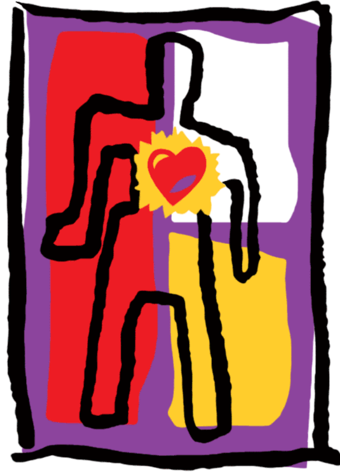

The Alliance Training Center, Inc.

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

Leah Klusch, Executive Director

Nurse, Educator, Consultant

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.*

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[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.

The MDS System

Historically, LTC facilities had been reimbursed under a methodology based on each facility's cost of providing the care. That changed with the advent of the Balanced Budget Act, which ushered in the prospective payment system. Through the implementation of a prospective payment system, reimbursement transitioned to a system in which rates are adjusted for the relative resource utilization of different patient types, rather than on each facility's actual expenses.

The heart of the prospective payment system is the federally mandated process for clinical assessment and documentation of all residents covered by Medicare or Medicaid—the Minimum Data Set (MDS). A comprehensive process based on the Resident Assessment Instrument, the assessment and documentation that comprises the MDS is implemented by an interdisciplinary team of providers and evaluates a set of clinical and functional factors, such as the presence of pressure ulcers (clinical) and cognitive loss (functional). The MDS coding is based on the resource utilization group (RUGS III) classification system, and assesses the resident needs and services, and the level of skilled nursing required to determine the level of reimbursement.

MDS assessments are required for residents on admission, and then periodically, within specific guidelines and timeframes. MDS information is transmitted electronically by nursing homes to the MDS database in their respective states. MDS information from the state databases is then rolled up into the national MDS databases at the Centers of Medicare and Medicaid services (CMS).

The system is based on activities of daily living (ADL). Residents are "scored" based on their dependency. The more dependent the resident, the higher the potential ADL score, and ADL scores are determined in four key areas:

- Bed mobility
- Transfers
- Eating and drinking
- Toileting

The higher the *documented* ADL score, the higher the reimbursement. Note the emphasis on "documented."
The prospective payment system is designed to not only help control costs, but also help nursing home staff identify health problems early, when intervention can be accomplished at a lower cost and with improved outcomes. In this vein, as LTC facilities work to improve quality of care delivered, they need to document with increased accuracy and efficiency in order to realize the significant operational and financial benefits.

Most agree that the solution lies in effective caregiver staff data collection and documentation. Regardless of quality improvement or process redesign initiatives in the past or present, LTC facilities cannot claim that they meet high quality standards if they cannot *document* their accomplishments.

Keystroke Documentation vs. Voice-Assisted Care

If documentation is the key to better care outcomes and a more fiscally sound LTC community, then how do LTC facilities achieve the best documentation possible so they can benefit from improved resident outcomes, lower costs, and increased revenue? The solution lies in collecting accurate resident care from front-line staff. For decades the "gold-standard" in documentation was paper-and-pencil: notes about care rendered would often be hurriedly scribbled on any available piece of paper requiring "reconstruction" eight and sometimes 12 or 16 hours later. The result: hit or miss documentation at best—not the ideal system for optimizing quality, holding unnecessary costs down, or driving up revenues. It's too easy to forget about all of the actions taken with each resident during a shift, and unless staff is charting using the same terminology, then inconsistency creeps in.

Despite the fact that the majority of LTC facilities still rely on paper-based processes, there are several technology options available to help achieve enhanced documentation, including PDAs, Tablet PCs, and touch-screen devices. However, the technology that has been most proven to be extremely accurate and effective at increasing productivity by supply chain giants like WalMart is voice, which is now permeating LTC facilities.

In fact, the results experienced by LTC facilities implementing voice-assisted care prompted Craig R. Barrett, Chairman of the Board, Intel Corporation, to single out voice-assisted care technology in his keynote address at the 2006 Healthcare Information and Management Systems Society conference. Barrett cited voice-assisted care as one of nine cutting-edge technologies that will improve healthcare while reducing costs.

Voice-assisted care is proven, advanced technology that has been successful in supply chain management for more than 20 years. Today, it is taking on limitless potential in LTC by removing the burdensome tasks of memorizing care needs, charting and reporting. Importantly, it goes well beyond the functionality of keystroke systems because voice-assisted care is real-time care: it is point-of-care documentation that has been proven in LTC facilities across the country to increase accuracy, reduce overtime hours, provide instantaneous communication with other staff and, through improved documentation, increase reimbursements and drive revenue to the bottom line.

The Business Value of Voice-Assisted Care

Simply put, voice-assisted care is the only system to combine point-of-care documentation with on-demand information retrieval and instant communications. It makes it easy for staff to hear detailed resident care information, document their completed tasks and instantly communicate with each other at any time and any place—all via a lightweight headset and a pocket-sized wireless computer. Voice-assisted care closes the information and time gap between care delivery, care documentation and care outcomes management by giving nursing and other healthcare professionals easy access to real-time reports that enhance resident care and maximize reimbursement.

Point of Care Documentation: Charting in Real Time

Unlike kiosks that require staff to document care by going to a centrally located kiosk when convenient—at times, hours after care is delivered, voice-assisted care's point-of-care documentation provides caregivers the ability to document their actions and observations in real-time so a caregiver can document care while making the bed, for example. There is no manual data entry—nothing to write—caregivers "speak" the specific plan of care as they administer it, all while multi-tasking.

Changing the Documentation Paradigm

Voice-assisted care changes the assessment and documentation paradigm in two important ways: the system provides real-time point-of-care documentation and is proactive rather than reactive. Caregivers respond to easy-to-follow voice prompts through ultra-light headsets and "tell" the system when the care is completed, and the results are automatically charted. Voice-assisted care is also proactive in that *a change in a resident's clinical or functional status is monitored and assessed in real-time*. Caregivers are alerted to potential issues at the point-of-care. For example, when weighing a resident, if the weight a caregiver speaks is lower or higher than expected, the caregiver is asked to re-weigh the resident immediately. This saves clinical staff time when it comes to identifying weight-related issues, and enables caregivers to implement an immediate change in the care plan. Caregivers also receive reminders for turning/positioning and scheduled toileting, as well as appointments, and voice-assisted care enables caregivers to more efficiently review progress of wound treatment effectiveness, I/O reporting for IVs, tube feeding, and flushes. In each scenario, ADL scores are automatically calculated daily, providing LTC facilities with the opportunity to improve reimbursement opportunities.

A Complex Process Made Easy and More User-Friendly

Voice-assisted care converts an otherwise complex and challenging process to one that is simple and user-friendly. Resident plans of care reside in the AccuNurse web-based application, where they are available to caregivers through their headsets. As care is completed, caregivers "tell" the system, and documentation is completed at or very near the point-of-care, while details are still top of mind for the caregiver and easy to recall. Throughout their shifts, caregivers can ask for specific plan of care information and receive reminders and alerts while they are with the resident. They can immediately "chart" their actions simply by speaking into their headsets. Updates to plans of care are immediately heard

by caregivers. All of this is accomplished hands-free as caregivers are observing or helping residents with ADLs such as grooming, eating, ambulating—there is never any writing and, unlike wall-mounted touch screen devices, caregivers are never interrupted before they document, and never have to wait in line to do their charting. With voice-assisted care, there are many more opportunities to boost accuracy so resident status is easier to monitor and manage, which leads to a more resident-centered and complete plan of care; and, ultimately, improved experience for residents and families.

The Benefits of Voice-Assisted Care

The benefits of voice-assisted care impact numerous clinical and operational areas across the LTC organization:

- **Improve Reputation** – Caregivers employing voice-assisted care technology are recognizing its capacity to help them *improve their image and reputation* as being more responsive to residents' needs by being proactive with care and ADLs, for example, through reminders for toileting, transfers and appointments, and other changes in resident status that cause concern. The voice-assisted care solution enables the development of a tailored toileting plan of care for each resident that includes notifications and reminders for caregivers. This reduces the likelihood of incontinent episodes and the associated costs.
- **Operational and Fiscal Results** – LTC facilities have used voice-assisted care to *maximize reimbursements* through increased accuracy as staff simply talks to document care throughout each shift. At the same time facilities have *reduced operating costs and increased efficiency* by cutting overtime and shift overlap by replacing meetings with change of shift voice reports, reducing paperwork and report writing, and reducing time spent searching for other staff.
- **Improve Workforce Recruitment and Retention** – LTC organizations utilizing voice-assisted care also appreciate its impact on *recruitment and retention*. At least one LTC facility is integrating its implementation of voice-assisted care into its career ladder program. Organizations are also seeing a marked decrease in turnover following the implementation of voice-assisted care.
- **Do Better on Surveys** – The automated reporting features of voice-assisted care make preparing for *annual surveys* easy. Following the implementation of voice-assisted care, documentation is virtually 100%. Comprehensive reports are available for each resident for any time period selected, providing LTC facilities with the documentation to support the level of care provided.
- Virtually every LTC facility implementing voice-assisted care has achieved a payback within 6 – 12 months, making voice-assisted care an *extraordinary return on investment*.

Image and Reputation

There is a familiar saying among caregivers that patients or residents and their families understand that "time will tell" if they are receiving good medical *treatment*; however, they will know immediately if they are receiving *good care*.

LTC and skilled nursing facilities have long-recognized that residents, and certainly their family members, judge quality of care by such factors as the alertness and responsiveness of caregivers, the proactive manner in which institutions communicate with family members, and environmental factors, such as whether or not the facility provides a calming, peaceful setting. Voice-assisted care has been shown to have an important impact in each of these areas.

The dynamic "messaging" feature of voice-assisted care means that caregivers are constantly receiving reminders and updates about each resident's status and special concerns. Because a tailored toileting plan can be implemented for each resident, for example, episodes of incontinence can be reduced. At UPMC Cranberry Place, an LTC facility northwest of Pittsburgh, after implementing voice-assisted care, low risk residents with loss of bowel and bladder decreased by 50%. PUMH Cokesbury Village in Hockessin, Del., saw a marked improvement in its quality indicator for toileting following the

implementation of voice-assisted care. According to Theresa Green, RN, quality improvement/staff educator at Cokesbury Village, prior to implementing voice-assisted care the facility was approaching a quality indicator level of 90% for toileting; following the implementation of voice-assisted care the level dropped to 38%.

Because voice-assisted care is real-time documentation, it moves intervention "upstream" in the care process. While standard documentation procedures drive care planning that is reactive or post-event, voice-assisted care documentation enables caregivers to implement intervention much earlier, on a prospective or proactive basis. In addition to the toileting example above, voice-assisted care impacts problems such as pressure ulcers. Pressure ulcers are also a serious problem in LTC facilities. A 2006 Internet article[1] reported that nearly 24% of residents—about 1.8 million people – in LTC facilities experience pressure ulcers, with an estimated cost of treatment of $1.3 billion annually. Beyond the obvious impact on residents, according to the article pressure ulcers are also one of the most common causes of litigation involving LTC facilities. The same article reported that lawsuits related to pressure ulcers are the second most common lawsuit after wrongful death, and total approximately 17,000 annually. Settlements range from under $50,000 to $4 million each.

After implementing voice-assisted care UPMC Cranberry Place saw a 75% reduction in pressure ulcers among high-risk residents, and a 43% reduction in pressure ulcers among short stay residents.

The ability to communicate instantaneously with other staff through voice-assisted care's silent-paging feature also means that staff are more responsive to residents and can get assistance faster when needed, and makes for a more peaceful, serene home-like environment for residents. Perhaps the most impressive feature, said Charles "Chuck" Emerick, director of nursing at UPMC Seneca Place, in an article published in the January 2008 issue of *Nursing Homes Long Term Care Management*, is how pleased family members are that, when they call, staff have information available about their loved one at their fingertips.

"When someone asks, 'How's Mom today?' the unit secretaries call it up," said Emerick, "and give them specific answers right away. They like getting immediate feedback about their loved ones."

Positively Impact Reimbursements

The fact that voice-assisted care is the only point-of-care technology available that literally enables caregivers to document conveniently and immediately after they are providing care provides LTC facilities with assurances that they will receive credit, from a reimbursement standpoint, for the actual care they are delivering. Voice-assisted care, quite simply, increases the accuracy of documentation because staff no longer have to take time away from their resident care tasks to key in data at a kiosk, or wait until end of shift to convert their handwritten notes. This increase in accuracy alone has led to a dramatic increase in maximizing reimbursements for LTC facilities.

[1] Medical News Today www.medicalnewstoday.com /articles/39327.php

At UPMC Seneca Place, Medicaid and Medicare reimbursement increased 9% and 4.5% respectively, creating hundreds of thousands of dollars in additional revenues and very quick 3 month payback. The implementation of AccuNurse at Seneca Place paid for the implementation of AccuNurse in the next 3 sites across UPMC's portfolio of skilled nursing facilities. At Church of God Home, a Continuing Care Retirement Community located in Carlisle, Pennsylvania, in just seven months following implementation, reimbursements increased over $100,000.

The impact of accurately capturing ADLs is clearly illustrated through the example where one organization failed to accurately document a single patient turn (positioning in bed) at each required interval. Over the course of a 90-day stay, the institution billed only 87.8% of what it was entitled, resulting in an *underpayment of $6,878*. (Appendix 1).

Cutting Operating Costs and Increasing Operational Efficiency

As the federal government continues to plan for ways to control costs by lowering reimbursements to LTC facilities, it becomes even more important for these organizations to ensure that they are operating as efficiently as possible. Voice-assisted care has been shown to play a critical role in reducing total staffing hours in order to deliver the care required, especially in cutting overtime and reducing shift overlap by replacing meetings with reports, reducing report writing, and increasing efficiency through such improvements as reducing the amount of time staff spends searching for colleagues.

A study conducted by the National Institutes of Health summarized the impact this way:

- Nurse overtime was reduce by 55%
- Paging/staff calling was reduced by 55%
- Searching for staff was reduced by 65%

The study showed the annual labor savings at one institution to be significant: Nurses saved 588 hours, resulting in cost savings of more than $26,000; nursing overtime was reduced 1,764 hours, representing just over $118,000; CNAs saved 600 hours in time, for a savings of $9,000; and CNA overtime was reduced 216 hours, or $4,752. The hours saved totaled 3,168, equivalent to 1.53 FTEs, for a total cost savings of $158,400. (Appendix 2).

Another time-consuming task, if performed manually, involves identifying residents who did not have a bowel movement in the last three days. Within three months following implementation of voice-assisted care at UPMC Seneca Place, time consumed by this task decreased from 27.5 hours each week to just 45 minutes per week (see example report in Appendix 3). The time-savings equals 26.75 hours per week, or 107 hours per month, and represents 0.67 FTE.

Also at UPMC Seneca Place, all CNA paperwork was eliminated and time spent generating reports fell by 95%. Further, voice-assisted care resulted in a reduction of 83% in searching for other staff.

UPMC Cranberry Place experienced similar, dramatic results. Staff time involved in generating reports fell by 49%, and time searching for other staff by 91%.

At Church of God Home in Carlisle, CNA paperwork was reduced by 95%, while overhead paging was reduced by 75% and searching for others reduced by 75%. Further, licensed staff overtime was reduced by one to two hours per day, and nurse aide staff overtime was reduced by three hours per day. End of shift reporting at Church of God amounted to savings of 15 minutes per CNA per shift, and 15 minutes for nurses per shift, for total savings of $24,000 per year.

At Peninsula United Methodist Homes, where they replaced kiosks with voice-assisted care, nearly all CNA paperwork was eliminated. In just a single PUMH facility, more than 2,200 nursing hours were saved per year in one 65-bed facility.

Recruitment and Retention

LTC facilities implementing voice-assisted care have witnessed a significant impact on staff recruitment and retention. UPMC Seneca Place saw turnover of LPNs drop by 74% and CNAs by 40%. PUMH Methodist Country House in Wilmington, Del. experienced a 19% drop in turnover in all positions in just three months following implementation. Interviews with staff suggest that the reasons have to do with increased job satisfaction. The staff feels as if they are providing better care for residents, and are more responsive to their needs and to the concerns of family members.

Chuck Emerick at UPMC Seneca Place explained it this way, “We now have more accurate documentation and everyone is done right on schedule. But, most importantly, our CNAs go home at night knowing they’re taking better care of their residents. That’s a winning scenario for everyone.”

Jim Palmer, chief operating officer for UPMC Senior Living agreed, saying, “The improved quality care, the satisfaction of the staff and the reimbursement improvements are all there. There’s little doubt that voice-assisted care is a good investment that fits UPMC’s corporate vision.”

UPMC believes so strongly in voice-assisted care that it holds out the new technology as a recruitment and retention tool as part of its Geriatric Advancement Program (GAP) at recruitment open houses. GAP is a clinical ladder program that enables aides, CNAs and LPNs to advance titles and salaries.

Annual State Surveys

The comprehensive automated documentation features of voice-assisted care means that institutions are constantly collecting data and are automatically building documentation for their next annual surveys. As reported in the NIA study cited earlier, voice-assisted care provides access to ever-changing resident information, which can be particularly helpful during annual surveys. Resident-specific or unit reports are available for a specific date or range of dates[2], and a printed version of a resident’s entire care plan, or just a single section, could also be requested by caregivers.[3]

Peninsula United Methodist Homes (PUMH) Country House recently experienced the value of voice-assisted care when it received a G-Tag citation during a recent state survey, appealed the decision and won.

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[2] National Institute on Aging Final Report, AccuNurse System, p.15
[3] National Institute on Aging Final Report, AccuNurse System, p. 17

During the facility's June 2007 survey process, PUMH Country House was cited for not repositioning a resident, and received a G-tag (a G-tag citation means that, in the opinion of the surveyor, actual harm was done to the resident). Among other things, the citation results in an increase in insurance premiums, negatively affects the organization's reputation, and is posted on the Internet for public information.

In this case, the director of health services, Kim Drake, RN, was convinced, based on the documentation provided by voice-assisted care that, indeed, the resident had been out of bed at least two times per day, that staff had performed skin checks, and the resident had been at meals. *Armed with this documentation Drake and her colleagues challenged the citation at a dispute resolution hearing, and won.*

At Church of God Home, Mary Hartman, director of nursing, conveyed her institution's experience with the annual survey. According to Hartman, the surveyors spent a great deal of time looking through process charts and data. "In one instance," she said, "the surveyor asked for the intake and output sheets for a particular resident, and our nurse was able to pull up the entire record very quickly. When she handed it to the surveyor, literally a few minutes after the request, the surveyor stopped and said, 'Wow! This is excellent.'"

Hartman noted the survey team's positive feedback. "The surveyors took notice that we utilized the best available tools that improve the care of our residents and help them achieve more productive lives," she said. "At the Church of God Home, we're all very proud that we're better positioned than ever to comply with both policy and practice, for our residents' sake and for our organization's sake."

ROI: Payback in Six to 12 Months

The organizations cited in this paper are benefiting financially from voice-assisted care in two important ways: First, by directly impacting their institutions' bottom lines through substantial, six-figure increases in reimbursements from Medicare and Medicaid. Second, by decreasing expenses related to overtime, paperwork, and inefficiencies such as trying to call or locate staff. Most organizations are experiencing a payback within six to nine months.

Across the range of clinical and operational activities, the benefits of implementing voice-assisted care are substantial: Eliminating four resident falls per year has a financial impact of $21,300; reducing CNA turnover by one per quarter has an annual impact of $12,000; decreasing one incontinent episode by each CNA daily (assuming 30 CNAs a day at $2.70 per episode) results in savings of $29,565; and preventing the progression of each type of pressure ulcer once per quarter yielded savings annually of more than $56,000 on average. (See Appendix 4.)

A Summary of Who Benefits from Voice-Assisted Care

In LTC, voice-assisted care helps improve overall care delivery and satisfaction for the following:

- **Residents** – By faster, more accurate and personalized delivery of care they need
- **Family members** – With peace of mind knowing their loved ones are receiving the best care available
- **Caregivers** – By liberating them from paperwork, searching for staff, unnecessary steps looking for manuals, meetings, and other non-value added activities that distract them from resident care
- **Nursing staff** – By putting information at their fingertips in real-time, helping them to actively manage care and more quickly identify changes in care status before they become issues
- **Administration** – By gaining visibility and accountability of staff activity, and making it easy to respond to surveys
- **Senior executives** – By improving reimbursements, lowering staffing costs and reducing litigation and compliance risk

About the Author

Leah Klusch is the founder and the Executive Director of the Alliance Training Center. As an educator and consultant, she has extensive experience in presenting motivating programs for a variety of heath care professionals. Her dynamic style and innovative ideas make her a highly sought after speaker and recognized nurse leader in the health care industry. Leah believes on focusing on learning, not teaching.

Have More Questions?

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Appendix 1: Bed Mobility Chart (showing document, actual and financial impact of not properly documenting one ADL over the course of 90 Days)

	Documented	Actual	Impact
Bed Mobility	3/2	3/3	
Transfer	3/2	3/2	
Eating	3/2	3/2	
Toileting	3/2	3/2	
ADL Score	15	16	
MC 5	$6,944	$7,907	**$963**
MC 14	$7,936	$9,037	**$1,101**
MC 30	$14,881	$16,944	**$2,063**
MC 60	$14,881	$16,944	**$2,063**
MC 90	$4,960	$5,684	**$688**
	$49,602	$56,480	**$6,878**

Organization billed only 87.8% of what it was entitled

Appendix 2:

Annual Labor Savings

	Hours Saved	Cost Saved
Nurses	588	$26,460
Nurses: OT	1,764	$118,188
CNAs	600	$9,000
CNAs:OT	216	$4,752
TOTALS	**3,168**	**$158,400**

Appendix 3:

West Side Unit
Skilled Unit BM Report
June 5, 2004 - June 9, 2004
(Night - Day - Evening Shifts)

Room	Resident Name	Date	Time	BM Desc.	C or I
282	Elody Jules	June 5, 2004	03:16 AM	Small	I
		June 5, 2004	06:36 AM	Large	I
		June 6, 2004	07:14 PM	Large	C
285	Elaine Johnson	June 5, 2004	02:16 PM	Large	C
		June 7, 2004	10:55 AM	Large	C
		June 7, 2004	03:50 PM	Small	C
		June 7, 2004	07:57 PM	Smear	I
		June 8, 2004	09:00 AM	Medium	C

Appendix 4: The Power of "One"

Benefits of Voice Assisted Care	Improvement by One	Year 1
	Reduced form and paper cost ($10 per resident per year)	$1,000
Metrics are showing at least 2 per quarter currently	Eliminate of fall per quarter ($5,325 per fall)	$21,300
Metrics are showing a reduction of 5 per quarter.	Reduce CNA turnover by one per quarter ($3,000)	$12,000
Metrics are showing a reduction of 25% overall.	Decrease one incontinent episode by each C.N.A daily (30 CNAs a day @ $2.70 per episode)	$29,565
Metrics are showing a reduction of 25-30% overall.	Preventing the progression of each type of pressure ulcer once per quarter ($14, 077)	$56, 308
	Annual Savings from the power of one	**$120,173**

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