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GRANITE STATE REPORT

"Always do right. This will gratify some people, and astonish the rest!" -Mark Twain

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Culture Change: The Process

by Melissa St. Cyr

AFTER ATTENDING CULTURE CHANGE SEMINARS, THE VISION IN MY HEAD WAS CLEAR — WE WOULD HAVE CULTURE CHANGE AT MY FACILITY, AND WE WOULD START WITH THE DINING SERVICES. I was a new administrator, and I scheduled a meeting with my director of food service, told him what I had learned, and shared my ideas for our new dining experience.

We agreed to convert our system to a buffet-dining program by purchasing buffet stations, linen, glasses, and specialty china, and we rolled the process out within two weeks. What a mistake. Culture change was a foreign concept, and change on any level would never succeed, no matter how positive, without knowledge.

At no time did the residents lead this process for change in our dining experience. We involved the staff and residents by asking for feedback, but we directed the change and they followed along with the experience we created for them. We struggled significantly throughout this first step primarily due to our limited focus. Change can only occur when all who are affected by the change lead the change. The approach

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Living in a Nursing Home: Lessons Learned

by Evan Carroll, AIA

THIS PAST SEPTEMBER I HAD THE OPPORTUNITY TO DEEPEN MY UNDERSTANDING OF SPATIAL DESIGN IN A UNIQUE WAY. THROUGH AN EXPERIENTIAL LEARNING PROGRAM, I LIVED AS A RESIDENT IN THE DEMENTIA WING OF A NURSING HOME FOR NINE DAYS.

I am a licensed architect and one of the two Principals of Bild Architecture, located in Portland, Maine. Our focus at Bild is on Life-Long-Design — design that will facilitate quality living environments for New England's aging population. We are interested in all design solutions: from home modifications to multi-unit community-oriented housing and new-construction home-modeled nursing care facilities. I grew up in Maine, received my architectural education at Roger Williams University, and returned to Maine to work in architecture in 2006.

A major failure of nursing homes has been that they are based on the segregation of generations.

Learning by Living, the program in which I participated, is the first program of its kind and was created by Dr. Marilyn Gugliucci of the University of New England. Historically, the program has been for doctoral students, and the participation by a professional architect marks a new step for the initiative. The goal of my participation was, through qualitative ethno/biographic research, to learn how to provide the best possible living environment for residents in nursing homes.

I chose to have this experience so that I would be able to conduct my design work with true empathy for the people who will use my designs. A professional goal of mine is to design buildings that contribute to people's social well being, and I believe that empathy plays an important role in social design that empowers its residents. In the remainder of this piece I will discuss some of the insights gained from the Learning by Living experience and how these insights can inform life-long design.

The Elephant in the Room: Age Segregation

A major failure of nursing homes in regards to promoting human development and self worth has been that they are based on the segregation of generations. Older people easily derive joy from observing and imagining the successes and youth of the younger generations. The future that they can hope for in the world is not in their peers but in the generations behind them, and it is inhumane to deprive them of that hope and joy. I saw happy people while I was in the home, partially because as a younger person I brought them happiness.

While I hope to be involved in many projects that prepare to house aging baby boomers, I will always be working towards the day when the solutions do not involve age segregation. In the best-case scenario, older people needing care should be able to live with and receive care from family or close friends. When this is not a realistic solution, nursing homes and assisted living facilities must be considered. Facilities such as these would do best when paired with our civic facilities. When paired with schools, day care centers, recreation facilities, city halls, community centers, libraries, and even sport complexes, malls or amusement parks, these previously insular facilities begin to come to life.

The Non-Architectural Factor: Trust

In existing facilities for the care of older people, the focus from the operators of the facilities has typically been on making the physical place "feel more like home." My experience at the veterans' home showed me that the number-one factor contributing to feeling comfortable was feeling "liked" by the staff members. In other words, one doesn't want to have people they don't trust and don't feel "liked" by in their own home.

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Marketing & Sales in Long Term Care

by Irving L. Stackpole, RRT, MEd

Part 2 of 4

The economic difficulties of the "Great Contraction" are all around us. The downturn in the housing market, lost value in investment portfolios, and high unemployment continue to damage consumer confidence. It doesn't appear as though we are in for an economic upturn any time soon. What can you do to survive and prepare for better times?

From a marketing and sales point of view, providers should bear eight factors in mind when making their marketing plans for 2012 and 2013.

In the last article, I addressed:

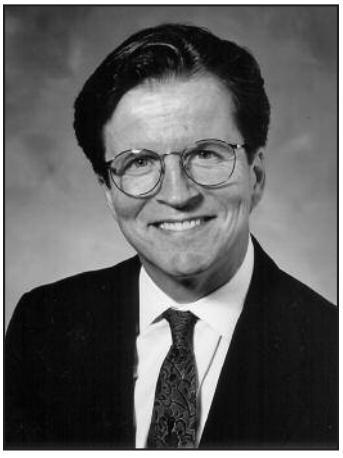
1. *Study the Customer.*
2. *Think Vertical – not Horizontal.*

In this piece, let's look at

3. *Focus on Value*
4. *Continue Marketing Investments*

Focus on Value

If you look at the retail sector, companies that focus on value are thriving, despite the dire economic times. Wal-Mart, Target, and others are meeting their consumers' needs with value propositions that say, "Save Money. Live Better" and "Expect More. Pay Less." Notice that there's nothing "cheap" about either of these positions. After all, "value" is what you get for what you give – the fairness of an exchange.



Irving L. Stackpole

In the long term care sectors we have failed abysmally at establishing our value propositions. In skilled nursing, we assume that customers don't know and don't care about the "price," because it is hidden behind a veil of complex insurance and federal/state regulations. And in the market rate seniors' housing sector, the pricing model has been like the famous scene from the "Wizard of Oz": lots of lever-pulling and button-pushing behind the curtain, and a one-price-fits-all rent or purchase price pops out! Not transparent at all; where's the value proposition?

This has to change and it has already started. Health and senior living are headed toward "value-based pricing". That's what Accountable Care Organizations (ACOs) are all about. The principle is: Show your customers what it costs to deliver your service, and demonstrate to them why it's an excellent value. This means being transparent.

For first-time buyers in assisted living for example, the question is: Why should I move in? Show these prospects that, compared to what they're paying now, your community is close in direct cost, and that the lifestyle/health benefits will add up to a better, longer, and happier life.

For current customers and consumers, the question is:

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MDS 3.0 Data Integrated into the QIS: New Measures to Examine in CQI Activities

by Kris Mastrangelo, OTR, MBA, NHA

MDS 3.0 DATA HAS ONLY RECENTLY BEEN INTEGRATED INTO THE QIS PROCESS. 28 MDS 3.0-based Quality of Care and Life Indicators (QCLIs) are included in the revised QCLI Dictionary announced and posted by CMS in late October. Some MDS-based QCLIs represent a prevalence of a condition in the facility; in other words, the number represents how many residents have the condition at a point in time (in this case, the point in time is the resident's most recent MDS).

Unlike most prevalence measures in the Quality Measure (QM) data specifications, the QCLIs do not exclude admission assessments. One example is Prevalence of Tube Feeding, which is simply a measure of how many residents had a tube feeding recording on their most recent MDS. If greater than 35 percent of the residents have a tube feeding, this area would be flagged for investigation in Stage II.

Other QCLIs measure incidence (or change between two points in time); one example is Lack of Transferring Rehabilitation Progress. This QCLI examines Transfer Self-Performance and the presence of therapy services. If the Transfer Self-Performance fails to improve at least one level or worsens between the 5-Day MDS and the 30-Day MDS, and the resident is receiving physical or occupational therapy, the resident would be counted into the numerator for this QCLI. If greater than 70 percent of the residents meet the definition, there would be an investigation of rehabilitative services in the second stage.

It is important to note that exceeding the threshold for a QCLI does not mean there is a deficient practice; it simply means that areas will be investigated in Stage II. When using the QCLI information in continuous quality improvement (CQI) activities in the facility, it is critical that facilities investigate residents who potentially meet the definition whether or not the facility exceeds the threshold for the QCLI. Certainly those areas where a threshold is at or near zero should take precedence, but all of the QCLIs represent an opportunity to examine care practices and outcomes. The Stage I tools as well as the Critical Element Pathways and Facility Level Task worksheets are tremendously useful for facility staff to use in their CQI efforts.

Training and Tools

Importantly, just like the regulations, the QIS is an "open book test." The tools that are integrated into the computers of the surveyors are available online at the Web site,

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Kris Mastrangelo

Heed Value and Invest in Marketing

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Why should I stay? How we manage the answer is "Pay a Fair Amount; Live Much Better." As customers and consumers become better informed, they will expect clear, transparent answers to: What is a "fair" amount? If you are not ready with an answer, someone else will take your business away.

Continue Marketing Investments

In a resource-constrained environment, the first impulse is to cut those variable costs that are seen as discretionary. Marketing investments should be spared a complete evisceration. As a marketing professional, this may appear self-serving, but don't take my word for it; there's overwhelming evidence that organizations who invest in marketing during economic corrections come out on the other side far stronger with more market share and higher margins[1].

It takes too long and costs too much to build reputation equity, name awareness, and brand preference to let them erode for lack of attention. If you cannot afford what had been done in the past, look at other ways to communicate to your audiences. Events at your location, publicized through local media, politician endorsements, employee incentives to bring new referrals, social media: There a countless low-cost/no-cost ways to get the message out.

Managers in the skilled care sector in particular have not historically been marketing gurus; with the capital, human resource, clinical and regulatory challenges each SNF faces, this is easily understood. There are resources available however. Perhaps a local college or university can help by providing an intern, or make your "social media" plans a school project. The point is that by doing nothing, your name and brand will "fall of the grid" of customer and consumer awareness and this is a disastrous outcome. And of course, if you call us, we would be delighted to help you assess your situation and make intelligent suggestions!

In the next installments, we will look at:

5. Adjust Service Portfolios

6. Examine Pricing

7. Stress Market Share

8. Emphasize Contributions to the Community

[1] Roberts, K. What strategic investments should you make during a recession to gain competitive advantage in the recovery? Strategy & Leadership; 1087-8572 2003

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Adopting Person-Centered Care and Culture Change

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taken to implement the dining experience was not culture change; it was a typical institutional approach.

Our next step was being nominated by our parent company, Fundamental, to begin the Your Choice 365 program, a program of person-centered care and culture change. We took the time to educate staff, residents, and family members by giving them the vision of culture change and where we hoped to be as a facility: one that honors residents' choices in all aspects of their lives, 24/7/365.

After these meetings, the juices really started to flow. A core group of passionate individuals that include residents, staff, and family members began meeting monthly, or more frequently if needed, to ask residents and staff what changes they would like to make. The group then helps implement the changes. At our neighborhood meetings there are discussions of the living environment, the camaraderie of the neighbors, and the ways that we can assist residents in making their home better.

Facing Hurdles

The changes engendered obstacles. The initial hurdle was de-programming the residents from an institutional model to a person-centered care model. When we asked a resident what time he would prefer his shower, for example, he would say that he got his shower on Tuesday at 3:00 p.m. It took several attempts, but with perseverance we have been able to get true feedback and to gain the resident's trust.

Another hurdle was getting the staff and residents to work together and be care partners. They need to learn how to work jointly as equal partners in a common goal, changing the dynamic of their relationship from caregiver/care-receiver to care partners.

At this point, we are in the throes of culture change. Our dining experience is successful now, and we have worked on many projects since then, some successful, some not. However, the successes far outweigh the failures, and each failure has brought a new lesson and has helped the staff and residents to grow. Although we still have regulations, budgets, and census to worry about, culture change has made the journey rewarding.

Melissa St. Cyr is Administrator of Pleasant Valley Nursing Center in Derry. She is a member of the Culture Change Coalition. She is also on the Board of NHHCA and Co-chair of the Development Committee

Living in a Nursing Home to Help Inform the Design of Homes

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It is important for me as an architect to realize that a nursing home resident's number-one concern while living at the home may have nothing to do with architecture and everything to do with the staff. On the other hand, architects do have a potential role to play in decreasing age segregation by encouraging community functions to be included in, or located near nursing homes. By designing nursing homes that are more integrated with the public, the pressure on staff to be both employees and friends is reduced.

A Way to Focus Renovation Efforts: The Senses

On the last day of my stay at the veterans' home I met with staff members to discuss my experience. With only a limited amount of time to prepare, I wanted to give them some food-for-thought to begin to imagine how to make improvements. I asked them to, instead of trying to think about how to make a room or unit "feel like home," think about the senses and how each of those senses can contribute to the feeling of home. I said that, often, too much focus is placed on what is seen and not on the other senses. Some atmospheric conditions that I suggested thinking about were: sounds, smells, colors, textures, lighting and spatial size and proportion.

Sounds that decrease a sense of home can include medical alarms and call bells, loud air handling systems, and the of shouting by staff members as they perform their duties. Music and friendly conversation can make a place feel more like home.

Detrimental ***smells*** are most certainly those of bodily excrement that are often not properly contained due to bad ventilation systems. A good smell is certainly cooking food, and this often can't be enjoyed due to remotely located commercial kitchens.

Colors, textures, and lighting are more traditionally thought of as architectural solutions, and can have a large impact for a small expenditure. Ability to dim lighting at night is a must, and a minimum of materials that are perceived as "commercial" is also essential.

Spatial size and proportion can be tackled in larger-scale renovations, but one sensitive area is the conflict between needing to maneuver wheelchairs and beds and the need for intimate residential scale.

A measure of success for all of these kinds of changes is to imagine being asleep and then waking up in each of the spaces in the facility. What is the first impression? Is it medical, commercial, or domestic?

Architectural Design: Basic Elements

When I think about nursing home design I try to remember that nursing homes only exist because of the need to economize the expense of nursing staff. If this need didn't exist, then nursing homes likely wouldn't exist. The home itself is a front-end investment that should be designed holistically to contribute to the building's primary function: mental, emotional, and physical health.

> ***Through an experiential learning program, I lived as a resident in the dementia wing of a nursing home for nine days.***

There are many "good design practices" or design elements that can be used. The ones listed below are not new ideas, but I feel confident in them based on my direct experience. The veterans' home that I lived in had some of these elements and was lacking others:

A range of public and private spaces allows residents and family alike to find the appropriate place to gather or be alone. Many facilities are lacking a place that is a both public and a quiet, library-like atmosphere. Single rooms are a must for new facilities particularly in regard to personal visits, be they conjugal, or simply private. Other specific needs are central gathering spaces for each unit of a facility, and a central space for the entire facility. An appreciated amenity

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MDS 3.0 Data

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www.qtso.com. Providers should familiarize themselves with the QIS process and utilize the tools for facility CQI.

It is also critical that all staff are trained in the QIS process. Frontline management staff (i.e., charge nurses) will have a great deal of interaction with the surveyors, and their preparedness will be a key component of the facility's success. Additionally, all staff (including direct care staff) should be aware of the changes in the survey process and how it will differ from what they may be used to. Understanding and managing the survey process are critical to success with the QIS.

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Living in a Nursing Home Gives Architect New Insights

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would be a private "dinner-for-two" dining room.

The ability to personalize space helps residents recognize rooms and feel pride and ownership while also helping staff to learn about the resident. A conflicting issue is the likeliness for residents to walk off with the belongings of others, and one solution is for each room to have a personal display case or shadow box for displaying personal effects.

Accessible outdoor spaces provide fresh air and contact with nature and can include: private patios, healing gardens, walking paths, community courtyards for barbecues and parties, and entrance spaces with comfortable places to wait for a ride. All inhabited interior spaces should have windows allowing sight to activities outside. An essential example of this is physical therapy rooms where the activity happening in them is traditionally linked to being outdoors.

Proximity to domestic activities can give residents a sense of familiarity, belonging and purpose. The more that domestic tasks like cooking, cleaning, and laundry can be done on a domestic scale the more there is the opportunity for residents to participate in, or at least observe, tasks that are familiar to them.

The possibilities presented by new technologies should not be overlooked. Hand-held devices for each of the staff can be used to reduce beeping of alarms in favor of vibration. The use of these devices can also allow the removal of nursing data entry stations. Video-chat is now simple enough to allow residents to "visit" with family in remote locations.

Other Observations: Sociability, Privacy

Sociability: There appears to be a place in the personal care industry for metrics about people regarding how "sociable" they are. Architects and personal care attendants alike could benefit from a standardized understanding of sociability. Standardized metrics obviously have flaws but they can also allow for a more informed understanding of how to provide for people with differing types of sociability.

Privacy: Privacy for residents and the need to monitor them are often at odds with each other. Architects should try to find solutions that meet both needs. As one example, in cases where residents need to be monitored even while in their own rooms, split doors can be used to keep out wanderers and allow visual and auditory supervision. Items that need to be kept away from residents, but that are also specifically for them, can be locked by staff in each resident's individual room.

HOLD THE DATE

Annual Meeting & Educational Program

ACHCA New Hampshire Chapter

Tuesday, March 20, 2012 at the Holiday Inn of Concord

Watch for the flyer.

The *ACHCA Granite State Report* is sent to all licensed Administrators in New Hampshire free of charge. If you know someone who would like to receive it, or would like to receive the newsletter online, e-mail me at bruceglass@rocketmail.com. If you are not yet a member of ACHCA, go to our website: www.ACHCANewHampshire.org for an online application.

-Bruce Glass

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