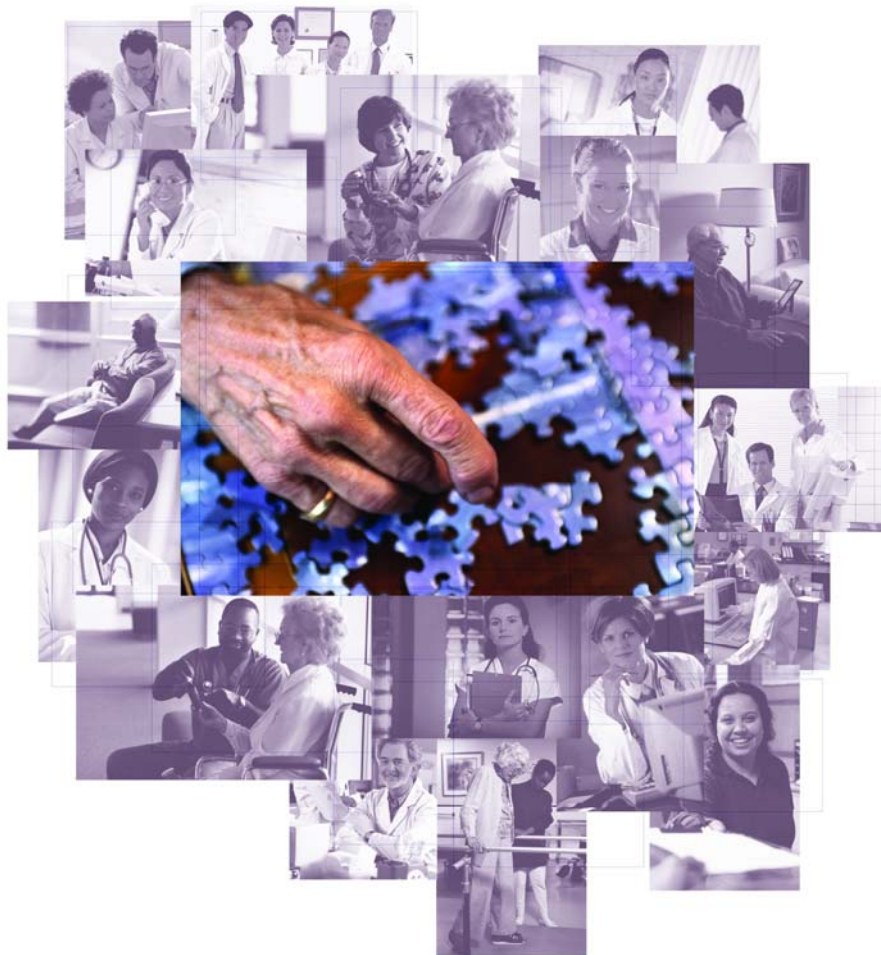


The Mechanics of Quality and Profit in Nursing Homes

The SNF Extreme Makeover



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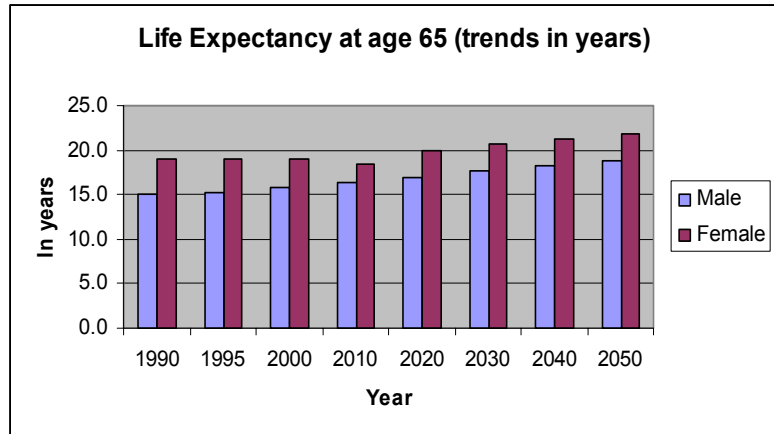
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HIGHER QUALITY AT A LOWER COST IS NOW ATTAINABLE

Nursing homes were originally designed to warehouse people until they die. This philosophy is consistent with the institutional model we have in place today. Now with the numbers of elderly needing long-term care services growing exponentially, the model of care must be one that champions alternative housing for people until they are restored and discharged to a less costly level of care and a more productive quality of life.

For people over the age of 65, there is a 41 percent chance that they will spend an average of 2.5 years in a skilled nursing facility. To meet society's needs, America must have long-term care "flagships" – models of a quality-based culture that put the patient first, and relegate profits to being the result of, not the reason for, being in the long-term care business. Public awareness to such change can only be by our example. Therefore, it's now time for long-term care to get its professional infrastructure organized internally around the case management model, using the following Mechanics of Quality and Profit:



model, using the following Mechanics of Quality and Profit:

- **Service Model:** A restorative service model for optimizing revenue.
- **Staffing Model:** Case management teams for energizing staff morale.
- **Computerized Case Management Systems** for making information visible for reimbursement and documenting outcomes.
- **Case Management Teams:** Patient-centered staffing for improving quality of life.
- **Activity-Based Cost Accounting** that eliminates "hidden costs" by attaining optimal efficiency and productivity.

We'll delineate the components and revisit this business model later in this report. The main point, however, cannot be emphasized enough: Providing high quality care at lower cost *improves* revenue and census growth; *eliminates* wasteful business practices that have sanctioned turnover and absenteeism as a cost of doing business, and *replaces* excess capacity with candidates for restoration and a respectable quality of life in their waning years. The impact on the profitability of the provider is an improvement of a minimum of 25 percent in top-line revenues and a reduction in operating costs of 15-20 percent, all due to the community's awareness of the flagship's excellent reputation and staff competency. This is done by implementing the Price Differential Equation and the Cost Differential Equation:

The **price differential** is accomplished by trading a Medicaid day for a Medicare day of coverage. Under the entitlement provisions of the Social Security Act, Medicare is primary to Medicaid and should be billed for the restorative services after a qualifying stay in the hospital. Most skilled nursing facilities (SNFs) are not billing Medicare to the extent of the law. The average length of stay has declined from 34 pre-PPS to 22 post-PPS. The reason is that the RUG's system of payment has given the wrong impression that coverage is determined by assessment, when in fact coverage did not change and is based on skilled interventions. With only 25 percent of the elderly getting their entitled coverage, there is plenty of room for improving revenue on existing caseloads. This equation is put in place by using the staffing models and Case Management System that are presented later in this article.

The **cost differential** is accomplished by saving staff time on meaningless tasks and improving their productivity by managing their time using the care plan interventions to direct the activities on the floor. The assignments that result from the care plan can be used to direct the workflow and document the completion of the work. This makes the staff accountable for implementing the care plan and eliminates work that is not related to relevant patient care. The ancillary services must also be controlled using formularies that constitute units of cost that are compared to the bills being submitted by the therapy company, the pharmacy, the lab and the hospital for related services so the SNF is not over-charged. This equation is put in place by the Activity-Based Cost System that is presented later in this article.

With this new restorative model and culture in place, flagship profits have no place to go but up.

CULTURAL DYSFUNCTION TRIGGERS NEED FOR AN EXTREME MAKEOVER

In long-term care, there currently are few flagships. Why? Nursing homes are suffering the most disturbing financial decline in history. The federal Medicare program is expected to be bankrupt by the year 2019, and 37 state Medicaid programs are cutting funding rate increases. At the same time, U.S. citizens are spending more and more on nursing home care. According to the Centers for Medicare and Medicaid Services, Americans spent \$92.2 billion on nursing home care in 2001 – an increase of 3.3 percent over 2000. It appears that at the same time the need for quality nursing homes increases, the quality of actual care provided is on the decline.

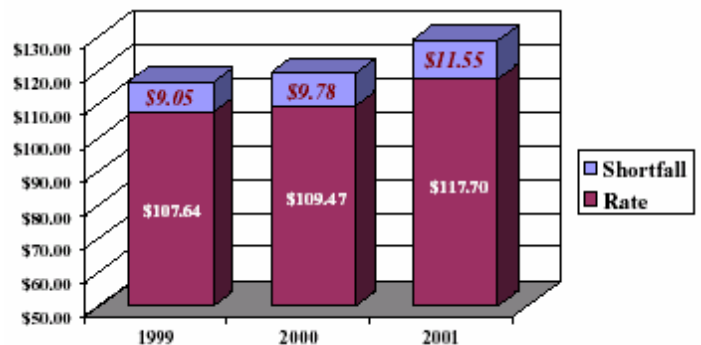
Here are other disturbing nursing home trends – indicative of a dysfunctional organization that needs its infrastructure reengineered so the Mechanics of Quality and Profit in long-term care can be attained:

1. **Nursing home complaints** have increased from 145,000 in 1996 to 186,000 in 2000. Resident care complaints were the most prevalent, growing 37 percent from 1996 to 2000. The U.S. Department of Health and Human Services recommends that states be given guidelines for establishing standards for follow-up on complaints.

2. **Nursing home image is not positive.** A recent article in a Peoria, Illinois, newspaper quoted a former resident as saying, “I would rather be a street person than live in a nursing home.” Another concurs: “I told my son, if something happens to me again, let me die. I don’t want to go back to one of those places.” The group tells of nursing homes with bad food, stolen clothes, unanswered calls, misdirected or just plain missing medications. They discuss violence – between residents and by staff – and nursing homes where the police show up on a regular basis. “Hot showers,” says John, “are a luxury.”

3. **Nursing home trends:** In 2001, 89 percent of nursing homes were found to have at least one deficiency, an increase from 81 percent in 1998. Total deficiencies increased by 46 percent to over 94,000. The average number of deficiencies per nursing home increased from 5.1 to 6.2. In 2000, 74 percent of the facilities in one major market were found to be substandard.

FIGURE I
Shortfall Per Medicaid Patient Day
All States In Each Year



4. **Public spending exceeded \$1.6 trillion in fiscal 2002. Eighty percent is spent in the last two years of the elderly's lives.** Medicaid spending of \$224.3 billion, up 10.8 percent; Medicare spending of \$242 billion, up 7.8 percent; overall health care spending increased 14.1 percent – the biggest increase since 1991. State budget deficits will total \$85 billion in 2004, constituting the largest budget gap in 50 years, and they are looking to cut 2 million recipients from the rolls. Bush's Medicaid plan would give power back to the states, allowing them "carte blanche" to alter Medicaid coverage, which currently provides health insurance to 45 million people. The Administration's proposal could allow states to charge higher co-payments, cut benefits and change eligibility criteria. Financial studies conducted by BDO Seidman indicate that Medicaid programs underpay nursing homes by as much as \$7 per patient per day, which means state Medicaid budgets are not meeting their financial obligations to the elderly and disabled recipients. Eleven states already have made cutbacks affecting more than 1 million recipients.
5. **The credibility of nursing homes is continually being challenged.** According to the U.S. General Accounting Office (GAO), skilled nursing facilities do not need a general rate increase to replace the October 1st "cliffhanger" cuts. The December 31, 2002, report states "it would be preferable to refine the patient classification system underlying the SNF prospective payment system," resulting in increased payments for some SNFs needing "greater patient resources." This conclusion is in line with the Medicare Payment Advisory Committee's recommendations, and acknowledges that hospital-based SNFs may be losing more money than free-standing SNFs. Another GAO report found that none of the temporary 20 percent increases were spent on additional staffing.
6. **Directors of Nursing seek solutions to staffing shortages.** There is increased interest in improving patient services by realigning the workflow and workload. Many facilities are enlisting non-certified workers to relieve the workload of Certified Nursing Assistants (CNAs). Caregiver Management Systems is working on a way to approve non-certified workers doing transport, feeding and some activities of daily living (ADL) work if it does not entail hands-on intervention. Certified Medication Aides, or CMAs, can perform up to 46 percent of an LPN's duties, freeing up the LPNs to perform more hands-on patient care. According to the American Health Care Association (AHCA), the shortage of nurses and nurse's aides is rapidly reaching the crisis point and is threatening the quality of patient care. Between 1991 and 2020, an AHCA study predicts the following growth in demand for nurses and nurse assistants:
 - a. Nursing facilities: registered nurses 66%; licensed practical and vocational nurses 72%; nurse assistants 69%.
 - b. Home health settings: registered nurses 270%; licensed practical and vocational nurses 268%; nurse assistants 263%.

What the nursing homes are selling is not what the government, their best customer, is buying. In 1999, the Centers for Medicare & Medicaid Services (CMS) issued the RUGs III formula for paying SNFs for Medicare services rendered to qualified beneficiaries. The theory is that acuity and outcome should determine payment. RUGs, or Resource Utilization Groups, do not necessarily meet the costs of providing the care, but they do motivate facilities to economize on their costs. Therefore, Resource Utilization Systems need to be designed and put into use. The approach combines disease management for residents and time management for the staff.

According to the Senate conferees, Disease Management – the proactive, coordinated approach to medical care delivery for people with chronic illness – is a critically important emerging innovation in America's health care system. It has the potential to save lives and save significant taxpayer dollars. Congress

is committed to enacting incentives for clinicians to utilize more standardized approaches for detecting and treating chronic illness.

Currently, more than 75 percent of Medicare beneficiaries have at least one chronic condition, and almost 33 percent have four or more conditions. Furthermore, beneficiaries with chronic conditions account for about 80 percent of Medicare program spending and the number of beneficiaries with these conditions will increase from 12.5 million now to 15.7 million in 2020.



The above citations are really symptoms of the problems – how the internal workflow is organized, how the staff performance is measured (or not measured) and the need for much improved management information systems. All of these problems are examples of internal cultural dysfunction, and indicative of the need for a cultural revolution. The demand from the public and the government purchasers is for more accountability and less talk about more money. The current nursing home infrastructure has been in place for 50 years. It is outdated, inefficient and not cost-effective.

MY STORY: WHERE THIS NEW BUSINESS MODEL CAME FROM

It was late November. The Chicago area had an early snowfall that continued from one day into the next – 16 inches in 24 hours. It was a nightmare getting anywhere, including Fox Valley Nursing Center in Elgin, Illinois.

I received a call that morning from Lynn Webster, the new ADON, saying that the staff was not showing up on schedule. The DON hadn't yet arrived, either (and she didn't show up for three days, and shortly thereafter became the former DON). Lynn wanted to know what to do. I told her to list the critical tasks by patient and assign the list to a specific person. Then, work in teams to deliver food, medications and clothing.

When I arrived, there was a different feel and atmosphere at our facility. There was activity, but it was focused on the residents, not on busy work. There were no meetings, no breaks, no complaints, and no time for wasting time. It felt good. Lynn and Janie were in charge, but they were not chasing around trying to get staff to show up. Instead, they were directing the teams to certain problems – such as laundry, transporting residents to meals and calling families to assure them that all was well with their loved ones.

ATTITUDE OF STAFF

The attitude of the staff was the best it had ever been. They were on a mission and were not going to be deterred. No turnover, no call-ins, no insubordination, no name-calling, no excuses – just good, efficient performance and the satisfaction of getting their jobs done.

Seventy-two hours later that same staff was still on the watch, working and sleeping in shifts. No one was allowed to push himself beyond the ordinary, but everyone tended to the residents. There was more accomplished in that three-day period with half a staff than at any other time with our full staff. Lynn, Janie and I decided to never go back to the former organizational structure and workflow. The new facility would be without autocratic, departmental, territorial limitations. We had found a new way of functioning – better than ever before.

FUNCTIONAL MANAGEMENT

I called it functional management because a problem solver was manning every priority function in the facility:

PROBLEM	TEAM MEMBER FUNCTION
Clothing getting lost, stolen or misplaced	A Clothing Aide to keep track of the clothing between the resident and the laundry and the family.
Getting nursing treatments done	A Treatment Nurse for each shift.
Odors	A Room Care Aide assigned to every room, saving the CNAs' time so they could serve the residents.
Residents' weights/meals not being eaten	Restaurant Waiters assigned to specific tables so residents got what they wanted, and were assisted if necessary.
Exercising and strengthening the residents	Restorative Aides exercised and stimulated the residents two shifts per day.
Showers	Shower and Skin Care Aides managing the baths and showers daily.
Privacy and independence for the residents	An Ambassadors Club, which listened to residents' desires and helped devise a method of integrating privacy times with dressing and eating time for organized functions, such as meals, activities and social events.
Cognition and interaction of dementia residents with other, more functional residents	Psycho/social clubs organized around medical diagnoses that allowed for the interaction of the functional residents with the lower functioning residents.
Pain management	A Pain Program and a Pain Manager with the responsibility of treating the condition for her caseload.
Respiratory disease management	A Respiratory Program for each resident who had this problem and a Respiratory Manager who had the responsibility of treating this condition for his caseload.

Now the staff was accountable – they had to sign off when doing each task. Now they were more efficient – each task had an estimate of the time it should take. Now they were more productive – each task was focused on an outcome goal. Now they were more satisfied with their work, because they were restoring the residents.

From my prospective as the Administrator, we had redefined the service model for a nursing home. We had realigned the work and reorganized the pecking order into teams. From that we built a system of procedures, policies and forms to support this new culture. The system was named The Caregiver System. It starts with the assessment of each resident's condition and results in a care plan of standardized programs.

These programs are assigned to specialists who are specifically trained to solve or alleviate a resident's specific problems. This gives the team leaders something to measure: accountability, performance and effectiveness. It also leads to a much more efficiently run facility because the work is better organized and focused on outcomes.

MORALE OF STAFF

The problem solvers were organized into specialty teams with specialty programs designed to respond to the assessment. We set up a library of blueprints or templates for each available program and standardized as much of the process as possible, which built consistency and allowed the staff to complete each program.

Immediately, staff morale rose, absenteeism subsided and turnover was reduced significantly. Why? Because of the actual feeling of making a positive difference in each resident's condition. We stressed a philosophy of getting all the residents better. If we could get a reputation in the community of being problem solvers, we would get more referrals. This, in fact, happened: During the pre-team days, occupancy declined to 169 in our 207-bed facility. After the institution of teams, the occupancy rose to an average of 199. The Medicare census was 4 when we converted to specialty units; 13 months later, it was 34. The specialty units were distinct parts on the first and second floors. We had 36 Medicare beds, 100 chronic care beds, 50 dementia/confused/Alzheimer's beds and 21 respiratory/pulmonary beds.

Before the snowstorm, Fox Valley was decertified, disorganized and operating on a conditional license. The conditional license was due to a drowning in the whirlpool when a therapist walked away from the tub.



We were being pressured by the state to shut down or turn the facility back over to the owners. Within three months of the conversion to an organizational structure, the license and certification were reinstated. The facility was also rated as one of the best in that region by getting five out of the six stars of quality along with a deficiency-free survey.

After the snowstorm and due to an enhanced Medicare program and better services to the Medicaid program, the facility had record months of profits and cash flow. The increase in census was a major factor in our profitability, because the excess capacity costs were eliminated. Costly turnover and call-ins were gone and the risk of injury to staff and residents diminished to zero. What had been a group of 12 middle managers running departmental teams were now three case managers running case management teams. This new approach also eliminated \$200,000 per year in middle management costs.

We now had hospitality aides supporting the case management teams with room care, restaurant services, clothing care and basic entertainment. The unit care CNAs served the dependent residents, the Restorative Aides provided the restorative programs, the Rehab Aides assisted with the rehab cases and the therapists and nurses specialized in certain diseases and nursing diagnoses, all in a blueprinted and programmatic format created by our computerized library of care. This library was set up to standardize the response to the assessment-triggered programs based on each resident's problems.

REALIGNMENT OF WORKFLOW AND WORKLOAD USING CASE MANAGEMENT TEAMS

From my snowstorm experience came a new beginning, and I began developing a functional management system designed to realign workflow and workload to reorganize the service product that would better serve the market for long-term care and better reward the investors. Our company's new quality-improvement system re-engineers operational forms and procedures into an efficient case management tool, using functional management teams and computerized information systems.

When I tell the snowstorm story, the reaction is "sure you can do it on adrenaline, but it will wear off and slide back into the abyss." This certainly was not my experience. The staff informed me that they knew how to do this all along, but no one would let them do it. I believed them, because they were the ones that made it work.

After the three-day snowstorm lesson, the facility was reinstated, made a profit every month thereafter and was eventually sold for three times what it was worth before it was fixed. The new ownership eventually turned it back into the traditional nursing home departmental structure and failed again. As for me, I moved on to another waiting disaster, but this time I knew the formula.

Since then, my son, Kip, and my wife, Shari, have computerized and helped implement the functional management process in more than 100 nursing homes. It has never failed to work; however, we have found most new owners/operators won't keep it in place once they take over ownership and management because it does not conform to the old infrastructure. Also, our system does not lend itself to absentee ownership, autocratic management and departmentalized structure. However, it can be implemented in any nursing home if there is a true desire to be more efficient and cost effective through standardization, reorganization and computerization.



THE NEW INFRASTRUCTURE

As I referenced earlier in this report, here's what I believe are the components of a new infrastructure that meets Medicare and Medicaid's reimbursement priorities as well as the public's need for improvements in the quality of life for the elderly:

- **The Restorative Service Model**
- **The Staffing Model**
- **The Systems Model**
- **Case Management Teams**
- **Activity-Based Cost Accounting**

The Reality Of The Resistance To Change In Long-Term Care Requires Some Extreme Measures To Avoid Clinical Meltdown. So Let's Envision The SNF Makeover As The Catalyst To Implementing The Mechanics Of Quality And Profit In The 21st Century.

SNF EXTREME MAKEOVER REVEALS: A NEW RESTORATIVE SERVICE MODEL

The Four R's of serving long-term care's person-centered care objectives combine the medical model and the social model into the Restorative Model:

- Recovery process – disease management and post-hospital care
- Rehabilitation process – therapy with concurrent rehab nursing
- Restorative process – restorative nursing and psycho/social programming
- Reintegration to a communal setting – discharge planning for referral to the lowest necessary level of care

The term “nursing home” had its genesis in a nurse providing services in her own home to an aging person. Over the years and due to the increasing demand, we have added to the concept of a nurse providing services in a home as the model for aging. The dichotomy arose when the number of residents exceeded the confines of a real home and thus became an institution. Today, it is still an alternative, not a home.

We waste time and money trying to sell it as a home. At best, it is an unwelcome alternative. In order to change the culture, we must change its perception, and to do that we must focus on function, then form. The modern-day nursing home must be a positive alternative to home, not home itself. To avoid the feel of an institution we must make it sociable and holistically functional. It must therefore,

- Prevent hospitalization or re-hospitalization using preventive measures,
- Rehabilitate and restore physical well being as much as medically possible,
- Retain personal dignity,
- Restore emotional and spiritual well being, and
- Regain the independence of living as an individual in a community of other aging Americans.

I used this approach to Rehab and Restorative Services as the New Restorative Service Model:

OLD MEDICAL/SOCIAL MODEL	NEW RESTORATIVE MODEL
Nursing home	Restorative Center
Services: nursing, therapies	Physical services: physical education, physical programming
Housekeeping	Hospitality services
Dietary	Hospitality services
Maintenance	Hospitality services
Room	Hospitality services
Social events	Emotional and spiritual services
Activities	Psycho/social programming
Bible study	Volunteerism and chaplaincy
Focus was on income	Focus now on outcome
Census	Discharges to lower level of care
Cash flow	Optimal utilization of resources
Profits	Better outcomes for the government payers

THE NEW STAFFING MODEL

The current departmental structure impedes interaction and efficient delivery of restorative services. It is a holdover from autocratic practices discarded decades ago by other successful businesses. In our new structure the use of service-directed teams must be utilized. The components of the new staffing model are:

- **Placement of patients** in restorative programs requires a complete physical, psychological, sociological and spiritual assessment of their problems and needs. This will indicate where they are physically located and dictate the specialized services teams providing their daily programming.

For example, a physically dependent, chronically ill restorative candidate will reside in a Chronic Care Unit organized to meet that person's restorative needs. The categories specifically are designed for his or her individual needs: exercise, nutrition, ambulation, cleanliness, recreation, social events and spiritual events.

On the other hand, a physically independent Alzheimer's restorative candidate will reside in an Ambulatory Care Unit organized to meet that person's restorative needs: exercise, nutrition, ambulation, cleanliness, recreation, social events and spiritual events.

- **Specializing the services** dictates the skills required of the staff to deliver the outcomes for each restorative candidate. It eliminates the rotating of residents and staff to balance the

workload. The emphasis on restorative programming is the first step to a Disease Management environment whereby medical problems are prevented and quality of life is enhanced.

- **Ramping the case down through the rehabilitation and restorative process** enables the therapists to phase patients out of their care into nursing care without a hitch in pursuing the improvement in functioning as the outcome. This can be a natural plan if the patient is the center of the equation rather than the conduit to maximum reimbursement. The optimal revenue stream will be produced by this ramping down process. If the patient is non-weight bearing, for example, and the nursing staff is carrying the case, the therapists need to be involved in coaching the nursing staff on safety and the nursing staff needs to be involved in strengthening and certain mobility needs of the case. At the right time, the therapists become involved for their role as teachers and coaches to the nursing rehab and restorative programs already in motion. The impact on reimbursement is positive because the patient's restorative period is extended and focused on the maximum outcomes for the optimal incomes.



Turnover and absenteeism are imposing problems for long-term care -- symptoms of the underlying problem of staff morale. As long as the nurses and aides don't get their jobs done, they will remain malcontents -- unproductive and inefficient. Their work must be organized for them based on the patient's medical and mental conditions, and risk for injury needs. This system of dispatching the workload and time usage so it is used to measure performance must be based on standardized models of care customized to the patient's problems.

These caregiver models have been built to respond to the Minimum Data Set (MDS) assessment process and nursing diagnosis as it pertains to the nursing process. As improved systems are implemented, morale is improved and hidden costs reduced.

'LEARN TO EARN' AND 'SKILL TO BILL' CAREER LADDER

At the two facilities where this model was tested and perfected we had a "Learn to Earn" program for advancement and "Skill to Bill" as the financial justification for advancing staff. Under "Learn to Earn" the staff members are given the opportunity to better themselves in the health care profession. A Career Ladder is cooperatively built for each person. The steps on the ladder are established by the staffer committing to written career goals. If the person is a CNA and the steps taken are toward the goal of becoming a nurse, the ladder will include functions that relate to restorative services for the elderly and disabled. If the person is an aide and the goal is to become a therapist, the ladder will include functions that relate to rehab services. If the person has a desire to pursue social work, the ladder will include specialization in conducting psycho/social programs. Under "Learn to Earn" the company will provide financial assistance for pursuing that track. The Career Ladder Agreement each person signs embraces the obligation to work according to company policies, systems and targeted outcomes for the betterment of the quality of life for the patients.

Under the “Skill to Bill” advancement program, no increases in compensation are provided if there is no increase in work skills. If the person has signed the “Learn to Earn” Agreement, he or she is accepting the policy that advancement is predicated on learning and gaining additional skills. In doing so the staffer must move up or move on. Additional increases in compensation cannot be made to reward tenure in today’s competitive health care market. If a staff person wants to remain a CNA for the duration of her career, no increase in compensation can be provided, except for cost-of-living adjustments, and the person is encouraged to look elsewhere for employment.

This philosophy and business practice is in direct opposition to the theory that the best workers are the ones that have been loyal but choose to stay put. Under this theory, the 20-year housekeeper will make as much as the two-year nurse, even though the skill required to be a nurse is far more expensive and complex than cleaning the rooms. Regardless of the divergence in theories here, we must look at the reality of cost versus benefit. The nurse brings a skill that can be billed and the housekeeper is support. The latter is value added, but is limited to a non-skilled position, while the nurse adds value that the customer is willing to pay for.

Under these programs, five dramatic things occurred:

1. Turnover instantly dropped.
2. Absenteeism instantly dropped.
3. Fall rates and skin problems instantly were reduced.
4. Morale improved and deficiency-free surveys were accomplished.
5. Better recruits sought employment at the facility.

Under this strategy the “hidden costs” were reduced and the quality improved. Over a period of six months we were able to propose that anyone needing placement would be accommodated and that former employees at the facility would be welcomed back if they chose to improve their skills. Also, employees that advance to a management level according to their career objectives are assisted in finding advancement in the expanding business. In other words, there is always a place for a person that is learning to earn and developing a skill to bill.



THE NEW SYSTEMS MODEL

Clinical systems are currently an outgrowth of inductive thinking, not deductive processes. Inductive thinking results in increasing the variables to the point of inefficiency and low effectiveness. A deductive process is a model built on probabilities emanating from an assessment of physical, psycho/social and spiritual needs. Computer programs can provide structure and focus to the clinicians in their assessments and care planning, freeing them from the compulsion to check everything every day, thereby getting nothing productive done.

Some generic labels have been put on such systems – clinical pathways, critical paths, templates of care, protocols, etc. In reality, they are exercises in basic common sense: managing the restorative needs of individuals to promote successful outcomes. For example a stroke patient with diabetes, hypertension, COPD and CHF has some very standard needs: breathing, eating, dressing, bathing, grooming, walking, exercising and communication – all called activities of daily living.

That same individual has some very special needs: medications, therapies, restoratives and activities. All of these ingredients can be structured by a restorative library of services and customized to each restorative candidate as “an episodic case.” This system of restorative management is called case management. Historically, case management has been based on the specialized training and skills of the caregiver. The case management system includes the functions to be performed for the special needs of a special group of cases. This forms the caregiver team by function:

FUNCTION	POSITION
Restorative services:	
Medications	Pharmacology nurse
Medical treatments	Treatment nurse
Rehabilitation services:	
Direct therapy	Therapists
Restoratives	Restorative Aides
Psycho/Social	Psycho/Social Aides
Spiritual services	Chaplains
Hospitality services	Hospitality Aides
Environmental services	Maintenance and grounds personnel
Administrative services	Management personnel

Each restorative candidate has a set of personal outcomes (goals) connected to the need to provide a means of measuring staff performance and care progress. It is the pursuit of outcomes by the case management team that becomes the measure of quality, satisfaction, staff morale and profitability for each team.

CASE MANAGEMENT TEAMS

Each case management team has its specialized caseload, with individual functions to fill daily by shift. Each has care plan assignment sheets on the unit to direct their interventions, coordinate the various disciplines and to document their outcomes. This Communication System interacts with the family as well: In changing the care plan interventions or goals, the authority to seek family and physician approval resides with the team leader (Case Manager). For every problem, the problem solver is the caregiver.

Built into the team structure is a natural progression of skills that form a career ladder. The Hospitality Aide on a Chronic Care Unit can get certified and become a CNA; then a nurse, a therapist or a social worker. The opportunity to progress provides more status, money and job satisfaction. Along with this structure comes less overtime due to low absenteeism and less turnover. *Maslow's Hierarchy of Needs* is met for both the restorative candidate and the caregiver.

Case Management in business vernacular is a “school of fish” action plan versus the current departmental whale that perpetuates antiquated morning stand-up sessions and ineffective quality assurance committee meetings.

ACTIVITY-BASED COST ACCOUNTING

With the advent of Prospective Payment Systems (PPS) for long-term care, the cost report became obsolete for determining the cost of care for long-term care services. Payment is now based on 44 acuity levels, not average cost per day. This requires a change in the systems underlying the determination of costs per patient day. No longer is an average per diem sufficient; it is more relevant to know the cost by RUG's Grouper than by ancillary and the amount of labor that is being expended for each patient's episode versus the revenue stream that the case mix justifies.

The internal systems in long-term care need to be structured around the care plan and doctor's orders for therapies, medications, medical supplies, labs, X-rays, etc. Since the rate is not going to fluctuate with actual costs, the systems need to map out the workflow and workload using standard time values for interventions and formularies for what ancillary services should cost. This way, a budget can be established for each case over a period of time that will show how a profit is generated, or a loss incurred.

Break-even analysis is critical if a high-cost patient is to receive adequate care in a fixed rate system. Medicare pays a rate based on acuity, but not necessarily the cost of delivering that care. The rate assumes a certain level of efficiency and cost effectiveness. If the operator is not attaining these theoretical levels, it will result in a loss – and the attainment of profitability is then based on luck, not management.

Activity-Based Cost Accounting is founded on setting up restorative models that will establish limits on costs related to the acuity of the patient. Therefore, all costs must be related to the patient care plan and ancillary orders if it is to be meaningful. In practice, the system that sets up the delegation of work to the staff based on minutes of care generated by the care plan will base labor on time required to deliver the care, not on guesswork. The therapy department must be given models (templates) of care that have minutes attached, and the outcomes must be measured in relation to standard minutes required to attain the needed outcomes.



A high-cost patient will more than likely produce a profit over a period of time. On the first day of admission most cases will lose money because of the intensity of services required. As the care improves the patient's functioning, labor and ancillary costs will decline. If this information is made visible it can be viewed as it is happening. The Case Managers can then make informed decisions on utilization review and case mix. If this information is invisible, Case Managers would have to either guess or rely on luck to determine if there is a profit generated for any case.

Our studies have proven that a high-cost patient is most likely to produce positive outcomes and highest profits if the direct labor costs and the use of ancillary services are managed based on a systematic Activity-Based Cost Accounting System.



EDUCATION IN AMERICA IS POWER

If we want to be recognized by the public as professionals, we must conduct our business affairs in a mode of educating the public on the restorative processes needed for aging America. Ownership and management do not have to be solely about profitability at the expense of people's lives. Both objectives can be attained with a newly organized cultural infrastructure founded on optimal resource utilization using case management systems.

Therefore, the long-term care "flagships" that shall fly over America and become the examples of quality will have the following banners:

- Standardized person-centered care plans
- Computerized point-of-service documentation systems
- Functionalized restorative-directed work teams
- Community-based ownership
- Performance-based compensation

There is plenty of money being spent on long-term care. Eighty percent is being spent in the last two years of people's lives. The government needs to be getting more for that money. If the rehab and restorative programs are implemented as proposed, the outcomes will justify the providers' incomes. The providers need to make due with their present labor resources and use technology to improve efficiency and productivity so the health care dollar is more effectively spent. If this is done, both the state and federal governments' budgets can be balanced and the elderly and disabled better served.

ABOUT THE AUTHOR

Jerry Rhoads is a CPA and a Fellow in the American College of Health Care Administrators. He has written three books on nursing home accounting and systems and more than 100 published magazine articles on health care reimbursement and cost systems topics.

He is currently President and Chief Executive Officer of Caregiver Management Systems Inc., a management consulting and software firm specializing in long-term care. He created the Caregiver charting, staffing and cost system while running two skilled nursing facilities and a CCRC.

He wrote the white paper in 1975 on case-mix reimbursement for HCFA that lead to MDS and RUG's development. He also sat on HEW and HHS committees in the 1970s and 1980s that formulated the current RAI linkage to case-mix formulas based on nursing minutes of care.

Jerry was President and Chief Executive Officer of his own CPA firm that began in 1977 and grew into a consulting firm and software development company. Prior to that he was a partner in two other CPA firms after leaving the Health Care Consulting Division of Arthur Andersen & Co. in 1969. While there, he was assigned to head up the Blue Cross of America project for auditing claims and cost reports as the first Fiscal Intermediary for the entire country when Medicare and Medicaid legislation was originally passed and implemented. He later was the partner in charge of the Aetna Insurance Company Fiscal Intermediary project for auditing claims and cost reports.

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