Transforming the Culture of Aged Care: Shifting Paradigms

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Overview

- Describe the current institutional model of long-term care and its drawbacks
- Review major transformative movements of the past 20 years
- Define and illustrate the three components of transformation
- Look at nursing and medical director roles
- Aging in community and the emerging demographic
- A song or two?

A History of the Modern Nursing Home

"A hospital and a poorhouse got together and had a baby, and that baby was the nursing home."

- William H. Thomas, MD

Founder, The Eden Alternative®

U.S. History

- 1965 – Medicare and Medicaid Act
  - Funding for long-term care
  - Tied to medical, not social reimbursement
- 1987 Omnibus Budget Reconciliation Act
  - Established standards and safeguards (resident rights, surveys, QIs, CNAs etc.)
- No other significant changes in operational model in the past 45+ years

The "Hospital" Model

- High rise, dense housing
- Multi-person rooms
- Nursing stations, med carts
- Centralised food prep with meal trays
- Top-down hierarchical system
- Departmental "silos"
- Low prestige of hands-on staff
- Life centred around treatments and other medical or therapeutic interventions
- Rigid schedules
- Little or no choice in daily life

Institutional "Fallout"…

- Aging seen as decline, medicalised aging
- Marginalisation and disempowerment of elders
- Loss of autonomy and choice
- Tasks over relationships
- "Artificial" life, "cult of clock time and task" (McLean, 2007)
- System of backward incentives
- Loneliness, helplessness, boredom
- Erosion of meaningful engagement

The Number One Myth in Long-Term Care:

Nursing homes were designed to follow the institutional model because they emphasise efficiency and cost-effective operation over humanistic, individualised care.

Why It's a Myth:

- Because there is *nothing* efficient or cost-effective about a top-down hierarchical system with a siloed departmental structure!

Questions

- How many survey findings or QOC issues have arisen from inadequate communication, lack of clear empowerment boundaries, poor interdisciplinary collaboration or inflexibility to meet individual needs?
- How much money is saved with double rooms, compared to that spent on staff time and staff/elder/family frustration over moves due to roommate conflicts or infection control issues?
- How much distress among people living with dementia is a function of the environment and care approach?
- What is the cost of *excess disability* caused by the institutional model of care—of elders *and* staff?
- What is the liability cost of operating a home in which people don't want to live??

Seeds of Transformation…

- Restraint reduction initiatives
- NCCNHR (now Consumer Voice)
- OBRA 1987
- Live Oak Regenerative Institute (1970s)
- The Eden Alternative 1992
- Pioneer Network 1997
- Household model (1990s)
- Providence-Mt. Saint Vincent (1990s)
- "Person-Centred Care"
- The Green House Project 2003

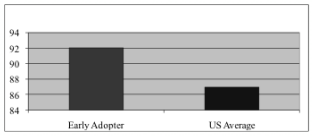
Basic Common Tenets

- Developmental aging
- Restoring honour to older adults
- Shift to social-relational model with medical support
- Relationship-focused care approaches
- Opportunities to give care to others
- Variety, spontaneity, and meaning in daily life
- Focus on well-being
- Flattening of organisational hierarchy → daily decisions moved to elders and those closest to them
- Physical structure that reflects values of home
- Contact with the living world

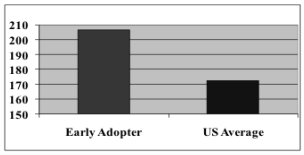
Early Studies

- Elliot (2009): Four-year study of culture change adopters vs. control homes. Adopters had significantly higher occupancy (3%) and revenue ($11/bed/day for a 140-person home), equal to $584,073 additional annual revenue
- Grant (2008): Study of a for-profit chain engaged in culture change, showed increased elder autonomy and dignity, and higher staff satisfaction c/w control homes.

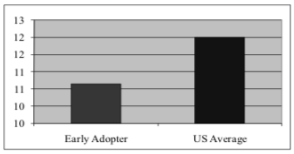
Early Adopters vs. National Average Occupancy 2007 (from Elliott)



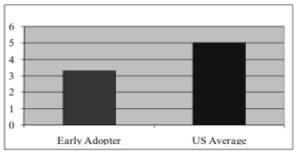
Average Net Per Day Per Resident Revenue (standardized by org. size)



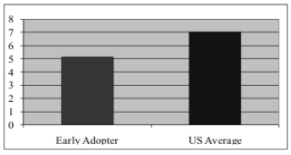
Early Adopters vs. National Average % High Risk Long-Stay Residents with Pressure Sores



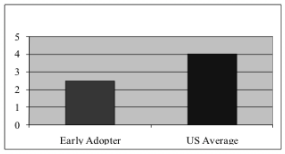
Early Adopters vs. National Average % Long-Stay Residents with Restraints



Early Adopters vs. National Average % Long-Stay Residents with Catheters



Early Adopters vs. National Average % Spending Most Time In Bed or Chair



Transformational Models of Care

Personal Transformation

- Positive view of aging
- Valuing elders
- Valuing relationships
- Experiential learning about nursing home life
- Education - leadership and others
- "Soil warming"
- Mission, vision, values
- Enlightened communication, facilitation techniques

Live Oak Definition of an Elder

- An Elder is a person who is still growing, still a learner, still with potential and whose life continues to have within it promise for, and connection to the future.
- An Elder is still in pursuit of happiness, joy and pleasure, and her or his birthright to these remains intact.
- Moreover, an Elder is a person who deserves respect and honour and whose work it is to synthesize wisdom from long life experience and formulate this into a legacy for future generations.

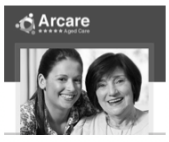
Operational Transformation

- "Flattening" hierarchy
- Involving elders and direct support workers
- Creating interdisciplinary self-directed teams
- Communication
- Collaborative decisions
- Honouring each person's knowledge and expertise
- Job descriptions and performance evaluations
- Dedicated assignments…

Making the "Fuzzy Stuff" Real
Dedicated Staff Assignments

"It Takes A Community - A relationship-centred approach to celebrating and supporting old age"

(https://www.youtube.com/watch?v=lUJWFWXz-wY)



Daniella Greenwood
Strategy and Innovation Manager

Arcare Aged Care

- 33 residential care communities in Victoria and Queensland
- Some "sensitive care" areas for people living with dementia
- Daniella Greenwood (Dementia Strategy and Innovation Manager) – appreciative inquiry survey of 80 elders, staff and family members
- Identified four main categories, including "connections"
- Many comments highlighted the importance of continuous relationships
- Began to formulate a pathway for dedicated staff assignments in all areas where people live with dementia

Arcare (cont.)

- Staff education sessions
- Re-application process for all hands-on staff, must work at least 3 shifts/week with the same 6-8 residents every time
- Positive feedback from most staff and managers
- Within 6 weeks, staff spending more time with elders, without sacrificing task completion

Arcare (cont.)

- One early-adopting community (38 residents):
  - 69% decrease in chest infections
  - 90% decrease in pressure injuries
  - 100% decrease in formal complaints from families
  - 45% increase in family satisfaction
  - Decrease in avg. day/evening care partners in a month from 28 → 5!!

Results (cont.)

- 25% reduction in skin tears
- 12.9% reduction in falls
- 2.92 kg average weight gain
- 51.6% reduction in PRN psychotropic medication use
- 27.5% reduction in sick leave
- 50.2% reduction in staff turnover
- 19.8% increase in job satisfaction for PSWs
- 30% increase in job satisfaction for nurses

Castle & Anderson, (2011, 2013)

- **Study 1: 2839 UD nursing homes**
  - Significant decreases in pressure sores, restraints, urinary catheters, and pain in home with >80% dedicated staff
- **Study 2: 3941 US nursing homes**
  - Significantly fewer survey deficiencies in several QOL & QOC categories with >85% dedicated staffing
  - Follow-up study also showed significantly lower PSW turnover and absenteeism

Two recent studies

(Kunik, et al. 2010; Morgan, et al. 2013)

- Factors leading to "aggressive behaviour"
- Both studies found a major factor to be a decrease in consistency and quality of staff-resident relationships

The Green House Project

History

- Developed by Eden founder Dr. William Thomas and initial support from RWJF grant
- First homes at Traceway (Mississippi Methodist) in Tupelo, MS 2003
- Outcomes study by Kane, et al. *JAGS* 2007
- Now ~250 homes on 48 campuses across three dozen US states, ranging anywhere from 1 to 18 on one site. Multistory projects as well.

Core Values

- Real Home

(Natural surroundings, fully accessible, de-institutionalisation, meals onsite, congregate dining, lifelong living)

- Empowered Staff

(Versatile direct support "Shahbazim", Clinical Support Team, Guide, empowered team-based approach

- Meaningful Life

(Elders control rhythms of the day, choices to maximum extent, spontaneity, full engagement, risk negotiation, reciprocity, family involvement)

Some Organisational Features

- Most are long-term care certified (some rehab, some AL)
- 10-12 residents per household
- Meets **intent** of regulations without defaulting to institutional structure and practices
- Lifelong living
- Not restricted by payment source
- All LTC residents qualify (dementia, hospice, post-acute, oxygen, even ventilator)

The Shahbaz

- Persian: "royal falcon"
- Central support role
- PSW-equivalent certification
- 128 additional hours:
  GH philosophy, cooking and safe food handling, basic activity/engagement skills, basic home maintenance skills, team building and rotating coordinator role development, dementia, CPR, first aid

Guide

- Acts as Administrator (GM) of record
- Coaching approach to leadership
- Grows an empowered team of employees and elders

Clinical Support Team

- More like a home care model
- Visit houses regularly and work collaboratively with Shahbazim
- Provide clinical support, but do not dictate or drive life in the homes

Some Design Non-Negotiables

- No more than 12 people
- Independent units/entrances, even in high-rise
- Private rooms with en suite shower
- Spa room with tub
- No nursing station
- Med cabinets in rooms
- Ceiling-mounted lift tracks
- Open kitchen
- One dining table

St. John's Community Integration




Living Room / Dining Room / Kitchen




Bedroom / Bathroom



Garden / Gazebo




Multistory Project Example: Leonard Florence Centre for Living Chelsea, Massachusetts

Outcomes: Rosalie Kane Research

The Green House® Project

Results from 2003-2004 research - Reported in Journal of the American Geriatric Society, 2007

Improvements in Elders Quality of Life – Green House vs. Nursing Home:

- Privacy, dignity, autonomy & individuality
- Food enjoyment
- Relationship
- Meaningful activity
- Emotional well-being

Outcomes: Rosalie Kane Research (continued)

The Green House® Project

Improvements in Elders' Quality of Care:

- Lower incidence of decline in late-loss ADLs
- Fewer bedfast elders
- Fewer elders with little or no activity
- Lower prevalence of depression

Improvements in Staff Quality of Life:

- Felt more empowered to help residents
- Greater job satisfaction
- More likely to remain
- Knew elders better

Sharkey, (2009) Green House workflow study

- Time in direct care activities: CNA 70%, Shahbaz 53%, *but* 23-31% more direct care time per person per day
- Non-care personal engagement: 24 minutes per person per day vs. 5 minutes in traditional SNF
- Transport time: 38 minutes/d (GH) vs. 84 minutes/d (trad.)
- Walking assist: 32% (GH) vs. 7% (trad.)
- Significantly less staff stress and improved well-being in several domains

Other Studies

- Horn, et al. (2012): Overall cost savings of US$1300 - $2300 / year for GH residents vs traditional (daily care costs + hospitalisation); variance due to RUG scores
- Jenkins (2011): Operating costs the same or slightly less than for traditional care to a comparable number of people; additional cost to construct buildings (~8000 sq. ft. ranch homes, 10 bedrooms with baths, etc.)

PS: Culture Change Is Hard Work!!

Global Aging in the 21st Century

- In 2000, there were 600 million people aged 60+ (triple the number in 1950)
- Est. 2 *billion* people aged 60+ by 2050
- 33% of population in developed nations >60, 20% in developing, and 15% in the 42 poorest nations (defined as per capita income < US$10,000)
- **"Potential support ratio" (# people aged 15-64 for each person 65+) = 12 in 1950 → 9 in 2000 → 4 in 2050**

Today's Solutions = Tomorrow's Failures

Current View of Aging

- Aging = Decline
- Focus on hyper-achieving ideal of adulthood (creating economic wealth, multitasking, corporate culture, myth of independence) devalues those who do not produce or who ask for assistance
- Wisdom, perspective, and gifts of elders go unappreciated
- Suburban sprawl, dependence on the automobile, forces elders to leave their neighborhoods

Declinist view of aging + Poor community design =

- **Marginalisation of Elders**
  - Isolation and age-segregation in the community
  - Institutionalisation of frail elders
- **Medicalisation of Aging**
  - Older adults in general
  - People living with dementia

Paradigm shift 1

- Older people (*and* people living with dementia) are vulnerable populations who need care and services, and
- This rising population creates a societal burden

Vs.

- Older people (*and* people living with dementia) are a valuable asset to our community, and
- Life experiences and wisdom benefit younger generations, and help strengthen the resiliency of their communities .

Paradigm Shift 2

- The support of older people (*and* people living with dementia) should fall on relatives, and/or professional care staff, at home or in long-term living environments.

Vs.

- The community has a responsibility to support older people (*and* people living with dementia) through support systems that reach beyond family ties and monetised care systems

Paradigm Shift 3

- It is up to community planners to create inclusive communities

Vs.

- Elders (*and* people living with dementia) and a broad citizen representation need to be actively involved in planning for inclusion

The Ultimate Culture Change Question:

Is transforming nursing homes and senior living campuses good enough??

"Instead of thinking outside the box, get rid of the box." – Deepak Chopra

How to Afford Global Aging??

Move toward a society that:

- Stops segregating and disenfranchising old people
- Stops segregating and disenfranchising people with dementia

Benefits

- Strength-based view of aging
- Elders share wisdom, experience, and perspective with younger generations
- Younger generations partner with elders for systems of mutual support
- Elimination of community features that disempower and disengage elders →
- ** Elimination of learned helplessness and excess disability (high contributor to cost)

Inclusive Community Components…

- Physical redesign of existing neighbourhoods
  - Walkable communities
  - Improved public transportation
  - "Satellite" retail spaces or services
  - Mixed use buildings
  - Multigenerational communities
- Reciprocity (need *not* be commodified!), e.g. Maryland "Time banking" project
- Community gathering spaces
- Education in all sectors

Perspectives…

"If we want things to stay as they are, then things will have to change."

- Giuseppe di Lampedusa

Thank you!

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