Montgomery County Commission on Aging
Summer Study 2015

Long Term Care Services and Supports: Nursing Home Quality

Executive Summary

Nursing home care and services are critically important to vulnerable adults, mostly seniors, as well as their caregivers. According to the 2014 annual report by Voice for Quality Care, nursing homes in Maryland received a D+ rating for nursing home care and quality in Maryland, and a large percentage of repeat deficiencies in meeting federal regulations three years in a row. In order for the COA to understand and advocate for the needs of seniors in Montgomery County and Maryland, it is important for Commissioners to learn about the challenges faced by nursing home providers and consumers as well as best practices and opportunities for improvement in quality of care and services. Long-term care services and supports also have important economic considerations for national, state, and county governments. Medicaid spending for long-term care in Maryland nursing facilities alone was over one billion dollars in FY 2014.

Our primary goal for the *2015 Summer Study on Long-Term Care Services and Supports: Nursing Home Quality* was to educate Commissioners about the challenges surrounding the measurement and provision of quality care (note: 533 oversight regulations) in nursing homes in Montgomery County, and opportunities to enhance that care. ***That goal has been met,*** with follow-on work (see Recommendations) that the Commission may undertake to deepen their learning and enhance potential advocacy efforts on behalf of Montgomery County Nursing Home residents.

How the Summer Study Was Conducted:
Ten commissioners participated in the study and (in addition to the five presenters and two staff) meetings were attended by 12 individuals and representatives of organizations involved and interested in long-term care services and support.

Prior to the first Summer Study meeting, Commissioners identified and shared background reading materials intended to ensure a common base of knowledge. Materials included:

- Voices for Quality Care Annual Report
- Overview of the Medicare Quality Compare Rating System
- Overview of the Five Star Rating System

Commissioners invited select presenters to share their expertise including:

- Kathy Schoonover, Montgomery County Manager, Licensure and Regulatory Services HHS Public Health
- Eileen Bennett, Supervisor, Montgomery County Long Term Care Ombudsman Program
- Kim Burton, Director of Older Adults Programs, Mental Health Association of Maryland

- Theressa Lee, Director of the Center for Quality Measurement and Reporting, Maryland Health Care Commission. (Carol Christmyer, Chief of Long Term Quality Initiative was initially invited; she retired July 1, 2015 and Theressa offered to share general information).
- Susan Stone, Administrator/Guide, Baltimore Greenhouse, an alternative provider of long term care services.

Findings:
The Summer Study participants (Appendix A) developed a large number of findings. Among them:

- The nursing home industry is heavily regulated and, as a result, complex in management, staffing and financing.
- Nursing Home Quality surveys are based on facility's ability to follow regulations to meet "**minimum**" standards as opposed to quality of care and quality of life for residents.
- Staffing is a major challenge. The Director of Nursing "sets the tone" and hires nursing and direct care staff in each facility. Many are in need of training in "people skills" such as communication and compassion, and critical thinking.
- A troubling shift in nursing home staffing from licensed registered nurses to licensed practical nurses—who are not as well trained in critical thinking skills and have responsibility for greater numbers of patients—resulting in lower wages, higher staff turnover and lower quality of care for residents.
- Discharge planning for the transition from nursing home to home or assisted living poses a challenge for most facilities.

Recommendations:
The Summer Study participants identified recommendations focusing on training, processes, legislation, and technology. Recommendations ranged from those that are very broad to those that are very specific. Some call for action by the Commission and others; additional recommendations point to the need for a better understanding through data gathering and analysis. Among the recommendations:

- Learn more about the quality of care and regulations governing nursing homes in Montgomery County (identify individual county nursing home quality ratings) to better understand the complexities impacting management, staffing and financing.
- Advocate for the creation of a Montgomery County Nursing Home or Long Term Care Coalition to support and continue the work of Maryland's new Long Term Care Culture Change Coalition.
- Advocate for a Medicaid waiver to determine which of several nursing home and long term care models provide the best patient care and quality of life. Also, advocate for the inclusion of the Greenhouse model and other potential alternative nursing home models into state nursing home quality survey tools.
- Advocate for passage of the CARE Act (Caregiver Advise, Record, Enable (CARE Act). See http://aarp.wpengine.netdna-cdn.com/wp-content/uploads/2014/03/CAREGIVING-CAREAct-OnePager-Design-NATIONAL-2-18-14-4.pdf .
- Advocate for increased nursing home staff education, training and support: critical thinking, people skills, and communication—especially discharge planning.
- Advocate for Mental Health Services for residents in need.

- Share this report with the Maryland Department of Health and Mental Hygeine Office of Health Care Quality, the Maryland Department of Aging, and Nursing Home Administrators, and others at the State/local/federal levels.

A full list of detailed recommendations is included in Appendix B.

Montgomery County Commission on Aging
Summer Study 2015 Report

Long Term Care Services and Supports:
Nursing Home Quality

Why the Summer Study Was Undertaken

The Commission on Aging (COA) recently sponsored four activities to identify issues of concern to caregivers of older adults. These activities were: a 2013 COA Summer Study on Caregivers and a COA Stakeholder Forum on Family Caregivers of Older Adults in February 2014, a 2014 Summer Study that explored best practices and approach models for caregiver support, and a 2015 Summer Study that explores the complexity of nursing homes and the quality of care provided in nursing home facilities in Montgomery County, Maryland.

The 2013 Summer Study identified the most significant challenges faced by family caregivers, educated Commission members about these challenges and developed recommendations including an expansive investigation by the Commission on Aging's Health and Wellness Committee to gather information related to existing legislation, resources, and programs in order to establish a baseline of knowledge specific to this issue.

Following the 2013 Summer Study, the CoA's Health and Wellness Committee continued to focus on caregiving issues and supported the COA recommendation for the County to fund a Caregiver Coalition Coordinator position. It was determined that a caregiver coordinator would be better equipped to conduct, map and develop caregiver resources.

The 2014 Stakeholder Forum resulted in caregiver recommendations including the benefit of a single point of contact and a centralized information source to address caregiver concerns and easy access to critical information. Specifically, caregiver participants requested:

- Focus on the coordination, organization and leadership of caregiver support activities, information and services in the form of a caregiver coordinator, coalition or council
- Easy access to culturally relevant information about assistance and resources available to caregivers, including the quality of care provided in nursing homes
- Enhanced respite care availability and accessibility
- Information about and access to available mental health resources

The 2014 Summer Study built on recommendations from the 2014 Stakeholders Forum recommendations to explore and identify best practices for and approaches to meeting caregiver support needs and challenges implemented by State and local governments and caregiver support organizations across the country.

Now, in 2015 the COA maintains its focus on caregiving by deepening its understanding of the complexities of Long Term Care Services and Supports— Nursing Home Quality, in particular.

Introduction: The Issue

The Commission on Aging Health and Wellness Committee reviewed the 2014 Voice for Quality Care Report on Nursing Home Quality and found the results for nursing homes in Maryland, several in Montgomery County, received a quality rating of D+ for 3 years in a row. Many of Montgomery County's poorest and most vulnerable residents depend on nursing homes for their care. As County residents continue to age, the demand for long term care in current and future facilities will increase.

An article in the Washington Post (January 11, 2015), about a study from the Georgetown University Long-Term Care (LTC) Financing Project, concluded Americans are seriously under-estimating their future needs for long-term care.

That study reported that about 60 percent of adults ages 40 to 65 do not think they will need LTC. In fact, 70 percent of people 65 and older eventually will need LTC at home or in a facility. This includes 20 percent who will need two to five years of such care and 20 percent who will need LTC for longer periods of time. While this summer study focuses primarily on the quality of care provided by nursing homes available (34) in Montgomery County to meet current needs for long term care and issues facing current residents of these facilities, demographic data clearly projects the need for improved and increased numbers of facilities, innovative strategies and resources to meet increasing demand in the near future.

Current strategies for the provision of high quality LTC services include nursing homes, assisted living facilities, hospitals, hospice care and home care. At this time, the objective of providing a suitable quality of life for residents of current facilities, including home care is, in general, not being met. This summer study identified issues in nursing homes facing administrators responsible for their effective performance that should be addressed in the immediate future. Training of and working conditions for paid caregivers to help them understand and meet the quality of life goals for residents of LTC facilities is an immediate need in Montgomery County.

Innovation in the management and administration of nursing homes and assisted living facilities, and the resources to meet future needs is imperative. Current financial resources in Maryland include existing federal, state and county health and poverty programs, faith based sources, NGOs, LTC insurance by residents (in which only 2% of the population participate), as well as pensions, IRAs and Social Security, Social Security being excluded from taxation in Maryland.

Long term care services and supports have important economic considerations for national, state and local governments. Medicaid spending on nursing homes in Maryland in 2013 amounted to $1,174,482,767 (Medicaid spending for long term care in Maryland in FY 2013 can be found at http://kff.org/medicaid/state-indicator/spending-on-long-term-care/)– and continues to rise. Managing care and services within a complex regulatory environment (534 regulations) frequently results in "managing to the regulation" as opposed to providing patient-centered care as noted by nursing home quality surveyors and LTC Ombudsmen in Montgomery County.

Summer Study Goals

Commissioners anticipated the following outcomes for this Summer Study:

1. Educate Commission members on issues related to nursing home care and quality in Montgomery County including:
   - Review of Medicare Quality Compare Ratings
   - Learn about rating changes including the new Five Star Rating System
   - Review the Voice for Quality Care Annual Report
   - Learn more about the reimbursement structure
   - Report/Observations from the Montgomery County Long-Term Care Ombudsman(s) Program
2. Collaborate with other Montgomery County Commissions and groups — including the Commission on Health and the Montgomery County Long Term Care Ombudsman Program as well as local nursing home experts and leaders - — to better understand the challenges associated with nursing home care and quality.
3. Recommend legislative action related to nursing home care and quality that the CoA might want to promote and support during the 2016 Session of the Maryland General Assembly (e.g., education requirements for staff).
4. Identify best practices and make recommendations related to nursing home quality.
5. Raise awareness about this important issue.

How the Summer Study Was Conducted

Ten commissioners participated in the study, and (in addition to 5 presenters and 2 staff) meetings were attended by 12 individuals and representatives of organizations involved and interested in long-term care services and support. A full list of participants is included in Appendix A.

Commissioners invited presenters to share their expertise including:

- Kathy Schoonover, Montgomery County Manager, Licensure and Regulatory Services HHS Public Health
- Eileen Bennett, Supervisor, Montgomery County Long Term Care Ombudsman Program
- Kim Burton, Director of Older Adults Programs, Mental Health Association of Maryland
- Theressa Lee, Director of the Center for Quality Measurement and Reporting, Maryland Health Care Commission. (Carol Christmyer, Chief of Long Term Quality Initiative was initially invited; she retired July 1, 2015 and Theressa offered to share general information.)
- Susan Stone, Administrator/Guide, Baltimore Greenhouse, an alternative provider of long term care services.

Summer Study participants were provided and reviewed the 2014 Voice for Quality Care Report on Nursing Home Quality, an overview of the Medicare Quality Compare system from the Centers for Medicare and Medicaid (CMS) website, and an overview of the Five-Star Quality Rating System, also from the CMS website. Commissioners discussed the literature at length during the first meeting prior to the presentation by the first expert speaker.

Stakeholder Presenters shared their expertise to help educate summer study participants learn more about challenges faced by nursing homes:

- Management and administration of services, staff and the provision of care,
- Observations about the impact of those challenges on the quality of life and care of nursing home residents, and
- Thoughts about opportunities to enhance the quality of care and services provided in nursing homes and other nursing facilities.

Summer Study participants engaged the presenters in robust question and answer sessions and used their new knowledge to begin formulating ideas about if and how the CoA could make a positive impact and recommendations they might consider putting forward.

Stakeholder Views (Details found in Appendix B)
Myrna Cooperstein, a Commissioner and Health and Wellness Committee member. Even with 25 years experience as a geriatric social worker, Myrna experienced day-to- day challenges and concerns regarding her mother's care. Myrna became her mother's advocate for:

- Appropriate discharge planning
- Communication among and between facilities and their staffs
- Understanding which facilities could provide the appropriate level of care and when that level of care was not safe for her mother

Even knowing which nursing homes provided good care proved not good enough:

- Her mother's roommate rummaged through her drawers
- Her mother was not dressed appropriately when Myrna visited
- Daily activities were unsatisfactory or non-existent
- Day-to-day staff assignments were inconsistent

Kathy Schoonover, Manager, Montgomery County Public Health Licensing and Regulatory Services, explained the complex regulatory environment in which nursing homes operate. There are now more than 500 federal regulations, in addition to state and county regulations, impacting the operation of nursing homes. Due to the complex regulatory environment, training and constant oversight are needed to assure meeting regulatory requirements and the provision of quality care.

Nursing Home Quality Surveys focus on nursing services, physician services, environment of care, activities, environment, coordination of care, and more. The survey itself is a "snapshot" of what is happening in a particular facility at a point in time. Facilities fall in and out of deficiency all the time, face penalties for deficiencies and have access to an appeals process.

Concerning Trends:

- The shift from registered nurses to licensed practical nurses
- Increased severity of patient illness
- The preferences of facilities for short-term rehab patients versus long term care patients
- No minimum staffing requirements for nursing homes. In fact, the regulations themselves are the minimum standards

- No discernable differences in trends related to deficiencies for non-profit versus for profit nursing homes

Potential Solutions to deficiencies must address the root cause of the deficiencies:
- Competent and appropriately skilled staff
- Critical thinking skills of staff

Eileen Bennett, Supervisor, Montgomery County Long-Term Care Ombudsman Program. The Ombudsman Program focuses on *quality of life* versus *quality of care*. It includes seven certified staff and 40 trained and certified volunteers who visit facilities at least once a month. Eileen also identified the CMS Nursing Home Compare website, one of many consumer tools. The 5-star rating indicates the facility met **minimum** standards at the time the facility was last surveyed (up to 18 months prior) and represents a tool for consumer use.

Concerning Trends impacting residents in Montgomery County Nursing Homes:
- Older residents with decreased mental acuity
- Lack of sufficiently trained staff to address decreased mental acuity
- Inadequate staffing patterns (1 aide for 15 residents)
- Poor discharge planning
- Inadequate number of hours of care. Research indicates that 4.1 hours of care in a 24-hour period is "adequate," many facilities provide less than 4.1 hours of care. ***This issue provides the CoA with an opportunity for advocacy.***

Potential Solutions:
- Enhance the level of staff skill to address decreased resident acuity
- Adequately staff nursing homes to address resident needs
- Improve Nursing Home discharge planning practices
- Require an adequate number of "care hours" in nursing homes

Commissioners identified and discussed opportunities to learn more about the complexities of Nursing Homes (NH) and how they operate in Montgomery County to help improve the lives of residents and their families:
- Explore the CMS mandate for "person-centered care"
- Participate in the Summer Series on Culture Change and/or invite a speaker to discuss culture change in nursing homes
- Learn about best practices in other states, pilot projects, etc
- Collaborate with Schools of Public Health/Public Health Programs to introduce and encourage new students to work in and improve the care of older people
- Review standards for continuing education for NH staff
- Engage local resources including the Association for Healthcare Research and Quality (AHRQ), the National Institute on Aging (NIA) and pubic health programs
- Share Summer Study outcome and recommendations with Rona Kramer Maryland Secretary of Aging.

Kim Burton, Director of Older Adults Programs, Mental Health Association of Maryland, compared the challenge of classifying the quality of nursing homes to the quality of schools – it is not just the number of teachers or staff, but the *type* of staff. She noted that the director of nursing or administration sets the tone of each facility.

Concerning Mental Health Trends in Nursing Homes:

- Few Nursing Homes include a psychiatrist on staff.
- Maryland does not have standards for mental health services in nursing homes. *This may be an advocacy opportunity for CoA.*
- White males age 80+ are at high risk for suicide.
- Depression among residents is high.
- Seventy percent of people in nursing homes have mental health issues, compared to 42% in assisted living, and 25% in the general population over 60.
- Dementia creates special challenges for impacted residents, their families and Nursing Home staff.

Potential Solutions:

- Advocate for the state of Maryland to create standards for mental health services in NH.
- Include the services of psychiatrists and other mental health professionals in NH, especially for high-risk residents.
- Provide NH staff with mental health support.
- Educate and provide support for staff, residents and families caring for those with dementia.
- Help families identify available resources other than nursing homes that may be available: can care can be provided in the community for less; "money follows the person" (MFP/CFC).
- Enhance discharge planning to include mental health services for residents moved from a nursing home to the community to prevent readmissions.
- Consider the use of telehealth/telepsychiatry, especially in rural areas.

Theressa Lee, Director of the Center for Quality Measurement and Reporting, Maryland Health Care Commission shared general information about the MD Health Care Commission:

The Maryland Health Care Commission (MHCC) is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access by providing information on the availability, cost, and quality of services to policy makers, purchasers, providers, and the public. The Commission provides information to the public, under the Department of Health and Mental Health. The independent commission operates with 15 commissioners appointed by the Governor. The agency conducts surveys of nursing home residents and families, with a matrix to measure services. There is momentum for a consumer/patient focus, a new global perspective for care coordination/ silos/ reductions/ transitions to settings. Health Services Cost Review Commission (HSCRC) – Consumer Engagement Workshops seek family/patient perspective. See www.hscrc.state.md.us. The Long-Term Care part of the agency has four divisions that address:

- Analysis/data research, quality measurement,
- Provider of nursing home/bed needs/ expansion/justifications, and
- Health information/ technology and
- Telemedicine care coordination.

The website, www.marylandqmdc.org, provides information about Maryland Health Care Quality Reports including long-term care quality measurement and the Maryland Consumer Guide to Long-Term Care.

The CoA may want to collaborate with the MHCC in its advocacy efforts.

Susan Stone, Greenhouse, Administrator/Guide. Modeled after the Eden Alternative, designed by Dr. Bill Thomas, where patients are called "Elders" and those who care for them are called "Shahbaz." The Shahbaz is a versatile worker who provides a wide range of assistance, including personal care; activities; meal planning, preparation, and service; and laundry care for seven to ten elders. The Shahbaz also performs light housekeeping duties.

Greenhouses operate under a cross-functional horizontal model where everyone pitches in to provide for the patients within what is still a highly regulated environment. The Greenhouse model is primarily non-profit, typically situated on campuses with lots of land and opportunities to redesign their space. Greenhouses operate on endowments and are successful at raising money. The Greenhouse in Baltimore is a vertical building financially operated by Catholic Charities, a non-profit. Their motto is, "Love, Teach, and Serve." Their goal is to "break even." The Greenhouse name is trademarked (but architects interpret the models differently).

Choice and convenience of the Elders is paramount. Elders don't eat at a specific time, but eat when they want to eat, wherever they choose to eat. Meals are personalized and prepared fresh for each individual, a "choice-based" diet.

Nurse/patient ratios require thoughtful planning to accommodate regulations. Usually, there are 10-12 Elders per floor, no more than 15, with 3 Shahbaz. The staff ratio is 1 Shahbaz to 6 Elders. Medications for each Elder stay in the Elder's room, locked in a cabinet and charted with computers.

Rehabilitation services at the Greenhouse, including physical and occupational therapy, occur in the Elder's room so there is no "strengthening" in a public gym. Elders walk the halls, use the building stairway, and do a lot of things exactly as those who get rehab at home. Also, every bedroom has its own Hoyer lift. A separate rehabilitation room is available for use when needed.

All Shahbaz have the Geriatric Nursing Assistant (GNA) certification, and are paid $14.25/hour. Patient ratios are wonderful, but some GNAs coming from old models want to do patient care, only—not laundry, cleaning and cooking. Ms. Stone has 5 staff that has been with her since 2012; not a good retention rate—about 15% people leave.

Concerning Trends:

- High staff turnover rates.
- Surveyors have a difficult time assessing a Greenhouse facility because it operates so differently.
- The facility needs at least 100 beds for economy of scale (50% rehab beds; 50% Long Term Care).

Potential Solutions:

- The Greenhouse model offers potential Nursing Home residents a different care model, more private and homelike—continue to develop this model.
- Incorporate the Greenhouse model into Nursing Home Quality Survey Tools.

Summer Study Findings
Enhanced Nursing Home quality begins by:

- Addressing the impact of providing service in a heavily regulated and complex environment
- Acknowledging the need for and incentivizing culture change and innovation in long term care facility management, training, critical thinking and other skills on the part of administrative, management and front line staff
- Securing the financial resources to meet future needs of the facilities and their residents (current financial resources in Maryland include existing federal, state and county health and poverty programs, faith-based sources, NGOs, LTC insurance purchased by residents (which should be encouraged), as well as pensions, IRAs and Social Security)
- Improving the management and administration of nursing homes (the Director of Nursing, sets the tone for each facility).
- Hiring staff skilled in critical thinking, empathy, respect and compassion cannot be overstated.

High Level Recommendations (details in Appendix C)

- Learn more about regulations governing nursing homes in Montgomery County to better understand the complexities impacting management, staffing and financing.
- Advocate for the creation of a Nursing Home or Long Term Care Coalition to support and continue the work of Maryland's new Long Term Care Culture Change Coalition.
- Advocate for a Medicaid waiver to determine which of several nursing home and long term care models provide the best patient care and quality of life— include the Greenhouse model and other potential alternative nursing home models into state nursing home quality survey tools.
- Advocate for increased nursing home staff education, training and support: critical thinking, people skills, and communication—especially discharge planning.
- Advocate for passage of the CARE Act.

Conclusion and Next Steps:
All five goals of the Summer Study have been met, with follow-on work (see Recommendations) that the Commission may undertake to deepen their learning and enhance potential advocacy efforts on behalf of Montgomery County Nursing Home residents.

In addition to a large number of findings, participants offered many recommendations addressing process, legislation, and technology. They will be presented to the CoA Executive Committee for discussion and determination.

Appendix A

Summer Study Participants

K. Nicole Bell, Intern
Odile Brunetto, Director, Montgomery County, MD Area Agency on Aging
Janet Carter, Right at Home
Myrna Cooperstein, Commission on Aging
Tammy Duell, Commission on Aging
Susan Emery, Circle of Rights
Emily Glazer, Montgomery County Health and Human Services
Mel Greberman, Public Health Resources
Sarah Gotbaum, Elder Women's Aging Alliance
Austin Heyman, Office of Community Partnerships
Noelle Heyman, Summer Study Co-Chair, Commission on Aging
Arva Jackson, Summer Study Chair, Commission on Aging
Judith Levy, Chair, Commission on Aging
Tina Purser Langley, Holy Cross Hospital
Charles Kauffman, Commission on Aging
Shaffiran Livingston (Toy), Holy Cross Hospital
Sarah McKechnie, Holy Cross Hospital
Jerry Morenoff, Commission on Aging
Mary Petrizzo, Holy Cross Hospital
David Richman, Commission on Aging
Spencer Schron, Commission on Aging
Beth Shapiro, Jewish Federation for Group Homes
Lindsey Vajpeyi, Alzheimer's Association
Syed Yusuf, Commission on Aging

Appendix B
Detailed Stakeholder Views

Myrna Cooperstein, a Commissioner and Health and Wellness Committee member, shared her experience caring for her mother as her mother moved across the continuum of care from independence to nursing home care. Even with 25 years experience as a geriatric social worker, Myrna experienced day-to-day challenges and concerns. She described her mother as an independent widow who lived an active and good life—until she fell and needed physical rehabilitation. From that point on, Myrna became her mother's advocate for appropriate discharge planning, communication among and between facilities and their staffs, understanding which facilities could provide the appropriate level of care and when that level of care was not safe for her mother. Even knowing which nursing homes provided good care proved not good enough: her mother's roommate rummaged through her drawers, her mother was not dressed appropriately when Myrna visited, daily activities were terrible or non-existent and there was little opportunity for interaction between her mother and the staff as staff assignments were inconsistent from day to day. Mryna noted that the LTC Ombudsman was very helpful. Myrna's experience with her mother provided the backdrop for remaining speakers.

Kathy Schoonover, Manager, Montgomery County Nursing Home Licensing and Regulatory Services, explained the complex regulatory environment in which nursing homes operate. She indicated that there are now more than 500 federal regulations, in addition to state and county regulations, impacting the operation of nursing homes. Surveys are unannounced and are usually performed by a team of 4-5 highly trained nurses over a period of 4-5 days. Survey nurses undergo intense training over a 6-8 month period and must pass an examination in order to be certified to survey. The survey teams go to each nursing home in the County every 12-15 months. The survey itself is a "snapshot" of what is happening in a particular facility at a point in time. Many complaints about a specific nursing home are self-reported because facilities are required to self-report specific types of events.

Surveys focus on nursing services, physician services, environment of care, activities, environment, coordination of care, and more. At the end of the survey, the survey team determines if there is any deficient practice and, if so, the scope and severity of the deficiency(ies). Kathy noted that facilities fall in and out of deficiency all the time. Facilities face penalties for deficiencies and have access to an appeals process. Due to the complex regulatory environment, training and constant oversight are needed to assure meeting regulatory requirements and the provision of quality care.

When asked about keys to successful nursing homes, Kathy identified competent staff with critical thinking skills. When asked to identify concerning trends she noted the following: the shift from registered nurses to licensed practical nurses, increased severity of patient illness, the preference of facilities for short-term rehab patients versus long term care patients. During a question and answer period, Commissioners also were advised:

- there are no minimum staffing requirements for nursing homes; the regulations themselves are the minimum standards,
- there are no discernable differences in trends related to deficiencies for non-profit versus for profit nursing homes, and

- solutions to deficiencies must address the root cause of the deficiencies, lower staff turnover, and enhance critical thinking skills among staff.

Eileen Bennett, Supervisor, Montgomery County Long-Term Care Ombudsman Program, noted that the program has been in existence for 35 years, that it does not involve a prescribed process, and that it is resident-driven. The Ombudsman Program focuses on *quality of life* versus *quality of care*. The Program is a model that has received national recognition. It includes 7 certified staff and 40 trained and certified volunteers who visit facilities at least once a month.

Program staff and volunteers identified discharge planning (no warning or planning time for family members) and poor staffing patterns (e.g., staff do not respond to call buttons) as areas of concern for residents and their families. Based on research, 4.1 hours of care in a 24-hour period is 'adequate' to meet the needs of residents. Many facilities provide less than 4.1 hours of care. This may present an opportunity for legislative advocacy on the part of the CoA.

Eileen also discussed the Nursing Home Compare website. She noted that a 5-star rating means the facility is meeting minimum standards. Published ratings are not real time ratings; they indicate results from the last survey performed at that facility—which could have occurred during the previous year. Therefore, the 5-star rating serves as just one of many tools available to consumers to help with LTC decision-making.

Additional observations from the Ombudsman program include:

- residents are getting older
- consistent staff is helpful
- difference in level of support and care on weekends is obvious
- observations do not drive the work; complaints drive the work of ombudsmen
- person-centered care is needed
- choice for residents is important (food, activity, etc.)
- sexuality of residents is important
- the current focus of nursing homes is on tasks, a task completion orientation
- staffing is not adequate and it is not uncommon for 1 aide to care for 15 residents
- care transitions are guided by money and other funding sources
- hospitals are not being paid for readmissions within 30 days of discharge, which leads nursing homes to accept people with high acuity needs.
- professionals work in silos; they could enhance resident and staff experience by working together
- some facilities pull staff from other network facilities during surveys to meet minimum staff ratio and support
- there is not a lot of innovation in nursing homes
- little attention is paid to cultural diversity
- residents and caregivers are not educated about care options
- mental health needs are often not addressed
- consider including residents in staff training programs
- open facilities to community meetings to benefit residents

Kim Burton, Director of Older Adults Programs at the Mental Health Association of Maryland (a statewide non-profit), also addressed the group. Kim compared the challenge of classifying the quality of nursing homes to the quality of schools – it is not

just the number of teachers. Staffing is a big issue; it is not just the number of staff, but the *type* of people. It all depends on culture change, training and support.

Kim and the Alzheimer's Association have developed curricula to educate assisted living and nursing home staff about dementia and mental health. The State DHMH approved the training program. Aside from this training program, she suggests learning more about whether or not we can teach respect, compassion, and empathy. She noted that nursing home employees are under a great deal of stress (living paycheck to paycheck, there is a bias against them, both the staff and older adults are abused). More importantly, the director of nursing or administration sets the tone of the facility. Nurses are trained about the body, but not necessarily in the soft skills—and people tend to hire people with skills similar to their own.

Also challenging is the fact that in many nursing homes, sicker and healthier populations are "at the same table," and conversations do not go well. There are negative dynamics related to dementia. Kim recounted how in her son's class, the students were educated about how to help a child in the class who has autism. Residents in nursing homes also need to be informed about dementia. Families often feel guilty about placing their loved ones in a nursing home, and they are grieving; they are not educated about dementia. More education is needed for families and residents.

Nursing home residents with mental health issues include people with long-term diagnoses who are living longer (there can be conflicts and struggles with family and friends); also people with mental health conditions that had not been diagnosed in the community (such people growing up in the 30's were sometimes labeled "eccentric"). There are also people who later in life are depressed or anxious or both, or have cognitive impairment. Institutionalization contributes to the rates of depression and anxiety. Individuals come into the nursing home in a traumatic state. They may have been living alone, feel they cannot manage on their own, might worry about their pet, or hope to go back home. It depends on family support, but often the family wants to be protective and not take risks. They may decide on a nursing home if they are not aware of other choices.

Kim notes that culture change has been going on for a long time in our country, but only recently in Maryland. It is a very slow process. A toolkit has been developed for senior housing and nursing homes to help them evaluate where they are on the culture change continuum. Risk factors for mental health issues include physical conditions like cancer, diabetes, heart disease; as well as loss of mobility and independence, loss of choice/dignity, isolation. The nursing home environment feeds it. People going into nursing homes are likely to develop mental health issues. Seventy percent of people in nursing homes have mental health issues, compared to 42% in assisted living, and 25% in the general population over 60.

There are some promising developments to help with culture change, such as the Medicaid Waiver/Community Option in Maryland. Medicare covers rehabilitation services in nursing homes, but not long-term care. If one wants to leave a nursing home, one can explore if care can be provided in the community for less; "money follows the person" (MFP/CFC). Younger people in nursing homes (for example, someone who is paralyzed) who want to live in the community are motivated to use CFC in community that costs less than nursing home care, but not in a segregated setting. If a depressed

person is moved from the nursing home into the community, without mental health services, he/she might end up in a hospital (possibly dehydrated, or with a broken hip).

Maryland does not have standards for mental health services in nursing homes. *This may be an advocacy opportunity for CoA*. Often a nursing home will not admit a resident with schizophrenia because the facility does not have a psychiatrist. Some places have a good team, but others have a psychiatrist who, rather than provide individual care, goes down a row of patients prescribing medication. Rural areas have very little mental health services available. Telehealth/telepsychiatry are promising options.

The only way change will occur in nursing homes is if regulations require change. Nursing homes are over-regulated. Nursing homes are responsible for "whole health." It is important to let nursing homes know good standards and help facilitate them. There is a stigma attached to nursing homes and mental health. There is also a lack of education in nursing homes. Mental health professionals might make a recommendation that other staff or family won't go along with.

Kim also addressed suicide in older adults, and said that suicide in white males over 80 is "off the charts." There was also mention of "passive suicide," for example, when a resident stops eating or drinking. Kim differentiated right-to-die issues from suicidal ideation/depression, noting that suicide is often the result of depression. Caregivers are at high risk for depression and anxiety. Staff she has worked with is eager to obtain supportive resources. Stress management for staff is greatly needed.

Kim provided copies of handouts. One document was "NF & AL Based Behavioral Healthcare Challenges and Opportunities" (dated 7/7/15); and the other was entitled "Suggestions to the OHCQ Behavioral Health Sub-Group; on Behalf of the Maryland Coalition on Mental Health and Aging" (dated October 31, 2014). She also mentioned that NIH has published several issue briefs. She provided links to the references and webinars, which might be helpful for our recommendations.

Theressa Lee, Director of the Center for Quality Measurement and Reporting, Maryland Health Care Commission, also addressed the group. (We had invited Carol Christmyer, who had been the Chief of the Long Term Quality Initiative, but she retired on July 1, and has not yet been replaced.) Theressa offered to share the following general information about the MD Health Care Commission:

The Maryland Health Care Commission (MHCC) is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access by providing information on the availability, cost, and quality of services to policy makers, purchasers, providers, and the public. The Commission was established in 2005 or 2006. It combined two entities that had dealt with planning, and access/quality into one. With a budget of $13 million, this State agency's funding is supported by nursing homes and hospitals, which are, assessed a fee by law. The Commission provides information to the public, under the Department of Health and Mental Health. The independent commission operates with 15 commissioners appointed by the Governor. Summer Study participants were surprised that many of us active in Montgomery County had not been aware of the Commission. Eileen said the MD Health Care Commission is the "best kept secret," that they are data gurus who produce useful output. The agency conducts surveys of nursing home residents and families, with a matrix to measure services. The MHCC also has a

consumer advisory group and are seeking new volunteer members. Commission on Aging members were encouraged to participate.

Maryland is the only state that sets hospital rates through a Medicare waiver with CMS. This agreement is reviewed annually. The cost of hospital care must not increase beyond the cost of living increase in Maryland.

There is momentum for a consumer/patient focus, a new global perspective for care coordination/ silos/ reductions/ transitions to settings. Health Services Cost Review Commission (HSCRC) – Consumer Engagement Workshops seek family/patient perspective. See www.hscrc.state.md.us.

The Long-Term Care part of the agency has four divisions, which address: analysis/data research, quality measurement, provider of nursing home/bed needs/ expansion/justifications, and health information/ technology and telemedicine care coordination. The website, www.marylandqmdc.org, provides information about Maryland Health Care Quality Reports including long-term care quality measurement and the Maryland Consumer Guide to Long-Term Care. The organization is currently repurposing the website. *The CoA may want to collaborate with the Commission in its advocacy efforts.*

Susan Stone, Greenhouse, Administrator/Guide, shared her insights with participants during the third Summer Study meeting.

She began by explaining that the Greenhouse is modeled after Eden Square, designed by Dr. Bill Thomas, where patients are called "Elders." Those who care for Elders at Eden House are called "Shahbaz." (The Shahbaz is a versatile worker who provides a wide range of assistance, including personal care; activities; meal planning, preparation, and service; and laundry care for seven to ten elders. The Shahbaz also performs light housekeeping duties.) While treating his older patients, Dr. Thomas became interested in helping them become happier and more comfortable. He felt patients were physically fit but still with a great sense of longing. He found nursing homes to be schedule-centric as opposed to patient-centric operating for the convenience of the operator, organized and with a hierarchy that is vertical. Greenhouse operates under a cross-functional horizontal model where everyone pitches in to provide for the patients within what is still a highly regulated environment. Susan indicated that many choosing to work in this environment find it very challenging.

The differences between the two models are striking. The old (and more familiar) vertical model can be for-profit or non-profit organizations, and consists of a facility director and 15 or so departments—each with its own head and assistant in a single large or small building. The Greenhouse model is primarily non-profit, situated on campuses with lots of land and opportunities to redesign their space. Greenhouses operate on endowments and are successful at raising money. The Greenhouse in Baltimore is a vertical building owned by Catholic Charities, a non-profit. Their motto is, "Love, Teach, and Serve." Their goal is to "break even." The Greenhouse name is trademarked, but architects interpret the models differently.

Unlike the traditional nursing home, each Greenhouse facility has only private rooms, each with its own bathroom and shower. Pictures of Elders are on the outside of each room, with very small room numbers. When entering the Greenhouse, you walk into a

living room with comfortable furniture and a hearth as opposed to institutional lobbies and corridors. There are no "bunkers" (nurses stations). Nurses work at a small and unobtrusive station near the kitchen. The kitchen is open to the living room. There is no real separation in the sense of offices, hence no real way to give the impression that someone is in charge. Many people -- elders and staff -- think this kind of living and work situation is what they want, but they find the differences far too challenging.

Due to the small number of Elders in each Greenhouse, there is no major production of meals, no line in which to wait. In order to make the space more personalized, the kitchen becomes central. All staff are trained to cook and certified as "Serve Safe," a five-year certification. Each facility must have a master menu (reviewed and approved by the state). Elders don't eat at a specific time, but eat when they want to eat, wherever they choose to eat. Meals are personalized and prepared fresh for each individual, a liberalized diet. Some people order food in.

There is no housekeeping or laundry staff. Shahbaz clean, cook (and eat with the Elders) and do laundry. These activities create a very intimate personal relationship between the Elder and the Shahbaz. Shahbaz become like family members to the Elders. Laundry is washed for only one person at a time in regular machines, with the washer in one room and the dryer in another according to regulations. The Baltimore Greenhouse sends out heavy linens (sheets, towels, and bedspreads) for cleaning. Susan would have included three commercial washers and dryers had she been a part of the planning, as sending out heavy linens for cleaning is a cost factor for the building.

Another difference between Greenhouses and a nursing facility is the day-to-day management of operations. The administrator has to fix the problems him/herself. He/she has no staff, no one to whom to delegate tasks. The administrator orders whatever is needed, pays the bills, provides food service, stocks the store room, maintains the refrigerator, empties grease traps, and changes batteries on door alarms. Greenhouse administrators have to figure out how to create systems to manage the operation every single day.

Nurse/patient ratios require thoughtful planning to accommodate regulations. Usually, there are 10-12 Elders per floor, no more than 15, with 3 Shahbaz. The staff ratio is 1 Shahbaz to 6 Elders. Shahbaz carefully observes their Elders, identify potential issues and work in partnership with nurses to resolve those issues. Medications for each Elder stay in the Elder's room, locked in a cabinet and charted by computers.

Staff has to know each other's strengths and weaknesses. For example, many people do not like to cook. A strong cook will support a weaker cook. The Life Enrichment (activities) person provides Elder-Centered activities, for example, history discussions for whoever is interested, for example. No one is forced to participate in activities. Shopping is popular and arranged by Shahbaz. Shahbaz transports elders to activities in a van owned by the Greenhouse.

A questionnaire is given to each Elder and Shahbaz who applies to work or live at the Greenhouse. When Susan arrived, they had gifts for her, related to her questionnaire responses. The same thing happens when new Elders arrive. People know and care about you. The Greenhouse does have Social Services and Admissions. Social Services is an advocate for the resident but focuses on meeting requirements for

regulations. Shahbaz are actually more involved with the Elders and clue in the Social Workers to individual needs.

Rehabilitation services at the Greenhouse, including physical and occupational therapy, occur in the Elder's room so there is no "practicing" in a public gym. Elders walk the halls, use the building stairway, and do a lot of things exactly as those who get rehab at home. Also, every bedroom has its own Hoyer lift. A separate rehabilitation room is available for use when needed.

Every Greenhouse campus is a bit different. Some start with "legacy" buildings and slowly build cottages on the campus until the building is no longer needed. The Greenhouse in Manhattan is a large vertical building. Albany began with a legacy building, built cottages over time, and then demolished the big building. Some Greenhouses start with just land.

The Baltimore Greenhouse is located near old Baltimore stadium, which is active and used all year long. Surrounding the stadium are senior and assisted living apartments. Hopkins/Bellevue built a 40-bed facility with no opportunities for scale. Susan thinks 100 beds would provide for more balance and economies of scale. There is no office space for the Administrator or the Director of Nursing—examples of design flaws in the Baltimore facility. Medicaid funds thirty-six of the Elders, and 12 are rehabilitation residents funded with Medicare. It took Susan six months to identify operations and budget issues and realign the budget.

Susan indicated that all Shahbaz have the Geriatric Nursing Assistant (GNA) certification. Patient ratios are wonderful, but some GNAs coming from old models want to do patient care, only—not laundry, cleaning and cooking. Susan looks for interactive pleasant people. Some Elders are demanding and disrespectful which can be hard to understand and requires patience and a gentle soul. She has 5 staff that has been with her since 2012; not a good retention rate—about 15% people leave.

The pay for Shahbaz is a bit more ($14.25) than standard. It is notable that the Greenhouse saves money in other ways. Catholic Charities offers a 2% raise each year, but they may move to a different pay structure. The Administrator makes less than at a traditional nursing home with no bonuses.

The Greenhouse provides interactive trainings (12 required by the state), team training and continuous education that frequently occurs during shift meetings at the lunch table.

Rehabilitation services are provided through a contract with RehabCare, who documents and follows Medicare regulations. The difference is in how and where the service is provided: personal and in the individual's room. Elders can make their rehabilitation appointments when it is convenient for them. A Commissioner commented that the process sounded like adult day care but with overnight stays.

Surveyors have a difficult time with this system. Quality and satisfaction are more anecdotal, the result of talking with patients and families.

The Greenhouse uses checklists to help ensure patient safety.

The Greenhouse has a van to transport Elders to medical appointments, shopping, etc. Senior Ride can pick them up, families transport some, and others travel independently. Elders must indicate their time of return and the Shahbaz will facilitate transportation for those who need help.

The monthly cost per resident is approximately $5000. Sixty percent of Elders have Medicaid as a payer—and that is not enough money to sustain the Greenhouse. Medicaid reductions continue. Greenhouse residents tend to live longer than the usual nursing home resident due to the care they receive. Greenhouse is a social model that also provides medical care. The Baltimore Greenhouse will break even this year—after two years. Susan said the mix of residents must be 50/50 rehab and LTC, and 100 beds are optimal to break even.

Elders and their families must complete the standard nursing home 3871 form and patients must be appropriate for the setting. Greenhouse does not discriminate based on provider or payer source. The Greenhouse environment in Baltimore is not appropriate for Elders who wander or have severe mental health/dementia issues. The facility cannot serve persons who need ventilators, dialysis, or intravenous nutrition. Wound care and tube feeding are provided. The Baltimore Greenhouse has a long wait list and is advertised only in Baltimore.

Greenhouse Headquarters are located in Crystal City, Virginia. One hundred Greenhouses are available in 24 states; the first was built in Alabama.

Appendix C

Recommendations: Comments and Detail

Prevent isolationism and engage Elders, such as providing a group reading of the newspaper every day and bringing people into the conversation.

Finance

- We need to think about and create new financing options and concepts.
- CLASS Act legislation failed to pass at the federal level. Individuals contribute to their own long-term care costs.
- Consider not just how we pay for care, but how we ensure that those providing care are paid appropriately.

Regular inspection of facilities by federal, state and local government to identify quality of life and care issues.

Obtain a Medicaid waiver from CMS by DHMH

- A 2-5 year pilot program to encourage 1, 2 or 5 facilities to work outside the system providing patient-centered care in the manner of the Greenhouse to identify what works, what we can change.
- In the current system, people are managing to the regulations.
- Look at the current systems to try to address these national problems.

Regulations initially were in place to control the facilities with poor standards of care. Now there are minimum standards of care.

Create opportunities for flexibility using the Greenhouse and Culture Change Models.

Build on what works and standardize. Sweden and France have progressive systems. Pull people in for interactive opportunity.

Supporting infrastructure: care transitions and staffing. Give nurses more leeway to work within the scope of their license.

Change is hard: engage nurses from the beginning of culture change planning.

Improve staff ratios in nursing homes to improve quality of care.

Enhance staff education and training:

- Ensure SNFs deliver the highest quality care by increasing staff training.
- Effective communication and support is key. Orient and educate nurses, CNAs, dietitians and others in "soft/people skills" to diagnose and understand issues, and respect cultural differences. Communicate the availability of education (including the utilization of webinars) and support options, and share them with caregivers.
- Recognize the stress of the care providers inherent in this environment, and consider creative incentives to ameliorate the prevalent tensions in this work.
- Provide training to treat the increasing population of individuals with conditions such as those diagnosed with Alzheimer's disease and dementia and people with

severe behavioral, brain-based disorders to ensure appropriate, competent, and sensitive care.
- Develop and implement networking with colleges, engage those students (who sometimes get disconnected from older people), and encourage their participation in providing care in nursing homes for CEUs.
- Rude behavior from nursing staff should not be tolerated. Treat people with respect and dignity.

Consumers. Want a smaller, more homelike, less institutional environment. A smaller facility can also better address those with special needs. Facilities are increasing the number of rehabilitation beds to help sustain their financial viability.

LTC Coalition.
- Create a long-term care coalition to enable nursing home administrators to talk with administrators, nurses to talk with nurses, and front-line staff to talk with front-line staff.
- Is there a way the Commission can encourage the formation of an LTC Coalition?
- Nursing Home Administrators should receive the COA report/ recommendations.

Increase the pay of nursing home staff. Better compensation is needed.

Technology.
- Provide training via webinars for nursing home staff at the facility.
- Bring technology, education and sensitivity training to the facilities.
- Implement telepsychiatry.

Pilots: Evaluate pilot programs and different models and incorporate those learnings into any Waiver pilot program.

Develop a "guest mentality."
- Use the hospitality model to change habits and culture in nursing homes.
- Treat patients like hotel guests; then develop services to accommodate patients.
- Increase the integration of residents into the community.
- Duplicate more of the Adult Day Care concept into nursing homes.

Nursing home residents are the most vulnerable.
- Explore the LTC Coalition model and how the CoA might facilitate.
- Could the nursing home administrators obtain CEUs for participation in the coalition?

Maintain some relationship with the LTC Culture Change Organization so they understand/support our recommendations.

Enhance critical thinking skills.
- Develop a "help desk" for nursing homes (management and frontline staff) to provide support and options for issue resolution. Let the help desk do some of the critical thinking (telemedicine). There should be no linkage to enforcement, but rather a link to educational opportunities. (The State did this with Quality Assurance, suggesting ways to resolve issues and enhance quality rather than

penalizing facilities.) Note trends in issues and create training programs to address identified issues.

Nursing Home Administrators have a lot of impact. They do the hiring.

- Elect a patient council in each nursing home or a dining hall council. Listen to the residents/patients.
- Interview staff to find out how they feel about the nature of the job they are applying for, to help vulnerable adults and other patients.
- Involve Nursing Home Administrators in the CoA Stakeholders meeting.

Regulate nursing home facilities so they cannot admit anyone new until deficiencies are resolved. New legislation may be needed at the State level to implement this.