide fashion. Where cost control was part of a systematic approach, rather than dealt with in an "ad hoc" fashion, the implementation of cost control measures seemed the most effective and the evaluation of changes' effects on quality seemed most important.

However, the locus of much of the expense reduction activity seemed to be division directors or department heads. They evaluated their operations and sought ways to reduce costs or worked with administrative staff in the budgeting process to find areas for expense reduction. It was at this level that a systematic process of expense reduction seemed to have its greatest impact. Some facilities involved all levels of staff in expense reduction. These "grassroots" efforts were important for giving all staff a sense of involvement in the expense control process, but they did not often identify major opportunities for cost reduction. Instead, they provided a number of instances of more modest savings. In smaller facilities these more modest savings may be a major factor, but they were less important in the financial picture of the larger facilities.

LESSON #4: USE A BALANCE OF EXPENSE CONTROL AND REVENUE ENHANCEMENT

All of the facilities in which we met with staff used both expense control and revenue enhancement to respond to the resource constraints in their environment. One of the basic realities of the future of long-term care is that reductions in Medicaid reimbursement will continue over the next few years. Expense control in facilities will be important, but it will not be enough.

Facilities may, in the future, have to find new revenue streams to help maintain current quality standards in their nursing home care. Sub-acute care, adult day care, and outpatient rehabilitation services are areas that many facilities are currently entering to develop new revenues.

An ongoing systematic process of identifying new revenue sources would seem to be a reasonable part of each facility's strategic planning process. Now, it seems that such efforts are almost solely the responsibility of Chief Executive Officers; however, the amount of time that they commit to such activities varies considerably.

Lesson #5: Systematically Evaluate All Changes

One of the most disturbing of our findings in our site visits came with our inquiries into how facilities evaluated new expense control or revenue enhancement efforts. In far too few instances did facilities institute systematic evaluations of their innovations. The research team queried staff about the impact of changes on the quality of care and resident quality of life. In many instances, staff had no convincing evidence with which to answer our questions. Unfortunately, one of the most common responses from staff was, "we have noticed no increase in complaints." In the world of long-term care, however, changes in the number of complaints is not a useful measure of changes in quality of care or quality of life.

We also noted considerable variability in the degree to which staff could provide precise measures of the amount saved by any effort. It was not unusual for staff to have only a relatively crude sense of the saving associated with specific changes. Any change, and especially those that might have a impact on quality of care or quality of life, should be accompanied by an evaluation plan. This plan must involve a number of steps. Facility staff must:

- identify potential threats to quality inherent in the innovation,

- talk to staff, families, and residents about the potential change to determine its acceptability and to understand their perceptions of the potential impact of the change,
- identify the measures that will be used to evaluate the effects of the change,
- identify how the changes in costs or revenues will be measured and traced,
- institute the change on a trial basis for a limited time period among a limited number of residents,
- get feedback at the end of that time period from staff, families, and residents on the aspects of quality identified as important,
- estimate how much will be raised or saved by implementing the change, and
- involve staff, families, and residents in the final decision concerning the "roll-out" of the innovation.

We were informed about a number of instances in which exactly this process occurred. Unfortunately, we were also told about a number of changes for which it was obvious that this process had not occurred. In these instances, staff believed that the change had not in any way degraded the quality of care in the facility, but they based their beliefs on surprisingly little systematic information.

CHAPTER 2:

REDUCING COSTS

AND ENHANCING QUALITY

The most important lesson to be learned in this manual is LESSON #1 from the previous chapter -- the relationship between cost and quality in nursing home care is not fixed and must be evaluated anew with each innovation. Depending on the cost item, reductions in cost can enhance quality, have no impact on quality, or reduce quality. But, it all depends. Ideally, an administrator wants to find opportunities to reduce expenses that, when implemented, enhance residents' quality of life and the quality of care that they receive. These opportunities **do** exist. To prove that you can, in fact, reduce expenses and not experience a decline in quality, we begin this manual with seven case studies. These examples come from our study facilities and demonstrate that lower costs do not mean lower quality of care.

Most of the study facilities focused on cutting down on the number of drugs administered, particularly psychotropic drugs. Sometimes the homes were focusing on quality by trying to reduce unnecessary psychotropic drugs and were delighted to find that they also saved money. Often they were trying to save money on pharmacy expenses and were delighted to find that a significant reduction in psychotropic drug use was also beneficial to residents. Some of the homes invested money in the services of experts to help to reduce the use of psychotropic drugs through behavioral programs or more intensive activities programs. However, these facilities believed that not only did these programs improve the quality of care, but the net result was a savings to the facility in terms of lower medication costs and staff time.

CASE #1: CUTTING MEDICATION COSTS LEADS TO REDUCED PSYCHOTROPIC DRUG USE

Recreational activities have been creatively reconsidered at most of the homes. In general, the homes showed a great deal of innovation and flexibility in arranging recreational opportunities for their residents. In some of the homes, there has been a movement away from big, expensive one-shot events to smaller but more frequent and flexible programs on the units. This saves money as well as the staff time needed to transport residents. It also seems to provide the residents with more individual attention. One facility changed from holding large group events to using part-time, young, less experienced staff who hold small group events in the unit's dining rooms. According to the Director of Activities, this saves money and meets the needs of the less mobile residents of the home, who find it difficult to go to an auditorium. The part-time staff are assigned to specific units and know the residents well. One home also allows community groups to use its auditorium at no charge. This is an advantage for its independent residents who may go to all rehearsals and performances.

CASE #2: ACTIVITIES AREA OFFERS SAVINGS AND BETTER PROGRAMMING

One home increased spending in activities and found savings in the long run. It hired a full-time activities person for each unit. This individual has an office in each unit's day room. Although this involved a large initial outlay, the facility believes that it has saved money in staff time because residents are kept occupied all day if they want to be, and nursing staff has more time to do clinical and administrative work. Additionally, staff believe that this has led to savings due to reduced use of psychotropic drugs because therapeutic activity aides can spend time with residents who demonstrate behavioral symptoms.

One activity director saved money by not buying expensive factory-made equipment. She has the maintenance staff build the equipment if possible. This not only saves money, but since the facility is making the equipment itself, it can be customized. For example, a board was built with material specifically for a railroad engineer who is an Alzheimer resident at the facility.

One dietitian used a computer to analyze her recipes. She found that she did not have to offer as many individual servings of vegetables in addition to the entree

CASE #3: SAVINGS IN DIETARY LEAD TO MORE CHOICE AND BETTER NUTRITION

because many of the entree recipes included vegetables. She not only saved money, but she began to actively seek recipes that included vegetables, because she found that more of the residents would eat vegetables when they were included in entree recipes.

Another facility reduced expenditures for food supplements by encouraging residents to eat more of their regular meals. The dietitian did this by making pureed foods more edible and attractive. She bought an expensive food processor and used molds to shape pureed food to look like non-pureed food. She also worked with residents to improve menus.

One of the facilities began to focus on high incontinence supply costs. They found that they were using huge amounts of pampers and blue pads. They cut back on the blue pads, but instituted skin audits to make sure that pressure ulcers did not develop. However, they found that their laundry costs began to soar because of so many wet linens. This led the home to review the need for scheduled toileting and bladder and bowel training for the residents. They increased these activities, which are preferred responses to incontinence, and reduced their costs for laundry, pads, and diapers.

CASE #4: EXAMINING COSTS OF INCONTINENCE SUPPLIES LEADS TO BETTER CARE

CASE #5: COST-EFFECTIVE CHANGE IN LAUNDRY SYSTEM INCREASES RESIDENT SATISFACTION

One facility closed its in-house laundry and sub-contracted it out. This saved the facility a considerable amount of money, and it also led to better quality laundry service for the residents. With the new system, the laundry is now delivered to each room. Less clothing is lost and clothes are now hung on hangers, with a clean mesh bag containing underwear.

One home began to look at residents on restorative rehabilitation more carefully to determine who was ready to leave restorative rehabilitation for maintenance therapy. Because this facility was discharging residents from restorative rehabilitation earlier than it had in the past, this led to an intensive review of the maintenance therapy done on the units. They wrote procedures for unit staff to follow. They gave in-service training to unit staff. This forced the unit staff to accept more responsibility and encouraged them to ambulate residents during evenings and weekends. Now, the physical and occupational therapists, an RN and an aide, conduct "restorative rounds." They look at each resident's record and at the resident to see if there has been any deterioration since discharge from restorative rehabilitation. This facility also makes sure that any ordered therapy begins within a day of a new admission. Prior to this change, because of bureaucratic issues, rehabilitation did not start for five to seven days. Thus, the facility could not charge for it and the resident did not get the needed therapy.

CASE #6: CHANGE IN REHABILITATION GUIDELINES LEADS TO BETTER MAINTENANCE THERAPY

An in-house dialysis program can give treatments to residents in the facility without having to take them off-site, which wastes hours of their time and staff time. Residents who must go out to clinics or dialysis centers need aides to go with them. One facility, which is trying to open an in-house dialysis area now uses three full-time aides a week to take residents to their dialysis treatments. The addition of this service can save money on staff time as well as make things more comfortable for the residents who spend hours in transportation and waiting at off-site clinics.

CASE #7: ADDING SERVICES CAN LEAD TO STAFF SAVINGS AND BETTER QUALITY OF LIFE

CHAPTER 3:

91 MONEY SAVING AND REVENUE ENHANCEMENT IDEAS

This chapter contains a listing of all of the ideas we gathered from our on-site visits. However, let us offer a work of caution before you use any of these ideas. Review Lesson #5 in Chapter 1. This lesson describes the steps that must be taken before any change is undertaken. Especially when dealing with those suggestions that might have an impact on quality of life or quality of care, a detailed plan for involving residents, staff, and families should be in place. A plan for evaluating the effect of the innovation on cost and quality must be in place. Particular care must be observed when dealing with staffing and medication issues.

Below is a quick reference guide to this chapter. It is organized according to major headings and includes the page in this chapter on which the reader can find suggestions concerning each facet of nursing facility operation.

QUICK REFERENCE GUIDE TO CHAPTER 3

MONEY SAVING IDEAS

SUPPLIES

Reducing Laundry Costs and Incontinence Supplies While Improving Care

1. One facility found that it was using huge amounts of pampers and blue pads. It cut back on the blue pads, but instituted skin audits to make sure that pressure ulcers did not develop. However, they found that their laundry costs began to soar because of so many wet linens. This led the home to review the need for scheduled toileting and bladder and bowel training for the residents. They improved their incontinence care and reduced their costs for laundry, pads, and diapers.

Reviewing All Supply Requests

2. In one facility, the Director of Nursing Services reviews all requests for supplies before they are ordered from central supply. The staff must justify orders before supplies are given out. She has asked staff to look at what was being ordered to see if residents' needs are being met. She believes the staff do not think about what is being ordered and how it relates to the residents' needs.

Reducing Unused Supplies

3. A DNS conducts "weekly runs" from room to room on a random basis, looking for unused supplies left by staff in residents' rooms, which must be thrown away if not used. The director has virtually stopped this "storing" of supplies in residents' rooms. The DNS indicated that the facility had reaped considerable savings from this strategy.

Keeping Close Watch

4. Another home allows few supplies on the floors. Staff must request the amount of supplies they need each day. If they need more, then they have to call for them.

Locked Storage

5. One home of about 250 beds saved approximately $500 a month by having a locked storage case for all cleaning supplies, food supplements, and spices and flavorings for food. A supervisor must unlock the storage case, and the employee has to measure out the exact amount s/he needs.

Buying in Small Quantities

6. One home found that buying small containers of milk was cheaper. When the larger sizes were used, there was always milk left over that had to be thrown out. This home also found that buying smaller quantities of saline dressings made more sense; much of the larger size was wasted.

Buying Expensive.

7. Some homes have found that expensive, good quality supplies saved money over inexpensive, poor quality ones. One home had used a cheaper diaper product but found it more cost-effective to use a more expensive product because more of the cheaper product was being used. Another home tried using a cheaper foley catheter drainage bag, only to discover that it frequently leaked.

MEDICATION

Reducing Psychotropic Drug Use: Saving Money and Improving Quality of Life

8. Facilities that reduced psychotropic drug use found that they not only saved money, but they also improved residents' quality of life. Some of the homes actually spent money to help to reduce the use of psychotropic drug through behavioral programs or more intensive activities programs. These facilities believed that not only did these programs improve the quality of care but that the net result was a

savings to the facility in terms of lower medication costs and better use of staff time.

Focusing on Utilization Patterns

9. A pharmacy consultant regularly reviews every medical record. This review is not simply the required review to identify medication problems. It also focuses on reducing the total number of medications and on searching for less expensive alternative medications, which still meet residents' needs.

Buying Medication in Bulk

10. Two facilities are looking into buying some medications in bulk. One is working with a PBM (Pharmacy Benefits Management Company) that gets lower prices from drug companies because it buys in bulk. By working with this company, the administrator believes he will save about 20% of his medication costs. In addition, the PBM will offer even lower prices if a facility will buy only medications from a list of approved medications devised individually for the facility. However, the facility still allows physicians to prescribe medications off the approved list, when they are necessary and appropriate.

Analyzing the Fiscal Impact of the Use of an In-House Pharmacy versus a Contract with an Outside Pharmacy

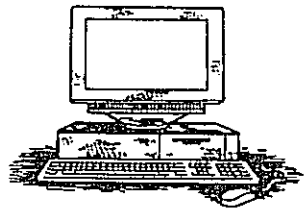
11. Some homes believe that they saved money on an outside pharmacy, while others believed that they saved with an internal pharmacy. One administrator believes that you pay top dollar for drugs outside the facility and that if she used an outside pharmacy, nurses would end up doing more reviews of medications. She also believes that the in-house pharmacy helps keep down the number of drugs.

Formularies

12. Some of the facilities used formularies, or lists of approved or preferred drugs which are dominated by generic, over-the-counter drugs and less expensive antibiotics, rather than more expensive brand name medications. Some facilities had a list of medications that were very expensive, and physicians were not allowed to prescribe unless approved by the Medical Director. The facilities indicated that less expensive drugs are only substituted if resident outcomes were not affected and if a resident was accustomed to a specific drug and wanted to remain on it even after

being informed of alternatives, the medication would not be changed.

COMPUTERIZATION AND AUTOMATION



Linking Clinical and Financial Information Systems

13. One nursing home has a large vendor that links both clinical and financial information systems, which saves time and money on inputting documentation. The system captured itemized services and determined charges for each unit as well as helped with the necessary documentation for the case-mix project in which the facility is participating.

Automating Departments

14. One facility has its therapeutic recreation department completely automated, and the documentation for activities has improved considerably, while the time required for documentation has been reduced.

15. This facility also has an automated time reporting system. "Instead of manual time cards, we have automated the time system. We had to purchase the machinery, but we were still able to realize cost and time savings and eliminated half a clerical position."

Automating Cost Reports

16. One CFO automated all cost reports to improve the flow of paperwork. The reports are now finished one month prior to the due date.

Voice Mail and Automated Switchboards

17. Facilities that have implemented automated switchboards and voice mail indicate that these systems have saved money and freed administrative and professional staff for other tasks.

Bar Coding

18. Facilities are exploring bar coding to provide them with better inventory control and allow them to cut down on supply inventories.

Banking Changes

19. One facility decided to change the way they do banking for their employees. "We brought in ATM machines to do payrolls. This allows employees to put their money right into their account or the account used by the facility. This saves money because there is no paycheck and no bank reconciliation. We used to hire a truck to bring cash for those employees who wanted cash. Now they use the ATM machines."

Reducing Redundant Documentation

20. One facility made a concerted effort to reduce redundant documentation. This facility discovered that many forms were redundant and found ways to eliminate the unnecessary documents. The facility created a standardized chart for CNAs that includes everything about the resident and the tasks they need to do to assist the resident. Using the forms saves time and holds the CNAs accountable for tasks.

PURCHASING AND MAINTENANCE SERVICES

21. Most of our homes reviewed all of their service contracts frequently and renegotiated each contract before they were renewed. One large home renegotiated a contract for waste removal, cut its cost in half, and saved $30,000.

LAUNDRY

Contracting Out Laundry: Using "Caps"

22. Two of our sample facilities found that using contract laundry staff on-site saved money and improved its service to residents. One home closed its in-house laundry and subcontracted out its laundry services. The administrator then worked out a contract that included a cap on the total laundry costs. If the costs come in under the cap, the vendor keeps the excess; if the costs come in over the cap, the loss is shared between the vendor and the facility. This saved this large facility about 10 percent of its costs, or about $80,000 a year. In addition, this change also led to better quality laundry service for the residents. With the new system, the laundry is now delivered to each room. Less clothing is lost and clothes are now hung on hangers, with a clean mesh bag containing underwear.

Eliminating Lost Laundry

23. One home hired a part-time "clothing coordinator," who makes sure that the residents' clothing does not get lost. This has freed up professional staff who used to spend time looking for lost clothing and made residents and families much happier.

24. Another facility began a sophisticated labeling system that reduced the amount of lost clothing.

HOUSEKEEPING

More Efficient Machines.

25. One facility bought better, more efficient machines to clean floors. The machine saved time and prevented accidents.

More Effective Staff

26. Another facility added an executive housekeeper and eliminated one supervisory housekeeping position. This home used to have "maid" and "porter" positions. By

30. Another dietitian deals with the high cost of food by discussing her concerns with the residents and trying to satisfy their needs and desires. For example, the residents wanted "lox." Because lox is salty and expensive, a compromise was reached to use a lox spread. When lettuce cost $4 a head, the residents and the dietitian agreed that it was too expensive to buy. The residents agreed that they would not buy it if they lived at home.

New Systems for Delivering Food

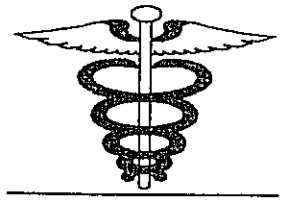
31. One home instituted a new dietary tray system. This new system saved the facility $100,000. The facility converted to a tray system from a system in which they set up trays on each floor from a hot wagon. Before the new system was instituted, the home gave the residents the opportunity to discuss the change at a Resident Council meeting. The benefits of the old system were that it allowed residents to choose what they wanted to eat on the spot; the new system now requires them to make their choices in advance. In order to deal with the problem of residents changing their minds, the home has put in a designated telephone line to the kitchen to change individual orders. In evaluating this change, the DNS said there has not been a significant change in residents' weights, the food is now kept hotter than before, residents wait less time for their food and there is better portion control. The food looks more appetizing.

32. Another facility uses individual trays versus a pellet dish and saves money.

In-House vs. Store-Bought

33. One dietitian has reviewed the cost of buying food rather than making it in-house. For example, she now buys pre-made coleslaw.

MEDICAL SERVICES



Medical Services Firm

34. One home used a firm that specializes in providing medical staff to nursing homes. The facility Administrator believes that this arrangement saves money. He also believes that, under this arrangement, the facility has the necessary control that is sometimes lost by using individual physicians from the community. However, these physicians do no tasks for which they cannot bill. Thus, they do not attend meetings, and they have a larger caseload than medical staffs who are on a facility's payroll. Such a dramatic change in a critical area like medical services must be carefully monitored to determine its impact on quality of care and quality of life.

Physician Assistants and Nurse Practitioners

35. One home maintains a panel of physicians but also believes that the use of physician assistants and nurse practitioners as physician extenders is very cost-effective. Their salaries are about one-half of a physician's salary. The home has used nurse practitioners as physician extenders for a few years and considers the results very satisfactory

ACTIVITIES

Increasing Spending and Save Money in Nursing Staff

36. One home increased spending in activities and found savings in the long run. It hired a full-time activity person for each unit. Although this involved a large initial outlay, the facility believes that it has saved money in staff time because residents are kept occupied all day if they want to be. Nursing staff has more time for clinical and administrative work. Additionally, staff believe that this has led to savings due to reduced use of psychotropic drugs because therapeutic activity aides can spend time with residents who demonstrate behavioral symptoms.

Moving Away From Expensive One-Shot Events

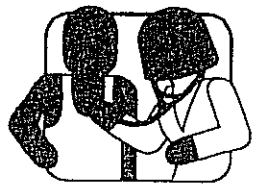
37. In some of the homes, there has been a movement away from big, expensive one-shot events to smaller but more frequent and flexible programs on the units. This saves money as well as the staff time needed to transport residents. One facility changed from holding large group events to using part-time, young, less experienced staff, who held small group events in the unit's dining rooms. According to the Director of Activities, this saves money and meets the needs of the new residents of the home, who find it difficult to go to an auditorium. The part-time staff are assigned to specific units and know the residents well. This home also allows community groups to use its auditorium at no charge. This is an advantage for its independent residents who may go to all rehearsals and performances.

Making Own Equipment

38. One activity director saved money by not buying expensive factory-made equipment. She has the maintenance staff build the equipment if possible. This not only saves money, but since the facility is making the equipment itself, it can be

customized.

STAFFING



Cross-training Staff

39. In one of our study facilities, the Director of Activities introduced a day room program in which specially trained nurses' assistants conducted activities with residents as they monitored the day room on each unit. These staff assisted with breakfast and lunch in the day room and also helped residents in the day room with toileting. But, at all other times, they conducted relatively simple activities planned and developed by the activity staff. Activities staff still conducted more sophisticated activities and special programs on a regular basis in the day rooms. This reduced the need for additional activity staff and used the aides' time more efficiently. Some aides preferred this dual role, while others were more comfortable with the traditional duties. They were allowed to choose, and some continued performing only their traditional tasks.

40. One Director of Dietary Services noted that she had achieved considerable savings by cross-training all the staff in her department. This resulted in savings because staff from one shift can more easily cover for staff from other shifts who do other tasks. Paying these staff overtime for a short period of time was less costly than bringing in temporary staff for a full shift.

41. In another instance, evening and night shift nursing staff did MDS data entry when they were not needed by the residents.

42. In another case, recreation therapists helped feed residents at lunch.

Reducing Administrative Staff

43. One facility replaced its Director of Social Work with a part-time consultant. The consultant runs the family council meetings that occur in the evening. This meant a major increase in the caseload for the remaining social workers. However, the effects of this increased workload were mitigated by moving the social work offices onto the units themselves. In addition, this change occurred in a facility that added recreation staff to each unit. The administrative staff believe that this has reduced some of the need for social work activities in the facility. The social work consultant, who comes in one day a week for 8 hours, helps the staff social workers with any problems with the residents. The consultant reviews the social worker's notes and paperwork on the residents and assists with the Resident Assessment Protocols. Also, the social work consultant is responsible for keeping abreast of requirements and informing the social workers of any changes. The staff social workers now report directly to the part-time social work consultant, but they also report indirectly to the Administrator and Associate Administrator on the days when the social work consultant is not physically present at the facility.

44. One facility no longer has a Human Resources (HR) Director. Instead, the Associate Administrator now serves as the HR Director. HR staff maintain the day-to-day activities in the department, but they report to the Associate Administrator, who now is responsible for HR policy and union negotiations.

45. In one facility, the Director of Activities assumed, because of a reduction in force in 1995, direct activity responsibilities in addition to her administrative duties.

46. In another facility, the Director of Nursing Services is now responsible for training and education.

47. In one faclity, a policy was developed whereby all nursing administrative staff had some direct care responsibilities. The facility also reduced its number of unit coordinators by one-third, giving some coordinators responsibility for multiple units. They did this by taking many of the documentation and paperwork responsibilities of the unit coordinators and placing them with lower cost administrative staff.

Staff Retention

48. A number of the facilities noted special programs or special care taken to enhance retention. They tried to meet staff needs as much as possible, being as flexible as possible with shifts and keeping an open-door policy for staff. High

retention reduced staff training costs and supervisory burden, and was thought to have a positive impact on the quality of care in a facility.

Changing Shift Times

49. One dietitian analyzed the activities of her staff throughout the day. She then changed the shift hours from 12:30 p.m. - 8:30 p.m. to 12:00 p.m. to 8:00 p.m. This change did not result in a reduction in staffing levels, but it did reduce staffing costs. The facility no longer had to pay dietary staff at a higher rate for that portion of their shift from 8:00 p.m. to 8:30 p.m.

Sharing Administrative Positions

50. Some facilities are in a special position in that they are part of a multi- facility system. These facilities can often minimize administrative and clerical costs by having administrative staff serve more than one facility. One of the facilities in the study uses this strategy with its Director of Social Work and with clerks in its administrative division. Each does the same job at two different facilities.

Use of Volunteers, Students and Special Sources for Staff

51. One of the study facilities makes it a practice to recruit volunteers through local businesses. The businesses sponsor events for the residents (e.g., a bank does an annual casino night and another business provides theater tickets) and the business's employees work with facility staff in preparing for and conducting the activity.

52. One of the study facilities has a long-standing relationship with a local CNA training school. Students work as volunteers at the facility as part of the internship required by their course of study. These students will often continue their volunteer activities after completing their course of study, recognizing that this makes them more marketable candidate for any job openings that might occur at the facility.

53. Another facility has a long-term relationship with a social work program at one of the local universities. Students do internships and practicums at the facility.

54. Several of the facilities in the study look for ongoing governmental programs for special populations and use these as a source of volunteers. These individuals aren't true volunteers in that they are paid, but their pay comes from some agency external to the facility. In one instance, a facility used individuals involved in a youth employment program. The youths worked as transport aides and in a variety of other roles in the facility.

55. One facility worked with a program attempting to mainstream individuals with developmental disabilities. These individuals worked in food service, in housekeeping, and in maintenance, with their salaries being paid by the mental health program, rather than the facility.

Daily Variable Staffing : Staff Allocation Chart

56. One Director of Nursing Services (DNS) has a regular day shift complement of nurses that includes two agency nurses who work regularly at the facility and know the residents. The DNS can use these nurses, or cancel, on a daily basis. She also makes daily decisions about whether to replace aides or other nursing staff from evening and nightshift who call-in sick. She makes these decisions on the basis of a staff allocation chart that gives her a picture both of the staffing on each unit and of the level of resident need on each unit. The chart includes the unit identification number, its staffing, its census, the number of bed holds on the unit, the number of vacant beds, and the number of residents requiring special care (e.g., case-mix index for the unit, finger sticks, tracheostomy care, dialysis, oxygen, skin care for pressure ulcers, etc). The DNS uses the information on this chart, which is updated daily, with her clinical judgment concerning the minimum and maximum staffing levels for each unit, to decide whether to use agency nurses, call for extra aides, or pay overtime to facility staff to maintain appropriate staffing levels.

"Tailored" Staffing

57. In one instance, a facility was able to maintain five nursing assistants (CNAs) on a 40-bed unit on the 7 a.m. to 3 p.m. shift instead of hiring a 6th aide by modifying its staff patterns. Since breakfast time was not a major issue on the unit because residents were allowed to have breakfast in bed or in the day room, administration believed that it did not need 5 aides at that time. However, the administrators recognized both lunch and dinner as more demanding for staff. So, one aide was taken from the 7-3 shift and was given a 9:30 a.m. to 5:30 p.m. schedule. This CNA was originally assigned to specific residents, but, from this facility's experience, the best role for the CNA became freeing up the time of other CNAs by assisting with

ambulation, toileting, and helping with rehabilitation and exercise. While staff initially sought this position eagerly because of the change in hours, they soon discovered that it was a demanding shift. So, the administration offered the CNAs working the 9:30-5:30 shift, the incentive of no weekend assignments. Not only was this facility able to keep its aide numbers the same, but other benefits accrued as well. First, the facility no longer used "part-time" staff to supplement aide staff at meals. These staff were costly in that they were difficult to find, hard to retain, difficult to replace, and inefficient in terms of costs. All they did was assist residents with eating, but it was impossible to hire them for just the hour during which residents were dining. In addition, they were a poor alternative to a better-trained staff person who could do multiple tasks and knew the residents well. Second, the administration believes that the residents' accident rate was reduced by this change. This rate tended to rise at shift change when there was a complete turnover in staff. Now, with the 9:30- 5:30 staff, there was greater continuity and care coordination between the two shifts.

Better Use of Staff

58. In another facility, a reduction in aide staffing, tailored staffing and a change in laundry service combined to generate substantial savings. Previously, laundry was done in-house and could only be sorted by floor. Thus, night shift aides spent a considerable amount of their time sorting the laundry for the individual residents and dealing with laundry issues. The laundry is now done by a subcontractor, who delivers laundry to each individual resident. This change to a laundry subcontractor, which saved money in and of itself, also allowed the facility to reduce the number of aides on the night shift by one per floor (the aide who was busy sorting laundry all night). A single night shift CNA for each floor was assigned a new shift from 5:00 a.m. to 1:00 p.m., to be sure that direct resident care in the morning did not suffer. Since this change eliminated more than 10 FTEs, it is the type of change that must be carefully evaluated for its effect on quality of care.

Part-Time Staff at Peak Hours

59. Another facility did not change its allocation of full-time staff, but implemented a program that utilized part-time staff. The facility reduced its full-time aide staffing and supplemented the full-time staff with part-time staff at critical peak hours to assist with toileting, feeding and transportation. How well these staff are trained and how well they know the residents they care for is a crucial issue in evaluating such a strategy.

Changing Professional Mix

60. Some facilities have changed their mix of MSW and BSW social work staff. The more clinical work is the responsibility of the MSW staff, while the BSW staff assist with discharge planning and entitlement counseling.

Using Technology to Reduce Staffing Costs

61. One facility had day shift unit clerks on each unit, who were CNAs. These individuals were responsible for record-keeping, filing, and other administrative tasks. The facility studied the activities of these staff, centralized these staff in a Medical Records Unit, and introduced computers. The facility has been able to return one quarter of these clerks to hands-on care on the units.

62. Another facility eliminated one clerical FTE by computerizing part of its operations. Rather than having supervisory or administrative staff provide information to the clerk/typist who would then complete a form, the forms were computerized and the supervisory staff simply used a computer to complete them.

63. Computers also helped another facility cut down on their infection control nursing staff. They determined that one infection control nurse was largely engaged in reviewing records and compiling and transcribing data, while the other played a more directly clinical role. The record-keeper's position was eliminated. The remaining infection control nurse now carries a laptop computer and enters data on infections into an electronic data base as she makes her rounds and continues her clinical activities.

WORKER'S COMPENSATION

Changing to Private Insurers and Negotiation

64. Two facilities changed from the State worker's compensation plan to private insurers. One of these facilities saved $300,000 a year by changing from the State Insurance Fund and the other reduced their workers compensation cost by one-third.

65. One facility saved $150,000 by renegotiating their premiums with State worker's compensation insurance fund.

Appealing

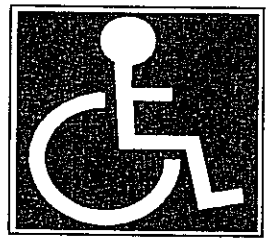
66. Another facility went through an appeals reimbursement process to show that worker's compensation was understated on the facility's cost report in the year. This facility recovered $600,000.

Rebidding

67. Some facilities also re-bid their insurance policies frequently in order to maintain competitive rates. One of these facilities maintains a one year contract with its insurers to maintain maximum flexibility and create a competitive situation among insurers.

68. Another facility consistently works with two or three insurance brokers, each of whom represents multiple companies, and signs only annual contracts. They believe that the prices generated by this ongoing competition among potential insurers outweighs any costs reductions that would be generated by multi-year contracts with a single insurer.

REHABILITATION AND MAINTENANCE THERAPY



Encouraging Maintenance Therapy

69. One home began to look at residents on restorative rehabilitation more carefully to determine who was ready to leave restorative rehabilitation for maintenance therapy. Because this facility was discharging residents from restorative rehabilitation earlier than it had in the past, this led to an intensive review of the maintenance therapy done on the units. They wrote procedures for unit staff to follow. They gave in-service training to unit staff. This forced the unit staff to accept more responsibility and encouraged them to ambulate residents during evenings and

weekends. Now, the physical and occupational therapists, an RN and an aide, conduct "restorative rounds." They look at each resident's record and at the resident to see if there has been any deterioration since discharge from restorative rehabilitation.

ADDING REVENUE

MAINTAINING A "GOOD" REPUTATION INCREASES NEW ADMISSIONS

70. One administrator believes that it is important to maintain quality. If the product is good, it will sell. This facility often spends money to make money, and it is very concerned about delivering good care. This is a facility that is making a profit as it focuses on quality care. "Running a quality operation is just as profitable as running a non-quality home."

REHABILITATION THERAPY

Beginning Therapy Immediately

71. One facility makes sure that any ordered therapy begins within a day of a new admission. Prior to this change, because of bureaucratic issues, rehabilitation did not start for five to seven days. Thus, the facility could not charge for it and the resident did not get the needed therapy.

ADDING SERVICES

In-House Dialysis

72. In-house dialysis can give treatments to residents in the facility without having to take them off-site, which wastes hours of their time and staff time. Residents who must go out to clinics or dialysis centers need aides to go with them.

Adult Day Care, Home Care, Assisted Living

73. A number of the facilities are either operating adult day care centers or are thinking of adding this program as well as home care services and assisted living services. In addition to the added revenue, the homes are concerned about being part of a "network" so as not to lose potential residents.

Offering a Continuum of Care.

74. The addition of services that constitute a continuum of care may enhance revenue as it offers residents more choice, serves residents needs and adds more qualified staff. IV therapy, for example, allows facilities to keep nursing home residents in the facility instead of transferring them to a hospital if they need acute care. Hospice services offer death and dying comfort to residents in their home.

REVIEWING RATE SHEETS.

75. One CFO believed that many facilities too readily accept their Medicaid rate. He carefully reviews rate sheets to determine if the rates are correct. If anything looks wrong, he will file an appeal. Another facility said that errors have been found in the rate sheets.

COMPUTERIZING COST REPORTS

76. Computerizing cost reports has also helped facilities find the best method of cost allocation.

INCREASING MEDICARE.

Adding Skilled Nursing Services

77. The facilities are adding short-term rehabilitation, IV therapy, weanable ventilators and other "sub-acute" services; and they are joining the Medicare case-mix demonstration project.

Offering Medicare Part B Services.

78. One facility had been contracting out Medicare Part B services. A recent NYS court decision in the case of James Square Nursing Home, Inc. vs. Brian Wing as acting commissioner of the Division of Social Services ruled that "Medicaid Agencies can only recover to the extent that the third party is liable for the services and to the extent that Medicaid actually paid for the services." This facility is therefore going to begin to offer its own Medicare Part B services.

JOINING THE RUSH TO MANAGED CARE

79. Some of the facilities offering "subacute care" are doing so to take advantage of the current lucrative reimbursement from managed care companies. A few of the facilities are negotiating with managed care companies so they are not excluded from the currently developing care networks. Making certain that care for traditional longer-stay residents does not suffer because of this change in emphasis is an important issue in evaluating this strategy.

80. One facility has joined with other providers to create an independent practice association (IPA) that is a limited liability corporation of shareholders. This association will negotiate with managed care companies on behalf of all of its providers. This facility believes that by being proactive rather them to be reactive they can limit the amount of individual rate negotiation that will limit managed care reimbursement.

Marketing the Facility

Publicity

81. One facility focuses on getting publicity for any innovative programs.

Increasing Communication Between Home and Hospital

82. Some facilities have hired staff specifically to work closely with hospitals. One

facility hired a nurse screener who goes to hospitals on a regular basis to evaluate potential residents. This home has also tried to work with hospitals in creative ways. For example, the facility may accept a resident who may not be able to go home with covered home care hours, if the hospital agrees to accept some of the risk by covering some of the home care costs if necessary.

83. One home regularly invites discharge planners to tour the home and stay for a luncheon and an educational program.

CHANGES IN ADMITTING PRACTICES

Going Out and "Getting" Residents

84. One facility has changed the way it does business. Instead of waiting for a call for a new resident to come in, staff now go out and seek residents by visiting hospitals and potential residents and family members.

Maximizing Reimbursement

85. Admitting staff are now focused on maximizing reimbursement. One facility is very careful whenever it admits a short-term rehabilitation resident. It tries to make sure that the individual has a home to go back to after rehabilitation.

86. Another facility has an Admissions Coordinator who carefully tracks the acuity level of potential new admissions.

87. In another facility, the Director of Nursing Services reviews all PRIs for all admissions.

88. Most facilities carefully examine source of payment before admitting anyone. One facility makes sure that there is a source of funding available after the first 20 days of Medicare when a co-pay is required for a continued Medicare SNF stay.

FOCUSING ON FUNDRAISING

Foundations and Corporations

89. Some facilities have looked to foundations and corporations for grants to support new programming and staffing strategies.

State Demonstrations or Grants

90. Some have participated in State demonstrations or grants.

Development

91. A number of the facilities are involved in the current Medicare case-mix demonstration. One home has started a new development office that will focus on large grant funds of $300,000 to $400,000 a year.