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**Changing the Culture and Improving Quality: Innovations in  
Long-Term Care  
Alliance for Health Reform and Robert Wood Johnson  
Foundation  
October 19, 2007**

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[START RECORDING]

**ED HOWARD, J.D.:** If I can have your attention I think it's appropriate to get started now. My name is Ed Howard with the Alliance for Health Reform. I want to welcome you on behalf of our Chairman Jay Rockefeller; I'm sorry Co-Chairwoman Susan Collins, and the other members of our board to a briefing on how to move our long-term care system closer to the needs and the wishes of the people who are actually receiving the care. Our partner today is the Robert Wood Johnson Foundation, the county's largest philanthropy dedicated to improving health and healthcare in our country.

The foundation has a long history of supporting efforts to improve long-term care. The President of the Foundation is [inaudible] by the way. They've also done a major project on examining possible changes in long-term care financing that you may have seen some results from earlier this year.

Wendy Yallowitz from the Foundation is in the audience just to make sure we don't take their name in vain. If you have questions about the Foundation, about long-term care, and their involvement I'm sure she'd be happy to try to respond to them.

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The topic today is Culture Change which may strike you as some sort of social engineering slogan, I don't know, and maybe it is. But there are profound policy implications, as well. There are about one point six million Americans in nursing homes. There are thirty-seven million baby boomers who will soon be aging into the territory when greater long-term care need is expected. Between Medicare and Medicaid state and federal governments finance more than two-thirds of long term care spending. And almost two-thirds of nursing home spending. There is a good fact sheet, by the way, on some of the basic numbers, in your packet from that Georgetown Financing Project.

One other number, about a third of those turning 65 in 2010 we expect to need nursing home care some time in their lifetime, a third. But they're not looking forward to it. The image of today's nursing home is not a pleasant one either based on the quality of clinical care being developed or the sense of control that people are afraid to lose once they enter a nursing home. And that's what the culture change movement is all about.

You're going to hear about a bunch of ways that people who are committed to better long-term care are pursuing to make that care more resident centered and less institutional and more home-like. And I think we have

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assembled just an incredible group of folks to help in that discussion.

A couple of logistic items, some of you may not have heard before, I mentioned the packets of materials that you have. There is a lot of background information. There is good sheet on the backgrounds of our speakers, more extensive than the intros that I'll be giving them, copies of the slides that you'll be seeing up on the screen. By Monday you can view a Webcast of this briefing on [Kaisernetwork.org](http://Kaisernetwork.org). A couple of days after that you'll be able to read the transcript that will also be posted there and on the Alliance at [allhealth.org](http://allhealth.org). And for those of you that are somewhat more in tune with the popular culture there is podcasts that you can download.

In those packets, by the way, there are green question cards you can use. There are microphones that you can come to ask your question in person. And if I sound like a nudge it's because I really like to be able to read your evaluations after this and if you would do us the favor filling out that blue evaluation form afterwards you'll help us be able to respond to suggestions that you make to make our briefings better and of more value to you. So, as I said we have a terrific group of speakers and so turn your cell

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phones to vibrate and your heads to the front and let's get started.

And we're going to get started with Bonnie Canter. Bonnie is the Executive Director of the flagship organization pursuing culture change in long-term care, it's called the Pioneer Network. Her work at the Ohio State Medical School to make its graduates aware of the challenges of aging and long-term care have gained national recognition. In fact, Ohio State is now known as having one of the top geriatric programs in the country. Now, at the Pioneer Network Dr. Canter is bringing some of that same dedication to the task of changing the culture of the entire long-term care system. And we're very pleased Bonnie to have you with us here today to inform the Washington audience about that.

**BONNIE CANTER:** Great, thank you so much. Can everybody hear me in the back? Wonderful. OK, thanks so much for the opportunity to be here today and since as Ed said I've spent the last twenty-two years of my career in academia I am going to start with a question, which is do you think there are more McDonalds in this country or nursing homes?

Well, it turns out that there are approximately four thousand more nursing homes in this country than there are McDonalds. Now, what does that mean? It means we've got a

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big thing to tackle right now and if you're ever looking for a good statistic to quote that is a fine one.

The transformation of the nursing home is long overdue. The existing products that we have fails to meet the needs of frail older adults and families who love them, costs are high and your community's and states struggle to support the existing model without compromising quality of care.

So to address these quality and efficiencies concerns organizations are moving to find new and creative ways to what we call create home and community for nursing home residents while still providing the high quality care that a medically complex population needs.

The bottom line is that in this time of rebalancing and unified state long-term care budgets this culture change and the resident centered care that results will be of great importance, not only because the philosophy is compelling and I think you'll agree to that in a few moments. But because the business case, in terms, of quality and cost supports investments of change at the operational level and the policy level. And at the end of my presentation I'm going to be focusing on some of the key things that all of you in the audience can do in your districts and states and federally to help make this happen.

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And the most important thing we can all do to make it happen is—can everybody see this? This is an easy button, culture change right now is very complicated. Our goal here today is to figure out a way through policy and operations to make culture change the norm, to make culture change the default mode and we're not going to be successful until...

**MALE SPEAKER 1:** That was easy. [Laughter]

**BONNIE CANTER:** we need you in this process. So, I start with another question, who here is aging? Please raise your hand. [Laughter]

Look around; if somebody did not raise their hand we will call the squad. When did you start aging? Well, I won't get into that debate that it was sometime around birth. And where have you always lived since you started aging? You have lived at home wherever home may be.

And what you have here are some basic characteristics on your left of what home is. And some basic characteristics of what lack of home or homelessness is. Why on earth in our communities in the year 2007 are we creating a cadre of homeless older adults? Meaning folks who are living in nursing homes without the basic characteristics that we all want.

Isn't that what your constituents want? They want to be able to say are the values of choice, respect, and self

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determination practiced here? And if we work together the answer is going to be yes. And only then will nursing homes be the place where we would want to go to live or where we would want our loved ones to live.

Part of the other reason to do this is what physicians tell us is that no matter hard they work to help someone be healthy or more well it will not work if they don't have a sense of community. We are bred, our genetic code is for us to live in community. The cavemen died out that weren't able to delegate somebody goes and gathers, somebody else goes and cooks. If you were someone who could not live in community you didn't make it. If you take community and home away from our older adults they will never be healthy.

So, what we are proposing is to take resident center adaptations that we will all be talking about today we will show you and we have research that proves that improved quality of care and measureable financial success both for states, the federal government, and our organizations comes from this residence centered care. And then what that provides all of us with is the opportunity to see if efficiency and quality is inter-related outcomes which means again to the bottom line we should be reimbursing those

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organizations that can improve quality of care better than we are doing now.

Now, one of the places you can turn if you are looking for assistance with this is the Pioneer Network. You have information in your handouts about the Pioneer Network. We were formed in 1997 and we are the ones along with many others who champion these values that we talked about to make nursing homes a place where life is satisfying, humane, and meaningful.

And that movement is known as the culture change movement. We are an umbrella organization. We are not a membership organization. We support the kinds of transformation we're talking about in a wide variety of ways and to put a little plug in we will be having our National Conference, you all have this in your handouts, here in Washington. We expect to see you all there. And so we'll be able to work even more closely together.

But everything that needs to be done is not a federal concern. It's a state concern, as well. So, what you will find as you go back to your states is there are thirty-six active state coalitions that are independent. We helped organize them along with some others. Diverse stakeholder involvement, they are coordinated with other state efforts

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and their responsibility is to help to get culture change going on the state level.

What we also know is that there is no funding for these coalitions and one of the things we are going to leave you with at the end is some questions about how we can fund them, perhaps, through civil penalties money and some other innovative ways. So, the key questions that I'm going to do with the remaining few moments that I have is to talk about what is resident centered care, why we all want it, where we are now, and what's it going to take to make it the norm?

Very quickly I'm going to share with you a scenario that happened in a medical directors home in Cleveland, Ohio, go Indians, I have to get a little plug there. Medical director was called in the middle of the night by the DON and the DON was telling him about four residents who had fevers between 99.8 and 102.2. He had only one question for her and the question was why were you taking their temperatures in the middle of the night?

[Laughter]

And her answer was that's when the staff has time to do it. In a nutshell, we are going to talk about why that was wrong and how resident centered care will solve that.

So, what is resident centered care? It's taking the proper health care and merging it with resident support based

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on a core set of values we talked about those already where choice, dignity, self-determination, and purposeful living. We respond to each individual's needs and desires and then we create home. And creating home is what separates resident centered care from all of the other discussions of patient centered care that you hear about in the acute setting.

There are many ways to talk about culture change and of course we will be talking about some of the smaller living environments. The Green House Project, the Eden Alternative, the Household Model, et cetera. But those are just markers for some of the ways that we go about doing it including permanent work assignment. If you think about it people who know the resident's best will be able to figure something out very quickly. A flattened hierarchy, decision making at the resident's level and dismantling the routines and daily systems to allow for freedom and choice.

Now, I'll bring this back to a level of all of us. If I woke you up before you were ready to get up or if I didn't feed you when you were hungry, fill in the blank, would you be grumpy? Yes. Would you be able to participate as well as if I let you sleep on your natural schedule? Absolutely not. If you don't believe me and you have a two year old at home try it with them. If you have a teenager try it with them and then ask them to go somewhere when

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they're hungry, especially somewhere they don't want to go.  
Need I say more?

So, what we know is that by providing resident choice, by creating what we call normalcy, going back to people's natural schedules were going to get better clinical outcomes, the range of clinical outcomes is going to be broadened because we get it. We know how people will react and the clinical concerns will be uncovered sooner.

So, what's it going to take to make this resident centered care the norm? What do we all have to do? First, it's important to know that this is no longer a question. We have gone from debates to conversation. We all agree, the question is how.

What we need to do is help everyone know it works. Help everyone know that the business case is very sound from a state perspective and from an organizational perspective. You can secure resources and you can just as well if not better than the traditional care.

What are the steps? Very briefly, first we have to reframe the question. George Lakoff says to his students at Berkley "Don't think of an elephant." And as soon as he says to them "Don't think of an elephant. Now whatever you do don't think of an elephant." Do you know what they do? They think of an elephant. And when we say to people "oh, no, no,

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no, it's not your traditional nursing home. This is different. It's culture change" all people see is the traditional nursing home. So, what we need to do is change the terms. We have to undo the debate and stop using other people's terms. So, instead we don't want to talk about the locus of care what we want to talk about is values. The value of honoring the dignity of each elder and the staff members and by doing so many of the costly problems both in terms of money spent and lives unfulfilled will be addressed and eventually solved. And can be solved, we believe, within a three year period.

We are also working with new organizations which, of course, is part of the reason we're here today, folks that truly can make a difference in policy and practice. And then the next is we believe very strongly that we have to drill down and get into the educational system. People have to learn about this in our schools. They have to learn about it in the universities and in the training program.

And the last thing that we have to do and I will be closing in approximately two minutes is to promote the business case. You have to work along with us to help up explained that this is a very smart move for the states. It is a very smart move for the Federal government and it is a very smart move for the organization. Recent studies have

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shown this and let me give you two brief examples, here what you will see are non-adopters those who have not engaged in culture change and early adopter homes. And as you can see from 1996 to 2003 there was a significant change in citations through surveys.

Next what you will see is what has happened to operating margin with the early adopter homes and those that have not undergone culture change. And as you can see the operating margin over time for those that have undergone culture change is significant.

Now, this slide says, for those of you that can't read it, if I don't think it's going to work will it work? If you in this room do not think it's going to work the answer to that question is no it's not going to work. Because we need some changes in policies and practices most specifically, as you will see in your packet, there is going to be a symposium that CMS is going to be doing along with the Pioneer Network in April here in Washington. We need you there. What we are going to do is work through either the perceived or the real issues in regulation that impact how one can deliver resident centered care through the environment. We will then be drilling down and going back to the states and we have hired an individual to help us work at the state level.

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Secondly we are very firm believers that people that are not trained to do things are just not going to do them. Most of our Medicare dollars go into graduate medical education in the acute care sector in the hospital. We need to work together to ensure that some of that training doesn't just take place in places that are engaging in resident centered care but that the organizations that are providing that also get some reimbursement.

And finally as you'll see many of our states have true issues with Medicaid reimbursement. They disincentivize resident centered care. We can show you that if you apply these policies folks will be healthier, acuity will go down, independence will go up and as a result reimbursement goes down. There is a disincentive to engage in culture change. We would like to work with you to develop waiver programs and to change the way we are reimbursing long-term care to encourage and not disincentivize resident centered care.

So, with that I am going to close and thank you so much for your attention. I look forward to working with all of you in the future so that we can create a more just and humane future for our most deserving citizens. I believe that as a society we can do better. I believe that together we will. [Applause]

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**ED HOWARD, J.D.:** Thank you very much, Bonnie. We are going to turn next to Rosalie Kane who's a Professor of Public Health and a bunch of other things at the University of Minnesota. She's a veteran of other Alliance for Health Reform and certainly the Alliance for Health Reform's Executive Vice President's experience over the years. She is one of the most respected long-term care analysts in the country, by far.

She's looked carefully at the some of these culture change models that Bonnie was alluding to and we've asked her to give you some detail about them and the experience with them to go with the kinds of principals that Bonnie has laid out.

Rosalie, I am just so happy to see you here on our podium here.

**ROSALIE KANE:** Well, thank you I'm happy to be on this podium I didn't think I could be on it without having been elected to something or raised money for a campaign or something of that nature.

Thank you all for being here. It's really wonderful to see this large a group. I thank RWJ for sponsoring this. This is a topic that's very, very close to my heart. And what I'm going to talk about will dovetail very nicely with what Bonnie has talked about. I was asked to provide some

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specific examples and then ultimately to zero in a little bit on the small house models and the Green House model of nursing home as one example. So, that's what I'm going to do and I'm going to show you some photographs along the way because a picture is worth a certain number of words.

So, as Bonnie already said the goals of culture change, we're focusing now on the culture change within the nursing home, those places where nobody wants to go are to improve quality of life for residents and the individualization that Bonnie talked about as a vehicle to get there. A greater resident control and choice, continuity of the social lives and the interest that the residents have they don't just get bored at the moment that they move into the nursing home. So, they have a whole life. Some people have more of their family and their resources around them but they do want to continue their lives in their larger community but then there is also a need to create community within the nursing home.

So, we're working on individuality and we're working on community both in the goals of culture change. So, there probably could be many different ways of subdividing the approaches we would have on the ground. I think of sort of these four general approaches and all kinds of specific actions can be incorporated under them.

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So, we're trying to transform the physical spaces, the built environment, the equipment, the furnishings, everything about the design because physical environments do shape behavior, the behavior of residents, the behavior of staff, the behavior of visitors and that would elude both to the private spaces where people live and when you think it over if your private space just amounts to a bed and a chair in a shared room you really don't have private space.

And then the common spaces that are going to be shared if you lived in an apartment or in a neighborhood there is always common spaces. So, we're interested in both of those environments. We're interested in transforming staff roles at all levels as a way to bring about those changes and I'm talking about the professional staff and the line staff who don't always have professional degrees but are credibly important in the nursing home.

Transforming all the routines, the programs, everything that's done in a nursing home and, of course, transforming your philosophy. In terms of physical point there is such a wide range of things that can be done. I put private rooms and bathrooms first and foremost. Karen Schoeneman who's going to be speaking later from CMS knows that I have been talking about that ever since the days of OBRA. I was on that little committee in 1982 and was very

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forceful in suggesting a recommendation that CMS immediately the costs and benefits of private rooms for different populations so we could determine whether as a regulatory matter we should be demanding private room unless by choice and maybe about fifteen years later I got a chance to do that study and indeed we know about the power of private rooms and bathrooms.

But then there is kitchens, most of our single residents don't go anywhere near a kitchen, even family residents don't go near a kitchen. Kitchen, laundries, the fireplaces, you can read this. Getting it all down to residential scale you don't want to sit in a room like this to watch television. That's not a normal living space. There has been this movement in the neighborhoods—one nursing home in Rochester, New York and that area famously called it from hallways to households.

You can see some really elaborate spas in place of the hideous shower rooms, I visited a lot of them, that was some really awful stuff in traditional nursing homes. And removing nursing stations there shouldn't be fortresses behind which the staff hides, lots of things that you can do.

In fact, the good news is that our nursing homes largely have to be rebuilt. We don't expect every nursing home to turn around and change their physical environment.

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But a lot of the nursing homes in this country were built in the 1973's and the 1980's, some of them even earlier. So, that gives us an opportunity to do different things.

And these are all nursing homes. This is a fireplace, wood burning, which is a hard thing to get by regulations. Even Green Houses don't have wood burning fireplaces. Nice chair there in Northern Minnesota. The reason why I have this one up is to show you a nursing station, I don't know if even in the back or even in the front you can see it because it's only that little desk with the computer and a shelf over and above. And the ten elders who live in this particular neighborhood in this nursing home that's all you need.

I have seen nursing stations that are concierge's desks, all sorts of different opportunities rather than that fortress. And this one is just showing you an extreme. It's a part of Evergreen in Wisconsin and this is a spa that actually has a fireplace if we could see around the corridor we would see the shampoo bowl, the vanity table. You wouldn't mind spending time in that. And a nice curtain.

So, and that's the physical environment, in terms of staff, we've already heard about the idea of broadening and deepening the role of line staff where a universal worker is just a term that's used for that. Obviously you have to make some kind of job descriptions, nobody does everything but the

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concept that people would be able to do a much broader range of activities because after all if somebody wants the newspaper you wouldn't want someone to say, "Gosh that's not my job. We'll have to send the newspaper aide over to get you one later." We talked about permanent assignment as seen the reorganization of shifts big time. For instance, where is written that most of the action should happen between seven and three and it's of the weekdays. I mean why might you not want more staff at different periods of time? And I've seen nursing homes where they don't even have anything like a standard shift. They have all sorts of different times for different people to come in.

Now, with another hat I've reviewed all state nursing home regulations. Some of them get in the way of that. Some of them mandate the staffing ratios right down to the times of the shifts and that would be a little destructive. And, of course, empowering staff is what it's all about. On the programmatic end we have different ways of dealing with death which used to be the dirty secret of the nursing home. You whisk out the body and hope that nobody notices, none of the residents are supposed to get depressed or know that people are dying here.

Lots of different creative work to change care routines and in this package you're going to find a lot of

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material. I applaud the Alliance for what they put together because you can find resources on all of these things.

Bathing without Battle, et cetera and if you can't send me an email about it.

Putting care plans in the first person has proven to be powerful. So, instead of the professional team writing it up it comes up like I like to get up usually around ten in the morning and I do like to read the paper before breakfast. Or I'm a night owl, that kind of thing.

The philosophy, we already heard about normality and emphasis on quality of life. Under this big tent as Bonnie suggested that is the Pioneer Network and is the culture change movement there are lots of movements within the movements. And so a lot of you have probably heard about the Eden Alternative and this is just this notion of overcoming boredom, loneliness, and lack of meaning through the flattened hierarchies and other strategies, the least of which though important are animals and plants. The Well Spring Consortia is kind of an effort to improve quality care through new kinds of alliance and planning teams and its quite impressive thing. There is lots of material about it. There are culture change agents out there and I put some of their names at the bottom of my group of slides in case you want to go to their Websites and see the kind of things

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they're doing. We've gotten to the point now where culture change is a band wagon and there are people who have real expertise in helping organizations move from A to, not B, but to Z in the culture change arena.

I'm going to talk about the Green House in a minute so we're going to leave that. I hope you can read this but perhaps you can't because my color coding doesn't work very well in a big room. These elements are elements of a good quality of life thanks to CMS and the lady on my left and others I had the chance to work for a five year period to try to develop and test measures, first to determine what the elements of a good quality of life might be for people who live in a nursing home and then figure out if we could measure them.

So, I'm here to tell you all of these things are measurable. They're all outcomes as they pertain to the individual older person and living in the nursing home the comfort and the sense of security are the most basic and then we go up through the hierarchy. And it's very much like that lovely slide that Bonnie showed about homelessness in a nursing home.

So, let's go to the Green House, what are they? Some of you might seen the movie that was playing in the background before you all got settled and it's a very

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worthwhile movie to get a hold of and to look at. But it is a vision for a radically different deinstitutionalized nursing home. The idea was one of Dr. Bill Thomas who also brought you the Eden Alternative idea.

Essentially the physical plants have been so transformed that they are small houses with no more than ten people in them. Bill's original idea was seven. Each house is completely self contained. You don't go into another part of the nursing home and it's another Green House if it's not self-contained it doesn't fit with the model.

They are meant to be homes with all the symbols. The first architect thinking if you wouldn't have it in you wouldn't have it in your home we're not going to have it here. They had a little trouble with the Exit signs and the Fire Marshals and it looks a little silly to have a small living room and a lit Exit sign on either side but for the most part they achieved what they wanted.

Private rooms and baths for everybody. But very inviting public space if you want including fireplace and kitchen, a residential kitchen, and so on. And the philosophy is completely transformed in terms of quality of life and the other thing that is transformed is the organization of the staff. The idea is that the staff of these small homes called Resident Assistance if it truly is a

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Green House they might use the work. Chaboz [misspelled?] and chabazene [misspelled?] which are new terms that were developed. Chabazene is the plural of chaboz for the nurse's aide level. That person is the one who is responsible for all the life of the home, that group of people and then everybody else that regulations tell us that we must have in nursing homes and the common sense tells us we must have such as nurses, doctors, social workers, activities people, dialecticians, therapist, they're all visiting clinical support teams that come to the Green Houses and help. That's the general model.

So, you have a community of the line staff and residents who are usually referred to as elders. Those people do, those line staff, the chaboz, the chabazene do have expanded roles, they do cook the meals, they do the light housekeeping, they do the laundry. This is really quite heretical when you think about our former and still present concerns about infection control and so on. So, it is dramatic change.

The last two things I want to say about the Green House in general is it was expected to be done within Medicaid reimbursement. This isn't something fancy for the well to do. And I'll be very disappointed, frankly, if we achieve a huge extra added reimbursement for Green Houses

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because it's my hope that we just redeploy and we do it within the existing reimbursement. We already have a natural lab in this country reimbursement rates vary widely.

And the other thing is that it has to be done within the regulatory structure. The first Green Houses were developed in Methodist Senior Services of Mississippi and Tupelo Mississippi. Does anyone else know what Tupelo is famous for? Who was born there? Right, Elvis Presley. I didn't know that until I got to go visit his home and everything. So, I'm not going to, there is material in the packet about the model, what they did in Tupelo. They had to work out the details of the general vision that Bill Thomas sketched. This is what a traditional nursing home looks like, what the one the people moved to looks like, this is the Green House. This is the sign that used to be on the door of the old nursing home. If you can't read it, it says "Please observe our visiting hours 11:00 AM to 8:30 PM." And the other sign says Welcome on the Green House door.

This is a move going into a residents actual room where do you see sconces and a nice entry way and this is their home in the nursing home. This is an old shared room. I love this picture because two televisions are on the same bureau because that's the only place they could put it. Now, this is the new place. This is the lounge, the lounge and

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this is the dining and the dining, and if these pictures are put up you'll be able to look at them at leisure so that's what the Green House is like. They use a technology like lifts in order to enable independence.

This guy has his bird and then his bird goes into its house in the residents own room. Now we did very intensive research on this model and its all there for you to look at in the package. We did it for two and a half years with the first four Green Houses that opened. We had two comparison groups. I promise you it was rigorous and we hypothesized that the residents would have a better quality of life, greater satisfaction, quality of life out of all those dimensions that I listed that the staff would be better satisfied, more empowered, that the families would be happier and the bottom line is all those things are true. So, I don't even have to show those slides, they're all in your packet. All our hypothesis were confirmed and also we used the minimum data set data and found that the quality indicators that are used standardly in nursing homes they were either better occasionally in the Green House, they were no worse.

This wasn't an intervention to change quality of care it was an intervention to change of quality of life. Now, what's happening now is that the National Green House Project

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got funded, I'm happy to say by the Robert Wood Johnson Foundation, is working vigorously to get more Green Houses in every state. And then we're seeing other firms doing small house nursing homes that are fairly similar in nature but without the trademark of Green House and they're moving into ordinary neighborhoods instead of on campuses. And so it's extraordinarily exciting. We do have to work very hard at expanding and sustaining, expanding is easier than sustaining and that's where the pioneers and everybody in this room can help us where to sustain the innovations we have to work against culture creep, against institution creep and lots of training efforts. We do need to check out our regulations.

This is one new greenhouse in Michigan and that's an ordinary house in a residential neighborhood behind. It's sort of-the campus [inaudible]. And this is the new ones that are being developed. My last slide and in Perrysburg, Ohio Otterbein Healthcare has decided that they're going to move their nursing homes into small houses not Green Houses here but small houses. And they're putting them in ordinary neighborhoods largely neighborhoods for seniors. But that's a whole great ship.

So, I've enjoyed this lightening excursion through what's actually happening in the culture change movement. There's much more that could have been said I put down, I

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wanted to make sure that my colleague Lois Cutler was mentioned since she took most of these pictures and I gave you some other resources including the Green House Website. And thank you for listening. [Applause]

**ED HOWARD, J.D.:** Thank you, Rosalie. Next Jay Sackman joins us. Mr. Sackman is a consultant to the Service Employees International Union. He's been the Executive Vice President of the nursing home division of SEIU's local 1199 in New York City. He's also been a key player in putting together a partnership between labor and management in the city to pursue culture change in non-profit nursing homes. And we're particularly grateful to him for having rearranged his schedule in the last couple of days to be with us today.

Jay, thanks very much for coming down.

**JAY SACKMAN:** Thank you very much, Ed. Can you hear me back there? Which microphone is on? Is my microphone on? Good morning, and I want to thank you, Ed and the Alliance, for inviting me to be here this morning and I want to also thank you for organizing the agenda this morning so that Bonnie and Rosalie came before me to frame the context and describe the vision for all of you of the work that we've been collaborating on in New York and hope to be collaborating on around the country.

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I actually just recently separated from the 1199 local in New York where I had been for the past forty years as an Officer of the Union and as a lawyer representing nursing home workers. And I separated from the Union because I felt that there was a real need to spread the word around culture change around the country. And help do some of the collaborative work and other places around the country.

How many of you are looking forward to the day when you can move into a nursing home? So, that's pretty sad, right? And one thing that I know about Public Policy is that the if the public doesn't want it they're not going to pay for it. And part of the problem here is that the public and policy makers are not willing to invest new money in training and in rebuilding the infrastructure of a very old system that was developed about forty years ago with the enactment of Medicaid and Medicare. Something really needs to be done because many of us some day are going to have to move into a nursing home.

Some of us are lucky we have families who are going to take care of us at home. But some of us will have to move into a nursing home and if we don't do something about nursing homes today then it's just going to get worse and worse and we're worried about the collapse of the system. So, one of the things that I know is that nursing home

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workers are just wonderful people. They do God's work. They love the residents that they take care of every day. But they hate the institutions that they work in.

These are dehumanizing environments where people are stripped of their freedom and their dignity. Nursing home workers are supervised like they work in a factory. They don't have any input on the care plans of the residents. I mean it is the opposite of the type of home like environment that Bonnie and Rosalie were talking about that we would like to be creating for people so that they can move into a place that they can call home.

So, there dehumanized institutions where there is no joy and there is even no sadness. People aren't even given an opportunity to grieve over those people who they take care of. Something really needs to be done about this. And we have been doing something about it in New York.

So, let me give you of background, 1199 in New York represents 270,000 healthcare workers throughout the state of New York, and Massachusetts, and Maryland and the Service Employees International Union represents nearly two million workers all across the country. Many of whom are long-term care workers. We started pilot projects about five years ago in New York as a result of collective bargaining. Now many of you know that typical labor management relations are

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pretty acrimonious. There is no winners, no losers, we generally compromise on really important issues that we should be discussing and there is very little chance for innovation or change in the work place. And we've seen many industries die here in the United States because of the lack of initiative and leadership on the part of the Union to move or change agenda in those industries.

In New York we were in collective bargaining in 2002 and the Union was campaigning at the State and Federal level for staffing ratios to improve the quality of care in nursing homes. And we were trying to bargain over wages and benefits and job security for the workers. And at the same time the not-for-profit nursing homes raised the question of, well why don't we talk about quality of care? Aren't there some things that we could be doing together?

So we tabled the discussion about staffing ratios and tabled the discussion about quality of care for future discussions and created a table around which leaders of the Union and leaders of the industry began the discussions about where we wanted to go with this conversation. Because we were all fed up with the situation as it exists. In New York City, as you can imagine if you've never visited there, there are many nursing homes and they are huge. They're the size of apartment houses. Some of them house as many seven

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hundred people. So, you can just imagine what the institutional environment is in places like that that were built in the 1960's.

And everyone around the table felt that we needed to do something about that. So, we started bringing in speakers and we brought in literature to read. We learned about the Pioneer Network and the culture change movement that was taking place around the country. And decided that we needed to move in that direction.

And after a conference that we held back in 2003 everybody came up with the slogan that "Together we can create a person centered culture." And we used our training funds and we used our labor management project which are collectively bargained initiatives put together by the industry and the union to leverage some of the resources that we had so that we could move the culture change agenda in forty very large not-for-profit nursing homes, mission driven organizations in the New York metropolitan area.

So, I thought it said two minutes, I see it says five minutes. We have held seven conferences. Now one of the things that we did in order to leverage this is that in the 2002 budget in New York we campaigned for money for recruitment and retention. Because turn over in nursing homes is a very, very big problem and it results in poor care

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to the residents because if the staff is not familiar with the residents that they are taking care of then the quality of care declines.

And also for a layer of funding called quality improvement money that the employers had to apply for from the state to do training initiatives in the nursing homes.

And we won hundreds of millions of dollars to help leverage this agenda in the state of New York and as a result we were able to hold several conferences and between the conferences do on the job training of the direct care workers and the professional and clinical staff in the nursing homes. And used our labor management project which does change management work to facilitate the change process. And five years later we have a lot to show for it.

Now we got a grant from a Commonwealth Fund a couple of years ago thanks to the support of Mary Jane Corn to do a study of the work that we've done. And I want to go through this for just a minute or so because I know that I don't have that much time and I want to make sure that Karen Schoeneman has enough time to talk about her policy recommendations and the support that she's been giving the movements for culture change.

So, what they recommended is and this is going to be reported on the Commonwealth Fund Website in just a couple of

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weeks, you'll be able to read the full report, which is really, really rich in statistics and anecdotes from the homes that they studied. Number one that the management and the union have to work together, the workers and management have to work together on this and they have to do so in large conferences, they have to do so in the work place. They have to have labor management committees so that the workers have a voice in the change process.

Number two that there needs to be changes in the way the institutions are managed. And some of the recommendations that they're making based upon the studies that they did of the some of the projects that were initiated by us is that instead of having nurse managers run the units you'll have Community Coordinators running the units. And some of those Community Coordinators can come out of the rank and file. They could be housekeepers, they could be CNA's, they could be Social Workers, or Recreational Aids running those communities.

But those communities are self contained, self managed, they do their own scheduling. They ensure consistent assignment of the staff to the residents which is another thing that's a big link to quality of care. And that very important of all of this is that we move the food to the floor. Now you see in nursing homes, how many of people have

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you seen lined up in wheel chairs so that they can get to the elevator, so that they can be moved to the cafeteria where they can be fed their food. That is really an institutional environment and I don't think anybody would want to live in a place like that.

If we could move the food to the floors and have the self directed neighborhood work teams work together on feeding the residents we could ensure that the residents are properly nourished.

On a Union side there needs to be Union support. The leadership of the Union has to support this so that the workers who are represented by the Union feel that they're covered by the Union representatives and that they're not going to get in trouble for being what would be called class collaborationists, cooperating with the employers.

Fourth that when you dig down deep what's interesting in this study is it showed that some of the barriers to culture change are the managers and the leaders of the Union. But then when you implement some of these change processes what happens is that the workers become much more motivated and some of the things that they're saying in the studies are that, "Yes, I'm doing more work but it's much more satisfying work now."

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Fifth that we have to make sure that we interview and assess the needs of the residents and the families of the residents in this change process. It's very, very important that the resident and their families have a voice in the change process. It can't just be what management wants to do or what the Union wants to do. But residents and their families have to have a voice in all of this. And they finally start making some recommendations in the report that it has to be expanded into the whole home. That the scheduling of the work has to be done at the community level, we had only initiated these projects on the day shift, and they should be implemented in an evening and the night shifts, as well. And that we have to continue to find the funding both at the institutional level, as well as, at the state and federal levels to pay for the training that's needed and the back fill that's needed so that the staff can attend the training sessions so that they can learn about how to do this work.

So, it's been very exciting for the past five years. We have a lot of successes to report and we believe that we can replicate this model of change management in other places around the country. And we're looking very much forward to working with the Alliance and the Pioneer Network and with CMS and with other providers around the country and with

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state legislators around finding the funding that we need in order to do the training so that we can change the way nursing home care is provided. And thank you so much.

**ED HOWARD, J.D.:** Thank you very much, Jay.

[Applause]

Last we turn to Karen Schoeneman. She's Senior Policy Analyst and Project Officer in the CMS Division of Nursing Homes. She's in charge of CMS'S efforts to promote culture change including the joint conference that Bonnie was talking about with the Pioneer Network next year about which there is a flyer in your materials. And Karen also agreed to join us at the last minute. And we're especially grateful for that. It isn't always as easy as it might be to get someone from CMS to come to an audience like this. So, we're especially grateful for that. Karen?

**KAREN SCHOENEMAN:** Thank you very much, Ed. I'd like to thank the Alliance and RWJ for putting this on. I want to let the audience know that number one I am at the worker B level of CMS. I am not at the, I can swing the agency to do what we don't want level. But I'm at the level where a lot of work gets done. I want to let you know that I have been off work a month with a case of Bells Palsy, which means my face is paralyzed on one side, it is temporary, but you'll notice it affects my speech a little. So if you can ignore

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the lisping, I will try to speak a little slower than usual, although still come in, in the few minutes that I have and tell you what's going on at the Government. Yes, I'm at CMS System Division in nursing homes. We are the big, scary, Federal regulator. We are the ones who train the State Survey Agencies and what I do there I co-lead the survey process and, I specialize in Quality of Life. But I wasn't born there, at CMS. Before that, I spent a long many years as a feisty social worker, trying to get residence things they needed in long term care, and I had my heart broken by the institution.

By the institutionalization of the institution that said nobody can have anything special, or everyone will want it. That sounded to me like a good idea. Give it and let everybody have it. But the institution just can't do it.

In there, although it was set up for efficiency of the staff, it's not efficient. Nobodies happy. How many of you have been inside a nursing home? How many of you have seen a lot happy people and a lot of hugging and loving. And people knowing each other. How many of you smelled good food? How many of you have seen what I've seen in the culture changing homes? Pats in the middle of the hall, dogs walking by, ice cream sundae carts coming through, people who know each other, having snacks out of the fridge on their

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household. It's an amazing thing, I've seen it for my own self.

I was lucky enough because of my role at CMS to be invited by wonderful Sara Burger, who is here in red, raise your hand a minute there, from the National Citizens Coalition for nursing home reform to a very interesting meeting that happened in 1997, when NCCNHR threw their heaven knows how they did it efforts to push things in the process that are good, got together a bunch of people, thirty-three of us, innovators and I was the only regulator, to find out about this new thing that everybody was doing to turn an institution into a home. And at that meeting which was three days, they locked us up in a blizzard, they wouldn't let us out for any meals from 8 in the morning till 11 o'clock at night, we met, we fell in love, and we started a movement.

So, I have been with the Pioneer Network, which that group formed, and the movement now for 10 years. And so I was able to bring all this wonderfulness back to CMS and explain it to them, and the agency has gotten aboard big time. Huge time, we are on this train. And I will tell you why. Because the OBRA Law, the nursing home with form act provisions of the OBRA Law mandates rights, dignity, meaningful activities, choices, quality of life, my stuff, my bag, my thing, that thing that I always wanted to get for the

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residence. But it wasn't happening, institutions cannot make that happen. And now, these people who I was meeting, had turned their places, even in old buildings, that looked the way they all look, they have turned them into home, an amazing thing. And if you haven't seen one, a least take a look at the Green House movie and take a look at some of the other videos that are out. But preferably go to one of these places because it feels like home. You got residents who are so busy living life they don't have time to talk to you. You've got lively life going on. I've seen shoot outs in an Alzheimer's unit. I had to fall down dead, and nobody was scared, because the attitude had changed from let's keep it quiet, don't scare anybody, don't do anything special, keep the lighting low, blah, blah, blah, that's wrong.

I have seen families be happy and say to me, I can finally go home and sit on the couch and not have to cry whenever I leave, because my mother's hanging onto my arm and begging me to stay and take her home. But now she's saying I am home, I got to go off to the harvest is in, and the dogs need me, and the little kids are coming by, life has arrived in nursing homes.

Now is CMS on board? Yes it is, over these years, much, much, much has happened, because we see this is the fulfillment finally of the OBRA law, we must have this, we

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are going to have this and we need to make sure the Feds, and all the state survey agencies, are not in the way of this. And they have been very good at being educated. I've done some of it, my colleagues are doing some of it, CMS has put out five broadcasts on culture change that are sent out to all the survey agencies, providers can watch them so we are learning and then we are teaching.

We are answering questions, some of your handouts I didn't do Power Point show, are indications of what we are doing. We had a big Q and A letter that went out. People asked us simple questions that I thought were mind blowingly odd that they had to ask them. Like can a staff and the residency eat together around the same table? How far have we gone in into an institution, where we had to wear a uniform, stand up not sit down and just shovel food and you couldn't socialize, the answer was, yes, of course they can.

That's like home as long as people who need help get help. So the questions we're getting, and there aren't that many, for the federal requirements, truly aren't in the way, are just they want to make sure that the surveyors aren't going to come and hurt them, when they try to do this new thing.

What else have we been doing? Well, you know, besides broadcasts, the Mississippi Delegation, the two

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Senators and several of the Representatives road in, and the Administrator put out a letter, which I wrote, actually, you know, I'm at that level where we actually write the things. I didn't say that, that was just a whisper to side.

**ED HOWARD, J.D.:** This is all off the record.

**KAREN SCHOENEMAN:** I know. [Laughter]

But that letter is in here. And the letter says— what the delegation said is there any— we want you CMS to let the survey agencies know that Green Houses can qualify as nursing homes under all of the Federal regs and so the letter says that. And we threw in a few more things, like gee we like culture change, gee we think we want to help out. Ask us your questions, tell us what's wrong. We will help.

Culture change has actually become, get this, institutionalized, into the big institution of CMS and the government. Not only among the survey and Cert people that I represent, the regulators but the payment people, the measurement people, everybody's heard of it. The people that are developing the new MDS, they're all studying.

We have it in the action plan, in the Administrators' action plan there is culture change projects. I've been doing some of them. The next one is upcoming, the one Bonnie mentioned, which is in that gold colored hand out. There it is, "Creating Home in the Nursing Home." A chance for the

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public to gather to talk about the physical environment and regulations Federal and State, and life safety code, which do not come from CMS but we adopt them. They come from their own organization that's existed for a hundred years.

We wanted to have a chance, it's more like a hearing than a training, the Regulators are going to listen, the public is going to speak. Out of that's going to come a workshop of invited stakeholders who can action plan a year's worth of work.

What are we going to do at the Federal level, the research level, the State level, the educational level to make sure in the terms of the physical environment people who want to build wonderful things are not being assaulted by old regulations that describe old looking things.

We are trying as regulators to put it together, to interpret our own regulatory language to say yes this OK and yes that's OK and be careful with this. I've seen actually a nursing passing Meds with a cockatiel on her shoulder. I've seen amazing things. [Laughter]

Things of home. It's just an amazing thing. All right, let me see, I've got two minutes left. OK, so we wanted to make sure that the State's Survey Agencies, as well as, the FEDs—we have ten regional offices of CMS that we're all speaking the same tune.

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So, we're starting to have some regulator forums by teleconference. I just had one on Wednesday and that was a chance for some of the states to present what they're doing with culture change projects. They're all out there speaking. Many of them are participating in these State level culture change coalitions that Bonnie mentioned.

But in addition to that in some of the states they're actually looking at their own State Regulations and going to the Legislature and saying "Tweak the language. It's standing in the way of something." Now that's coming from the Survey Agency who implements to the Legislature who writes it to say we've got to take account of this new thing here and make sure we are in favor of something that is better for quality of life.

Besides the regulators doing that I'm hoping that everybody starts doing that and everybody notices things. Rosalie's got this wonderful Website set up at the University of Minnesota which lists all the state regulations according to the Federal topic. So, if you look at hand rails there's the Federal language all the state ones are there now.

That was never assembled in the history of the world. Rosalie's got it now. [Interposing]

[Inaudible] we can use that to see if there are some old regulations mostly at the state level that still dictate

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something that is not right anymore, like big old nurses stations. There are a few states that actually still have that yet they don't need that anymore.

There are some wonderful efforts because people are talking to each other, listening to each, gathering together, and all saying this works. Let's do that, let's get rid of the institution forever. And even though you may not have the money to remodel, once you gather your staff together, once you make— how many of you are familiar with the nursing home that has like three wings, and then a nurses station in the middle? Maybe two wings and a nurses station in the middle. Those two have become neighborhoods, two different neighborhoods. Even though that building looks sort of the same they might break out a couple of rooms to be the dining area, and break out another room to be the living area and that small group of residents and small group of staff get to know each other and what happens? They fall in love.

They get to know each one of you. Imagine two tables worth of you were now in a household and the staff just dealt with you? I would know that you like to get up earlier than you and you like tea and you like coffee and you want creamer and you want pie. I want pie. I want to go in the fridge at night and find something in there.

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I don't want to find what hospitals have, saltine cracker, graham crackers, and green jello cut into squares.

[Laughter]

That is not my preference. I want a Snickers bar. Let me order a pizza. Let's call the Chinese restaurant, do they deliver? I want to pet the dog. I want the children to come by. It's all happening and we can all make it happen together. Thank you.

[Applause]

**ED HOWARD, J.D.:** Thank you so much, Karen. Let me remind you that we have microphones that you can come up to and ask a question. I know there are some people here who are from the nursing home industry or from State Regulator organizations and I would particularly like to encourage you to comment in one way or another or question our folks in one way or another to clarify some of the points that might otherwise go unclarified.

And let me start if I can with a couple of things we were talking about before the program started and conveniently enough both Karen and Rosalie have mentioned and that is the questions of barriers to this kind of a cultural change that either exists in people's minds or on Statute Books or Regulatory Agendas that stand between where we are

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now and the kinds of vision of a culturally changed long-term care system that we've heard so much about.

Karen, you asserted that there really wasn't much in the way of a Federal barrier and Rosalie you talked about the survey that you've done and the Website that the survey results are encapsulated on about what's still a barrier on the state level. And I think we could very much profit from hearing a little more about that.

**ROSALIE KANE:** Karen, I'm sure has something to add. I would just say that Karen is correct the Federal Regulations that are lean. They're not particularly specific except in a few areas around certain kinds of assurances when are needed. They're mostly very short.

Most of the variation and action is at the state level. I've been reading all of the state regulations on everything now and yes, there are some states that say that staff can't eat with residents. There might have been a reason for that sometime but probably that has to be changed. There are states that the bed can't be pushed to the side of the wall though that was changed by statute in the state of Florida. So, there is a lot of variation, the word nursing station does not occur in any place that I could find in any Federal regulation. But states can go on for pages and pages

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about how many people to a nursing station, what the visual field should be, what the distance should be, and so on.

So, there is a lot of detail at the state level that needs a little bit of fixing and some of these fixes have to be to support preferences and to support loosening up the way that we do things with our workers.

**ED HOWARD, J.D.:** And let me just reiterate something that you said but you didn't have your microphone on at the time and that is the URL for your Website is at the end of your presentation on the hard copies that you have.

Karen?

**KAREN SCHOENEMAN:** And the Federal regulations don't have much in them that's wrong because what they have is residents—here's my favorite Federal regulation residents should have and I'm not going to give you the exact language, residents should have a choice over their schedules, their activities, and anything else that's important to them. That's been in there since the passage of the original OBRA regulations which went into effect in 1990. A choice over schedules what time you get up and go to bed.

Well, guess what they haven't have one yet except in places that are changing their culture to accommodate it. Because if you do that you have to figure out how do the meals get served, how does the bathing get done? What about

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the shifts who come in? When is X, Y, Z done? What about mediation and med pass? But they've figured it out. So, the Federal regulations support culture change. There are a couple of things I don't like, only a couple, there is actually still one that says it's okay to put four people in a room. Oh, please that's a real antique. How many of you want to live with three strangers who have unusual habits at night?

**ROSALIE KANE:** How about two or even one?

**KAREN SCHOENEMAN:** Even one, yes, but the state regs, as Rosalie mentioned that bed up against that wall thing. All these regs come from some problem somebody went to their Legislature, or the Feds, or to Congress and said here's a problem, stop it, write something. And so they all came from something. But in many cases the people who wrote and had the problem their all dead now and nobody knows why that language is there anymore.

And now it's time when you can say we don't see a reason for that anymore and so the state coalitions can take Rosalie's Website and go "look our state's the only one that has this language. That's kind of stupid. Let's go to the Legislature and knock on the door and say the other forty-nine states don't have that. "We can get all the remaining few things out of the way and make sure the surveyors don't

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have an attitude problem of their own. That they think something needs to be that way because they were trained that way in their training as professionals that happened thirty or forty years ago.

**ED HOWARD, J.D.:** Bonnie, you wanted to add something?

**BONNIE KANTOR:** Yes, I want to add that in the culture change movement we have a great deal of respect for the State and Federal regulations and standards and by no means does anyone want to lower those standards. It's a different approach to meeting the guidelines. And I'd like to give you just a quick example of how one can abide by the regulations and ensure the highest quality of care and quality of life.

If we have somebody in a nursing home who has diabetes which is a very common occurrence in a nursing home and that person is decisional, doesn't necessarily have decision making capacity but as that chocolate cake goes by they know they want it. Now culture change would never say—the culture change movement we will allow that person's blood sugar to get out of control and lower their health status because they wanted that cake. So, I want to make sure that everyone knows we are not compromising someone's health.

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But since we understand the connection between emotional health and physical health we will figure out a way for that person to get some cake. And so I guess I want to use this as an example and its one that Karen is very familiar with, as well, so what would we do that would abide by the regulations and let that person be happy? Because as we said if they're happy their going to be healthier, quality of life and quality of care are intertwined. The entire team would need to get together and know that Mrs. Smith wants that cake it's coming today. So, for the entire course of that day or part of that day someone will have been checking her blood sugar making sure that it is at a point that she can have that cake.

Then afterwards everyone is going to do a little more work so this builds on what Jay was saying nobody wants to do less work. No one even wants to do the same amount of work they want to serve the resident and so if it means doing some additional blood draws to make sure that after she had that cake she's going to be OK they're going to do it and they're going to happily do it because they know Mrs. Smith, I think that's what I called her, very well.

Now, the most important thing there is that the care plan has to indicate that that's what they're going to do. So, that when Karen's folks come through they're going to

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understand that sometimes her blood sugar might be a little off but we have a plan to take of it. We are not going to compromise her health but we are going to respect her desires in the process. But the care plan has to be able to indicate that. We will never accept lowering her health status because of what we want to do. Instead we work with the entire team to make sure that we respect her and we keep her health status where it should be or increase it because she's happier.

But it takes a little extra work and people are very happy to do it and it takes satisfying the regulations. We would never ask for anything less.

**ED HOWARD, J.D.:** Thank you. There are several questions here that have come up on cards. I'll try to weave them together and I suspect that at least a couple of them might have been evoked by your picture of the Osh Kosh fireplace, spa, and they all involve how much money this is going to cost. Is it possible to design a long-term care system that spends the same amount of money as we do now? And yet is consumer friendly.

This person wrote to Green House and said give me some data on how it works as business model and didn't get any response. That really is kind of a central question.

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Can you do this on budgets that nursing home operators in almost every state are complaining are inadequate?

**KAREN SCHOENEMAN:** Yes, you can. Now if there's going to be new capital cost one has to look at that separately, of course, and the capital cost of constructing the Green Houses, for example, is actually less than it would be to build a new nursing home in a big box or to renovate one.

There has been lots of studies about private rooms and bathrooms that's slightly more expensive in capital costs and way cheaper operationally. So, there really—we do know that it's cheaper to run the nursing home if people have their private space. The fireplaces were a little over the top and said would you spend your next dollar on the fireplaces and the spas? And no we probably wouldn't.

That happened to be a rather well endowed place that is a model for all sorts of things. But, yes, it can be done and I think it can be done through redeployment. The Green Houses themselves have proformas now I'm sure Wendy can help you with that and there is material on the Green House Website that show how you can make the financials work. It will be a little different in each state but you plug in the information and you can make it work.

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There isn't just only one way to mix and match the stuff but it can be—but they have one way up there that shows that it can work.

**ED HOWARD, J.D.:** Okay, Bonnie and then Jay.

**BONNIE KANTOR:** I have a one word answer that's going to take me a couple of minutes to get out. Turnover. I don't know what the turnover is in some of the organizations that you are used to but on front line staff it can be well over 100 percent per year. Correct, Jay? When you undergo culture change it has a dramatic impact on the work of the front line staff and turnover.

And so when we want to talk about the business case you have to look not at silos but at the business model in general. When people get up when they want to get up and if I polled all of you some would be eight some would be six. There would be someone who wants to get up at five. And then we translate that into then when do we need our staff here? And all of a sudden we realize that a quarter of our staff could get here at eight o'clock which means six additional people can say, "well wait a minute, you mean I could get my daughter off at the bus?" and she's so happy to be working there. And someone else could say, "You mean if I got in here at five you mean I could pick my daughter up from school?" Yes, you could.

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So, what we see are staff that are very happy and who stay much longer so turnover is less. And now you think of marketing budgets and advertising budgets and all of those good things and care goes up because you've got the same people caring for the individuals and so it takes much less time to give the bath. Agitation goes down because they know how to give the person to bath and so the person doesn't leave because bathing and agitation is a key source of folks saying, "I've had it."

And so you have to not look in silos to see the business case and you realize if you take that one thing, turnover, you can eliminate so much unnecessary cost and your quality is going up at the same time. So, absolutely the business model is extremely sound.

**ED HOWARD, J.D.:** Jay?

**JAY SACKMAN:** I've been for the past several years responsible for the over two hundred nursing homes in the New York metropolitan area and some of them look like Holiday Inns and resorts and others are very old buildings. Culture change to some extent can make a place look better but it's not about that.

I know of one nursing home on Long Island that looks like a Holiday Inn and yet it has rigid schedules and there is no freedom whatsoever. As opposed to another nursing home

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in New York City which I will name, Greater Harlem Nursing Home, that has very little money to spend but there are self directed work teams. Nobody says that's not my job.

Everybody works together, they're very personable with the residents and their staff love going to work every day and they do create a home like environment even though no money has been invested, virtually into creating a different look.

So, it's not— it could be about that. That can drive some of it, removing the nursing stations, creating nicer bathrooms, creating a nicer look with paintings and wallpaper, and carpeting and make it more like some of these very pretty homes that were shown up on the screen but even in a place that doesn't have any money to invest you can create a person centered culture where people feel like they're at home.

**ED HOWARD, J.D.:** Very good. Actually, Jay, let me take the occasion to ask you a couple of the questions that have come up on cards that are different sides of the same coin but are related to the question of staffing that both you and Bonnie were talking about.

On the one hand someone asks how difficult to deal with the resistance from nursing staff to make these changes? After all, you're turning over what had been considered professional responsibilities to untrained or lesser trained

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staff. On the other hand someone asks or observes that nursing homes are one of the most regulated industries in the country and wonders if you actually did say that 1199 got a waiver to allow the reformulation of the staffing models?

**JAY SACKMAN:** Well, I didn't say that we got a waiver. But I'll talk about the— we have invited Keith Service who was in charge of survey and inspection in the state of New York to every single one of our conferences. We keep him plugged into every change initiative that we're working on in any of the homes. He talks to the survey team so we've done a culture change in the survey department in the state of New York to sensitize them some of the experimental work and some of the innovations that homes are make happen.

No, we didn't get a waiver but we have worked with them and so when the survey team comes in and sees something different going on they know what it's about and they've been given advance notice of it.

There is just as much trouble and I'm going to be honest with you. I hope you would want me to be honest with you— there is just as much trouble dealing with nurses giving up control as there is in the Union organizers giving up control and the Union delegates or Shop Stewards giving up control over work rules. There is resistance on both sides

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and I think that instead of dealing with the resistance head on what you need to do is show some leadership and bring people back to why we're doing this.

It's about the values of person centered care that's what it's about. It's about the residents; it's not about my turf, your turf. And eventually people in any kind of organizational change process you're going to find the layers of resistance and people not wanting to give up control. The nurses have been a problem, social workers have been a problem. The Unit Directors have been a proctor and on the other side the Union sometimes is a problem and doesn't know how to approach a problem in a way that we can solve the problem together.

So, we've done a lot of training on- joint training, by the way, on interest based problem solving. We get all of the managers in the room and all of the union people in the room and we train them on how to solve problems together.

**ED HOWARD, J.D.:** Bonnie, do you want?

**BONNIE KANTOR:** Yes, very quickly, I think that the- you know when I say very quickly I don't mean it. One of the benchmarks of the culture change movement is the phrase "Person before task" and we haven't used that yet today. It is the cornerstone.

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Part of the problem isn't that these individuals are the problem. Part of the problem is we in our communities are not educating and training folks in a way that facilitates this kind of care. So, that if in our nursing curriculum we are training folks to be task oriented it's not their fault when they come into the nursing home that they're trying to do their tasks. They're doing that which they were told to do.

And I want to point to an example not from nursing but we've got right over here Randy Linder, Randy do you mind? Randy is the Head of the National Board of Nursing Home Examiners who really sets the tone for much that is going on and in the next iteration of the job description for nursing home administrators, and again this is still in draft form, so this is not an official statement and I don't work for NAB. The nursing home administrator is now going to be responsible for ensuring resident centered care throughout his or her organization and will be held on both the examine and in the course work and everything else they do to ensuring culture change throughout their organization.

So, if you're going to get a job in a nursing home your administrator in the future is going to insist that you do this because he or she is going to be held responsible for it. So, from the top down we've got a perfect example this

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is not how nursing home administrators have been trained in the past, which means we can do the same for physicians. We can do the same for nurses and Randy who has both national and state responsibilities sets a really good model for that.

**ED HOWARD, J.D.:** Okay. Thank you. Before we go to the floor let me just say we have about ten minutes left for questions. We have more cards than I'm going to be able to throw at our panelists so if you really, really, really want to get your questions asked you'll do the way Sarah has done and come to the microphone. Would you identify yourself, Sarah?

**SARAH BERGER:** Yes, Sarah Berger with John A. Hartford Institute for Geriatric Nursing New York University. I coordinate a coalition of six geriatric nursing organizations across the country, most of whom are working in long-term care and they are very interested in this. My question to you and it's kind of a perfect safe way from the last remarks that were made and the interesting question. Rosalie, I think you were the one who did the assessment of the Tupelo, Mississippi group and one of the things you found was that the national quality measures were either the same or slightly better. And as someone who knows a lot about those quality measures it doesn't give me great comfort to think that they weren't stupendous and wonderful.

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My question is how can we coordinate these two issues of quality of care and quality of life? They're still going on separate tracks. Somehow and I'd be glad to help you in any way I can with the 20,000 nurses that I communicate with. We've got to get them integrated. So, my question to you is what are your plans? How are we going to improve that and see that the clinical quality improves?

**ROSALIE KANE:** That's a great question, Sarah. I was actually thrilled that because I heard so much background noise about you can't do this, you can't do that the quality is going to get worse if nurses aren't doing A, B, C, D, and E and it didn't. But you are right it's an extremely good question.

I want to just say one word about the previous one which was in the Tupelo implementation back to RN's and licensed staff they were at first quite resistant to all of the changes. It was partly because so much attention was put into the training and the empowerment of the CNA level person that everybody else including the nurses felt they had no role.

They suddenly found a brand new role that's very exciting in working on collaboration and on the ground training and it made a big difference. As far as putting the clinical, my husband who is a geriatrician, is one to say

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that nursing homes don't have [inaudible] they're not homes, they don't have nursing. That certainly used to be true once upon a time and in order to really deal with the chronic disease management that we need to see, both the management of chronic physical problems and of chronic psychiatric diseases we do need to have information systems. We need to have triggers. We need to have a proactive kind of management system, medical directors and attendant physicians have to be involved.

Line staff need to be taught how to make observations and there is some exciting work going on in some of the nursing homes that are dedicated to culture change to also create sort of transforming ways of doing the healthcare. I think you triggered an important issue.

**ED HOWARD, J.D.:** Go ahead, Bonnie.

**BONNIE KANTOR:** I think that, Sarah, you're right on target that neither one can be left behind and they must be put together. And I think that part of this has to do then with how we evaluate success as you indicated.

And I want to again, because I like to teach through example or talk through example, if you think about consistent assignment which enhances quality of life because we talked about community getting to know each other. And we schedule something like going to the bathroom I think what we

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will find is that quality of life and quality of care coincide. And I'm going to take that one step further, with consistent assignment the front line worker truly knows when somebody really needs to go the bathroom. They know their schedules.

So, we have de-scheduleized it's not going at two and four, and six it's when that person needs to go. Because we have done that we have done a number of things, one we've probably prevented a potential fall as the individual tries to get up and go to the bathroom. We've also made the person feel an awful lot better because they haven't had accidents and they may be going down and going to more activities now.

We also are preventing a certain number of UTI's, urinary tract infections, and we are potentially impacting the survey process and more importantly the prevalence of the cubuti [misspelled?].

These are the kinds of examples of the things that we have to be focusing on as where quality of life and quality of care coincide and where we can measure both. Because if...

**ROSALIE KANE:** Without disagreeing though because what Bonnie is saying is true. I think that Sarah was bringing up issues that have to do with the kinds of meds that are given, the prescriptions in the first place, there

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is a lot of room for healthcare at large and I think that's where we bring the two systems together.

**ED HOWARD, J.D.:** We have someone who has been very patient at the back microphone and while she asks her questions, question I hope actually, I will ask you to pull out those blue evaluation forms and if I can be so presumptuous as to characterize it as this, evaluate success as we have just heard about. Yes, go ahead.

**ALICE HEDT:** Thank you. I am Alice Hedt. I am the Executive Director of NCCNHR and as Karen pointed out the culture change movement was birthed in our organization. And I want to commend the Alliance for having this meeting because we need to be talking about this in this country. And our concern at NCCNHR is that we know culture change works, we know it's what consumers want, and families want, and residents want, if you go to our Website last week was Resident's Rights Week and we have hundreds of statements from residents and artwork depicting what they want in terms of quality. And what they're saying is that they want resident directed individualized care.

Our concern at NCCNHR is that the nursing home reform law is twenty years old. We're going to be having an event on Wednesday looking back here in Dirkson [misspelled?] at

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the nursing home reform law and why these changes haven't come about in the twenty years.

So, I guess my question for the panelists here is what would you say needs to be changed so that we can have culture change for the one point seven million residents in nursing homes.

**BONNIE KANTOR:** We probably all would say something different because there is a lot things that need to be changed. The statute, the OBRA statute is twenty years old, and while it calls for complete maximum physical, psychological, and social well-being there is a lot of vagueness in the goals. And then we get into to specificity around the details and there is a huge movement towards safety in this country, correctly so, because of scandals in the hospital world.

I think we're going to have to accept that people are going to die. They're going to die in nursing homes, they're going to die out of nursing homes. They're not going to die in metabolic balance. So, that we can't have an attitude that we're always looking for who to blame with each mishap and we can't get to the point where we're going to consider it an error anytime a person is walking in a nursing home and breaks their hip.

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If we call that a medical error that is a problem because it's not a medical error when someone's living at home and breaks their hip. So there will have to be quite an attitude change. Much as I love OBRA there are contradictions within it and then what's going to take priority.

**ED HOWARD, J.D.:** Jay and then Karen.

**JAY SACKMAN:** We need somebody like Al Gore to talk about the next problem which is the real eight hundred pound gorilla in the room here. And that is the workforce problem.

There is just in another few years there aren't going to be enough workers, nurses, CNA's to do this work and nobody is doing anything about it. And the opportunity—we have to grapple we have this opportunity right now because if the funding was available to motivate high school students to do this work. And if we developed training programs that were centered around person centered care we could change the system from the bottom up at the same time that we're doing things on the regulatory level, at the same time that we're moving this movement at the institutional level.

But something has to—this is the biggest problem that's out there. We can talk about creating home but if there aren't enough workers to go around and yes maybe the problem will be solved by people coming in from the Philippines and from Africa and India and from the Caribbean

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countries. But is that what we want? Don't we want to take care of our elders here in this country? We need to do something about the workforce problem.

**ED HOWARD, J.D.:** Karen?

**KAREN SCHOENEMAN:** Since the movement is called culture change, and hi Alice it's nice to see you I didn't know you were there in the back, I'm thinking that the next phase is when people are confronted with a brand new idea and they don't quite know how to do it they fall back on their education.

And I'm seeing now the start of the development of education for the professionals, administrator, medical directors, RNs, LPNs, aides. I haven't seen it come for social workers yet. It's starting to come to activities, to train them from the beginning in a culture changed way of person directed care so they don't have something to unlearn. Unlearning is really hard it's like that don't think about the elephant. And I'm thinking the surveyors need to get some re-education too because most of them, like me, were trained a long time ago.

I've had to unlearn institutionalization and everything from what I think is good, like Rosalie says and I agree with you, that the quality measures and indicators make some assumptions that certain things are good and we

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shouldn't have these things and we should have those things. And we have to do a national dialogue on what is good.

But in terms of the education of the Institute for Care Giver Education which is a culture change training organization up in Pennsylvania has just about—they're just about getting it ready to start, the first that I know of in the nation an LPN school that is teaching the LPNs from the beginning. Their whole LPN education in a culture changed way.

They've already got Nurse Aide training going that way. And that model of that school curriculum can then be passes around to others. That's just one. The LPNs are key in the who has the power in nursing homes. The same thing is happening with Bonnie's project with the medical doctors. Medical education, once they go out and get trained in geriatrics in a culture changed setting for their practicum they'll see, oh yes we can do it this way.

I think the educational part is important now.

**ED HOWARD, J.D.:** Thank you. Bonnie:

**BONNIE KANTOR:** I agree with Karen about the education, of course, through the Commonwealth Fund we are going to be able to affect how both medical directors and undergraduate and graduate medical education is staged in culture change.

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However, the one thing that I would like to add in response to Alice's question of what will it take, to be bold and blunt, we don't value older people in this country.

And until we value older adults we will not be valuing those who work for them. And it will take a bit of a mindset. So, in my mind twenty years is not a long time on that journey.

**ED HOWARD, J.D.:** Randy, if you have a quick question that we can get a quick answer to.

**RANDY LINDER:** I am Randy Linder. I am President and CEO of the National Association of Boards of Examiners of Long-Term Care Administrators. Building up on Jay's comment about the workforce, we've been very concerned we can do and we are very committed to enhancing the leadership of administrators and preparing them for our culture change environment. However, currently, well over the past ten years we've seen the number of people coming into the profession shrink by over forty percent.

And right now we're probably bringing in a thousand new candidates a year into the profession at best that sit for the licensure examination. And we know that not all of those are going into nursing homes. As an administrator of record, some of them are going into assisted living, some people take the examination because they're maybe in a senior

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corporate position or they're in an academic setting and want that credibility. And part of the problem is the perception of the profession. And it has the stigma that nursing homes in general have.

And if I were to turn around to this audience and ask how many in this room are thinking of aspiring to become a nursing home administrator I'd probably get as many hands as though who want to live in a nursing home or if I were to ask how many were advising their children to become administrators as a profession of choice it would probably be the same.

I'm wondering what and, maybe I'll direct this question to Karen, as part of OBRA there were proposed nursing home administrator standards at that time and they just somehow got lost over many of the other things that were on PICFA's [misspelled?] plate at that time. And as a result of that we have a lot of barriers that make it difficult for people to come into this profession or to move between jurisdictions and it's because we have federal regulations that mandate licensure but then it was left up to the states to salvage the standards and so they range from high school education to Baccalaureate degrees, specifically in long-term care administration, and training programs from zero to two thousand hours. And so we have a Hodge podge mess and we're

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seeing the same thing develop in assisted living, in that profession. Is there anything CMS could do to help us?

**KAREN SCHOENEMAN:** Is there anything they can do?

Well, I'll tell you there isn't anything they are doing that I've ever heard and I've been there seventeen years now. So, I came in sort of with OBRA, I came in 1989 and I've never heard anybody say anything. Nobody's ever put the work administrator and standards together in a sentence in front of me there.

Is there anything they can do? I think CMS is really—we are the implementer, we're not the originator. And we seem to be really into Federalism which to us means leave some things to the states that can be left to the states. Since I just work there I'm not even going to tell you what my opinion is of that.

[Laughter]

Who cares what I think? But I think that that's why you don't see anything coming in terms of standards for any of the professions. So, your work is either going to be to change the federal attitude or to just work at the state level to get more consistent.

**BONNIE KANTOR:** And I probably would choose the latter. I mean I do understand the issue and there are quite a few states that require only a high school education and

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this is multiplied across all the professions that there is variation in standards. I do think that nursing home as we know it to kind of phrase is a dinosaur. I don't think that twenty years from now we'll be exactly talking about nursing homes like this. I think we'll have some sort of merging of what we now call assisted living and what we call nursing homes.

We'll still need somebody to administrator this entity though so the question is do we really want the requirements to grow out of the job as opposed to the a bunch of educational standards that will be anachronistic. I want to say one thing about the first question Alice asked too.

I think that what we need is a civil rights movement in relation to older people. The same thing that we have with younger people with disabilities where we haven't said these are people who need services, they have care needs they need a care plan, we are saying these people who have disabilities and every single person in a nursing home qualifies as having a disability that would qualify them to be ADA. They need accommodations.

And I think we're going to find them getting their accommodation all over the place for their disabilities, fewer and fewer in nursing homes. So, maybe we won't, Randy, we might not need as many nursing home administrators in the

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future. But we will need an administrators for whatever the brand new model is. I think we'll have to think together what that will be.

**ED HOWARD, J.D.:** Thank you. We're going to have to draw this to a close. Just a couple of loose ends here we will, the good Lord willing and the bandwidth allows, post the pictures from Rosalie Kane's new presentation on our Website with her slides. And if we can figure out a way to do it we'll even put the movie on there too.

Alice mentioned not only OBRA in general but the fact that they're going to be doing a program on it next week and I want to also call your attention to a program that we intend to be doing on the hill on December fifth taking a look at OBRA 87 and looking forward about the issues that you've just heard discussed.

We're really talking about reforming nursing homes in America. Everybody along this panel, a lot of you out in the audience, they are, in fact, very really pioneers in this movement. And you might say that you're trying to reform the nursing home industry in this country ten beds at a time or seven beds at a time under the original vision. One thing we know is it's a huge task and we're going to have to enlist a lot of people from a lot of different political viewpoints and ideological viewpoints into making that happen. Thank

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you all for coming here. Thank you for filing out that evaluation form. I want to thank Wendy Yallowitz and the Robert Wood Johnson Foundation for getting us on to this topic with this audience and ask you to join me in thanking the panel for an incredibly good discussion. [Interposing]

[END RECORDING]