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THE CHANGING FACE OF LONG-TERM CARE: LOOKING AT THE PAST DECADE

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Abstract

Baby boomers on the verge of retirement who are considering future long-term care needs are searching for options that will promote comfort and quality of life in an environment comparable to the home left behind. Culture change is taking on different faces throughout long-term care, moving from a traditional medical model towards a holistic approach. New models of care address individual needs of the aging population. This article has three aims: (1) to evaluate the current state of culture change throughout long-term care, (2) to describe models of change seen among the long-term care industry, and (3) to report on existing work comparing the Green House Model of Care to two traditional nursing homes in Tupelo, Mississippi.

In traditional long-term care settings, quality of life interventions that address dignity, freedom of choice, and individuality are not always a priority. For many older adults, life in a nursing home is a predictable routine that lacks individual choice, personal decisions, privacy, and dignity. Because stability in the long-term care workforce is problematic, basic needs of residents may be unmet. Furthermore, traditional nursing homes rarely target special interventions aimed at improving quality of life (Kane, 2003). Baby boomers who will be retiring and are concerned about their future as it relates to long-term care have demanded new models of care be designed.

CULTURE CHANGE: FROM A LONG-TERM CARE PERSPECTIVE

Throughout the history of long-term care, the medical model has been a dominating force. For many, the medical model conjures a mental picture of long hallways, dreary interiors, and uninviting furnishings. Traditional nursing home care has historically been provided to accommodate regulatory requirements without consideration of meeting the resident's individual needs. This negative mindset needs to change. Administrators must lead the change effort for residents and for staff (Barba, 2002; Hollinger-Smith & Orthgara, 2004; McDougall & Roberts, 1993). Models of care exist today that hold promise for elder care as culture change permeates the nursing home industry. Individualized care that moves the focus to the resident while encouraging autonomy must be addressed.

Nursing home administration, nurses, and nurse aides throughout the United States are inviting culture change to the nursing home environment. The new face of long-term care is

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being approached from a variety of angles. For example, the emphasis is often on building relationships, focusing on what makes residents and staff happy and fulfilled. The focus is much more respect-oriented. Decisions that affect staff and residents were often made in a top-down fashion. Now residents' and staff members' opinions and control at the ground level are deemed important, and they have the ability to make decisions about details of daily life (Eaton, 2002). This change has been in motion for approximately a decade. Culture change in long-term care is about going beyond the regulatory requirements and meeting all of the residents' needs, not only physical needs. A structured environment where regulators determine how the residents' needs are met gives little room for creativity about how the staff will provide resident care. Culture change innovatively examines how human needs can be met while still following the regulatory requirements (Eaton, 2002). This is not easy given inadequate funding and the low priority long-term care receives from state and federal legislators.

How change should be managed by administrators and staff is often one of the most difficult aspects of the process. Change should be approached from small scale to large scale (Cutcliffe & Bassett, 1997). Key factors need to be identified in the beginning. It is important to recognize change agents within the organization. Communication at all levels must be stressed throughout the process of change, and expectations should be addressed during the planning phase.

Deutschman (2005) used ethnographic methods to study the culture of three nursing homes. Nursing assistants described shared beliefs and practices that define the social culture within the organization. In most cases, the assistants said that they did not feel appreciated and respected to the extent that they felt was appropriate. A recurring theme among assistants was the need for change, especially improving communication between direct care staff and leadership.

In sum, the need for change is clearly documented. Identifying key stakeholders and securing appropriate resources are vital decisions for successful implementation of the change initiative.

THE MOVEMENT TOWARD QUALITY OF LIFE IN LONG-TERM CARE

Dr. William Thomas introduced a concept called the Eden Alternative in the 1990s in an effort to reduce loneliness, boredom, and helplessness among the residents in nursing homes (Rabig, Thomas, Kane, Cutler, & McAlilly, 2006). Dr. Thomas, a Harvard graduate with a specialty in geriatrics, identified the need to improve the quality of life for older adults. In the Eden Alternative, the individuality of each resident is recognized, as well as the need for residents to know staff personally. An important goal is for residents to feel secure and that caregivers can meet personal needs. This concept is about bringing lost control back to the resident in a homelike setting.

Hierarchy with managers at the top of the organizational chart is changed through the practice of the Eden Alternative (The Eden Alternative, no date). Self-directed teams are empowered to participate in decision-making about the resident's care and choices. These

teams are comprised of nurse aides who take on greater responsibility in decision-making regarding the residents' daily care. The aides usually have the same resident assignments and understand that they are communicating about the resident to the charge nurse or supervisor on a continual basis. The teams work together and problem-solve about concerns reported by a resident or family member (Yeatts, Cready, Ray, DeWitt, & Queen, 2004). An example is meal tray setup for a particular group of residents. If a concern is brought to the charge nurse or staff, the team will discuss ways that they can improve the process and identify how they can meet residents' requests while maintaining regulatory compliance. The Eden Alternative encourages nursing home staff to integrate plants, animals, and children into the daily life of nursing home residents, thereby increasing quality of life.

Another movement that started in the late 1990s also has worked to advance culture change initiatives within long-term care. The Pioneer Network, like the Eden Alternative, encourages resident autonomy in choice and decision-making related to residents' individual needs. The Pioneer Network also emphasizes the relationship between residents and staff and integrates plants and animals into a home-like environment (The Pioneer Network: Culture Change in Long Term Care Nursing, n.d.).

In 2000, Meadowlark Hills, a healthcare center in Manhattan, Kansas, initiated culture change moving from a traditional model to a household model for residents and staff. The traditional healthcare center had existed for 20 years. Nothing was convenient for the residents; everything was planned according to regulation and meeting requirements without regard to residents. The Chief Executive Officer decided to make changes by asking residents, staff, and the community at large to determine how to create a homelike environment. Change was initiated that created small households for 15 residents or less. The traditional look of a skilled nursing home was removed by adding a front door, a living area, and assigning separate staff to each household. Instead of shared staff among the smaller households, staff now has permanent resident assignments. This is an important factor for providing continuity and increasing the ability of the staff to become familiar with each resident's individual needs (Meadowlark Hills, n.d.).

THE GREEN HOUSE®: DEFINITION AND MODEL DESCRIPTION

The Green House is a model of care that is emerging as an offspring of the Eden Alternative concept. Dr. Thomas, along with a team of dedicated individuals, established the National Green House Project in 2002. This initiative offered technical assistance to organizations that wanted to move from a medical model to a social model of care in long-term care settings. Mississippi Methodist Senior Services, Inc. (MMSS) in Tupelo, Mississippi was the first organization to implement the Green House Model, moving from a 140-bed nursing home (Cedar's Health Center located in Tupelo, Mississippi) to four Green Houses on the Tupelo campus. Within a year, MMSS built six additional homes on the same campus and continued transferring the residents in the 140-bed nursing home into the smaller Green Houses (Rabig et al., 2006).

The Green House is a skilled nursing home. It holds a nursing facility license, meets all the legal requirements of a nursing home, and functions under the regulatory requirements of the

Centers for Medicare and Medicaid Services (CMS). Unlike the sterile nursing home setting, the Green House is a warm, inviting home. Each residence houses ten elders or less who reside in small-scale homes. Each elder has a private bedroom, bathroom, and a shared hearth that serves as a place to gather. Every aspect of daily life has been planned in terms of creating a home-like atmosphere. Food and social interaction are important components of the Green House. The focus of mealtime and dining go beyond the meal and include socialization. The term used to describe the social experience of dining is convivium. There is an outside area with a patio, garden, and the ability for staff to observe from inside the Green House while giving the elder the freedom to enjoy the outdoors. A wireless call system that alerts staff is utilized by the residents instead of the loud noise of a call system often heard in a traditional nursing home setting. The nurse's station no longer exists; a sitting area for a quieter alternative has replaced it. Clinical records are not exposed for public viewing; they are recorded and stored electronically via a handheld device. Anything that implies the traditional nursing home is tucked away, allowing the comforts of the Green House to emerge. Lift tracks are located in the ceiling of each elder's room to enable a safe transfer from bed to bathroom or wheelchair as needed (Rabig et al., 2006).

The certified nursing assistants who work in the Green House are called Shahbaz (Shahbazim: plural), in an effort to overcome the stereo-typical term of nurse aide used in the traditional nursing home. This term was chosen in keeping with the culture change philosophy and separating of the institutional or nursing home mindset. The Shahbazim are Green House staff or elder assistants who receive 120 hours of additional training for the expanded universal role that includes cooking, cleaning, laundry, shopping, and more. Shahbazim are given greater latitude in decision-making and are empowered to function comfortably within the social model of the Green House. The Shahbazim, unlike traditional nursing home aides, do not fall under the management of a nursing director, supervisor, or a charge nurse, but rather under the management of the Green House guide. The guide is a nursing home administrator who oversees the care that the staff provides and determines if it meets standards established by the Green House Project Team. This individual is available on a regular basis and can be paged or called if needed. The guide receives training along with the other Green House staff (Rabig et al., 2006).

A full support team is within the premises of the Green House community and is available as needed. An individual in the outside community who volunteers to participate in a positive role of advice to the Shahbazim and offer assistance as needed is called a sage. The Green House guide and staff determine who is chosen for the role of the sage. This is an important position and is utilized for assisting the Shahbazim with decision-making and problem-solving for issues related to daily life in the Green House and assisting with mentoring new staff (Rabig, 2006). The sage participates in meetings and is entrusted with maintaining confidentiality. Licensed nursing staff work in the role of a visiting nurse and perform clinical care administered under the direction of physician's orders, while the Shahbazim care for residents 24-hours a day. Administrative and multidisciplinary team support remains nearby including nurses, a social worker, a dietician, and activity personnel. While this team is available for the Green Houses, they are at a distance, housed in a separate building (Rabig et al., 2006).

The Green House sets the stage for increased social involvement. The elders and staff work together to determine the daily schedule and share in decision-making. Boredom is decreased while quality of life and satisfaction is increased among elders and staff. The small size of the Green House allows the staff to address the needs of each resident on a personal level (Rabig et al., 2006). The staff know the elders that they care for, and the elders know the staff. The Green House has facilitated opportunities to educate the general public and extended community about the potential benefits of this model of care (Angelelli, 2006). The results thus far are exciting and have been recognized as a positive change in long-term care.

COMPARING THE GREEN HOUSE TO TWO TRADITIONAL NURSING HOMES

To date, little research is available related to outcomes in long-term care models such as the Green House. Dr. Rosalie Kane, a renowned professor of Public Health at the University of Minnesota, has published numerous journal articles focusing on long-term care and health needs of residents. She is seen as one of the best-known scholars in long-term care advocacy across the spectrum from skilled nursing, to assisted living, to home care (The University of Minnesota, n.d.). Dr. Kane led a research team to complete a 30-month study of the Green House Project in Tupelo, Mississippi. The Green House research project was sponsored by the Commonwealth Fund of New York City. Data were collected at baseline, 6 months, 12 months, and 18 months (Kane, Lum, Cutler, Degenholtz, & Yu, 2007). The most important components of the study were related to deinstitutionalizing nursing homes (Kane, 2006). The research team interviewed residents about their perceived health status, psychological welfare, social welfare, and quality of life. Family members of residents also were interviewed to document involvement with the resident, satisfaction with the Green House, and to assess caregiver burden (Kane, 2006). The Green House was hypothesized to increase family to resident interaction through personal involvement, visits, and spending time with the resident (Rabig et al., 2006).

Data about the staff were collected by interview to determine how well the staff knew the residents that they care for, if they believe that they make a difference in the life of the residents, and if they receive personal job satisfaction for their efforts. Post occupancy data were gathered for the residents, family members, and staff regarding the homelike environment of the smaller home, the hearth, the individual rooms, and other special qualities the Green House offers. The financial aspects of the Green House were examined to identify costs for building the model and to give other organizations an opportunity to see the financial impact of initiating a similar venture (Kane, 2006).

The comparative study completed by Kane et al. (2007) contrasts the Green House to two traditional nursing homes also owned by MMSS. Cedars is a 140-bed nursing home where the elders lived until they moved into the Green House on the Tupelo campus, and Trinity is a smaller nursing home with 65 beds less than 100 miles away. The elders, the Shahbazim, and the families in the Green Houses were compared to the residents, the families, and the certified nursing assistants (CNAs) in the two traditional nursing homes. The Green Houses

differed by elder case mix. An example is the Cedars' special care dementia unit, which is comprised of 20 residents. This group was moved into two of the first four Green Houses while residents needing various levels of care including skilled and assisted living moved into the remaining homes (Kane, 2006; Rabig et al., 2006). Residents who were at the end of life receiving palliative services or in a comatose state were excluded from the study.

The Minimum Data Set (MDS) was used to capture outcomes related to resident quality indicators. Staff outcomes including absenteeism, turnover, and work-related injuries were measured (Kane, 2006; Rabig et al., 2006). Overall, the pilot study results favored the Green House model over the traditional model of care. The Tupelo homes have a waiting list for resident admissions. Operation of the homes has been cost neutral with no savings or loss; however, the Green House does not have the primary goal of financial gain. The Green House is concerned with the physical and psychological outcomes that the elders experience, and results included high satisfaction for residents, families, and Green House staff. Staff turnover declined to less than 10%. Unexplained weight loss and nutrition issues improved along with a decrease in the need for supplemental nutrition. There have been no reported transfer-related back injuries in staff or injuries to residents related to the use of the ceiling lifts. Fewer issues that require regulatory evaluation, a lower incidence of decline in late loss activities of daily living, less depression, and less use of antipsychotic medication without an associated diagnosis have been identified in the Green House model as compared to traditional nursing homes (Robert Wood Johnson Foundation, 2005; Rabig et al., 2006).

Final study results were published in 2007 and included the following two major findings: (1) 9 of 11 quality of life domains were higher in the Green House than Cedars and (2) 4 of 11 quality of life domains were higher in the Green House than Trinity. The Green House residents were more satisfied than the residents in either of the traditional homes were. Emotional well-being was higher in the Green House than Cedars. Without explanation, incontinence was higher in the Green House than Trinity. There was no difference in 16 quality indicators compared to the traditional homes. Seven areas of social activity data equaled the traditional homes (Kane et al., 2007).

Future research will include mixed methods for Tupelo and other Green House models as they are completed. Research will further define how well the model works to improve quality of life among the elders and staff and what adjustments should be made in the future. Two areas that have been identified for future changes are the physical setting or functionality of the Green House and staff education about the Green House. Although the MDS is the current measurement of quality indicators for the Green House, the goal is to further define outcome measures specific to the Green House for residents, family, and staff that can be standardized to future Green House communities (Rabig et al., 2006).

RELEVANCE TO GEROPSYCHIATRIC NURSING

The changing face of long-term care, including culture change initiatives, is important for the future of geropsychiatric nursing. All phases of nursing, including academic, research, and clinical practice, have a growing need for nurses who specialize in issues related to the aging population. Initiatives that focus on quality of life in long-term care are needed for the

future wave of older adult baby boomers seeking new environments of care to spend their remaining years of life. The need for bridging the gap is significant, and this will continue to increase as the baby boomers seek aging services. The study of geropsychiatric nursing is especially important for clinical practice, teaching, and setting standards for nurses and nurse aides working in long-term care settings. Through mentoring of direct care staff in nursing homes and similar aging communities, geropsychiatric nurses have an opportunity to extend the knowledge of best practices and to reinforce the expected standards of practice within the field of aging. This effort will empower nursing staff while increasing the quality of care provided.

CONCLUSION

Solutions need to be identified in long-term care that improve quality of life for residents, are cost-effective, and provide a positive work environment for staff. Examples include the Eden Alternative, the Pioneer Network, the Meadowland Hills Program, and the Green House model. The Green House model was used as an exemplar in this paper and appears to be a promising initiative that may offer positive solutions for future elder care. Since this model is in its infancy, drawing conclusions would be premature without evidence from the multiple site evaluations that are currently in progress. Continued systematic investigations into contemporary models of care will provide empirical support for cultural change not only at the point of care but also in the health policy arena. This paper argues that traditional long-term care settings have not focused their efforts on residents' quality of life, and contemporary models have the potential to realize the possibility that the phrase "there is no place like home" may become a reality for future generations of older adults considering long-term care environments as their home.

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