The Alliance Training Center, Inc.

Getting the Dollars You Deserve for the High-Quality Care You Deliver

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Executive Summary

In the face of increasing costs, declining revenues, and new changes to the Medicare and Medicaid reimbursement system on the horizon, more and more acute care and skilled or long-term nursing facilities throughout the U.S. are focusing on improving the quality of care to increase financial performance.

Nursing home and long-term care (LTC) facilities, while they have the capacity to provide higher quality care at a lower cost, continue to struggle to implement effective strategies that enable them to directly increase revenues through higher reimbursements from the federally mandated payment system. In fact, the quality of the institutional documentation process to gather data that is congenial and supportive of the Minimum Data Set (MDS) can be directly related to the quality of payments received through the Centers of Medicare and Medicaid Services (CMS).

However, the vast majority of LTC facilities have not addressed quality of the assessment process to ensure they are receiving the right reimbursement for the care they are delivering. Why? Because the documentation process must begin with definitions of the MDS assessment process; and as part of this, the accuracy of the data with which a facility documents resident status through the MDS system is crucial, but currently lacking.

The solution to these challenges rest with LTC facilities adopting interdisciplinary assessment procedures and extremely accurate, 24x7 documentation of activities of daily living (ADL) through the assistance of technology that enables staff to accurately document care directly at or very near the point of care.

A study[1] documented in *Health Care Management Review* examined the relationship between quality of care and financial performance of nursing facilities and found that the facilities that produce better outcomes and care processes were able to achieve lower costs, and better financial performance. Although the study pointed to a connection among better clinical outcomes, lower resident care cost and improved operating margins, it concluded that quality outcomes do not automatically result in increased revenue.

This suggests that: (1) beyond a certain threshold, nursing facilities are not able to directly increase revenues by improving care quality, such as that required to meet regulatory requirements, or (2) nursing facilities with higher quality care were unable to adequately compile and disseminate this information, and thereby unable to realize higher reimbursements.

A separate study[2] documented in the *Journal of Nursing Administrators*, suggests that the likely gap between quality outcomes and the ability to directly impact revenue is due to the difficulties nursing facilities experience in producing accurate resident assessments and documentation. Since the assessment and documentation process, represented by the MDS system, not only directly affects reimbursement but also influences the quality of care for residents, *it is clear that mastering resident assessment and documentation is crucial.*

[1] Healthcare Management Review 2003. 28 (3): 201-216. Does Quality of Care Lead to Better Financial Performance? The Case of the Nursing Home Industry. Weech-Madonado R., Neff G., Mor V.

[2] Journal of Nursing Administration. 29 (12): 46-49. December 1999. Boroughs, Deborah

The Bottom Line: Nursing facilities are struggling with declining revenue streams and rising costs, driven in part by caring for residents with greater disabilities and post-acute care needs. Yet, the current policy to reimburse nursing homes, based on prospectively determined case-mix adjusted rates, impacts facilities two ways: 1) It rewards facilities that can successfully contain spending on care; and 2) *It rewards facilities that are effective in documenting care already provided, based on the MDS coding.* Further, the consensus about newly proposed changes to the reimbursement system offered by the Bush administration will squeeze nursing facilities even further, driving down reimbursements.

The Takeaway: Challenged to "do more with less," nursing facilities are finding it necessary to evaluate new technologies that will help them achieve the quality, cost, and revenue trifecta: improve resident outcomes, improve reimbursement, and lower the cost of care. Given the central role that the resident assessment and documentation process has in each of these three areas, nursing facilities are looking more closely at technologies that support improved resident assessment and documentation. While touch-screen kiosks and PDAs offer some improvement over simple paper-and-pencil charting and documentation, many LTC facilities are discovering that voice-assisted care technology not only drives increased reimbursement, but also improves care quality *and* produces dramatic cost-savings, paying for itself in many cases. Because voice-assisted care literally provides point-of-care documentation, it has been shown to help LTC facilities achieve disciplined, accurate and consistent documentation, and is quickly becoming the documentation technology in LTC that provides the most significant impact.

Recommendations: Through the experiences of leading senior care facilities, this paper will compare the functionality of keystroke-based technologies, in this case, touch-screen documentation and voice-assisted care, and how voice-assisted care provides an advanced system of clinical documentation that improves the quality of care, leads to lower care costs, and drives revenue to the bottom line.

Changing Technology; Changing Care Delivery

The nation's aging population presents one of the greatest societal challenges in America's history. Through 2020, the growing healthcare needs of the nation's aging population will produce a dramatic increase in the number and quality of the assets—the people, places, and technology—required to provide care to this segment of the population. The American Association of Homes and Services for the Aging (AAHSA) cites these statistics:

- By 2026, the population of Americans ages 65 and older will double to 71.5 million.
- Between 2007 and 2016, the number of Americans ages 85 and older is expected to increase by 40 percent.
- Approximately 60% of Americans who reach age 65 will need long-term care (LTC) some time in their lives.
- In 2020, 12 million older Americans will need LTC—roughly equivalent to the current population of the state of Illinois, or *twice* the current population of the state of Arizona.

How does the nation prepare to meet the challenges that will be part of this changing demographic? By transforming the healthcare system—beginning with the healthcare reimbursement system. In 1998, Congress took a series of steps to rein in the cost and improve the quality of care provided under the nation's healthcare entitlement programs. Medicare for the elderly is usually linked to acute care, rehabilitation and re-stabilization; and Medicaid, generally for residents where a longer-term stay is anticipated. Private insurance also is a source of reimbursement for some LTC facilities, depending on their payer mix.