SPECIAL  SECTION

RESIDENTS FIRST

A Long-Term Care Facility Introduces a Social Model That Puts Residents in Control

BY CHARLENE BOYD

Summary Four years ago the leaders at Providence/Mount St. Vincent, Seattle, decided to scrap the traditional medical model of long-term care and create an environment directed by the residents.

The traditional system in nursing homes is designed to foster dependence. Our new social model, in contrast, is almost entirely directed by resident preference and need, and it places a high value on human interaction.

So far we are having the most success with our assisted living program, which is built into apartment living as part of the rent. All services are available to all residents when they need them. The residents are forming warm relationships with resident assistants, and the flexible, nonmedical help they receive allows them to age in place.

The nursing center has been divided into "neighborhoods" of about 20 residents, each with its own staff. A cross-trained, highly capable staff is essential to support resident independence and choice. In one experimental neighborhood, nonmedical tasks that nurses have traditionally done are now being reallocated to resident assistants, who are paid half as much as nurses.

The physical heart of every remodeled neighborhood will be a kitchen, as we strive to create a homelike environment. Purposeful activity is replacing therapy in a void. And residents with cognitive impairments are gradually being integrated with more cognitively aware residents.

We believe that in the long run, resident-directed care will be less expensive than the medical model.

Four years ago the leaders at Providence/Mount St. Vincent, Seattle, had a vision. It came to us gradually, through many discussions, as we rewrote our mission statement. We decided we were morally obligated to scrap the traditional medical model of long-term care and create something completely new: an environment directed by the residents.

Why take a successful, respected long-term care facility—a *big* facility, with 110 apartments and 252 nursing center beds—and initiate profound, demanding change?

After all, as many of the staff, residents, and families noted, we were doing a great job delivering thoughtful, compassionate care in a medically oriented setting. If your mother lived here, she would not be forgotten or mistreated. She would be well cared for and well protected within the community of Mount St. Vincent.

But would she feel in control of her life?

No.

The single most powerful motivation to change is our residents' deep, healthy desire to retain control over their lives. They cannot do it under a medical model. In fact, the medical model guarantees loss of control and downward spiral of apathy and dependence.

"Institutional life in a nursing home produces a very low level of activity," according to Pat McNees, PhD, director of research at the Mount and a faculty member of the University of Washington. "Mostly residents do nothing and do not communicate with anyone. This inactivity and lack of human interaction contribute directly

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to loss of physical and cognitive ability."

The traditional system in nursing homes is perfectly, if unintentionally, designed to foster dependence. It strips away choice and motivation exactly like a hospital, where medical professionals decide which activities patients can or cannot tolerate, when they will take medicine, what they can eat, and when they will have therapy.

At the Mount, we followed this clean, predictable model for decades. Centralized departments and narrowly focused, task-oriented staff circled physicians and nurses in efficient orbit. Somewhere out on the far reaches of this universe were the residents—well cared for, safe, and virtually powerless.

In the name of compassion, we at the Mount took resident dependence a step further. If someone had problems getting dressed, for example, we did not *help* her get dressed—we dressed her. Residents who performed tasks independently were ignored by busy staff. This sent a subtle, potent message: You had to be weak or incapable to get attention.

If medically based institutional living creates increasing dependency and loss of function for its residents, while offering almost no opportunity for human connections, then it is time to create something new.

A Social Model

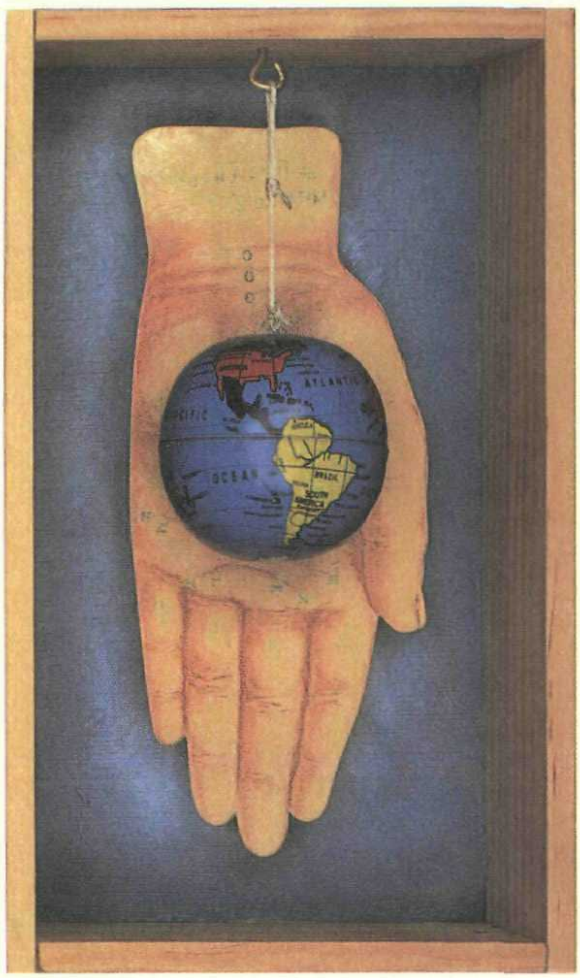
The new system is a social model. It is almost entirely directed by resident preference and need, and it places high value on human interaction. We believe that the *residents* should be the center of our universe. And it is a good thing we believe this so strongly, since making the change to a resident-directed environment is about as fast and easy as sending humans to Mars. "I keep telling myself it's fun," says Bob Ogden, administrator of the Mount. "Some days it's hard to keep saying that."

Ogden had the opportunity to start a long-term care facility from the ground up, when the Sisters of Providence asked him to help design and run Mary Conrad Center in Anchorage. First he worked with architects to create a environment that looked and functioned much like a private home. Then he deliberately staffed the 90-bed facility with people who had no training in long-term care and taught them to build on the residents' strengths. Just before he left to take over at Mount St. Vincent, Mary Conrad Center won a national award for innovation in long-term care.

Now, having proved that resident-directed care works, Ogden is bringing change to an entrenched institution—a much tougher proposition.

"A facility's had a good reputation for years, and somebody would be so bold as to come along and say they haven't been doing it right all that time," Ogden says. "It's really difficult to get the staff and the families to see that what we're doing is beneficial—because *they're* institutionalized now, and they're comfortable with it. So our challenge is to slowly but surely turn that around and get the residents in charge of their lives."

We believe that the *residents* should be the center of our universe.



Success with Assisted Living

How to make sure the residents are in charge is a constantly evolving question. So far we are having the most success with our 110 assisted living apartments because the situation offered a relatively clean slate: a healthier population and the chance to train a staff with no background in long-term care.

When apartment program manager Shirley McKnight was hired a year and a half ago, she immediately began restructuring the assisted living program. The program was then on an á la carte basis. Residents ordered from a menu of specific services, such as help with medications or bathing.

But the program had flaws. Residents were afraid to ask for extra help if they needed it; they worried that they could not afford to pull the emergency cord. They "made do" and grew more isolated. Meanwhile, many staff members saw their jobs as a series of unconnected tasks. They were often perceived as servants ("Some people called them 'chore girls'," McKnight sighs), and turnover was high.

Now the assisted living program, named Hand in Hand, is built into apartment living as part of the rent. Services are not negotiated on a financial basis:

All services are available to all residents if and when they need them. If a resident requires heavy nursing or intensified help with personal care in his or her apartment for several weeks, the rent does not go up.

The erstwhile "chore girls," now known as resident assistants, are committed to supporting resident independence. They recognize that resident needs change from day to day and include more than "chores." If a resident invites them to have lunch or listen to a story, they accept.

"If they don't, they're in the wrong place," McKnight says. "The job has components of being a care person, a neighbor, and a surrogate family member. The ability to communicate, and to listen, is most important. It's interesting that this kind of work has attracted people who are in the arts, who write. Most of our staff have college degrees. They really look on their work as an honor; they talk about being guests in the residents' homes."

The residents, who average almost 87 years of age, are forming warm relationships with resident assistants, and the flexible, nonmedical help they receive allows them to comfortably age in place.

"We have apartment residents who a few years ago would have been asked to move to the nursing center because of incontinence or dementia," McKnight says. But these residents just need extra help with toileting or redirection, not medical intervention. Hand in Hand provides them with an economical alternative to nursing care. The biggest difficulty has been persuading physicians, nurses, and residents that medicine does not need to control residents' lives.

Decentralizing the Nursing Center

If conceptual change is hard for everyone in the apartments, it is even more difficult in the nursing center. I see it as trying to get rid of a glacier. Glaciers are huge, they move very slowly, and their removal requires a lot of icebreaking.

We did not know that four years ago. We had an exhilarating vision of social change, and we thought we could get everyone at the Mount to understand it right away. But change will not come from inspired administrative meetings. The key, instead, is decentralization: dividing the glacier into manageable pieces.

Ultimately the nursing center will be decentralized in many ways, including an extensive physical remodeling. For now the changes are taking place in staffing and in philosophy.

With the old, centralized system, many of our staff were off in their own departments and their own worlds. They had little contact with the people who live here and no real motivation to see things through residents' eyes. We have gradually been breaking these huge departments apart, putting staff members in small, multifunctional teams that directly serve the residents.

> We are asking much more of each employee. We expect a pastoral care worker to help a resident brew coffee, a resident assistant to do laundry, a housekeeper to change an incontinent resident.

The nursing floors have been divided into "neighborhoods" of about 20 residents, and each neighborhood has its own staff: a consistent team that includes a neighborhood coordinator, resident assistants, recreational therapists, social worker, and housekeeper. But we are asking much more of each employee. We expect a pastoral care worker to help a resident brew coffee, a resident assistant to do laundry, a housekeeper to change an incontinent resident. Because the physical heart of every remodeled neighborhood will be a kitchen, we are requiring all our nursing center staff to get food handler's permits. This will put them in compliance with state and federal regulations when they want to help a resident make a sandwich. This kind of cross-trained, highly capable staff is essential to support resident independence and choice.

Of course, this has been unnerving for people who have worked at the Mount for years at specific tasks or in positions of medical authority. They were used to having their jobs sharply defined within a strict hierarchy and to having residents adapt their desires to the system. One nurse told a neighborhood coordinator (a sister who is also certified as a nursing assistant) that she was spoiling a resident.

"By giving into him and giving him everything he wants," the nurse scolded, "he expects more and more. He's become impossible!"

What were his "impossible" demands? Having his meal preferences honored, a male resident assistant to help with dressing, and a banana and cookies in the afternoon. All three requests are now being met as a matter of course.

As we continue to change, nurses will be relinquishing power in the neighborhoods. Our most experimental neighborhood, 5 South, is run by Kimberly Curtis-Scheer, former director of nursing. Her assignment, in a complete reversal of former priorities, is to see how much we can cut back on nursing without compromising the quality of care. She is reallocating all the nonmedical tasks nurses have typically done—phone calls, documentation, unit organization—so nurses can focus on medical needs. It is the only neighborhood job that is moving away from crosstraining. Resident assistants, who come to know residents in the complex way of family members, will use their team nurses as clinicians, people who hone in on specialized physical problems.

There are two reasons for this shift in power. One is the move away from the medical model, where residents' lives were controlled by healthcare. The other is economic. Nurses cost twice as

much as resident assistants. Every time we cut back on an hour of nursing, we can buy two hours of resident assistant time—a necessity for residents who have been spending far too much time "waiting" for contact.

Overcoming Resistance to Change

The neighborhood teams know that a big part of their job is to build on the residents' strengths. Even so, any innovation that means more work (and they all do) meets with some resistance. Our current approach to restorative therapy is a good example.

We believe that purposeful activity is a lot more inspirational than therapy in a void. So we met with the neighborhood teams and explained that we were not going to walk residents down the hall and back each day for exercise. The teams, to their initial dismay, were going to have to figure out how to incorporate walking into the normal routines of a resident's life. This was not nearly as quick and simple as the old way. Even families got upset; they worried that their relatives were not getting enough exercise.

Then, in one neighborhood, a goal was set: no wheelchairs in the dining room. This therapy had

RURAL ELDERLY'S SPECIAL NEEDS

In rural areas, as in urban ones, there will never be enough trained geriatricians to meet the needs of the growing elderly population, according to Joseph C. Barbaccia, MD, professor of family and community medicine at the University of California–San Francisco. Because of this lack, practitioners in family, general, and internal medicine must be trained to care for the elderly from a primary care perspective, he said.

The problems are particularly acute in rural areas, where those 65 years and older make up 13 percent to 16 percent of the population, compared with 12 percent nationwide, Barbaccia reported at the National Rural Health Association's annual meeting in San Francisco. The 25 percent of the nation's elderly who live in rural areas face much greater difficulty accessing services for a variety of reasons, he said.

Although rural workers remain in the labor force longer than urban workers, they have lower incomes in general, and a higher proportion of rural elderly fall below poverty guidelines, Barbaccia reported, drawing from a variety of studies. In both rural and urban environments, he said, health status is related to socioeconomic status. Those in lower-income areas have higher rates of chronic illness, as well as access to fewer health services.

"Home care is much less available in rural areas," Barbaccia said. He pointed out that nursing home residents are, on average, two to three years younger in rural areas than in urban areas, in large part because of the lack of services such as personal care to help keep them out of institutions. "No amount of increase in medical care will satisfy this need," he said.

Even though access to health services is undoubtedly lower in rural areas, Barbaccia pointed out that "health is more related to what the individual has done to preserve his or her health than to the availability of health services." He said that rural elderly are less likely than their urban counterparts to use positive health practices (e.g., nutrition, sleep, exercise, safe driving). He noted that illness prevention and health maintenance services are less accessible to the rural elderly. There are fewer physician visits, few geriatricians, and a slightly lower quality of care for infrequently provided services such as hip surgery or treatment for myocardial infarction.

Another barrier to care faced by rural elderly is relative isolation. They are less likely than urbanites to leave home to visit family, and there is no evidence that family ties are any stronger in rural areas than urban ones, Barbaccia said. Thus the rural elderly's isolation is often acute, especially among men, who adapt poorly to widowerhood and have fewer intimate friends than women.

In addition, Barbaccia noted, rural residents' attitude of independence and self-reliance means they are less likely than urban dwellers to seek services at community mental health centers, even though depression is more common in isolated rural areas. He pointed to the need for special outreach programs to identify persons in need of mental healthcare and educate family members and care givers about how to reach them (e.g., see Marianne Smith and Kathleen C. Buckwalter, "Mental Healthcare for Rural Seniors," *Health Progress*, March 1993, pp. 52-56, 70). He also emphasized the need for instruments to pick up cognitive losses (such as the Mini Mental State Examination and Geriatric Depression Scale) and the need for case management.

Barbaccia

Other steps practitioners can take to address the special problems of rural elderly, Barbaccia said, include:

- Developing or learning about informal helping networks among churches, service clubs, and social groups.
- Learning about more formal services available in the community.
- Doing functional assessments of the mental status of those with chronic illness and the very old.
- Working in multidisciplinary teams, since "geriatrics by nature is a service that requires collaboration."
- Using case managers to coordinate care for the frail elderly. He also stressed the importance of using information networks in documenting and sharing assessments and information across agencies.

—*Susan K. Hume*

A cozy den lined with bookshelves replaces the standard nurses' station. Staff will take care of paperwork out in the open.

a direct benefit to the residents; it strengthened their muscles and, more important, increased their control and independence. As residents walked more, they also became more alert and communicative, and suddenly it caught on throughout the nursing center.

For every success, though, there are times we have introduced concepts to the staff and met with intractable opposition. They laughed at incontinence training, a program that has had a 50 percent success rate in other nursing homes. The training requires the resident assistant to prompt the resident every two hours about going to the bathroom, to restore awareness and control. Our staff keeps saying they are too busy to do the prompting. I think they just are not in the habit of remembering, and, unfortunately, it is faster and easier to change a wet diaper—to do something *for*, instead of *with*, a resident. We are determined to persist, however.

Every change we have made has been controversial, and we have lost employees who could not make the transition. But the most controversial move so far has been the gradual integration of our nursing floor populations.

Until a little more than a year ago, our fourth floor was a locked, contained unit for residents with behavior problems, dementia, and Alzheimer's disease. Residents on the second and third floors feared the fourth floor. They worried that if they behaved badly or got too forgetful, they would be shipped one step closer to heaven.

We will not retreat to the convenience of a locked, contained unit as a way of avoiding the complicated needs of older adults.

It went completely against the philosophy of aging in place. Under the guise of medical necessity, we were tearing people away from every comforting, familiar thing in their lives just when their inner worlds became chaotic.

Today, the alarms on the fourth floor have been turned off, and no one has wandered away. As beds become available, we are putting more cognitively aware residents on the floor, creating a mix. We are also accepting more troubled residents into other neighborhoods.

A few weeks ago we took in a woman I'll call Katherine. She had lost her husband, she had had a stroke, and she screamed constantly. Naturally this was excruciating for everyone in the neighborhood, including "Donna," the woman in the room next door. Donna and her family quickly called what promised to be a tense meeting. We explained to them that we had started working with Katherine from day one, and we talked at length about the ways we are trying to discover and heal the source of her anguish. Donna's family was reassured that the level of Katherine's screaming had already been demonstrably reduced.

A member of Katherine's family was there to help everyone see Katherine as a person rather than a problem. We also pointed out that if Donna ever needed special care, we would work just as hard to help her. By the end of the meeting, Donna's family recognized that our decision to give Katherine a chance is based on compassion, and they agreed with it.

There are a lot of residents like Katherine. This is where the social model—the neighborhood—really becomes like a family, where you have to look at the strengths and tolerances of each member, realizing that some are dysfunctional but that each contributes in a different way. As members change and die, and new ones arrive, it is a challenge to keep the "families" balanced and minimize the stress of adjustment. But we will not retreat to the convenience of a locked, contained unit as a way of avoiding the complicated needs of older adults.

A Homelike Environment

So far, all the changes discussed originate in the heart and mind. They are far and away the most important. But we also believe that trying to create neighborhood families in a visually sterile,

hospital-like environment is an uphill battle.

Over the next few years we will completely remodel all our nursing floors into nine homelike neighborhoods. One is done: 2 North, the short-stay rehabilitation neighborhood. It represents progress, but has a lot of room for improvement.

"I think 2 North, as a short-stay unit, fell victim to that continuing hospital imagery of clean, stark, pure, and simple," says David Fey, the Mount's architect in residence. "It doesn't have the hominess we're striving for."

Every newly finished neighborhood will improve on the last, but all will share certain elements. Each will feature a light, spacious kitchen with round tables and all the usual home supplies, from tablecloths to teakettles. Instead of facing a breakfast tray at dawn, residents will wake when they prefer and fix their own breakfast or have the neighborhood cook whip up their order. Lunches and dinners will be prepared in the central kitchen, but brought up to each neighborhood so tempting smells can drift through the rooms. The cook will stock the cabinets and refrigerator with food and drinks the residents have chosen. If someone craves toast at 3 AM—or a banana and cookies in the afternoon—they can have it.

At the far end of the kitchen space, a cozy den lined with bookshelves will replace the standard nurses' station. Staff will take care of paperwork out in the open, at a large table. It is a concrete way of demonstrating that staff members should not be seen as secretive authority figures. Residents will be able to examine their files whenever they choose.

There will also be a laundry room with a wheelchair-accessible washer and dryer. Residents who enjoy folding warm clothes can do their own laundry. Laundromats, however small, will be social places, with room for people to sit and chat.

Because it can be difficult for some residents to get outside, particularly in our wet Northwest climate, we are bringing the outdoors in with three big solariums, each with its own personality. The possibilities at this point include a game room, a music room, and a conservatory with an aviary.

The neighborhoods will also have distinct personalities. Differences in style and color will help orient residents who visit other neighborhoods. Details will be chosen for their warmth: carpets, farmhouse wainscoting, pleated muslin shades on lamps, ceiling fans, and eclectic furniture. We are keeping plastic laminate to a minimum.

These socially oriented environments inspire activity by providing a means for familiar, pleasant domestic routines.

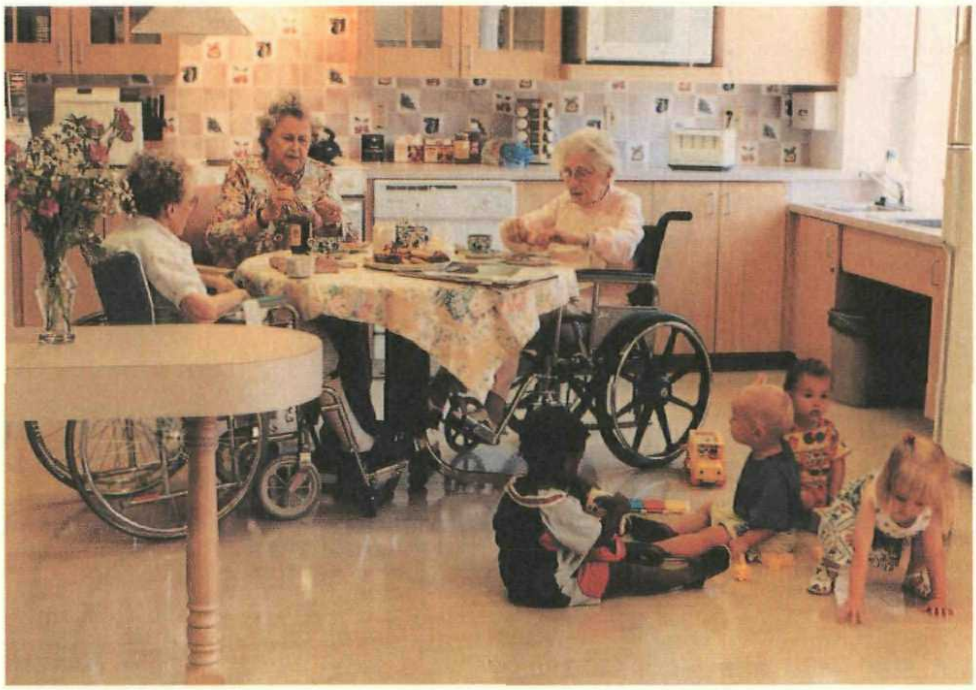
These socially oriented environments will have many benefits. They are more comforting than endless linoleum hallways. They inspire activity by providing a means for familiar, pleasant domestic routines—making soup, ironing, or reading at the kitchen table. They invite people to move from one interesting area to another. Most important, they offer a natural setting for unscheduled, relaxed conversation and contact.

Economy Essential

Two related frustrations have come up repeatedly as we remodel: state regulations and costs. "Right now, the regulations aren't written to support the kinds of changes we're trying to make," says architect Fey. "Our goal was to remodel with minimal capital investment, but every time we turn around, we come up against another regulation and we end up spending more."

Economy is essential to us. It is our second big reason for change. We believe that in the long run, resident-directed care will be less expensive than the medical model. We are aiming for a much higher ratio of resident assistants providing direct care and a much lower level of people in administrative services and licensed staff, and we

Continued on page 50



Instead of facing a breakfast tray at dawn, residents will wake when they prefer and fix their own breakfast in the light, spacious kitchen or have the neighborhood cook whip up their order.

RESIDENTS

Continued from page 39

are already seeing results. Reducing middle management reduces costs. The annual consumer price index for the health industry increases more than 7 percent each year, but when we raised resident charges, we were able to stay with the consumer price index increase for general business, which is only 3.5 percent.

We will see further reduction in expenses when the neighborhoods are fully remodeled, with functional kitchens. When residents are able to select exactly which foods they want for each meal, far less food will be thrown out at the end of the day. We are anticipating a 40 percent decrease in food costs.

We have always said that our change to a social model would not be more expensive than a medical model. Even if it turns out that the social and medical models are approximately equal in cost, the social model has a huge advantage: It allows the resources to go directly to the resident. It is customer service oriented, the option that nearly everyone would choose for his or her own long-term care.

We will be monitoring customer satisfaction constantly and carefully. McNees and a team of researchers, representing a joint effort by the Sisters of Providence and the University of Washington, are continuing their observations in the nursing center: How are staff and residents interacting? How does each person in the neighborhood spend his or her time? How are things changing?

The university will also be filming a real-time documentary at the Mount. Researchers will install a video camera in a nursing center neighborhood that has not been remodeled and leave it running nonstop for 72 hours. After the remodeling, they will install the camera again for another 72 hours to discover how the change from a medical to a residential environment affects those who live and work here.

We are testing a written survey form that residents, family, and staff can use to express an opinion about anything happening at the Mount. It is designed to help us keep track of what is working and what is not. Once the survey has been refined, we will distribute it throughout the neighborhoods. Using the form is voluntary, but so far we have been getting positive responses.

Probably the most important feedbact we get is via the grapevine: conversations with residents, family, and staff. Most of these conversations are informal and spontaneous; some take place during family and neighborhood meetings. Communication is much faster and more direct when you are working with a neighborhood group instead of a formal hierarchy.

One result of improved communication is that more people are involved in hiring decisions. New staff are no longer chosen through a centralized human resources department. They are chosen by residents, family, and staff to complement a neighborhood's unique personality. This creates closer bonds and greater commitment. We are seeing real reductions in staff sick leave and turnover.

Life at the Mount is improving, for everyone. Resident-directed care *can* work. And this is our third reason to make such a dramatic change—to show others that it can be done. I leave you with a sincere invitation: Come visit us. You will find that we are doing some things well and others with a large helping of confusion. We hope you can learn from us, but we want your opinion on what works and what does not. We know there are solutions we have not yet dreamed of. If you help us discover them, then perhaps we will find ourselves taking the next risks together □

For more information, call Charlene Boyd at 206-937-3700.

INFORMATION FOR INTEGRATION

Continued from page 43

1992, as a result of a Health Care Financing Administration grant, two rural Mercy Health System hospitals—Mercy Hospital, Tiffin, and Mercy Hospital, Willard—adopted the Senior Advantage Program and were linked electronically with Mercy Hospital in Toledo and St. Charles Hospital.

This networking created an opportunity for the two city hospitals to better serve patients. For example, statistics indicated that rural patient admissions were, to some degree, bypassing those of suburban and inner-city sister hospitals. The expanded network encouraged rural patients to remain within the Mercy network, utilizing inner-city and suburban Mercy-sponsored hospitals when appropriate. The computer linkage also improved patient information flow. The two rural Mercy hospitals' networks can transmit enrollees' membership records to the inner-city and suburban hospitals so that when enrollees are referred to these two healthcare providers, their profiles will be available when they arrive.

Although not part of First Inter-Health Network, the rural hospitals have been able to take advantage of the benefits and cost-effectiveness offered by the Senior Advantage Program and software. At a time when institutions must collaborate to serve needs, Senior Advantage has enabled these Mercy Health System institutions to present a more cohesive identity to the community and to increase staff productivity by sharing expertise.

Managed Care Applications

The model provided by the Senior Advantage software shows that this type of computer system can lend itself well to community-based case management and one-entry point contacts for patients. The system avoids duplication of recorded information and increases efficiency and effectiveness. Moreover, having an interhospital computer system in place positions the network to link electronically to other provider sites, such as physician offices, pharmacies, and neighborhood clinics.

Managed care providers like the pro-