“Surviving the Productivity Push” – BLOG POST

By nicespeechlady.com / August 19, 2018

This was not a post I wanted to pen. However, I often am asked about my thoughts on productivity. As an industry, there has to be a better way to balance quality with the ever-pressing quantity struggle.

However, this post is not about the ethics of having a productivity requirement, or trends in different specific number criteria across the country. It is about finding perhaps an idea or two that may be new to us to assist us in our current productivity struggle, or in preparing clinicians who are just starting out in the skilled nursing facility world. With the current standards for productivity in our industry, listed below are helpful suggestions in surviving – and perhaps even thriving – the productivity push. Also listed are factors that are out of our control, and what to do about them.

Beating the productivity game

New day, new schedule printed off. The same productivity requirement looms over us. What little changes can be employed to make a big difference in not feeling panicky between each patient? What can we do in order to not feel like we have to choose between going to the bathroom throughout the day, and meeting productivity criteria?

Listed are some brainstorming ideas:

• Start the day out performing evaluations. The benefit of this is that if there happens to be “down time” between patients that you do not have control over, you could work on finishing up documentation on start-of-the-day evaluations and make the best use of “between patient” times. Sometimes, a patient may be in the restroom, or finishing-up speaking to dietary prior to a session, or they may need to receive an injection in the middle of a session. If you start the day performing evaluations, then you have all of the data needed to document upon, and this creates an opportunity to “slip in” the finishing touches on evaluation documentation, if such out-of-our-control opportunities arise.

• Look to see which patients have outside appointments first before deciding when to see each patient. Dialysis and other medical appointments can interfere with patients’ availability, so check-in at the start of the day on exceptions to availability for the day.

• Have a system for “checking-off” documentation and other tasks that are needed. From crossing out a name after a visit has occurred, to putting a check mark after the name once the note is written, etc. – some type of system to stay organized for the tasks at hand is helpful.

• For facilities with multiple hallways or floors, you can attempt to see all patients on a hallway, back to back – in order to minimize time between patients. Opting to see patients in their rooms over transporting them to an office will save transition time, helping productivity.

• Point of service documentation. One way to still engage and provide point of service documentation is to educate the patient on what is being documented upon as it is being typed or clicked. “Mr. Jones, I am writing that during this session, you improved in your ability to remember information that was presented five minutes prior at a higher level than last time – without any help. Before it was 60%; today is was 80% — you did a great job on meeting this goal today. Now we are going to shoot for ten minutes.” It can be a benefit to allot the last five minutes each treatment session for documentation. Explaining to the patient why tasks were conducted, the importance of therapy – or “next-steps” are all skilled services and can be discussed during point of service documentation. A suggestion is to frequently “check-in” via eye contact while talking during documenting — so to not have the patient feel like we are ignoring them.

• Perform all caregiver training with patient present, so it is billable. If possible, shoot for having the patient present for all education to staff, family, caregivers, etc.

• Get familiar with other disciplines’ and other clinicians’ short-cuts on documentation in general.

• Have a frank and honest conversation with your supervisor, stating all that you are doing for improving productivity and ask for more ideas (so they know what all you are trying to do).

• Document in a retrievable place all of the details on the days you did not meet the requirement, and keep it stored away for covering yourself. For example, if productivity was not met due to a patient experiencing a fall, and you were assisting nursing with care — this impacted productivity. Keeping a log will be beneficial.

• Have an understanding with your supervisor about what to do if you “go over” time on a patient, and how to document this. At times, it is difficult to obtain exactly 45 minutes of treatment time – and keep the flow and quality of therapy optimal. Find out your facility’s policy on if you go over 5 minutes, for example, for necessary training.

• Stay away from “chit-chatters” in the office. If needing to collaborate, do so with productive time, with the patient present (if possible).

• For evaluations, find pictures of the patient in the electronic medical record if possible before searching for them, so you their identifiable physical features – if they are not in their rooms.

• Know preferences of patients – who is likely to prefer mornings, etc. Know which patients are going to be amenable to early-morning visits, and who would not want to be seen at the end of the day – and plan accordingly.

• Group insurance-indicated "group-able" patients once a week. Check with your director of rehab on which payor sources allow for this in your area. Grouping involves more than one patient with similar goals and all patients in the group are performing similar tasks, but at their own levels. Only 25% of the time can (insurance qualified) "group-able" patients be grouped, depending upon the policy, and only four patients can be allowed in a group. One option that clinicians consider is to have holiday group days, or each Friday. For SLPs, each Friday, you may want to have a dysphagia group, a communication group, or a cognitive-linguistic group. Take care to use the group code when billing. To aid in setting up the group, ask a therapy technician to help gather the patients for you about 15 minutes before group is about to start. One way to let all of the therapy staff know that patients are scheduled for a group is to post in the therapy office which patients are set for what time (to ensure another discipline doesn't plan to see them at the same time). Documentation will need to occur outside of the group typically for logistics' sake. At the start of the group, ask each patient (if they feel comfortable) to introduce themselves, why they are here and one interesting thing about themselves. Then, conduct the indicated therapy tasks. If it is a dysphagia group, everyone can perform the same exercises together. If it is a cognitive or communication group, a game-based format tends to be helpful, with the indicated therapy tasks being conducted before each patient's turn. When closing out the group, ask each patient to share one thing they enjoyed from the group, and one thing they are thankful for. Group sizes can vary, but sometimes, a four-patient group can be a fun change for patients who are used to one-on-one therapy. Plus, it aides in productivity results.

• Concurrent therapy – do it when possible, if allowed by insurance. Check with your director of rehab on which payor sources allow for this in your area. Concurrent therapy is different from group therapy in that only two patients can participate in a concurrent therapy session. As well, the tasks need to be different in nature – different goals, different areas, etc., need to be addressed. One patient has a turn in performing a therapy task, and then is asked to perform another task independently while the other patient then has a turn, etc. — and back and forth, and so on. Performing writing tasks and other visual tasks can aid in working on goals while each other patient is being assigned a task or receiving the turn in therapy. This allows for patients to work on skills they are becoming independent in, but in a safe environment and can receive assistance if needed. There is typically not a ceiling in the amount of time allowed for concurrent therapy.

• Have awareness of where the bathrooms are located, in relation to schedule timing.

• If you need to talk to nursing about a patient, if possible, ask that the patient come with you — in order to remain in billable time.

• Perform diet changes and other documentation as an education opportunity with the patient.

• Become great friends with the other therapists, therapy assistants, dietary, nursing and CNA staff. Fostering these relationships will aid you in a pinch when you need a favor to stay on-track, scheduling-wise.

• Take breaks, eat lunch – take a breather. Mandated breaks are just that – mandated. Self-care will assist in productivity.

• Keeping track of time via a timer or other method will allow the focus to be on the therapy at-hand and not time management.

• Establishing a system for figuring up at the end of the week how productive you need to be on the last day in order to meet the weekly productivity total can be helpful.

Factors out of our control — and what to do about them

Oftentimes, if the “stars do not align,” it nearly always impacts productivity. Listed are factors out of our control — and what we can do in response:

• Patient on isolation precautions. If a patient is on isolation precautions, point of service documentation is not possible, as exposure would want to be kept at a minimum. In response, concise documentation would be a benefit, after the session.

• Patient is with another discipline when we are ready to see them. If there are no other patients to see, the option to co-treat may be requested — if there is a therapeutic benefit to a co-treatment. Sometimes, other therapists may be amenable to co-treating the rest of their visit time.

• Refusals. Educating the patient on the benefits of participating would be in order for a refusal, as well as the potential negative consequences of not participating. Making therapy fun, making it light – might turn a patient’s decision around if they know that the session will be full of laughs and meaningful interactions.

• Rest-rooming. Taking care to use the restroom prior to clocking-in is helpful. Finding a restroom that is used less frequently and scheduling the day around that location may be of benefit.

• The meal-time factors. Needing to perform a swallowing evaluation during a non-meal time frame can be a challenge. Scheduling swallowing evaluations during meals would be optimal, but it is not always possible. Asking the dietary staff for a trial tray with all of the various consistencies can be requested outside of mealtimes for evaluation purposes.

• Patients cannot be found in the building. Asking nurses, and the other therapists and assistants on the schedule that see the patient for the day is one approach in locating roaming patients. Also, getting to know the patient's frequent "hide-outs" helps.

• Sickness in patients. Patients sometimes experience sickness on top of the qualifying medical event which landed them in a SNF. It may be of benefit to establish in advance how to modify the sessions so to accommodate participate in the midst of sickness, as well as minimize contact so to avoid transmission of the illness. Having a plan in advance will aid in reducing the chance of a refusal from the patient.

• Fatigue in patients. Oftentimes, patients may desire to refuse therapy due to fatigue and exhaustion from other therapies, or their diagnoses. Offering to have the session with the patient in bed, or another location that will best support participation is beneficial. Offering rest breaks, or breaking up the session in smaller parts might also beneficial.

It is nicespeechlady.com's hope that at least one suggestion out of this list was of benefit to you, in your current productivity course. Perhaps someday there may be a different system for the industry; for now, hopefully this has been helpful.