

Paradigm *shift*

Long-term care
should focus on outcomes,
not just treatment

by **Bill Gillette**



Jerry Rhoads

CEO
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JERRY RHOADS, CEO, Caregiver Management Systems, believes the long-term-care aspect of the U.S. healthcare system is woefully lacking and in desperate need of a major paradigm shift—which is what he and his company have been attempting to do for the past 15 years.

“Real-estate moguls originally organized nursing-home infrastructures to be like those of a hospital,” Rhoads says. “They didn’t design the layout nor the workflow to meet the holistic restorative needs of an aging population—that is, they pretty much saw the business as custodial with medication passes and shots. This is termed ‘warehousing,’ but it should be what I call ‘care-housing.’ This paradigm still exists in 95% of nursing homes and in most assisted-living facilities. The concept is to ‘keep them clean and dry until they die’—a concept that has obviously outlived its usefulness, to say the least.”

MANAGED HEALTHCARE EXECUTIVE recently asked Rhoads to discuss, among other topics, how his management ideas might be expanded beyond long-term care to the industry overall.

Q You say your long-term-care management model “brings a paradigm shift in the management structure of nursing homes by offering a higher quality of care at a lower cost.” That’s quite a paradigm shift. How much higher quality—and at how much lower cost?

A First, the term ‘quality of care’ in nursing homes must be defined. The regulators have defined excellence as the avoidance of 11 mistakes facilities make, and assume that if nursing homes are not making these mistakes more than the average

nursing home makes them, then quality exists. In reality, however, a more effective definition of quality relates to serving the patients’ holistic and functional needs: physical, emotional, social and spiritual functioning.

Patients’ needs generally are not being met in the current paradigm because the regulators have not properly defined quality, nor devised a reimbursement system to clearly pay for the pursuit of quality-of-life outcomes. Rather, the system is designed to pay room and board and an average amount for whatever else the facility chooses to do—in other words, the provider is paid regardless of effective quality standards. Also, in most cases, the providers’ current information systems do not lead them to the right conclusions and they underbill Medicare for restorative care and overbill Medicaid for medical care. This is a tactical error on the part of the provider because patients have paid for the Medicare insurance and aren’t getting the appropriate coverage—then they get transferred to a Medicaid status and still don’t get what they need.

Our management system organizes care around what the government is required to pay for, then makes sure it all gets billed correctly. Our system sets up assignments for the staff so they are more efficient and effective, which reduces cost per case. All of this focus results in a better quality of life for the patients, and it also provides \$300,000 to \$500,000 more in Medicare resources per year to the provider while saving Medicaid at least one-third that amount.

Q What are deductive-restorative services? Do all reputable facilities offer customized patient-treatment programs? Describe the team concept and how it contributes to better care at a lower cost.

A The typical nursing department has care plans to fulfill a regulatory requirement but do not use them to direct,

document and justify the bill for care. Their approach is inductive in nature since they do not pursue outcomes—rather, they pursue treatment.

Our deductive approach means that for each assessed patient problem there is an outcome destination established in the care plan and all interventions are designed to pursue that end. The staff is held accountable to these higher standards through their documented interventions, and from this organized structure the staff is much more efficient and productive in their pursuit of quality-of-life goals.

This nuance allows the organizational structure to go from a departmental basis to a team basis because the care-plan team can now follow a problem-solving process. [Our software] organizes the workflow into interventions by staff type by shift and holds the staff accountable for the delivery of the holistic services. This approach eliminates \$200,000 to \$400,000 in middle-management salaries for department heads who are no longer needed, because the two or three case manager RNs manage the restorative process. It also provides a natural career ladder for the entry-level clinical staff to become nurses, therapists or social workers, thereby improving retention, consistency and performance.

Q Can this management model be applied to other healthcare facilities?

A The short answer is yes. This management model is built on a deductive computer library of care-plan models that involve all clinical disciplines. It is a structure that will work in a hospital, physician's office, home care, hospice care, clinic, surgery center, etc.

Q How would you turn around the U.S. healthcare industry?

A The solution is to first standardize the benefit package for a national

at a glance

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EXPERTISE

Long-term care consulting firm that uses clinical documentation and reimbursement techniques, with its proprietary software and management methodologies, to improve the quality of life for patients in nursing homes while reducing staff turnover and operational waste.

FOUNDED

By Jerry Rhoads in 1991, who also co-founded the Dortha C. White Foundation, which educates families, consumers, government, owners and providers about social, political and payment changes needed in long-term care.

OPERATING MODEL

The Caregiver teamwork model is organized to pursue restorative services and improve a patient's functioning to the highest level so they have a more functional quality of life in the nursing home or even return to community-based care or to their home. Included in the model is the staff advocacy program, wherein a staff member is assigned to a patient for social and communication purposes, and the Ambassador Club whereby patients, staff and families are given the opportunity to point out improvements in care and/or programs.

MOMENT OF TRUTH

November 1987 during a snowstorm in Elgin, Ill. "I was the administrator of a 206-bed skilled-nursing facility in Elgin that was troubled, and it was my job to turn it around," Rhoads says. "For the first six months I probably made it worse—but then we had a snowstorm. It lasted three days, and only half the staff made an attempt to get to work. Because of the staff shortage, we had to devise a different staffing approach, so we organized the staff into teams that would deliver the priorities, such as food, medications and clothing, to our patients. In other words, we focused on the patients. During those 72 hours, we ran the facility better than we had with the whole complement of staff. There was no turnover, no absenteeism, no griping, no in-fighting—everything worked."

healthcare policy, then coordinate the benefits with the payment system so that it is based on the delivery of preventive and restorative services. The administration of this program cannot be done by a governmental agency because it will not live up to the letter of the law and will continue to use enforcement tactics, not education and nurturing for quality improvement. Money will continue to run healthcare until we make a commitment to only paying for proven outcomes. Private companies would set the individual premiums, manage the personal savings accounts of and pay claims for the insured, thereby taking the employer out of the loop.

At the same time, providers must be paid for outcomes. Consumers must

bear their own healthcare cost themselves and be given 100% tax deductions for staying fit and healthy. Those who are not making the effort to do this will pay more in premiums.

Finally, Medicare should be retained for catastrophic and chronic care and Medicaid has to be federalized and reserved for the uninsured. The spend-down of personal assets to get approved for Medicaid services must be eliminated. Self-reliant taxpayers must pay for their own healthcare costs by buying long-term-care insurance as a withholding item from their paycheck—otherwise, the abuse of dumping of assets to get on Medicaid will never get fixed. **MHE**