

2010 Next Steps Think Tank: Culture Change Consensus and the Household Model



HOSTED BY

UWM Center on Age and
Community
UWM Institute on Aging
and Environment

WITH SUPPORT FROM

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Introduction

WHY ARE WE HERE?

This white paper represents a summary of a three-day *Next Step Think Tank* held May, 20-21, 2010 hosted by the University of Wisconsin-Milwaukee's Center on Age & Community (CAC) in partnership with the Institute on Aging and Environment at UWM. These Next Steps Think Tank events are designed to explore critical issues in the field of aging and to foster deep thinking on a given question. Over the past six years we have been offering the Think Tanks, we have honed the event into a three-day format. A select group of invited guests with diverse viewpoints are invited to attend a pre-Think Tank evening event designed to break the ice and introduce the topic broadly. The format for the second day brings this select group together for a series of moderated discussions. The final day is a public forum, in which the select group explains their findings/ideas and continues to develop them with other participants who have an investment in the topic.

For the Spring 2010 Think Tank, a multi-disciplinary team of experts in long-term care (LTC) convened to address the topic "Culture Change Consensus and the Household Model." Three doctoral candidates in UWM's Institute on Aging and Environment, Addie (Johnson) Abushousheh, Migette Kaup, and Mark Proffitt, organized the 2010 Think Tank. This Think Tank was intended to guide their dissertation efforts which are focused on the structures, processes, and outcomes of the "household" model in long term care settings.

The underlying premise for this discussion was that Culture Change is the right and necessary thing to do in long-term care, but more information is needed on the "Household Model" as an expression of Culture Change. Those participating in the discussion included many who have been striving to make Culture Change a reality for decades—those who have built the buildings, who have modeled and coached (while actually providing the service, or walked alongside those who are), and those who have been doing the research that helps to make the case for policy changes—which are starting to happen. The two-day session was moderated by Dr. Anne Basting, Director of the Center on Age & Community. Her role was to elicit from the group those tangible and intangible aspects of the Household Model that make it an identifiable and effective element in the process of Culture Change.

ANNE BASTING CHALLENGED THE GROUP WITH THE FOLLOWING OPENING STATEMENT:

It is recognized that Culture Change is the larger movement. It addresses the busy nexus of the environment, organizational structure, and individual lives within it. To make our discussions more focused we specifically targeted one aspect of Culture Change—the "Household Model". We do not see the Household Model as the BEST model. Or even the preferred model. It is simply a model that is getting some traction, yet is not consistently described and could benefit from definition and evaluation before it goes that way of the FRIDGE, and KLEENEX. Until the words become so generic, they lose all specificity.

There was recognition among the gathered experts that in order to support the difficult and sweeping changes required to meet the needs of elders, Culture Change needs to be more clearly defined and evaluated. As you read the thoughts and ideas of those who agreed to take on these complex issues, recognize that many of our "breakthroughs" were possible only after much frustration, spirited conversations, and even avoidance. Anne gracefully enabled the group to grapple with the challenging dimensions of the topic and build consensus.

Participants



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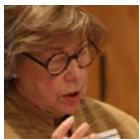
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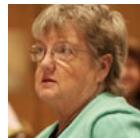
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Architect & President, Nelson-Tremain Partnership



LAVRENE NORTON
Executive Leader, Action Pact



WILLIE NOVOTNY
Executive Leader, Meadowlark Hills



MARILYN OELFKE
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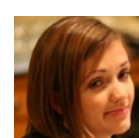
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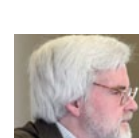
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GERALD WEISMAN
Director & Professor, Institute on Aging and Environment, UWM

2010 Next Steps Think Tank “Homework”

In preparation for participating in the Think Tank, participants were given a homework assignment which included reviewing a national survey conducted by the Commonwealth Fund on Culture Change and participating in a survey conducted by the Institute on Aging and Environment in 2010 entitled Culture Change and the Household Model.

THINK TANK HOMEWORK

There has been growing awareness of Culture Change among professionals and providers in the field as evidenced by the Commonwealth Fund national survey of nursing homes in 2007. Their survey measured the extent to which nursing homes were adopting Culture Change principles and practicing resident-centered care. One decade ago, few nursing homes were familiar with “Culture Change.” Today it’s a “household word” (pun intended). The survey, however, indicates varying degrees of adoption.

SO, WHY HASN’T EVERYONE HOPPED ON THE BAND WAGON?

The strength and weakness of Culture Change is in its “one size does not fit all” philosophy. While the Commonwealth fund surveyed the broad constituency of U.S. providers to take the movement’s temperature, the Culture Change and Household Model survey asked those already invested in the movement to weigh in on the desirability and feasibility of a variety of strategies culled from practice and evidence-based knowledge.

WHERE DOES ONE START WHEN THERE ARE SO MANY OPTIONS?

There is a need for increased systemic research which evaluates and supports Culture Change and the Household Model. The Spring 2010 Think Tank, along with a Culture Change and Household Model survey, attempts to address this need by revealing an underlying framework for implementation and investigation.

CAN A CULTURE CHANGE COLLECTIVE HELP TO GUIDE THE WAY?

In preparation for the Think Tank on May 19-21, we’d like for each participant to review the following list of action items and prepare any information that will be useful for our discussions together.

THINK TANK ASSIGNMENT...

1. Please take the time to review the *Findings from the Commonwealth Fund 2007 National Survey of Nursing Homes*.
2. There are a variety of outcomes and obstacles (benefits and barriers) typically associated with Culture Change and/or the Household Model. Because each Think Tank participant has a unique perspective, please identify and develop a list based on your insight and experience, making a conscious effort to address the following:
 - a. Tools and/or measurement strategies that enable care communities to establish baselines, benchmark progress, and compare their outcomes to the broader constituency
 - b. Existing data sets that can be used to evaluate Culture Change from a systemic perspective
 - c. Innovative techniques that are used to measure discrete outcomes
3. The Think Tankers have broad exposure to and knowledge of providers who are actively advancing Culture Change in their provision strategy. Please make a list of providers that you believe are exemplars of the movement and the Household Model.
4. A variety of local, state, and governmental incentives and regulatory changes are being employed to advance Culture Change practices. Please list those that you believe affect the movement.



Events

WEDNESDAY EVENING EVENTS

The Think Tank kicked-off with an evening of provocative presentations about Culture Change and Culture Creation. These included:

- Joel Treffert – Do all Roads Lead to Culture Change?
- David Green – Culture Change vs. Culture Integration: New Perspectives on Culture from China
- Emi Kiyota – Challenges of Global Aging: Housing Elders in Developing Countries

THURSDAY

Thursday entailed an intensive discussion using individual and group brainstorming exercises to answer key questions related to Culture Change and the Household Model. These questions included:

- How do you envision care in your future? — What does it look like and include?
- How do you define the Household Model?
- What are the outcomes of implementing the Household Model?
- How could one assess and evaluate outcomes of the Household Model?
- What are the incentives and obstacles for the Household Model?

FRIDAY

Think Tankers summarized and shared the results of Thursday's discussions in a public forum and elicited further reactions and commentary from all participants. The remainder of this white paper is a summary of Friday's events.

A Summary of the Public Forum Discussion

The following section reviews the discussion of Friday's Public Forum which summarized the questions posed to Think Tankers the previous day and opened up the discussion to a broader audience. Think tank participants were divided into teams and asked to synthesize the discussion for the six key questions addressed on Thursday. One member of each team presented these ideas in a public forum on Friday.

Response Summary presented by: Nick Castle

Group: Nick Castle, Lynda Crandall, Emi Kiyota, Willie Novotny, and Joel Treffert

Question 1: How Can We Design a Preferred Future while Living with Disabilities?

Imagine that you are each significantly, physically and cognitively disabled and your partner can no longer lift you. Describe what you are able to do, where you would like to live and what this place looks like.

RESPONSE SUMMARY

Our vision for the future includes four themes:

1. **POSITION:** Connection to family, community and nature, as well as the ability to come and go as desired.
2. **TIME:** Having a sense of purpose and meaning, enjoying daily "simple pleasures" and having control over our daily activities. We want to be respected.
3. **LIVING:** Personal privacy, especially in the bathroom, and a feeling of security and safety. Control over the temperature and television. Our space needs to be flexible enough to accommodate my furniture, my activities and space that welcome others – family and friends.
4. **FOOD:** Choice of what, with whom, and when you want to eat. An emphasis is placed on honoring cultural diversity and holiday traditions. As long as we knew we could have what we wanted, then it didn't necessarily have to happen on demand every day.

PREFFERED FUTURE DISCUSSION

MARGARET CALKINS: *One major issue with time is, who controls my time? I get to decide how and what I do with my time.*

Question 2: How Do We Define the Household Model?

In this activity on Thursday, Think Tankers were asked to create a definition for the Household Model. Each person had three minutes to write what was most critical within a household. One group was charged with creating a definition from the collection of comments.

RESPONSE SUMMARY

What we have is a synthesis from all of the comments that were shared on Thursday. The purpose of making it so long was to include the vital household elements that we were discussing yesterday.

A household:

- is a small grouping (typically 10-20) of residents and their dedicated staff with the purpose of fostering self-directed, relationship-based life.
- has pleasing, homey spaces with a functional kitchen at its hub—nurturing daily life, responding to individual residents, and fostering community life.
- is intimately-sized with clear boundaries and a variety of spaces typical of home, including the flexibility of private and shared bedrooms spaces as desired by the residents.
- includes clinical best practices, the tasks and routines and pleasures of daily life, cutting edge technologies to encourage life choices and promote functionality, mobility, wellness and growth.
- Household life is facilitated by an empowered self-led team of residents and staff. Deep knowing, reflective of true home, fosters a good life for everyone and is supported by the resources of the organization.
- The organization has been redesigned to position households and their leadership with the autonomy and accountability to respond to individual resident needs, as well as, the responsibility to create meaningful household life. In other words, the households, together as a team with the Administrator and Director of Nursing Services, become the vehicle for all operational decisions and administration, replacing the traditional department structure.

HOUSEHOLD DEFINITION DISCUSSION: REACTIONS TO DEFINITION

LAVRENE NORTON: *There were some fascinating thoughts that came out of conversation yesterday. One was, "let's stop talking about 'care' and start talking about 'life'". There is an assumption that if you have life, you have care; this puts us in frame of "being with, instead of doing to." The concept of using "self-directed" instead of using "person-centered/resident-centered" and moving to "self-directed life" is very powerful. The concept of using "intimate" boldly is an excellent way to describe household life; there is an intimacy about our household lives, which it really captures.*

STEVE LINDSEY: *It's the combination of the environment that was described and the opportunity for self-directed life that creates purpose, meaning and vitality which Nick was talking about before...to think you could live in a place with meaning, opportunity and value rather than living in a place where you receive care. Yesterday, I talked about a woman who resisted moving into our Household Model. She caught me and said, "now I realize in the OLD nursing home I was just a person that received care, but now in this household, I found myself again." It's such a powerful statement of what this model can do when you allow people to focus on self-directed living again.*

BARBARA BOWERS: *"Self-directed" doesn't work very well with people who have people with moderate-severe dementia or at least it needs to work differently. It doesn't seem to be in the definition. This is a tough thing to take on.*

LAVRENE NORTON: *We think "self-directed" does include everybody, but it requires the team to really discover the person. We had several nice discussions around the whole discovery process yesterday. It's not just deciding what somebody needs; it's somebody discovering the person and being able to then follow that person's lead.*

ROSALIE KANE: *In my definition there is the possibility for everybody to have a private room or to share a room if they choose. I think that takes deep thinking with how you would define the physical space, the reimbursement, and change the whole financial incentives and pricing. So the very rare person might share a room, but basically no one would have to.*

HOUSEHOLD DEFINITION DISCUSSION: CHALLENGES OF CREATING A DEFINITION

ANNE BASTING: *In yesterday's Think Tank discussions, we danced around a definition for the Household Model. I asked, "what are we afraid of?" I think people didn't want to be held to a single definition . . . How do you feel now?*

GAIUS NELSON: *That definition is elegant wording. It bring up the kitchen, but doesn't include who does the cooking and where. This opens up a lot of possibilities for how different organizations might do things differently. The nice thing about this definition is that it's broadening rather than limiting.*

LYN GEBOY: *I think it would be useful to clarify the differences between "house" and "household". When I think about "household" I think about sociological models and models that are very much about imposing care. When I hear "house", I think of the physical structure, which you don't really get with the term "household". With "household" I get more of the connotation of interpersonal care that I'm hearing everybody talk about.*

LAVRENE NORTON: *I hear the distinctions that you're making but people have used both words in exactly the same way. The Household Model is the term for the structure to make this happen. We really are talking about NURSING HOME's and the reason we are talking about NURSING HOME's is that they're the most deviant! They're the furthest from real life. The household is a structurally imposed reshaping of the environment. It rips the nursing home apart and differentiates what it has become from what it can be. If you go to places that are doing the Household Model, they always talk about their houses. This speaks to the interpersonal stuff. They will often name their houses, "the ___ house." I think the Household Model language came out of the need to clearly state, "hey, you have to reorganize; you have to transform skills and people; and you have to renovate into home."*

RUTA KADONOFF: *To me, household is the people that live within and the house is the physical structure. I think there is another dimension—"home". I think of the house as the physical structure and "home" as all of the things that make it MY home.*

MARGARET CALKINS: *Related to that, you can have the physical structure, but if you don't have the organizational/philosophical values you still don't have home. You can have an institution in a building that looks like a house.*

ROSINA BLOOMINGDALE: *So why wouldn't we use the word "home"?*

MARGARET CALKINS: *It reminds us too much of nursing HOME.*

BRIAN SCHERMER: *My only comment is on the word "definition". I think what we actually have is a set of "principles". I think what we're hearing is that these principles apply across scales and over time, perhaps in 2020, 2030, 2040, these principles will still apply and this idea of household as an ideal will still have meaning.*

HOUSEHOLD DEFINITION DISCUSSION: APPLICABILITY OF DEFINITION ACROSS SETTINGS

ANNE BASTING: *Do we need to specify that this definition is only for skilled nursing?*

ROSINA BLOOMINGDALE: *This is an open dynamic-living concept. If we incorporate the whole living-wellness perspective, it can translate to anywhere people live.*

BETH MEYER-ARNOLD: *The nice thing about the definition is it says, "variety of spaces". Therefore, it can be used in different settings such as assisted living and day care. I know we were creating this definition for skilled care, but there are a lot of us that are involved in something other than skilled care nursing homes who are concerned about these issues as well.*

ROSALIE KANE: *I agree that this is still useful but the "knowing" would not be "deep knowing" as in the long-term households. I want to say with complete respect to Adult Day Care that we lose specificity once we don't have bedrooms and people don't live there. It's not just visiting.*

LAVRENE NORTON: *This would work just as well in short-term care, especially when you have a designated household for rehabilitation. I think it absolutely can respond to their needs. There are a lot of conflicting issues, however, that develop when short-term people temporarily enter into a household where other long-term residents are trying to have a life. Many organizations serve short-term folks in separate households. I don't think those individuals would appreciate not having a household environment for themselves if a Household Model is right next door. It promotes wellness and provides the perfect opportunity for a person rehabbing.*

ANNE BASTING: *I'm wondering, are short-term institutions moving to a Household Model? Is that a driver? If short-term has it, why not give it to everyone?*

BARBARA BOWERS: *I would be careful about that. Short-term settings have to balance more towards recovery and rehabilitation. We run the risk of re-medicalizing the household if we do that.*

WILLIE NOVOTNY: *Just a little bit about Household Model and short term stay. In looking at that definition, it's brilliant! If everything fits, then it's a house. I've lived in houses that I didn't own and I didn't plan on staying there forever. During the time I lived there, however, it was my house. The people that stay in the rehabilitation houses are similar. They design their own schedule, but it has more structure than long-term residents because the goal is to get well. The values still stay intact even though it isn't their permanent place to stay.*

MARILYN OELFKE: *I want to echo Willie's comments about short-term stay. The Household Model promotes recovery. People need to make their own goals, which create a spirit of "we're here to get better and we're going to help each other to do it." A household promotes the idea of working together as an extension of their family.*

RUTH FUENTES: *You're absolutely right, when they come there, even if there's only seven to eight hours of the day, it's different because they feel at home. These ideas should respond to people of different cultures. Our day care is for Latino people so we have a set-up where it's homey for Latino people.*

**HOUSEHOLD DEFINITION DISCUSSION:
HOUSEHOLD MODEL OUTCOMES**

ELLIE OLSON: *I was just thinking about people with dementia and whether or not we've talked about "behaviors". You can have interpersonal conflicts that lead to survey problems.*

STEVE LINDSEY: *From a provider's perspective, one of the things we've been amazed with is the lack of those behaviors in a household. We've had people in previous institutional settings who had all of those behaviors. When they come into the household and reconnect at a personal level of a home, have people who know them deeply, and the same staff come in every day, it's amazing what a difference it makes in their life. There is a sense of peace because they're home and they're not at the institution anymore. Yesterday, we talked about how our homes are not always perfect. Routines don't always run smoothly and our house is not always picture perfect. With regulations we don't have a lot of room for "imperfect" and this leads to institutions. We need to have flexibility so that even somebody with deep dementia has a place where they can be "at home".*

NICK CASTLE: *I think we rule by the case of exception. The risk of hazards that exist in a household is exceptional. So even if 99.9 percent of the residents are okay, it only takes one person to harm themselves or others that creates a regulatory stronghold.*

ANNE BASTING: *Many people leave their homes because risks are too high and go into Nursing Homes.*

LAVRENE NORTON: *Nursing Homes are more dangerous*

ROSALIE KANE: *I think and hope that now that we've redeveloped the MDS, we're not going to talk about the behavioral problems anymore.*

BARBARA BOWERS: *We might start talking about this as reactions to environment rather than personal problems.*

DAVID GREEN: *We had a remarkable experience in 1990. No more physical or chemical restraints were permitted. We had a dementia unit for 36 residents. On this unit we had a roving gang of little old ladies going through the hall terrorizing the place. Keep in mind that these women were ambulatory dementia residents. Staff said we can't provide for this behavior and we are constantly taking them back to their rooms. The staff suggested creating an in-house day-care center. There was a portion of the building that was not being used that resembles a house setting with a kitchen, a dining room, and a living room. So every day we would take them there where they would do the things they had always done at home—wash floors, dishes, etc. The Behaviors disappeared instantly! At the end of day, when staff would take them back to the unit, the behaviors would immediately return again—agitation, insomnia, etc. They went back down to the day care setting and the behaviors were gone . . . Back and forth, day after day proved that the environment is the problem; it's not the disease!*

Question 3: What Outcomes are Associated with the Household Model?

On Thursday, the group was charged to create a list of personal and inspirational outcomes that participants would strive for if we were living in a Household Model. Some of these outcomes have been achieved in existing Household Models while others remain goals that individuals and organizations are reaching for, but may not yet have achieved. These are the elements that this particular group, or individuals within it, deemed important. The task at hand was not necessarily to develop outcomes that would be more generically desirable as projected to the general population. Each person listed outcomes on separate post-it notes and we grouped them loosely by likeness. We took that list of outcomes generated from yesterday's discussion that were framed as "I-Statements" and proceeded to group them into more well-defined categories. We took out the redundancies and things that were not really outcomes. From that, the following list was developed.

RESPONSE SUMMARY

FAMILY CONNECTEDNESS:

- My family likes to visit
- My grandchildren can stay with me
- I want to invite people to meals
- My family engages with other residents, not just me

CONTINUUM OF COMMUNITY:

- I can maintain neighborhood connections
- I can attend religious activities
- I am able to travel

RESIDENT CONTROL/AUTONOMY:

- I can take calculated risks
- I can walk around the block on my own
- I can wear clothes that require dry-cleaning

PHYSICAL SETTING (EXTENSION OF SELF):

- I feel that my space and possessions are secure
- No doors are locked to me and no area is off limits
- I have a patio off my room (I feel at home in areas beyond my own room)
- My closet is large enough for all of my clothes (areas/spaces have been designed with me in mind)

STAFF:

- There is low staff turnover
- The staff who work with me are under less stress than in a regular nursing home
- The staff have high satisfaction
- The staff self-schedule successfully
- The staff evaluate each other
- The staff assess leadership positively

USE OF TIME FOR INDIVIDUAL PURSUITS:

- I can play my French horn if I want to
- I can snuggle with my cat
- If I would like to, I can swim and exercise
- I have the opportunity to garden
- I have access to NEW movies and books
- I can be intimate with my partner



PHYSICAL WELLBEING:

- I am able to maintain my desired weight
- I can gain or maintain strength
- I am not depressed
- Any pain I may experience is kept under control
- I take few (if any) psychotropic drugs
- I have mobility and functionality
- I have early diagnosis of any health problems so there are fewer compounding problems over time because of delayed response

RELATIONSHIPS:

- My cats live with me
- I share space with my significant other, or a person of my choosing
- I can sleep with my dog
- I don't feel lonely

STAFF ATTITUDE TOWARDS RESIDENTS:

- Staff view me as having skills they can learn from
- Staff are compassionate
- Staff has genuine (non-superficial) communication with me
- Staff is interested in my family
- Staff has concern for my personal comfort as they provide care
- Staff really know all of the residents in my household; there is deep knowledge

ACCESS TO FOOD AND ENJOYMENT:

- My appetite continues to improve
- I get what want when I want it
- I can eat vegetables that I grow
- I can use my own rice cooker
- My preferences are available all the time
- I am encouraged to express my preferences

PERSONAL PREFERENCES:

- I am with people who are intellectually stimulating to me
- I am learning new things
- I am excited about life
- I can use bath oil

HOUSEHOLD OUTCOMES DISCUSSION: DEEP KNOWING AND DEATH

ANNE BASTING: *We haven't addressed opportunities for grieving. If the expectation is that they'll have deep knowledge, we need to think about what happens when people die.*

LAVRENE NORTON: *People living in a household should know when a person is dying or has died so they have an opportunity to grieve. HIPAA is restrictive where this is concerned.*

RUTA KADONOFF: *Residents should also know that they will be remembered.*

ROSINA BLOOMINGDALE: *The household promotes staff involvement on an emotional level rather than just a care-giving level.*

HOUSEHOLD OUTCOMES DISCUSSION: BUILDING THE BUSINESS CASE

GAIUS NELSON: *We all know that the environment has an impact. Is there data to support this and have there been studies to show us that this really occurs? There are anecdotes, but is research available?*

ADDIE (JOHNSON) ABUSHOUSHEH: *A lot of people are developing good things individually. It's like the U.S. is covered with a lot of stars. Its' joining those data and those experiences together into a constellation to form the foundation that equates to evidence. Right now there is a lack of evidence.*

JOEL TREFFERT: *When we listed desired outcomes, there was a notion that the gap between where we are today and where we want to be is just a matter of change. In my mind the biggest gap is related to funding. Our for-profit providers would love to provide these types of things, but they simply cannot afford it. We would be remiss not to acknowledge this.*

MARGARET CALKINS: *I agree totally about including for-profit providers, but if we went over that list of outcomes, there are probably 10 percent that require additional funding. Organizations pay for staff education already, so it's a matter of focusing on how they're doing their training. 90 percent of what is there does not require additional funding.*

RUTA KADONOFF: *I agree that the capital side of this is a challenge—the things that require money. However, on the care side, it is about using resources more efficiently and recognizing there are ways to redirect resources where they're needed. We have documented through independent research that total hours and time involved for caring for someone in a Green House® home are no greater than in traditional nursing care, but that time is spent differently. Direct care staff spends 30 minutes more per residents, per day in direct care activities and five times more time in direct engagement with residents than in a traditional nursing home. In the traditional nursing home, a CNA spends 45 minutes more per day than in a Green House home just transporting people from place to place. You also have to reduce your overhead. Get the capital out of administrative silos that never touch the resident and reallocate it to the frontline staff.*

BARBARA BOWERS: *We need to talk about the issue of staff development. Somewhere in the definition we should include that frontline workers take on responsibility and accountability to decide what happens. They need the skills and knowledge that facilitate this. CMS has shown, that you can have more staff and yet not actually do anything different or see improvements. I think everybody needs to raise their expectations for what the nursing home is and does.*



PATRICIA MABEN: *I have the privilege of consulting with a for-profit, low-income nursing home that is predominately Medicaid. It is one of the most joyous places you would ever want to be in. The facility, in cooperation with the local school district, hosts an all day kindergarten. The key there is enlightened leadership. The administrator came into a setting that the state was ready to close. She had two unions to deal with and she had huge staff turn-over. Leadership turned it around. Leadership is the key issue for both the for-profit and the non-profit nursing home. We have to change how we educate our leaders. Money is an issue, but this a cinder block building built in the 1950s, 1960s and an addition in the 70s. I would put anyone I love in that building.*

LAVRENE NORTON: *In the spirit of genuine group respect, I want to thank Joel for being provocative. The issues that he brings up are the perceptions of 45 percent of the nursing home leadership in the country and this has to be addressed if we're truly are going to make a difference. This needs to be a provoked step to move forward, which means showing the for-profit world that it IS possible. I spent ten years in the for-profit world and I know that their hearts are as good as ours; as human beings they care and their staff care. They have been put in a stranglehold in a regulated environment that has pushed them in a certain direction.*

ANNE BASTING: *Should we aim for financial sustainability or financial neutrality in the definition?*

ROSALIE KANE: *Attitude is the most important barrier. Policy and money are important, but in long-term care, attitude is the most important. This can be affordable with better outcomes. We can get to "yes", but it might not be the same answer for every setting. We need to consider individuality.*

Question 4: What are the Issues, Obstacles, and Incentives for the Household Model?

On Thursday, the group was challenged to generate a list of issues that arise within the Household Model. These issues are often perceived of as barriers to implementation. They were to identify the obstacles that stand in the way of implementation and then to list incentives that might enable them to overcome these real or perceived barriers. During this discussion, it became apparent that many of the “incentives” could also be used as outcomes.

RESPONSE SUMMARY

Issue	Obstacle	Incentive
LEADERSHIP		
Gain buy-in	Unmotivated Naysayer's Resistance to change	Right thing to do Pushed by board, consumer, colleagues
Flattening the organization	Resistance Fear	Empowers staff and residents
HUMAN RESOURCES		
Cross Training	Fear	Increase job skills and satisfaction Increase resident care
Leadership Development (Front-line staff)	Fear Cost	Increase retention Increase occupancy Increase satisfaction Self-led teams
New Hiring Process (Includes residents)	Increased time Uniform Implementation	Increase retention Increase quality
CULTURE		
Development, Mission, and Vision	Time/Patience Listen/Talk Effective Process	Marketing Operational guidelines
Resident Council	Lack of staff buy-in Fear Lack of leadership buy-in	Quality improvement Regulatory compliance Increased retention
Person Centered	Task orientation	It's the right thing to do
Encourage Relationships	Time Task orientation	Increased engagement
PHYSICAL ENVIRONMENT		
Kitchen	Disagreement Cost Space	Increased weight gain



ISSUES, OBSTACLES, INCENTIVES DISCUSSION: LEADERSHIP ISSUES

RUTA KADONOFF: *Leaders often struggle with the idea of losing control and power. The solution is to frame what their new role is and not leave them hanging out there to figure it out for themselves. You have to shape and frame what their new place in this organization is. They need to feel empowered. They need to know that they are a meaningful part of the team and bring strong contributions.*

BARBARA BOWERS: *You shouldn't just take something away, without replacing it with something new. I don't think we know what all of that is.*

KELLY GAGLIONE: *It seems to me that the business case needs to be made. I don't think people go into this business if they don't want to do the right thing. In regard to costs, you can put numbers on things like retention and things that benefit the bottom line like occupancy and market share, which can be motivating.*

STEVE LINDSEY: *In order to learn about how it works, come to a place where it's actually working. Regarding the business model, the "fear" listed as a barrier in all of those columns gives us a place to hide and I think the business model gives us a place to hide. The path of least resistance is return to the institutional model. We feel like we need to have control because there are regulatory agencies and if we're not perfect we get jumped all over. We have to stop going to the institution as a default. We have a moral imperative to treat our elders better. The household business model works, but you have to revisit it and tweak it. And for us, the business model works. Not only has it worked from the beginning, but every year it's gotten better.*

ISSUES, OBSTACLES, INCENTIVES DISCUSSION: FIRST STEPS – PILOT VS. PHASING

ROSALIE KANE: *The first step is visioning at board or corporate level. They need to learn about Culture Change and households and go visit places that are doing it. Piloting and incremental movements give you the opportunity to stick your toe in the water. You can do it on a small scale, but you must have the support of leadership!*

DAVID GREEN: *By doing a pilot you can work with those staff members that readily jump in. They are the innovators who are willing to try something new. When the outcomes are new and it doesn't create any demands on anybody else, you can do it on a small scale and you can do it inexpensively. But you absolutely have to make the commitment to it!*

LAVRENE NORTON: *I would say DON'T pilot! Once the decision has been made on behalf of the senior leadership, etc., you need to get everybody in the organization involved—just go with it. If you make it happen everybody will want it for themselves. Otherwise you're just creating a dementia unit. No toe in the water, jump in!*

ROSALIE KANE: *What about phasing?, because it can't usually be done all at once.*

LAVRENE NORTON: *Let everybody want it and be involved in it.*

ANNE BASTING: *Phasing instead of piloting . . . I'm going to push you on this one. What is the difference between piloting and phasing?*

LAVRENE NORTON: *Piloting is exclusive and creates boundaries. The purpose of exclusion is so that we can separate, scrutinize, and compare it to all of the rest. Phasing is a participatory process where you get everybody moving in a common direction.*

STEVE LINDSEY: *For me, one of the underlying differences is a pilot has the assumption that something might not work. When you're phasing something, it's like this is coming, we're doing it; we're rolling. It can be a long drawn-out process. We crunched ours down into 18 months. When we started, we had a traditional NURSING HOME that was only five years old. Despite that the change still worked financially.*

RUTA KADONOFF: *The difference is, "we ARE going this way!" We have seen what David is talking about with one of our sites. We had people who wanted to go first, but from the beginning it was clear that the entire organization was going to change in the same way.*

ISSUES, OBSTACLES, INCENTIVES DISCUSSION: IMPLEMENTATION PROCESS – KEY STEPS

GAIUS NELSON: *Organizations need to develop their operational model—who takes out the trash, who cooks, who does what? They need to define the staffing roles—how is the operation going to work on a day-to-day basis? In order to design it right, you have to know what is going to happen there. To develop an operational model, you need to decide how it will work on a day to day basis and who needs what resources in which locations. There is a void in the industry to a certain extent that ignores an understanding of how things will work internally and operationally.*

WILLIE NOVOTNY: *Let me try to thread together some ideas and speak to the business model. The NURSING HOME is a dead technology! If an organization is going to be in business in ten years, they have to strategically reposition themselves based on Culture Change. It is a major turnaround strategy. The first three years should really be planning how you're going to make it happen and you should spend some time speculating what your outcomes are going to look like. Of course this is not how it's going to turn out. Next, spend time thinking about how you're going to get there. The most important time is spent getting ready for the change. Part of that means you have to figure out how to do a short-term business growth plan. It has to make you profitable, so you can expand or renovate. So, the first part becomes getting good at what you're doing now. This needs to be step number one so you can go through with the rest of your plan. Then there is a three-year change cycle followed by another three-year cycle figuring out how to make it work financially. It's a major change. But, if you talk to anyone who's been doing it, it takes 7-10 years and then it starts working financially.*

LAVRENE NORTON: *By getting these processes put into place early, you can provide some immediate impetus. Start with self-led teams that study issues that have to take place as well as their architectural relationships. This dialog has to take place. Overlay the planning and the education. Everybody should be involved and it takes the work out of the study phase later. People stop resisting and start asking, "when are we going to do it?"*

LOIS CUTLER: *You need to get the board educated. You cannot put this change into words only; you have to experience it.*

ROSALIE KANE: *Where you start depends on where you are. You should start by identifying what your problems are and what you're prepared to take on. If you have a building that is outdated, that's where you should begin.*

RUTA KADONOFF: *Visioning and assessment are crucial. What's possible now with the resources that the organization has available?*

BRIAN SCHERMER: *Changing the physical setting is important, but it can be done in increments. For example, at Luther Manor's Adult Day Care, it wasn't "let's change walls and structure", it was "let's move the furniture". They did these small things to get people in the right physical relationship to one another. Building design tries to predict the future which is not always possible.*

DAVID GREEN: *The building needs to be absolutely the last thing you do! The board has to be converted, because otherwise you're going to screw up on the building and then you can't change it. The reason you do this incrementally is because you have a 10:80:10 split in your staff. Ten percent of your staff are early adopters and adaptive and creative. Ten percent are resistant to change and the remaining 80 percent are cautious to varying degrees. The cautious will start to buy in after they see something.*

ISSUES, OBSTACLES, INCENTIVES DISCUSSION: MOTIVATING CHANGE

LARRY SCHNEIDER: *I can't help but think, what do we need to do to get the attention of for-profits who want to tip a toe in the water? Its metrics, measures, having results to show, and engaging the champions who are making it happen. We need to show results related to census, loyalty, turnover, and occupancy.*

BRIAN PURTELL: *I think the key is to address regulations. I'm not saying regulations prohibit Culture Change. Providers suffer from regulatory paralysis. I have administrators who will call me with a question that has a common sense answer; they are paralyzed by regulatory fear. Also, even though we say that the survey process is embracing of Culture Change, many fear missteps and ramifications. If it isn't written in black and white, providers don't know how to get from point A to point B and won't go there. Fear of change can lead to missteps. We have to address regulations in order to have an effect. Our state agency is very embracing of Culture Change concepts, but still imposes high repercussions.*

STEVE LINDSEY: *That's the pervasive culture of fear! We recently had a survey team who came in and there was a Federal surveyor who had been shadowing the state surveyor. This enforces a multi-level culture of fear which is stressful for everyone.*

Question 5: AH- HAs

The group was asked to share some of the day's most surprising discoveries, revelations and most relevant points from the discussion on Thursday.

RESPONSE SUMMARY

- "Innovation is the enemy of yesterday's success." The household will be the demise of the institutional nursing home.
- Yesterday the group danced around and avoided defining the household. The first challenge was to differentiate between household and Culture Change. Second, coming up with a definition felt exclusionary, but at some level, it is meant to be exclusionary. If you can't define it, it's everything. We were surprised to see the extent to which and how long the discussion was as a group to try to grapple with this set of issues.
- We focused on skilled nursing which has short-term and long-term resident, but we didn't talk about the differences. There was no consensus on whether or not the Household Model would be appropriate for each.
- We didn't focus efforts on the larger social context. It was sprinkled in and we know that it's important.
- We are missing voices of residents! We need to talk to residents and front line staff or we are still "us and them."
- To have "self-directed, relationship-based life", we should be using the same term for residents and staff.

AH-HAS DISCUSSION: UNINTENDED CONSEQUENCES OF THE HOUSEHOLD MODEL

ANNE BASTING: *What does it look like when it's NOT working? Let's talk about unintended consequences. I want to get as specific as possible.*

BARBARA BOWERS: *Early in the Culture Change movement, the focus was on front-line staff and nurses were left out. Nurses should not be seen as the enemy; rather they're part of the solution.*

LAVRENE NORTON: *In the first households we worked with in late 90s, the issue was that nurses were resisting the change. That went away as nurses began to realize their new role and see the outcomes that were possible. Within the last five years, I see some growing pains in social workers and activities professionals. There has actually been some push-back by state social worker organizations. They don't see how a social worker can be a part of the household if it means they do something other than what they perceive to be "social work". In institutions this is paper work! The problem is they've forgotten what long term care social workers DO. In fact, household living is exactly what Social Work is about; creating this milieu where Social Workers can be all that they can be. Organizations that do all of this without redesigning their departmental structure to a household structure have poor outcomes.*



ANNE BASTING: *So, the Household Model can create problems with professional boundaries?*

LOIS CUTLER: *The physical environment has to be flexible. My focus is on environment—how is space used. In the first Green House®, I remember reviewing the blueprint which included bathrooms without doors. They obviously did a thorough review of the dementia literature that suggests continence improves when the toilet is visible. They did not take into account, however, the flexibility required within the space. There would be no way to shut the bathroom off for family or friends who may be visiting. Here was an idea that originated from research but in the practical application it needed to change.*

RUTA KADONOFF: *Similarly, we need more examples of what works. This movement remains a minority out there in the field. As a result, staffing turnover can be difficult. What happens when someone who helped with the transition leaves and someone new replaces them. The new person may not have had experience in households or a Green House® model.*

WILLIE NOVOTNY: *What we have today is based on a fear model. We always have someone causing us to do something out of fear. As providers we look at regulators as the problem; regulators are just doing their job—which comes from policy makers. Policy makers are responding to the general public's feelings. We need to stop looking for a bad guy responsible for all of this and realize that the system itself causes this problem. We act based on fear of what will happen if we don't do our jobs. On a local level, within our organizations, it's easy to attack nurses, social workers, aides, looking for a cause. They're doing what they were taught. It just keeps going if you are looking to attach something as opposed to seeking understanding first and figuring out how to change things that are within your piece of the world. You need to make people feel safe and be able to expose their fears. Then you can identify problems and really be able to make progress.*

ROSINA BLOOMINGDALE: *Social workers and nurses and activity people feel that way because they have remained powerless and it's perpetuated throughout. You can have knowledge and do your research, but if you don't consult with the people that live and work in those environments, you'll end up with problems like the bathroom door thing. A trans-disciplinary model is critical to successful design and relationships.*

EMI KIYOTA: *I was born in Japan and have been living in the U.S. for 12 years. I always ask the question, "can I live here?" In this case, I cannot really answer that; I still have reservations. Maybe it's okay for my mom to live there. You have to be careful not to be arrogant where elders are concerned. There is a stigma about the nursing home which gives me reservations about whether I would actually go into a household. We are not addressing issues of fear of social isolation or losing respect. When comparing an individualistic society to collective society, we need to ask, "what do we want to get out of it?" There is a disconnect between individual and collective goals. If we don't feel those gaps and educate ourselves, there are philosophical questions that it may not be conclusive. Can there be an individualistic way of doing something that has collective outcomes?*

ANNE BASTING: *Part of living in a house is that you gain something from not getting everything that you want. The idea of getting everything that you want is bizarre. There is a notion that you can gain something by giving something up. I refer to this as meaningful sacrifice.*

EMI KIYOTA: *Our elders are wiser and should get respect. You will have less social isolation, but I am not sure that you are creating a living environment where people gain respect from the outside community. There should be a way to work that in as well.*

JOHN GEORGE: *We have talked a lot about buy-in. Some people will buy in right away who are overly zealous. There are ethical boundaries that haven't been discussed. One staff member might go to their uncle's farm for the weekend and want to take a resident because they know Mr. Jones grew up on a farm. In another instance, a staff member might be purchasing a house and a resident wants to give them the down-payment. This has happened and we realized that as staff and residents form relationships, there are some things that are not okay. In other instances, residents might defer to a staff member for medical guidance because they perceive them as a surrogate family member. There are boundaries; this is not your mother. When relationships become part of your culture and you don't want to say "no", sometimes you still have to step in. There needs to be an ethics committee.*

ROSALIE KANE: *Here's a list of what can go wrong but typically more goes right than goes wrong:*

- *Institutional creep: you get back-sliding. You think you're doing something but after a while you're not. Medication carts return and there is clutter in the hall. You need to start anticipating what you can do when you notice those things.*
- *There can be problems with timing and sequencing. Things can go wrong within the first year of implementation when responsibilities are thrown on people who aren't quite ready. The temptation is to go back to the old predictable way.*
- *Over-cautiousness. Registered Nurses felt that they can no longer tell front-line staff what to do. They stop supervising them and seem to put aside their professional skills because they're unsure how to act in the new model.*
- *Communication and care planning. Front line staff and families may not be prepared to handle care conferences.*
- *Expectations are high. People get bent out of shape if they don't have easy solutions. There is difficulty with problem solving.*

JERRY WEISMAN: *An important issue is to assess the gauge of our evaluation tools. When we open a brand new facility, we might select the wrong evaluation tools and then we base decisions on misguided feedback. Which decisions are these the consequences of? You need to look at it as a system. You need to look across scales from the individual to the group to the organization.*

ANNE BASTING: *There is a pressure on evaluation to ask the right questions, but we must allow some time to determine what the right questions are.*

ROSALIE KANE: *Some people phone six months after opening and want to have research done. This timing is all wrong.*

STEVE LINDSEY: *We have to guard the entire household definition. People will be tempted to pull out what's easiest. What's easiest is the physical structure. Everybody is looking for the Household Model to fail and you'll see those that build the physical structure without changing their organizational structure and then they'll say it doesn't work. At a micro level within the organization, we can get so excited about empowerment with staff that we forget about accountability. Empowerment and accountability are the yin and the yang of the Household Model.*

GAIUS NELSON: *People will treat the household like a product and say, "I gotta get me some of that." What they see is the image, not the whole picture. The physical environment is easy to see and the other stuff is harder to get at. People build them and don't really operate in the model of a household.*

NICK CASTLE: *There is a market for lemons and there is the possibility of driving a wedge that further separates those "who have" from those "who have not". If research can tease out what aspects work about the Household Model, we can make those aspects mandatory for all types of models.*

BARBARA BOWERS: *In a community that has both the Household Model and the traditional institutional model, households can be seen as elitist.*

Question 6: Public Forum AH-HA's

The public forum group was asked to volunteer anything that struck them as important from the discussion.

RESPONSE SUMMARY

- The sense of individualistic society vs. collective society—The idea that societies have different degrees of emphasis on the needs of individuals versus the needs of the larger group. The concept raises interesting issues such as how the Household Model can be conceived as promoting a collective society; yet, it is often evaluated upon meeting individual based goals. Alternatively, a collective society may question why a separate setting is being created just for older adults versus one that supports multiple generations.
- Gain a sense of community by giving up a sense of privacy—The nature of the household life means focusing on relationships and knowing. Like the individual versus the collective society, the household environment must have a balance of community life versus private life. If the setting is appropriately planned, then there should be opportunities for both.
- Institutions can be conceived of as Intentional Communities—Rather than creating institutions that are built around the concept of medical care, promoting community can be an alternative overarching goal.
- Self-directed, relationship-based life—These words establish clear goals for Culture Change beyond the typically used terms “person-centered” and “resident -centered”.
- Write the play before you build the stage—A team must clearly articulate what life should be like in the household first before investing resources into the physical environment. The building is a powerful feature of the Household Model, but if not planned appropriately, it can contribute to aggravation and failed outcomes.
- Challenge of Leadership to concede control—Current long-term care structures create boundaries around management that are difficult to penetrate. Infusing a leadership mindset into a household team structure will require education, ongoing mentorship, and trust which creates new ideas about control.

Next Steps...

This white paper has attempted to summarize the essence of an intense two-day Next Step Think Tank. Participants were asked to reflect on the process and the outcomes of the Think Tank. Many noted the enormity of the work still to be done . . . the next steps.

The Challenge

Think tanks stir up and channel passion and energy toward making a difference.

As professionals and change agents, the gauntlet has been thrown to change the current state of nursing homes where people live today. Because we celebrate the diversity of approaches for Culture Change, the inherent challenge is to come together around more defined models. If Culture Change is going to be more than a slogan; however, and the Household Model is to gain the traction it calls for, there has to be clear and consistent strategies and outcomes. Culture Change has been criticized for being ill-defined and untested. While anecdotal reports of the benefits of Culture Change are abundant, research studies testing efficacy are scarce. Acknowledging that research on Culture Change and person-centered household based care are underdeveloped and present unique challenges, there is a need to begin to clearly articulate the components and processes of change interventions and to begin examining the feasibility and appropriateness of varied outcome measures for assessing efficacy. Further, Culture Change has largely been relegated to the not-for-profit providers. For-profit providers are often under-represented in the discussion. To get a broad adoption of Culture Change and make it an expectation, we need to redefine the business strategy and financial equation that organizations have come to rely on.

LOOKING INWARD: How can traditional nursing homes answer this call and move forward with Culture Change and person-centered activities in an authentic and sustainable way? We need to move forward with, not only what is aspired to, but what is truly achievable. Defining a clear vision will guide organizations as they take a hard look at current practices and define person-centered activities that can be part of the transition.

INCLUSIVITY: As an organization envisions their preferred future, they must include the voices of their current residents and direct care staff. Perspectives from other key stake holders need to be integrated into this on-going discussion. Those who are impacted by the changing services of long-term care may continue to be acted upon and become disenfranchised unless engaged directly. Only then should an organization begin to move forward and formulate how the existing physical environment could accommodate those activities.

COMPREHENSIVE APPROACH: The Household Model is one of many strategies for Culture Change. Think Tank Participants were very clear in their recognition that the Household Model is not just a physical environmental strategy. Organizational, operational, and financial Culture Change strategies must accompany the environmental change. If not, there will be an inherent misfit in the daily on-goings of household life for staff, residents, and the organization. Any model for Culture Change must consider the people, the organization, the environment and the desired daily experiences if long term care settings will become authentic places in our society.

DEFINING MODELS: Finally, a word about the benefits of defining and studying different models and the strategies for Culture Change should be mentioned. During the second day of the Think Tank, participants were reluctant to define the Household Model due to concerns that articulating ANY parameters would be too restrictive, lack flexibility and possibly lead to regulation. However, it also became clear from some participants that the Household Model should not be conflated with Culture Change. There is a need for greater specificity to develop a common language and understanding in Culture Change. While models and strategies can be flexible, there should be recognition that at some point you stop working within one and transition to another, which may be just as supportive of Culture Change. Defining models helps to support innovation through the recognition of variations in approaches. Greater specificity helps to create clear expectations regarding what outcomes may be attributed to different strategies. This, ultimately, will enable us to build the evidence necessary to inform, sustain and grow the Culture Change movement.

**2010 NEXT STEPS THINK TANK:
CULTURE CHANGE CONSENSUS AND
THE HOUSEHOLD MODEL**

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