Promising Models for Transforming Long-Term Care

Joe Angelelli, PhD
Guest Editorial

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Two promising models for deinstitutionalizing services and individualizing the care of elders are profiled in this issue of The Gerontologist. The Adards community in Tasmania, Australia, and the first Green Houses built in Tupelo, Mississippi, both represent the triumph of person-directed values transforming long-term-care settings. Common to each is the centrality of home as an organizing principle in everyday organizational life, where elders and those who provide the majority of hands-on care are empowered to define for themselves the rhythms and routines of the household, honoring the essential personhood of its inhabitants and sharing in the poignancy of companionship and elder-rich convivium (Thomas, 2004).

Each stands in sharp contrast to the way life is organized for elders in far too many long-term-care settings in the United States, where care and treatment regimens are determined not by elders or direct-care staff but by the arbitrary dictums of supposed operational efficiencies. Such conditions are not limited to traditional nursing homes. They are apparent also in recently built assisted living settings where idealized notions of individual autonomy and self-direction are undermined by the same hierarchical supervisory practices that plague most nursing homes (Aud & Rantz, 2004).

New household designs like Adards and the Green Houses are blurring the lines between nursing home, assisted living, and “independent” living. Indeed, the stories of both exemplars reveal the limitations of using a concept like independence as a point of reference in the debate about how to promote well-being for elders and their direct-care partners. The models showcase the ways in which interdependence is the true unifying concept animating an aging-in-community experience—interdependence at the primary, secondary, and ultimately very personal level as we seek ways to spread the diffusion of these and other likeminded innovations far and wide.

At the primary level of the organization and its surrounding community, both Adards and the Green Houses have designed flexibility into every aspect of operations and household life. Flexibility is championed by Cohen-Mansfield and Bester (2006) as an overarching management principle at Adards, one that guides the development of care practices with residents, enables self-scheduling among the extended care assistants (ECA), and shapes general attitudes toward staff among everyone in the community. This give and take is fundamental to embodying interdependence within a household. The preferences of elders and their hands-on care partners are realized in relationships, and decision making and self-direction proceed from there.

Flexibility is a critical management attribute in the Green House, too, and as Rabig, Thomas, Kane, Cutler, and McAlilly (2006) make clear, it does not come easily. The conversion of an antiquated 140-bed institutional nursing home to 10- or 12-person Green Houses represents a truly radical transformation never before attempted in the United States. It is therefore unsurprising that the leadership team in Tupelo have faced significant challenges involved with “getting the right people on the bus” for deep organizational change (Collins, 2001).

But as the Green House experience illustrates, this newly designed, household-enhanced bus is one that more and more people clearly want to be aboard. Steve McAlilly, the CEO of Mississippi Methodist Senior Services, tells the story of placing want ads in the local newspaper for individuals to work in the new Green Houses (after some employees were unable to transition from their former institutional certified nursing assistant [CNA] role into the role of Shahbaz). They received just two responses when advertising for a CNA but more than 70 when the ad was for a Shahbaz (S. McAlilly, personal communication, April 5, 2006).

The stand-alone quality of the Green House is a feature different from other approaches, where a household may either stand alone or exist within a multihousehold neighborhood, which itself may operate within a larger retrofitted or purpose-built.
congregate living community made up of several neighborhoods. The prescriptive design for physical separation of Green Houses is intended in part to prevent the artifacts of institutional life from reappearing in the Green House (e.g., it has been suggested that households connected to one another via covered walkways might lead to carts of supplies being wheeled into each home).

However, the physical independence of Green Houses may present special challenges in terms of nurturing interdependence among the Shahbazim and the Clinical Support Team. Members of the support team must be mindful of perpetuating the outside expert role that typically complicates relationships between hands-on care partners and clinical nursing staff. Rabig and her colleagues (2006) state that “treatment is the province of the clinical support team, and care the province of the Shahbazim” (p. 536), and early in the implementation that distinction was a challenge for the clinical staff to maintain. It is a distinction born out of an acknowledgement that medical treatment must remain under the purview of duly trained and credentialed staff and that it is the Shahbazim and elders themselves who should direct the household.

The experience from another version of the household approach in the United States is instructive on this point. The Household Model—as operating at Meadowlark Hills in Kansas and elsewhere—has found success by having nurses, social workers, activity professionals, and those serving in blended roles (similar to Shahbazim) become anchored in a particular household while also serving as mentors in other households (Shields & Norton, 2006). This mentoring arrangement grows the skill set of staff in all areas, particularly those who function in blended roles. All workers benefit from mentoring relationships while belonging to self-directed competency circles that include individuals anchored in different households.

In Australia, the extensive on-site mentoring of ECAs by independent trainers may mitigate the need for professional staff to be anchored in a particular household, though the presence of outside training experts would seem to present its own set of challenges. The relatively small size of the Adards community (36 residents) likely allows ample opportunity for shared work experiences and mentoring relationships to develop.

Media coverage surrounding the new household models in the United States is creating educational opportunities about person-directed care in the medical community and among the general public—both areas worthy of focused emphasis for the broader movement toward cultural transformation in long-term care. Like other physicians wary of sacrificing treatment of medical needs in these new models, the medical director at Mississippi Methodist was skeptical during the planning phase, but now he is reported to be one of the biggest champions of the Green House model. He recognizes that the dynamic is about replacing institution with home rather than supplanting medical considerations. Interestingly, Green House Project staff state that some family members now visit less frequently, as they report having fewer worries about their loved ones. According to anecdotal evidence, the visits they do have are said to be of a higher quality, thanks to the opportunity to experience the simple pleasures of home together.

As leaders in the cultural change movement continue to have their work recognized more prominently, their stories are shaping the dialogue about how best to promote self-direction among elders and their hands-on care partners. But as the cross-cultural consideration of Adards and the Green House reveals, the courage to acknowledge interdependence in a wider societal context is necessary if we are to take these and other innovative models to scale here in the United States.

There are significant differences in pay structure for hands-on caregivers working in the United States and Australia. As established by social policy, the “penalty rates” in Australia allow ECAs to work part-time while earning the equivalent of full-time pay, thereby making it possible to fit themselves into the flexible staffing arrangement possibilities at Adards. No such social policies exist in the United States, a point deserving greater emphasis in our national debate.

There is hope at least that “the business case” for cultural transformation is finally finding a receptive audience, as training and mentoring programs needed to stabilize the workforce are viewed anew from a return-on-investment perspective. In an environment where turnover rates are unacceptably high no matter how they are measured (American Health Care Association, 2002; Castle, 2006) and where costs associated with each turnover are estimated to be $2,500 (Seavey, 2004), taking incremental steps to implement consistent assignment in order to reduce turnover makes good business sense.

Yet a radical redesign like the Green House calls for significantly more than a new purpose-built environment and an investment in training. It requires a permanent redistribution of operational resources. Shahbazim are paid an average of $2.50 per hour more than they were in their earlier role as CNAs, and their additional pay—in an organization constrained by limited resources due to a high percentage of Medicaid residents—is apparently made possible by a reduction of departmental middle-management positions, by the stabilization of the direct-care workforce, and by other as yet to be quantified operational efficiencies. What, one wonders, has become of the work done previously by professionals in those departmental positions in Tupelo? The true believer in cultural transformation would argue that the organization needs fewer such individuals because less time must now be spent
attending to and documenting the problems that plague life in an institution. The researcher would respond that it is an empirical question—one that can be tested after the dozens of planned Green Houses come into being. The ability to replicate and sustain the Green House approach will be in evidence as the NCB Development Corporation and the Green House Project provide seed money and technical expertise to help organizations introduce the new model in at least 30 communities during the next 5 years thanks to support from the Robert Wood Johnson Foundation.

As the Adards community and the Green Houses appear to demonstrate, operational challenges can be overcome if approached creatively by visionary managers and dedicated staff, but spreading these innovations to even a modest number of early adopter organizations in the United States will demand a further reckoning and an explicit appeal to fundamental social justice, one in which the rights of elders and direct-care workers are championed together as long-term care emerges from the shadows on the national policy stage (Stone, Dawson, & Harahan, 2003).

There are promising state-level workforce initiatives underway (e.g., the Better Jobs Better Care research and demonstration projects) that showcase what can be done with an investment in the working life of hands-on care partners. There appears to be widespread agreement among professional associations, consumer advocates, and government officials that cultural transformation is happening and should be encouraged. The time has come for a sweeping federal initiative to build on the early successes of the Quality Improvement Organizations (Kissam et al., 2003), one that fully resources more training and innovations to even a modest number of early adopter organizations in the United States will demand a further reckoning and an explicit appeal to fundamental social justice, one in which the rights of elders and direct-care workers are championed together as long-term care emerges from the shadows on the national policy stage (Stone, Dawson, & Harahan, 2003).

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References