



## Better Measures, Better Outcomes

*Current practices are costing the long term care profession dearly, both in the quality of care provided and the level of resources wasted.*

**W**HILE NURSING facilities struggle to correct “mistakes” so as to please surveyors and avoid black marks, they too often lose sight of their real mission: producing positive outcomes for their patients. And the same blind spot seems to exist for those who regulate the profession.

The Centers for Medicare & Medicaid Services (CMS), for example, focuses on the 15 key elements in its nursing home quality measures when assessing a nursing facility’s quality of care:

### CMS NURSING HOME QUALITY MEASURES

1. Weight loss
2. High-risk pressure ulcer (PU)
3. Low risk PU
4. Pain (chronic)
5. Pain (post-acute care) (PAC)
6. Low-risk incontinence
7. Mood decline
8. In-dwelling catheters
9. Bedfast
10. Physical restraints
11. Mobility decline
12. ADL decline
13. Urinary tract infection
14. Delirium (PAC)
15. PU decline (PAC)

But what these measures really say about a facility—even one that receives an excellent score—barely touches the surface of what the facility should be



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achieving. While the measures may indicate that a facility has no pressure ulcers; weights are fine; pain is medicated; restraints are medically justified; infections are treated; delirium is diagnosed and treated; and patients are required

to improve in activities of daily living (ADLs), including ambulation, there is no mention anywhere of restorative outcomes. That’s because the measures

■ **The CMS quality measures barely touch the surface of what the facility should be achieving.**

are predicated on counting mistakes and making sure that providers correct errors they never should have made in the first place.

### Other Measures Of Quality

Perhaps a better list of 15 quality measures, one that differs dramatically from the CMS version, would be driven by measurable criteria that, when practiced objectively, would lead to an observable improvement in the quality of a facility’s operations as well as the quality of care:

### ALTERNATIVE QUALITY MEASURES

1. Low staff turnover rate
2. Low staff absenteeism rate
3. Low staff injury rate
4. Low patient injury rate
5. Odor-free and infection-free environment
6. Low number of family complaints
7. High number of discharges back to home
8. High number of discharges to a lower level of care
9. High number of patients restored to highest level of functioning
10. High number of patients participating in rehab programs
11. High number of patients participating in restorative programs
12. High number of patients participating in psychosocial programs
13. High number of patients in health and wellness programs
14. High number of patients in weight and diet management programs
15. High number of patients in pain management programs

Each element of this list is predicated on achieving a specific outcome, rather than on avoiding a specific mistake. This list also provides a way to hold facilities and staff accountable with objective data pertaining to patients’ wellness—not to their illness.

People in the trenches of long term

JERRY L. RHOADS, a certified long term care administrator, is president and chief executive officer of Caregiver Management Systems, Schaumburg, Ill.

care, those who work with patients day in and day out, are the real key to an outcomes-based system. They are the ones who must provide a set of measurable outcomes by which they can be judged and held accountable to objective data. Only in this manner can the true quality facilities separate themselves from the rest of the pack.

Experience shows that staff consistently respond to a challenge and a course of action that will benefit the patients and themselves. This approach requires a team effort in which outcomes are not dependent on departmental assignments. In fact, a facility might try getting rid of departments altogether and, instead, setting up outcome delivery teams focused on accomplishing the following objectives:

- Eliminate staff turnover by setting up a career ladder for staff and other incentive programs funded by the sav-

ings generated from eliminating turnover, which currently costs the average long term care facility some \$150,000 per year and is highly corrosive to quality of care.

- Eliminate staff call-ins by paying for perfect attendance funded by the savings from eliminating absenteeism, which costs the average long term care facility about \$75,000 annually. Staff with perfect attendance can be paid a stipend that they can use for classes.

- Eliminate staff and patient injuries by paying for a perfect injury-free environment funded out of the savings from eliminating high insurance premiums and workers' compensation claims. Staff who set up a precautionary environment can be paid a stipend that they can use to buy safety equipment and training on safety. Staff that set up a risk management program for preventing patient abuse and injury can be paid a stipend to use for team get-togethers and learning aids.

- Eliminate an odorous, infectious, and dirty environment by assigning the survey F tags to each caregiver team and paying for perfect surveys funded by the money saved by not having to gear up and defend surveys. Staff get paid extra for taking on the responsibility for zero-deficit operations.

- Eliminate family complaints by assigning the survey F tags to each caregiver team and paying for perfect surveys as noted above.

Enacting these steps can basically eliminate 90 percent of the hidden costs of providing long term care. This leaves plenty for staff and plenty of profit because the waste has been eliminated. W. Edwards Deming, the famed efficiency guru and statistician, taught this technique to the Japanese, and they capitalized on it for 20 years in the automobile business.

### **Pay For Performance**

A good way to get staff to buy into an outcomes-based system is for providers to offer a series of pay-for-performance rewards based on better team out-

comes. Such a system might include setting goals for the number of patients per month who will:

- Be restored and returned to the community;

- Be restored and returned to a lower level of care;

- Be restored to a higher level of functioning;

- Be in rehab programs;

- Be in restorative programs;

- Participate in psychosocial programs;

- Participate in health and wellness programs;

- Participate in diet management programs;

- Participate in pain management programs; and

- Participate in a weight management program.

Members of caregiver teams that meet their goals in each monthly category are then rewarded with specific prizes (free movie tickets, for example). Members of the top three teams in meeting their monthly goals most consistently over a 12-month period might receive special recognition at a year-end awards ceremony and be eligible for a grand prize drawing (a cash prize or gift certificate, for example).

Is this too complicated to get the outcomes the provider wants? It is not too complicated for an organization that is founded on teams rather than departments—on results rather than turf. The big question, then, is would this type of facility have problems with attaining high marks on CMS' 15 nursing home quality measures?

The answer is most likely no because the outcomes-driven facility will resolve CMS' defined quality mistakes and problems as a part of the work process that evolves from a team focused on patient outcomes rather than disjointed departments. And all of this leads to eliminating wasteful business practices that are costing health care \$400 billion per year, while leaving more than enough resources to do a quality job. ■