

Changing the Culture and Improving Quality: Innovations in Long-Term Care

Panelist Responses to Unasked Written Questions
November 2007

In October 2007, the Alliance for Health Reform, with support from the Robert Wood Johnson Foundation, held a Capitol Hill briefing to examine cultural transformation and its affect on quality of life in nursing homes. Panelists were **Bonnie Kantor**, Pioneer Network; **Rosalie Kane**, University of Minnesota; **Jay Sackman**, Service Employees International Union; and **Karen Schoeneman**, Centers for Medicare and Medicaid Services.

Following the panel presentations, many participants submitted written questions. Though several were addressed on the spot, there was not sufficient time to answer all. The Alliance asked the panelists to respond in writing to any or all of the remaining questions. Following are their responses.

Care/Quality

What impact do you think Culture Change efforts will have on the “institutional bias” in Medicaid? Don’t most people prefer to stay at home even if there are “nicer” institutions? Should we be looking at campus models that combine institutional care and community based care?

Rosalie Kane: The institutional bias in Medicaid usually refers to the systemic biases that make it easier for a consumer to enter a nursing home under Medicaid than to access home and community base services. The biases are both embedded in various State and Federal policies and also in common practices especially around hospital discharge. The Culture Change movement for nursing homes will not directly affect those biases, but many efforts of State LTC programs and CMS are directed at reducing those institutional biases. I agree with the premise in the question: Most people do not wish to live in an institution, however nice. To the extent that the culture change movement can result in nursing homes that are not institutional, the culture change movement will have had a wonderful effect. Residential settings are more institutional to the extent that residents lack privacy, lack freedom of movement inside and away from the residential setting, are unable to control their own schedule and their own space, and do not have control over the ability to remain in or leave the setting. Some consumers and their families like campus models, but I do not see how models that combine institutional and HCBS services in a campus model serve to reduce institutions. In fact, culture change movements may lead to campus models of the future with NO long-stay institutional care, though they may have an infirmary, a post-acute care unit for rehabilitation capacity, and/or a short term hospice.

Bonnie Kantor: Yes, the first choice for most of us is to remain in our own homes and arrange for support there as needed. But sometimes—and, in fact many times, -- this isn't possible. Our message is that a person doesn't need to stop "being home" when she moves into more supportive setting. Instead, we can create home and community in long term care settings. In a nursing home undergoing transformational change, we say that the care is individualized and the services are de-institutionalized. So, for example, medications are not dispensed during "rounds" but instead are provided to residents in a way that fits their own personal waking and eating routines, just like when you take medications in your own home. Other aspects of daily life like bathing are personalized too, so residents are not showered in institutional surroundings but instead receive bathing support in a warm, inviting environment by individuals who they know and trust. So, we are actually talking about de-institutionalizing the nursing home and providing incentives for smaller, more humane, life affirming and meaningful environments for people who need residential long term care.

Given the high rates of dementia and other mental health issues in the oldest old, how is resident choice handled in culture change facilities that care for this population?

Rosalie Kane: In my experience there is no single way of handling dementia and mental health issues in facilities immersed in culture change. Some creative efforts have been developed in and for facilities that are dementia-specific and other efforts have been made to incorporate people with dementia in the mainstream population. Most obviously, elimination or near elimination of physical restraints, careful use of psychoactive medications, training staff to understand the reactions of people with dementia and avoid exacerbating them, and programming (often one-on-one) designed to meet the needs of persons with dementia. Some excellent work has been done to engage family as well. Mental health issues in the oldest old, candidly, tend to be ignored, under-identified, and under-treated in all settings—I look forward to the culture change movement tackling this problem.

Bonnie Kantor: One of the key steps nursing homes take when they create a home and community where relationships can thrive involves eliminating the practice where direct caregivers rotate across units; instead, we promote consistent assignment to advance true resident-centered and directed care. That is, front line workers work in the same "neighborhood" or "household" every day with the same group or residents. Staff members then learn the preferences of residents better. Relationships are formed and everyone's life goes smoother as the natural daily routines of the residents are known. By empowering the direct care staff who know the resident with dementia or other mental health concerns the best, we are on the road to ascertaining the resident's choice. And, as care needs and abilities change, people are still able to express needs and desires—just in a different fashion-- and with consistent assignment, caregivers are able to understand the subtle markers and signs. In

addition, with consistent assignment, residents feel more comfortable and secure since they know their needs will be anticipated and thus some of the behaviors that stem from tension and anxiety are absent.

How does one identify/find a culture change facility in their community?

Rosalie Kane: A “culture change” facility is not really a term that can be used to identify a nursing home—it is a short-hand term for any and all of the efforts a facility makes to improve quality of life for nursing home residents and quality of work for line staff. Word of mouth is the usual way to identify facilities that are engaged in such culture change. Often the Quality Improvement Organization (QIO), the state nursing home trade associations, and the state ombudsman organization will be aware of such activities. Consumers can typically visit the websites and read materials available to the public. When exploring nursing homes in the community, prospective customers can ask directly whether the nursing home is engaged in culture change: note, if the informant asks you what you mean by culture change, I would take that to be a “no” answer. If a “yes” answer is received, ask for detail. I would always ask about the availability of private rooms and the basis on which they are allocated. I would also ask how free residents are to develop their own life routines while living in the setting, and would get specific about bedtimes, rising times, meal times, bathing choices, and the like.

Bonnie Kantor: To identify an organization that provides resident or person centered and directed care, one needs to first think about what it means to create home in a long term care setting. In general you want to find out how the staff gets to know residents. Does the interaction between staff and the residents appear warm and friendly? Do staff members know the residents they care for? Is the same team of nursing and front line workers assigned to work with same residents? How residents are involved in decisions and how basic choices are made about daily life then become key. Some questions one could ask to determine this include: Do residents wake on their own natural schedules and go to bed when they want? Do they eat what and when they want? And do they decide what they are going to do during the day?

Finance/Regulation

Do Green Houses and other small house models work as a business model? Are they cost effective in comparison with traditional models? Are states with Certificate of Need regulations bending the rules to allow culture change models to be built?

Rosalie Kane: Green Houses and other small house models certainly can work as a business model. For new construction, they are comparable (and sometimes less) than the cost of a traditional facility—obviously the cost per square foot will vary regionally and according to the levels of amenity the organization builds in.

Operational costs are also comparable to a traditional nursing home, but require a redistribution of costs. When considering the affordability of a small-house (or for that matter any capital costs in a nursing-home), the organization needs to consider its payer mix (and the possibility of changing it), and its total revenue stream from housing, home care, and the like. The considerations will be different for CCRCs and campus programs in contrast to a free-standing facility. The National Green House program and various other consultants for culture change have developed model pro forma tools for facilities to consider.

Bonnie Kantor: In general resident-centered care does not cost more—and in fact, providing care and services should cost less over time. Let's just focus on one aspect -- the impact on direct care workers and support staff. In resident-centered organizations, including the greenhouses and other small house models, the direct caregivers are trained differently and have more control over how they do their jobs. They work on self-led teams and participate in the care planning process and get to know residents better making their jobs more meaningful. This leads to workers who stay on the job longer, so turnover is reduced. The investment really does yield returns.

If culture change facilities increased the demand for institutional care how would this affect cost to the taxpayer through public reimbursement mechanisms (i.e. Medicaid and Medicare)? Can state budgets handle the increased demand?

Rosalie Kane: I do not anticipate that culture change facilities will increase the demand for institutional care, but rather will render nursing home care less painful for residents and family. As one of the other questions implies, people do not seek out institutions for themselves. The truest test of success will be if more people choose to pay privately for nursing homes. Assisted living apartments—themselves an enormous culture change for long-term care—are being used in many states by people who would be eligible for nursing homes, and the preponderance of payment is private pay. Since the 1999 U.S. Supreme Court *Olmstead* decision, states have been deeply engaged in changing the landscape for long-term care and long-term support services. The notion is that more people can be served in places where they would rather be without changing the overall rate of growth for all Medicaid long-term care expenditures in all settings. Medicare does not pay for long-term institutional care at all and until recently short-stay Medicare units have not been the focus of culture change. However, to maintain market share, nursing homes themselves have often taken steps to improve the living situation in short-stay units—providing single rooms and baths, cable ready and telephone ready settings, and gearing the unit towards hotel models rather than household models.

Workforce

What initiatives should be taken or are being taken to prepare leaders, managers and line staff to undertake/implement cultural transformation in states other than NY?

Rosalie Kane: Numerous initiatives are underway and more would be welcome to prepare the long-term care labor force at all levels for transformed long-term care. In terms of nursing homes, state AAHSA and AHCA affiliates have invested in leadership training at their state annual meetings; chapters of MADONA have worked on DON training; medical directors have slowly become more cognizant of the possibilities; and culture change consortia in many states have been working on culture change. The Quality Improvement Organizations (QIOs) have been charged to incorporate culture change into their Scope of Work. Going beyond nursing homes, we can identify enormous needs for continuing education and basic education that highlights the way older people want to live when they need long-term care. The groups needing to hear this message include Survey and Certification Agencies and state ombudsmen as well as the usual targets—long-term care providers and professions.

Jay Sackman: I start with the basic premise that top-down approaches to cultural transformation in nursing homes are doomed to failure. You just can't be effective if you use an institutional approach to creating a home. If you try you will just wind up with superficial change and the staff will not buy into the process. Everyone who works and lives in the home and the families of the residents must be engaged in the process.

The staff must be empowered to engage in an open dialogue with their employers as well as the residents and their families about the type of environment they want to create. The hierarchical institutional barriers which exist in most nursing homes are an impediment to that dialogue.

Although there are several effective change methodologies being utilized by leading pioneers of culture change, our experience in New York is teaching us that in an environment in which the employees are members of a labor union, if the leaders of the union, at every level, are engaged in this process, the outcomes will tend to be more holistic and lasting. The reason is that since culture change at its core is about relationship, the open communication and problem solving techniques that we have been using in New York, in a labor/ management context, have led to the formation of stronger relationships based on trust and collaboration.

I believe that the SEIU will be engaging in this dialogue with nursing home operators around the country. The values of the "culture change" movement are congruent with the values of the Union's members. If the members want it then the leadership of the Union has an obligation to give the members what they want.

How difficult is it to deal with resistance from professional nursing and medical staff, especially with regard to allowing “unskilled” staff to handle what were considered “professional” responsibilities? Which states have changed or are planning to change their Practice Acts to allow the implementation of culture change staffing concepts?

Rosalie Kane: Inertia and habit stand in the way of most changes, and in addition professionals sometimes worry about safety if the responsibilities of unlicensed staff are increased. At the program level, resistance to change is less likely if professionals are involved in developing the changes. Nurse Practice Acts can be a barrier in assisted living or community care; federal law mandates a licensed nurse on all shifts in all nursing homes. Much work has already been done to clarify nurse practice acts or (when needed) modify them to permit licensed nurses to teach and delegate tasks in long-term care. Resistance is overcome when it is clarified that the nurse is not legally liable for misconduct on the part of a delegate and when data are presented that show no harm and considerable advantage from that delegation that keeps nurses in the loop. A detailed study in the State of Washington, for example, showed not a single instance of harm and much benefit to delegation policies in assisted living. Besides delegation, exemption is a possibility: most states already exempt paid servants, family members, and attendants from their nurse practice acts. Only a small minority of states (NY and PA among them) prohibit nurse delegation. It is possible that other professional boards such as Pharmacy Boards and Physical Therapy boards also need to examine their practice acts.

Jay Sackman: It is difficult to deal with the resistance of professional and medical staff as well as the resistance of supervisory staff. They seem to be addicted to something which obviously doesn't work at every level. We all however need to be patient with each other. They have every right to be concerned about clinical outcomes. It is possible to create a clean, safe and efficient home and protect the professional standards of the clinical staff. We all just need keep our eye on the goal. The goal is resident directed care and creating a home.