Creating Home in the Nursing Home:

A National Symposium on Culture Change and the Environment Requirements

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Co-sponsored by Centers for Medicare & Medicaid Services (CMS) and The Pioneer Network

The Creating Home Symposium Recommendations Summary Revised 8/11/08

On April 3, 2008 the Creating Home in the Nursing Home: A National Symposium on Culture Change and the Environment Requirements took place with approximately 600 people in attendance. Experts on the subject of the environment and culture change gave presentations which were followed by invited responses from national stakeholder organizations. Two public comment periods were held in which anyone could make recommendations. Following the symposium the next day was an invitational workshop for representatives of national stakeholder groups concerned with the physical environment of the nursing home as well all speakers and responders, culture change experts, regulators and advocates to brainstorm recommendations and next steps. Specific attendees were:

Dr. Margaret Calkins of IDEAS Institute,

Gaius Nelson of Nelson-Tremain Partnership,

Betsy Brawley of Design Concepts Unlimited,

Dr. Cutler of the University of Minnesota,

Eunice Noel-Wagoner of the Center of Design for an Aging Society,

Nancy McNabb of the National Fire Protection Association,

Robert Solomon of the National Fire Protection Association,

Cathy Lieblich State Coalitions Liaison with the Pioneer Network,

Steve Chickering of the CMS Western Consortium,

Mary Gear of the Oregon Office of Licensing and Quality Care,

Carol Shockley of the Arkansas Office of Long Term Care,

Ray Rusin of the Rhode Island Office of Facilities Regulation,

Susan Weiss representing the American Association of Homes and Services of the Aging,

Tom Jeager representing American Health Care Association,

Nancy Fox representing the Eden Alternative,

Janet Wells representing the National Citizens Coalition for Nursing Home Reform,

Joani Latimer representing the National Association of State LTC Ombudsman Programs,

Marianna Kern of the American College of Health Care Administrators representing the Long Term Care Professional Leadership Council,

Amy Carpenter representing the Society for the Advancement of Gerontological Environments,

Jeffrey Anderzohn representing the American Institute of Architects,

Tom Lohuis representing Wellspring,

Barbara Frank of B and F Consulting,

Megan Hannan of Action Pact,

Sue Misiorski of Paraprofessional Healthcare Institute,

Jim Kinsey of the Institute for Caregiver Education,

Joan Simmons of the CMS Division of Nursing Homes,

James Merrill of the CMS Division of Nursing Homes,

Alfreda Walker of CMS Atlanta Regional Office,

Gary George of the CMS Philadelphia Regional Office,

Charlene Boyd of Providence Mount St. Vincent representing the Pioneer Network,

Sister Pauling Brecanier of Teresian House representing the Pioneer Network,

Steve Shields of Meadowlark Hills representing the Pioneer Network,

Jude Rabig of Small Houses,

Heidi Gil representing Planetree,

Joanna Kaufman representing the Institute for Family Centered Care,

Lynn Miller, long term care resident, Mary Jane Koren of the Commonwealth Fund,

Rob Mayer of the Rothchild Foundation,

Nancy Zweibel of the Retirement Research Foundation,

LaVrene Norton of Action Pact,

Kathy Greenlee Kansas Secretary of Aging,

Cat Selman representing the Quality of Life Alliance,

Beth Baker of the Washington Post,

Vera VanBruggen of the Kansas state survey agency,

Trish Brooks of the CMS regulations staff,

Carol Benner of the Advancing Excellence Campaign and the LANEs (Local Area Networks for Excellence),

Margie McLaughlin of the Rhode Island Quality Improvement Organization,

Kim McRae representing the Pioneer Network,

Sarah Burger representing the Coalition for Geriatric Nursing Organizations

Rose Marie Fagan representing the Pioneer Network,

Bonnie Kantor representing the Pioneer Network,

Karen Schoeneman of the CMS Division of Nursing Homes and

Carmen Bowman of Edu-Catering.

The following is a compilation of all recommendations made by speakers, national responder organizations, public comments and the workgroups of the invitational workshop. They are strictly a compilation, not a consensus.

The recommendations contained herein do not necessarily reflect the opinions of the Pioneer Network or CMS.

Creating Home Symposium Recommendations by Topic

CMS Federal Regulations/Issues

F 252 Change "homelike" language to "home"

Define "home" in the interpretive guidelines.
Consider the language-some do not believe this to be home. How do you collect the evidence that this is home?
Be more specific. Give surveyors examples and ideas of home. Probably specific items that surveyors can zero in on. Identify institutional trappings that should be eliminated. Such as:
No overhead paging.
No more large central nursing stations.
Small dining areas required in new construction.
Forbid meals on trays unless resident wants to eat in room.
No med carts, signage or anything that evokes a feeling of an institution.
Get rid of myths (red exit signs and overhead bed lights).
Eliminate chair alarms, bed alarms, overhead paging.
Disallow meals served on trays.
Change medication distribution systems to eliminate the large medication carts.

"To the extent possible" referring to the use of personal belongings is often implemented based on what is convenient for the staff or facility, with no real effort made to actually maximize resident choice or options. Surveyors need to ensure that facilities are actually accommodating residents' desires.

Utilize research for surveyors to evidence to support citations.

Helping surveyors, and training to document their findings and use those findings to show a violation of their findings. Training is key.

New Quality of Life Issue

Instead of citing extension cords under Accident Hazards cite it under Quality of Life, specifically Accommodation of Needs, as people need additional receptacle plug-ins installed in their rooms for things such as I-pods, lap tops, cell phones, etc.

Require a certain number of electric outlets in a room in new construction.

Telephone/Cable/Internet Access

Require a telephone for each resident.

Access to wheelchair-accessible and disability-accessible telephones should be addressed as a right not a necessity.

Nursing homes should not only provide telephone jacks in each room (for those residents who do not use wireless) but should also provide cable access and internet access.

Chair

Require each resident to have a chair.

Private Rooms

Create a standard that in new construction, all residents should have a private room unless by choice.

Change regulations to prohibit new construction of traditional, side-by-side shared rooms. So when shared rooms are built, they have a privacy enhanced design with a divider such as wall or wardrobes and each resident has a window (see Calkins Power Point presentation "Private versus Shared Bedrooms in Nursing Homes").

Private rooms should have shower.

Recommend private rooms also be considered in order to prevent a person from having to go through the trauma of the death of a roommate or multiple deaths of roommates.

I hope we won't have any more studies to say that it is a good idea to have private rooms and instead we will move quickly towards it.

Roommate Choice

In facilities that do not have all private rooms, residents should always get the final say on with whom they share a room.

Tag F175 Married Couples

Expand the definition of married couples to be more expansive of other relationships (life partner, consideration for mother –child relationships).

Choice

Surveyors need to place a greater value on (and therefore assess the extent to which) residents have direct input into their daily schedule (for each individual resident), the activities they engage in, how budgets are set and what money is spent on.

Residents should be given the opportunity to be involved in hiring of staff.

Residents who are on restricted diets should be given greater opportunity to choose the extent to which they want to follow the restrictions – in consultation with their physician and family as appropriate. But the final say should rest with the resident.

Consider ways to make mealtimes more pleasurable and a varied experience.

Resident rooms should minimize wall installations, such as over the head-board light fixtures, to enhance flexibility in resident choice for room arrangement.

Balance safety with informed choice of personal risk.

Determine risk-must be a vehicle for families and residents to evaluate and choose the level of risk.

Privacy Curtains

A cloth curtain does not provide the opportunity to be compliant with HIPPA compliant. Use these regulations. Does not provide auditory privacy.

Incentivize nursing homes to increase privacy in their shared rooms, e.g. acoustic privacy wall and door between.

Change regulations to prohibit the use of a "privacy" curtain as an allowable separator between people who share a room. Privacy should be defined to include acoustic privacy and the right and ability to close a door between two separate parts of the shared room.

There should be no requirement for ceiling mounted curtains to surround the bed. If shared rooms are adequately designed as Dr. Calkins explains in the enhanced shared bedroom concept, why would a curtain be necessary? If we can achieve that same level, or higher level, of privacy through other means (such as a wall or door) then a curtain should not be required.

Lighting Tag F256

Rewrite guidance to surveyors defining "adequate" lighting. Use American National Standards Institute/Illuminating Engineering Society of North America (ANSI/IESNA) RP-28 2007.

Revise, enhance and clarify Tag F256 Lighting at 483.15(h)(5) to insure clear, accurate information. Define methods of assessment to meet minimum lighting standards.

CMS letter should be sent with these clarifications.

Include availability of task lighting and appropriate outlets.

Reevaluate night lighting and sleep interruption.

There should also be education of family and individuals-that they don't need to accept conditions as they are. Don't know they can ask.

A measurement of the level of light available to a resident should be included in the survey process.

When an overhead light serves as a night light, a rheostat (dimming device) should be required

for controlling the level of light.

Rooms should have ample wall outlets and even floor outlets so that bed and lamp arrangements are not dictated by inadequate supply of outlets.

Insure federal and state agencies recognize residents living in nursing homes are visually impaired. We recommend that the Centers for Medicare and Medicaid Services acknowledge nursing home residents are visually impaired and support their special needs by petitioning the United States Surgeon General to declare individuals living in nursing homes and healthcare settings serving older adults are visually impaired and further, exempt nursing homes from the ASHRAE/IESNA 2004 energy restriction. We will otherwise be trading energy efficiency for an increase in falls, fractures, sleep disorders and general quality of life.

Increase available light during the day within nursing homes by employing greater use of skylights and daylight design principles.

Assess lighting for individual residents: can they see what is on their plate, can they see their tablemates, what does a person or cart look like coming down the hall, can they see to do hobbies, play cards, etc., how does it impact the person's risk for falls or other unsafe activities, and how does it impact their mood state?

"Sufficient Space" under Tag F455

Rewrite guidance to surveyors defining "sufficient space."

Recommend: CMS letter should be sent with these clarifications.

Spaces

Require wellness spaces- meditation.
Media room.

Surveyors should link their examination of environmental features to their actual use. In private resident room and bath areas, similarly they should inquire about whether the resident actually uses that tub or shower for his/her bath. They should inquire how many and which residents use various facility spaces such as dining rooms for fine dining, and other amenities.

The obsolete classic design for nursing stations should be replaced with multiple small desk areas large enough to hold a computer and located in lounge and dining areas where staff can share the space with residents and not be isolated behind a counter.

Facilities should avoid multi-purpose rooms and if unavoidable, the spaces should be delineated to specific uses such as reading space, dining space, television space, quiet space, activity space, etc.

The best environmental features (exercise equipment, outdoor gardens, town squares) may be underutilized by most residents unless programs and staffing are developed to accentuate their

use. Administrators should consider ways to enhance the use of various spaces.

Dining Spaces

Nursing homes should decentralize their central dining service into smaller dining rooms located throughout the facility. A dining table could be located in a library, in the room with the fireplace, in the sunroom or lounge. Cafeteria style dining should also be considered as a dining option.

Dignity

The bathrooms in public spaces in nursing homes should not be locked nor should signs be posted on the adjacent wall that state “use of the bathroom is reserved for visitors.”

Room Space

Consider whether it is time to increase minimum square footage of resident rooms (for new construction).

Increase minimum room size to 125 square feet for a private, and 125 square feet per person in a shared room (exclusive of toilet room).

Recommend new language for Tag 457 shared bedrooms shall be arranged such that each resident has equal space for possessions and for storage to accommodate visitors, flexible furniture arrangements and for a chair, equal access (to bathroom and entry door without passing through the other’s space and to a window) and equal amenities.

Storage Space

Increase accessible storage space for new construction.

If locked storage is not provided in the resident room or if general storage space in resident rooms is inadequate, there should be some option for secured storage at the facility level that is easily accessible to the resident.

Providing additional storage in resident rooms and baths should be a priority of nursing facilities. With the multitude of home-improvement retailers available that sell storage components in all shapes, sizes and price ranges it would not be difficult or costly to retrofit existing rooms with additional storage.

Consider developing a storage shed or off-site storage.

Conduct a walk-through to look for clutter. Remove or discard extraneous items and develop different approaches to corridor clutter caused by dishes, cleaning supplies and the like.

Closet Space

Consider whether it is time to increase minimum square footage of resident rooms, including closet space.

Require shelves, storage, bookcases in rooms.

Shower and Tub Rooms

Tub rooms should be for only one person - no more bathing suites.

Survey instructions should be amended so that surveyors look into all spaces that residents routinely use, including shower/tub rooms, and assess the space for environmental features the same way they do for other spaces in the nursing home. If shower and tub rooms are used for storage they are obviously not available for the purposes intended.

Surveyors should link their examination of environmental features to their actual use. In private resident room and bath areas, similarly they should inquire about whether the resident actually uses that tub or shower for his/her bath. They should inquire how many and which residents use various facility spaces such as dining rooms for fine dining, and other amenities.

Accommodation of Needs

Consider an approach to environmental regulation and interpretative guidelines that is geared to the functional requirements of the space.

At the minimum, lever hardware, preferably single lever hardware, should be installed at all sinks that residents use.

Automatic door openers should be required at the facility entrance, at the entrance to households or units, and at a minimum to one outdoor area located on each floor.

Knobs, drawer pulls, light fixtures and levers should pass the “fist test”—i.e. residents should be able to open them with a closed fist.

Outdoor Access

Easy access to outdoors with solid surface.

Encourage staff to hold resident activities outside.

Design interesting, interactive outside spaces-solid surfaces with ample space.

No resident should be prevented from being able to freely spend time outdoors, which doesn’t mean only being to go out when staff have time to take them.

Outdoor space requirements should follow Washington state regulations which require the outdoor area has: shaded and sheltered areas; accessible walking surfaces which are firm, stable and free from cracks and abrupt changes with a maximum of one inch between sidewalk and adjoining landscape areas; sufficient space and outdoor furniture with flexibility in arrangement to accommodate residents who use wheelchairs and mobility aids; shrubs, natural foliage and trees; and if used as a resident courtyard, the outdoor area must not be used for public or service

deliveries.

Provide increased access to safe, healthy outdoor environments and a variety of activities to encourage residents to go outdoors. Getting residents out of doors into the healing environment of nature and sunlight will provide opportunities for healthy bright light exposure and exercise and will likely prove to be one of the least costly prescriptions for better sleep quality and reduced depression. It is certainly a powerful demonstration of the best of person-centered care that optimizes quality of life. Getting people outside will require transformational thinking and a shift in priorities as to how staff is best utilized.

Decor and Furnishings

Consider purchasing furniture and decorations from community businesses as opposed to established vendors that specialize in nursing homes.

New Construction

All private rooms with direct access bathrooms.
Lighting should be required to follow ANSI RP-28 2007.
Require dimmers.
Increase room and accessible storage.
Private bathing experience.
Automatic door openers.
Easy access to outdoors with solid surface.
Make the most of technology, i.e. wireless call system, adequate lifts, beds that raise and lower, wireless Internet access and ample electrical outlets.
Multiple dining spaces unless the building houses fewer than 12.
Decentralize.
Bedrooms do not have to open to corridors.
Get rid of myths (red exit signs and overhead bed lights).
Eliminate cloth curtains.
Require two windows for semi-private.
Discourage multipurpose rooms for dining and activities.
Private spaces for family/friends.
No med carts, signage or anything that evokes a feeling of an institution.
No nursing stations.
Large windows with shading for glare.
A window for every room.
Give residents more control of light, temp, furnishings.
Breaks and handrails and alternate means of support.

Require new construction to reflect the household model, with 24-hour resident-accessible kitchens. Some states still require a 2-hour fire wall around the stove, while others do not. Review codes to allow greater resident access and participation in kitchen and food related activities, while maintaining safety, e.g. allowance of induction cook tops.

Do not allow four people to a room. Make the maximum only two people in a room, at least in

new construction

CMS should stop approving designs for new construction that are based on an institutional design including long hallways and huge dining areas, shared bedrooms, etc.

There should be a training product for surveyors and providers on lighting. Surveyor training on lighting should be mandatory; more that once; repetitive; q 6 mos. >12 mos.

Wireless Call Systems

Allow wireless call systems.

Consistent specifications for wireless call systems should be defined that eliminate the need for individual state regulators to evaluate the efficacy of multiple nurse call systems.

Locked Units

No locked units.

No Nurses Stations

Eliminate the central nursing station as the barrier between staff and residents: give staff office space, encourage/require more efficient electronic charting and other systems that capture care as it is being given, and support systems that put the staff in more direct contact with residents.

The obsolete classic design for nursing stations should be replaced with multiple small desk areas large enough to hold a computer and located in lounge and dining areas where staff can share the space with residents and not be isolated behind a counter.

CMS should stipulate that a requirement for direct line-of-sight from staff work areas or "nursing stations" is not required within nursing facilities.

CMS should stipulate that no fixed location is required for nursing staff to care for residents.

Tag F459 Requiring rooms to open to a corridor

Change requirement so that bedrooms do not have to open to corridors.

Tag F457 No more than four to a room (in existing buildings)

Change to maximum two people to a bedroom.

Change regulations to disallow 4-person rooms.

F254 Clean linen

Define "good condition."

Surveyor Training

Educate surveyors about culture change. Mandate periodic refresher training on culture change.

CMS send letter to regional offices and state agencies clarifying supporting environmental culture change.

Develop training product for all surveyors to enforce regulations.

Rewrite IGs that are vague.

Teach surveyors about accessibility and storage needs.

Go green.

Teach surveyors/give regulators the tools to more deeply assess satisfaction with roommate situation by room type. Of critical concern is control/lack of control residents have over whether they have a roommate and who that individual is.

Provide training for surveyors in assessing lighting in nursing homes. Surveyors should be provided light meters specifically designed for measuring interior room lighting. Nursing homes can request that local utility companies measure light levels using the methodology found in ANSI/IESNA (Illuminating Engineering Society of North America) RP-28-2007. Light levels can then be compared to the recommended light levels found on Table 1 Minimum Illuminance (ANSI/IESNA RP-28-2007).

There should be a training product for surveyors and providers on lighting. Surveyor training on lighting should be mandatory; more that once; repetitive; q 6 mos. >12 mos.

Equip every surveyor with tools to assess different environmental areas such as temp, light, sound.

Plans of Correction

Analyze plans of correction. Here's what to avoid or here's what you missed. Teach culture change through the process. Do not allow same old way of correcting i.e. in-services. Plans of correction lock staff into a behavior forever.

How plans of correction are navigated is something we can do right now. When somebody falls and the surveyor expects to see a new plan for how to prevent that person from falling it will probably be something like they'll sit by the nurses' station so we can watch them all the time. And then that plan of correction becomes what the nursing home has to do and what the surveyors expect them to do. So that what we can do now - there was such phenomenal information by all the presenters today - the stuff on lighting and glare was so eye opening (no pun intended). We can have a challenge to our surveyors and to the providers in this room that next time someone falls and there is a deficiency and a plan of correction for it that we go to what we really know is the source that instead of saying we are going to re-teach our aides to make sure the chair alarm is in place, instead what we are going to do is an assessment of the lighting, an assessment of the visual abilities and look to see if there are some ways to make the space support mobility. These are things we do not have to wait for a regulatory change it's

about how we're living now with our obligations.

Informal Dispute Resolution

Consult resident and family as part of informal dispute resolution.

CMS' Continued Support of Culture Change

CMS establish a culture change point person each state.

Clarify State/Federal/Local Jurisdictions

Determine what's federal and what's state (determine who has authority so we know where to concentrate advocacy efforts).

Perhaps CMS and AHFSA (Association of Health Facility Survey Agencies) can give guidance to what is state's authority and what is federal authority.
NFPA, state, and local fire authorities can give guidance to who's responsible for what.

Federal Requirements Miscellaneous

With focus groups of Elders and other stakeholders, we should examine all the current regulations that are stifling the creativity of our Elders and staff living and working in culture change homes, and work hard to remove those that are no longer valid, those that impose unnecessary hardship on creating real home, and those that serve the regulator, not the Elders.

Develop an easy-to-use MDS analytic tool that facilities can use to track differential outcomes and costs associated with their different bedroom configurations.

Recommend more focus by regulators on untreated vision loss.

Recommend that language change, particularly "facility" to "home." Until we stop calling it a facility it will still resemble a prison in our minds.

Recommend and hope that CMS will act as a facilitator to move culture change into the various states.

Regarding special focus facilities, recommend that what we need is an early detection system so that we're not going in so late, they're truly well intentioned and they're good people they just weren't exposed to the principles early enough. And so the solution truly lies in changing their organizational culture.

The punitive survey process does not fit with the person-centered model we are trying to implement in the culture change movement.

I would like to recommend that a topic that is added to this conversation is the survey process itself. There needs to be an acknowledgement that in a smaller environment the survey itself disrupts the lives of the elders and thusly, is not truly accurate in what surveyors "see." There should be given consideration to the size of the survey team in smaller household environments.

Most transforming communities are adding support of resident self-direction to job descriptions and performance evaluations. Shouldn't our federal and state regulators have the same in theirs?

As we discuss the need for language changes in culture change, we NEED to develop a different name for the survey process that better and more positively reflects the process. Maybe we could call it "Evaluation Process" or some other words to reflect a "collaborative team effort to improve quality of life for elders." How negative surveyor and plan of correction sounds! Thank you for the opportunity to be here.

Regulators should be able to accept standardized investigations completed by ombudsmen and their findings as valid for complaints that cannot be observed during an annual survey i.e. staffing patterns, call bell responses.

The first step toward ensuring that a facility can provide a more homelike feel is to insist that all facilities be fully sprinklered. Doing so ensures resident safety for a multiple dwelling and will allow for the trade-offs necessary to move toward residential models.

We cannot forget that the purpose of public regulation is to protect, and I want to reiterate NCCNHR's objection to regulators assuming the role of "collaborators" with providers of care, particularly when this role diverts resources from the protective function of their agencies. By coincidence, the April 4, 2008 Washington Post led with coverage of hearings on the FAA's relationship with the airline industry, disclosing the dangers to airline passengers when the FAA went "from aggressively regulating airlines to treating them like customers or clients." The regulatory role is necessary and appropriate.

We know that CMS regulations allow small homes [residential house configurations] and allow them on campuses but we don't know if they allow them to be moved off of campuses into communities under a single umbrella license. We plan to have nurses and staff in the homes 24 hours a day 7 days a week but we don't think we need a DON or Administrator in each of the homes at the levels prescribed. We would like to work with CMS and the PN around that.

State Issues

Compile information from homes on culture change journey in each state. Compile information from homes with good track records that are *not* moving on culture change. Convene state culture change coalition (or stakeholders) to review barriers and establish short, mid and long term goals – with strategic prioritization. Who: State Coalitions

State regulatory agencies and standard-setting organizations should collaborate to develop a set of model regulations that are directed towards the underlying intent of the OBRA regulations that promote innovation and flexibility, and do not exceed the scope of the Federal regulations.

States should be encouraged to develop methods whereby plan reviews for health care facilities are consolidated under a single entity in order to minimize redundant and overlapping requirements.

States should be encouraged to maintain consistency in the interpretation of codes and regulations. This can be accomplished by requiring that plan reviewers and final inspectors are the same person. This will create a situation where the regulator has an interest in the final outcome and firsthand knowledge of issues covered during the plan approval process. Additionally, a mechanism for tracking and documenting interpretations (both positive and negative) would help maintain an institutional memory in case of staffing changes.

Culture change coalitions and other advocates should work to educate state legislators (who often control state codes) on the value of private versus shared rooms for both quality of life and quality of care/costs.

Exceptions to compliance with NSFI requirements should be provided for small-scale food preparation areas. State and local regulatory agencies should be encouraged to defer food service sanitary oversight to long-term care regulators who are more familiar with the needs of nursing home residents.

Intergenerational programming should be encouraged to the greatest extent possible by allowing programs to co-exist under one roof.

In revising regulations, States should strive to develop a single uniform set of regulations rather than a separate set of regulations applicable to only a subset such as Green House ® nursing homes or “culture change nursing homes.” Even larger and older nursing homes can improve their care by creating households and using permanently assigned direct care workers with broader roles.

States should develop a convenient and transparent way to grant waivers of environmental regulations so as to create new ways to maximize quality of life in nursing homes. Technology will always outstrip old regulations and new ideas will deserve a trial. (Transparency of the waiver process is enhanced in states such as Minnesota that record all waivers on a website).

States should consider tying state waivers of construction standards to post-occupancy evaluation (POE) studies and the data from such POEs should be made widely available.

State moratoriums (on new construction) are preventing competition and free market economy because keeps occupancy rates low and no one can build. Limits innovation.

State governments must abandon their moratoriums on the construction of Medicaid beds. The determining criteria for new beds should be, "How are you promoting privacy, dignity, and choice, in this new construction?" or "How are you creating authentic home?" in lieu of demographic criteria based on arbitrary political boundaries.

This is a great time for a concerted educational effort directed at legislators.

I believe regulatory leaders are willing across the country to move this agenda forward. Don't wait for the changes in the regulatory language, don't wait for the regulatory agency to come knocking at your door. Call them up and tell them you are interested and you want to be on this journey. Tell them you see something in the regulations and ask, "What can I do about that?" I really believe regulators are willing to find ways to move around those. Even if we don't actually change regulatory language, it's not impossible.

The blueprint for professional licensing requirements and testing must include the impact of light on vision, health and wellbeing for older adults.

Develop a guide on culture change and the environment that focuses on critical state functions. Who: Pioneer Network convene state regulator subgroup.

Regarding surveyors serving in a capacity to support culture change, sit on committees, etc. we cannot go forward unless everyone who has an impact on what is sits down together and puts their heads together around what is. So we have to make sure that we have the resources to do all aspects of the job, to do enforcement well because we have the resources to do it and to sit at the table when there are areas of our jobs that are a hindrance of implementation of these ideas going forward.

In each state convene a committee to educate each other and plan together regarding state-specific issues and changes needed.

1.Identify all players with a role in physical environment issues (government and non-government):

LSC/NFPA
Fire Marshalls
Chamber of Commerce
Dept of Health (plans review)
Developers of LTC communities

Architects
City/State Officials
Community Groups
Boards of Nursing
Identify existing leaders and those with "power" who can help move agenda
Who: Existing Stakeholder coalition – LANE/Culture change

2. Bring the players to the table with existing state-wide coalitions:

Residents and families
State survey agencies
Providers
QIO
Ombudsman
Citizen Advocacy Groups
Nursing Academia
American Medical Directors Association reps
Coalition of Geriatric Nursing Organizations
Direct care workers
Social Workers
Clergy
Architects
Etc.

3. Cross educate physical environment coalition work regarding:

Resident choice
Private rooms
Lighting
Households/universal workers
Privacy
Dining
Consistent Assignment
Creating Home
Outdoor Access
Other relevant content
Use Business Case information to educate.
Resources: from # 1 and 2 – coalition members educate each other.

Note: residents, families, and direct care workers may need resources to participate.

4. Get consensus of <u>all</u> players about state initiatives and what needs to be done to implement.

Prioritize state initiatives.
Determine short-term, mid-term, and long-term goals.

Develop strategic plan.
Identify power base to assist ~ get them on our side… to participate.

5. Educate Broader outside Groups about advocacy on environment/culture change.

Town meetings
Media
Social marketing campaign to drive demand to push policy makers ("Where do you want to live?")
Resources: Money to develop culture change social marketing campaign (Press Kit, DVD, Power Point presentation, fact sheets, pictures, etc.).

6. Influence Policy Makers

Funding for Culture Change Initiatives

A. Compile and disseminate information about existing funding mechanisms to support culture change.

- Directly
- Indirectly (e.g. staffing levels)
- Federal and State

B. Use existing funding mechanisms to support culture change (who – each state).

C. Identify needs for restructuring federal and state funding mechanisms to support culture change.
Who: researchers, pioneer network, state coalitions, other national orgs.

D. Develop a political strategy to address restructuring funding mechanisms.
Who: Pioneer Network and state coalitions

Dissemination of ideas and materials needs also to go to the local building official level. Some of the bigger challenges in doing innovative designs has been less at the state level and more at the local building department level because they are unfamiliar with nursing home residents and operations. We need to educate the local building code officials.

State Regulation Issues:

1) State nursing facility environmental regulations favor the "traditional" nursing home. As a result, architects are guided to the traditional designs, e.g. large, isolating and centralized nurses' stations. Additional costs and construction are incurred when the certifying agency requires features that are not relevant. These can include a) privacy curtains in private rooms, b) shower curtains in a private room's "European" bath room, c) dirty utility closets when the laundry room is only a few feet away, d) bathroom doors in private rooms of dementia residents, e) full nurse's stations in small households when an armoire or built-in is all that is

needed, and f) isolated medication rooms when adequate medication storage is in the resident's room or integrated into kitchen cabinets, etc. In addition, the state environmental regulations often do not consider the special needs of dementia units; we still see new SCU designs that are no more than warehouses.

2) Added costs are one of the perceived barriers to culture change. The more we can eliminate costs the quicker culture change will be accepted. The following add cost but little or no benefit to the resident or there are cheaper alternatives for small households:

a) Requiring full spa rooms with commercial whirlpool tubs in each small household when there is a private shower in each resident's room.

b) Regulations that require isolation of the kitchen do not contribute to culture change. Isolated kitchens remove the social gathering place that many resident are accustomed to, inhibit the smell of cooking food which can stimulate appetite (sorry crock pots and food warmers are not the same), and restrict the resident's the ability to participate in meal preparation activities that have been an integral part of their life.

c) Requiring centralized and prep kitchens is a redundancy that also limits culture change for the reasons stated in #b above.

d) Fire safe areas in small, independent households. This adds a fire wall that provides minimal protection. When evacuating you try to keep at least two fire walls between the residents and the fire. In a small household, a single fire wall would not suffice; evacuation would need to be to a companion building. This is a feature that requires evaluation to ensure the safety of residents.

e) Requiring three compartment sinks in the household kitchen for washing pots and pans. In the household, pots and pans are smaller and dishwashers can handle them, just like a normal home.

f) Commercial hoods on household stoves. (We have no objection to these hoods but alternatives are worth evaluation, e.g. sprinkler curtains.)

g) Locks on all cabinets, doors, and ovens. Locks give the message "you do not belong" and "you are helpless." Only those cabinets and doors that need locks should have them, e.g. medicine cabinets or rooms that contain potentially harmful equipment.

h) Gates or other isolators to kitchens. We have observed numerous small households that do not isolate residents from kitchens and have no adverse circumstances. Gates may be the result of over analysis.

i) Requiring quiet rooms when residents have their own private room to go to.

3) Significant additional costs are incurred when a facility is built with culture change in mind

(e.g. a Green House) but the State must apply "hospital" like standards at the certification survey. We have seen this happen several times and seen the additional construction costs that are incurred and the lost income due to delayed certification and opening. In addition the culture change intent of the facility was diluted by application of out-of-date "hospital like" standards.

4) Failure to take into account modern materials when evaluating design can also limit culture change. For instance regulators required squeegees in private bathrooms to wipe down floors that had a non-slip surface when a towel would have sufficed. Do you keep a squeegee in your bathroom? (When Ted spent ten days in the hospital, he showered in a "European" bathroom with a non-slip floor. There was no problem with slippage when the floor was wet. There was no squeegee.)

5) Requiring noisy nurse call systems and individual room lights for small households. Again, there is the hospital atmosphere that can be eliminated by a pager system and the small household.

6) Promotion of personal alarms. The literature supports the limited utility of personal alarms, indicates that they are effectively a form of restraint, and documents that their effectiveness as a fall prevention device is limited to only a few cognitively aware residents.

7) States' failure to publish and update interpretive guidelines. Kansas has not updated their guidelines since 2003. Missouri does not make any guidelines available on the web. Without guidelines, there cannot be consistent interpretation of the regulations. Providers are left to interpret the regulations without the documentation to base their interpretation on. Note that we do not consider guidelines to be set in concrete. A guideline can be changed (weekly, if necessary).

8) Limited use of the web to communicate guidelines, regulations, and other pertinent information. This includes State ratings. Kansas does a fairly good job. Missouri is behind but coming up. Texas is has a very good survey data communication system. Some other States do not even have their regulations on the web.

9) Some survey agencies use a rote method of surveying which tends to interpret regulations without consideration of the residents. This lack of such consideration can inhibit culture change.

10) The SOM emphasizes process and quality assurance. From Ted's experience, using ISO certifications is an effective supplement to regulatory surveys (see #9 above). ISO surveyors implement internationally accepted standards of evaluating quality and processes. Adaptation of ISO certifications is a potential cost savings to governments and providers and promotes culture change through quality improvement and commonly accepted standards. In addition, scarce surveyor resources could be applied more efficiently.

11) Providers are dissuaded away from culture change when surveyors severely ding facilities

that are implementing culture change or have been given (State sponsored) awards for implementing culture change. This leaves the impression of a mixed message. This is probably a communication problem that is exacerbated by the rote survey instead of an outcome and QA based survey.

12) In the best of all possible worlds, States would have a joint commission of regulators and providers that review cumulative survey data, identify lessons learned, and publish and educate those lessons learned. Lessons learned would include better practices, provide QA and, when necessary, revision of guidelines or regulations.

In a word, outdated environmental regulations, lack of up-to-date guidelines, inconsistent interpretation of regulations among surveyors, literal interpretation of regulations without regard to the resident's actual needs, and lack of process and QA inspection standards are significant barriers to culture change.

Life Safety Code

Life Safety Code Miscellaneous Issues

It should be made clear that in small-scale operations, separation of clean and soiled areas is not required.

The risks surrounding security against intrusion or residents leaving unescorted are equally as legitimate as those for fire safety. It is unreasonable to believe that delayed egress hardware is the only safe method to secure a path of egress. Alternative methodologies such as Minnesota's Special Emergency Egress Control should be allowed.

The requirement for subdivision of small-scale household environments into two separate smoke compartments should be evaluated as to its efficacy and impact on the living environment for residents.

Examine the size of the facility in relation to the size of smoke compartment with safe means of egress (some people want to get rid of smoke compartments and some designs do not lead to using them).

Sliding/pocket doors must be explicitly allowed within all occupancy types within rooms serving low occupancy spaces.

It must be made clear that resident rights to use their own furniture should not be limited within fire sprinklered buildings.

Yard spaces should be allowed to be independently secured with provisions for emergency egress in case of fire.

I appeal to all of you who have a say in this that the NFPA current edition would get adopted by CMS quicker, in less than another decade because I think our elders deserve to see these changes that can create true home that looks, feels, and is home for them. So if the timeline that you outline holds true which is changes maybe get made in 2012 is it like another eight years before they get adopted? I was kind of dismayed by though the timeline that I heard in that discussion, CMS in 2008 is using the 2000 version even though the 2006 exists.

Recommend the NFPA look at senior issues when they start revising their codes and maybe it could be done under emergency conditions so that it gets raised sooner than 2009.

There are some small regulatory issues around corridors, open space and fireplaces [in small house configurations] which we need to resolve so we don't allow an over emphasis on traditional safety measures and to avoid what we've learned and with the effectiveness of sprinklers.

Corridors

Allow seating and resting areas in corridors.

Reduction in the corridor width; What should width be? Find a calculation for nursing home occupancy (no longer pushing beds); Formula based vs. prescriptive based. Need to recognize operational issues of the facility. Eliminate the requirement for eight foot corridors in nursing homes perhaps considering six feet instead.

Protrusions within corridors greater than 3 ½" or 4" should be allowed within defined circumstances. Explicit allowance should be made for protrusions that are unlimited in dimension, provided the required exit width is not reduced in excess of a specified (4") distance.

CMS should make it clear that alternative and dignified means of access to administrative services are allowable without requirements for wide halls and doors.

Sprinkler Trade Off

The first step toward ensuring that a facility can provide a more homelike feel is to insist that all facilities be fully sprinklered. Doing so ensures resident safety for a multiple dwelling and will allow for the trade-offs necessary to move toward residential models.

1. Engage an expert group to identify requirements that can be modified or eliminated due to sprinkler installations.
2. Require retrofitting of existing buildings with sprinklers throughout by 2010.
3. Identify potential incentives or funding sources for installing sprinkler systems in existing buildings.

Who: Stakeholder committee: NFPA, CMS, Pioneers, provider groups, installers and residents.

Life Safety Code Changes

Establish workgroup to include major stakeholders to:
Review existing LSC for areas of improvement:

- Needed changes
- Use of same code for hospital and nursing home
- Conflicts without applicable codes.

Organize recommendations and submit proposed changes to NFPA in 2010.
Coordinate a resource of code information for innovators.

Separate Life Safety and Building Codes must be developed to provide appropriate but less stringent requirements than those currently allowed for small-scale environments.

Encourage Use of Current Edition of Life Safety Code

1. Incentivize use of current edition of NFPA 101 Life Safety Code at all levels of enforcement.
2. Create advocacy groups to educate state regulators and lobby for consistency.
3. Encourage CMS to lead this effort at the federal level by providing funding incentives.

4. Educate states about resources available to them (training, etc.).

Who: CMS, architects, provider groups, code administrators and enforcers, insurers, etc.
When: by 2010

Create a PN LSC sub-committee (8-10 people)

1. Identify/target desired changes.
2. Sort by codes and standards for each change. (1. and 2. 6 months)
3. Develop code change language
4. Develop substantiation for each change (3.and 4. 6 months)

4.a. Gain major regulatory agency concurrence. (2 months)

5. Target code/standard entry point (individuals)
6. Meet with (5) entry point persons. (5. and 6. 3 months)

7. Modify 3 and 4 as needed. (1 month)

8. Submit proposals (strategy for who submits) (1 month)
9. Encourage adoption of changed codes

* Includes determination of need for separate chapters/Large and Small, depending on size, operation, population types, etc.

To be on committee: AHCA, AAHSA, CMS, State Regulators, Resident Representatives, architects, MEP engineer (appropriate to issue).

Build coalitions with organizations who share a common vision and purpose for improving environments for living and care, for example the American Association of Homes and Services for the Aging (AAAHSA), American Health Care Association (AHCA), American Society on Aging (ASA), the Gerontological Society of America (GSA), and the Alzheimer's Association. There is strength in numbers.

Performance-Based Alternative Action Plan

1. Form CMS/PN group to create a national model for state performance based review committee (month 0 to month 3).
2. CMS/PN workgroup to:

Research models (month 0 – month 3)
Discuss approaches (month 3-month 6)
Create model (month 7-month 15)

- State Level Performance Review Committee: State agencies, authority having jurisdiction, providers, consumers, experts.
- Explore non-physical plant performance standards (e.g. staff role).
- Examine areas for performance standards, including corridor width.

3. Create communication plan and advocacy campaign – include: partners, events, media, education (month 1-month 15).
4. Create incentives and pilot for state adopters (month 10-month 15).
5. Form technical assistance committee in PN to support state adopters (month 12-18).
6. Pilot initiatives in 3 receptive states (month 15-month 36).

Performance Based Design
CMS recommend to NFPA to utilize PERFORMANCE BASE DESIGN category as the vehicle and process frame to allow innovations of new home models to be in compliance with existing regulations.

a. Driving principle should be: "sprinkler system eliminates requirements that restrict fireplace placement, egress protrusions and furnishings, delayed egress control, kitchen equipment and design, and existing through intervening space, etc. 12 months
b. NFPA then take it through process and bring back.

New Kitchen Designs

1. Examine requirements in the Life Safety Code that already protect kitchen safety and would eliminate the requirement of a type one commercial hood over a stove.
   a. Form an action group of stakeholders to produce analysis as base for code navigation. 6 months
2. Stove/fire hood in sprinklered facilities:
   a. Create a less expensive and smaller product (residential in appearance) hood system that will effectively control grease laden vapors. These should be able to be used in any kitchen setting (existing or new plans).
   b. Providers should create an interface with a manufacturer(s) that can create a new product that meets safety requirements and new model objectives.

In the household model, CMS requires the compliance with NFPA '96 for nursing care. This hinders the aesthetic and noise volumes in the kitchen of the "house." Is there anything available or any way to get CMS/NFPA to approve a substitution for the Type I hood system? Even a smaller hood (stainless steel) is still too commercial. Can we utilize a Guardian Fire Suppression System with a residential hood system directly vented to the outside? NFPA 96 and 101 need to work with the CMS and designers to come up with something that is residential looking but provides the required life safety provisions.

Research and Funding

Research and Funding Recommendations

Develop Resources such as:

- Bibliography
- "Go to" person for students and journalists.
- Evidence-graded clearinghouse.
- Clarification of findings and outcomes for lay persons.
- Research 101 document/presentation
- Funding 101 document/presentation
- Listserv of experts for opinions and research compilations.
- Audience definitions – Who needs the info?
- Develop a web-based tool to incorporate these resources or links to resources.

Research Agenda – *What does long-term care want to know?*

- Business Case
- ROI – Return on Investment
- Stating Impact
- Quality of Life
- Capital Investments
- Funders
- Market studies and analysis
- Outcomes of business case could drive policy

Consumer-based – What do consumers want and how do we create an environment of getting that out to them?

- Case studies
- Provider implementation
- Informal research
- Tool studies for validity/reliability
- Survey the provider community to help define the agenda
- Policy and Process
- State analysis of survey process and surveyors
- Analyze processes and outcomes (e.g. retention rates by state)
- What states have enhanced support?
- What are the barriers?
- What process will help you move toward it?
- What happens in the absence of culture change?
- What are the quality of care/life implications in the *absence* of culture change?

Possible Action Steps

- Gathering input from other researchers not attending – pulling of research.

- Consolidating citations into one database – to see what topics are covered.
- Codify and categorize topics – identify expert review group.
- Resource for journalists.
- E-mail how to access information.
- Outreach for existing information.
- Communicate research agenda in everyday language that people can pick and use.
- Advocate for funding from the government to fund enable pilot studies and research through revolving loans and technical assistance – e.g. replicate "Coming Home" for culture change.
- Build coalitions and partnerships with other large organizations within their state and on the national level.
- Utilize technology and" the latest" such as audience voting over internet, blogs, etc.

Recommended Research Needed

Fund more research on the impact of the physical environment on both resident outcomes (clinical and satisfaction) and staff outcomes (burden, efficiency, and satisfaction).

Fund research to examine in greater depth the differences between traditional shared, enhanced shared rooms (accounting for differences in layout that affect privacy and control) and private rooms across the following variables/outcomes of interest.

a. Rate of nosocomial infections
b. Rate of hospitalizations
c. Rate of falls
d. Resident, family and staff satisfaction
e. Staff turnover
f. Census
g. Operational cost factors (differentials in staff time for care and cleaning/maintenance)

Use results of research, examining the life-cycle costs of constructing larger and/or more private rooms, to revise building codes and reimbursement formulas to support the least expensive life-cycle costs with acceptable outcomes (satisfaction and quality of life), not just the least expensive initial construction costs.

Research needs to be conducted to determine the actual life safety risks associated with cooking fires in small-scale operations. Alternatives to NFPA 96 standards for protection of cooking equipment must be allowed in the case of small-scale environments. It must be recognized that residential scale kitchens, fully protected by fire suppression systems provide adequate life safety without additional fire suppression measures. Similar alternative consideration must be made for small-scale operations including facility cafés and delis that serve limited menus for visitors, staff and residents.

Research needs to be conducted to determine the need for commercial food service requirements within small-scale operations.

ANSI/IESNA RP-28-2007 defines recommendations for light for vision for environments for seniors. Light for health is defined as the impact of natural light on the health of an individual. Increased research is needed to provide evidenced based guidelines for recommendations for light for health for older adults, equal to the recommendations for light for vision found in ANSI/IESNA RP-28-2007.18.

Design an effective system for making research and research findings relative to improving environments and safety for older adults easily accessible and available to architects, interior designers, builders, lighting designers and engineers, acoustical designers and engineers, product designers and other practitioners. Insure the latest research is in the hands of those responsible for designing better solutions.

Publicize research and information so architects can access when building.

Conduct research to determine the effects of a chair in the hall, do an actual evacuation, how long it would take for a staff member to move it, etc. Research also if the chair assists residents with mobility and enables them to be more independent because of access to sitting in a chair in the middle of a hallway.

Recommend research on the impact to a person of a roommate or multiple roommates dying.

Researchers need calls for research in culture change that support a wide variety of mechanisms meaning ability to apply for both large and small projects that not only look at proximal outcomes (such as resident quality of life) but also proximal outcomes that are shorter- term and more affordable in smaller research projects such as frequency of resident movements in a lighting study. We also need ethnographic and qualitative research that helps us understand culture change initiatives going on in the real world right now.

Recommend considering using a research methodology called Community Based Participatory Research whereby all people of the community are involved and have as much decision making power as the research team itself.

Research needs to be done on the topic of rural settings and culture change including how to overcome socio and economic barriers that are unique to small, low-income and sparsely populated areas. As with urban settings, rural areas have unique hurdles to overcome. We need to have research-based information to take to providers to really encourage culture change and show them why this is so important.

Evidence-based best practice research is needed to demonstrate the cost-effective impact of appropriate lighting on vision (acuity, contrast, glare, and color discrimination), photo-biologic health, and quality of life. Results must drive professional/clinical preparation and testing as well as regulatory oversight.

Evidence-based research is needed to demonstrate best education practice for instilling environmental/lighting competency and the environment of care culture in staff.

The long term care organization must be equipped with adequate resources (including lighting to support health and quality of life) to meet the needs of the population served. To that end, to the extent that regulatory mandates are utilized to achieve the desired positive outcomes, governmental reimbursement programs should recognize and fairly compensate for, added expenditures.

Research the time involved in passing medications in a main dining room versus in resident rooms. Research resident/family satisfaction and nurse/med aide satisfaction regarding passing medications in a main dining room versus in resident rooms. Study if medication pass conducted in the main dining room provides acceptable privacy for medical conversations.

Study if a cloth privacy curtain provides acceptable privacy for medical conversations.

Research case studies of what happens to a resident upon moving to an enhanced setting like a small house.

Gather information on any research being done on fireplaces, their use, and outcomes in sprinklered buildings (i.e. assisted living, etc.).

How many feet does research recommend using for hall width? Research/tabulate/survey nursing homes to see how often they evacuate using beds. How many in the last year/two years, etc.

Research validity for needing dishwashers to reach 180 degrees Fahrenheit. What does Food Code use for backing?

What is the research backing the NFPA's use of the fire suppression hood for all kitchens/where grease laden vapors are produced?

Research the effects of an automatic door opener on resident's initiation to go outside.

Conduct a study of how noise affects residents and how eliminating extraneous noise affects residents.

Research poor care outcomes' correlation to poor lighting. Create a study to show cost and benefit to increasing lighting.

Conduct a survey of the closet space given to residents and their satisfaction level.

Study the effect on residents to see their own personal effects around their home, not just in their rooms. Conduct a study that requires residents be involved in decorating their home and it's outcomes.

Federal and State Reimbursement Policy Issues

Need capital money.
Incentivize this work.
Financial support should not continue for old culture. Money should support new cultures & environments. They (financial folks) don't look at quality.
Incentivize conversion of double/multi bed rooms to private or community space.
Adequate reimbursement for new construction.

Identify Best Practices for CoN (Certificate of Need) and Reimbursement. Identify partners such as National Council of State Legislators, State Medicaid Directors, AHFSA, National Gov Assoc., and NCCNHR to do the following:

- Review existing information and identify gaps.
- Analyze existing info to identify best practices.
- Conduct research to fill gaps.
- Eliminate reimbursement regulations that are barriers to culture change.

Many states have a goal of reducing the number of nursing home beds in their state. Other states are losing beds due to enforcement or reimbursement action. Usually there's not a strategy for which beds to lose. Recommend that states use policies on reduction of beds and on CoN (Certificate of Need) for new construction, to drive private rooms and culture change.
Examples:
1) Create incentives for a nursing home to cut its beds in half by converting them to private rooms; 2) Create rules that require private rooms and culture change for any new nursing home construction; and 3) Allow a nursing home to convert its beds to a new construction that is for households and for private rooms.

There is an issue that prevents progress that is escaping recognition. In case mix states, independent Medicaid reviewers develop their own rules seemingly independent of regulations. They are often compensated based on the amount of funds recovered from nursing homes. Their demands for documentation are at times ridiculous and unreasonable and require caregivers to double and triple charting. I hope that CMS can collaborate with states to provide some logic and consistency to this issue. Outside Medicaid reviewers impact culture change by redirecting effort back to that which w e are trying to move away from.

New category of payment for new models—CMS.

Modify Medicaid/Medicare funding calculations to take into account cost savings accrued to the system from reduced infections and hospitalizations of individuals in private rooms.

Allow healthy partners to reside at the home without a Certificate of Need for a Medicaid bed and reduced rate.

It is time for CMS and state governments, through their reimbursement system, to stop

incentivizing illness, and start rewarding performance. "Pay for Performance" must become the norm, not the exception. Those providers who are willing to take the risks and sacrifices associated with true cultural transformation should be rewarded for those efforts. Pay for providers to convert un-private rooms to private rooms. To offset the costs related to this initiative, allow families of Medicaid recipients to pay the difference in cost between an un-private room and a private room, if they are so inclined. Pay for providers to develop advanced neighborhood models or to remodel into households, when the existing design allows for that transition, through a higher rate of return in the property component of state reimbursement systems. This higher rate should also apply to the new construction of authentic home.

Recommend allowing families to pay the difference between semi private and private room.

Private rooms will impact staffing and hours per resident day will need to be increased to accommodate.

Regarding recouping the cost of construction, finance agencies lag behind changes and developments and underwriting standards lag behind as well. They don't give benefit to changes that improve functionality and marketability of nursing facilities, assisted living, etc. and tend to look at them as a health facility not a living facility so that needs to be an area addressed also.

Miscellaneous

Learn from ICF/MR transition from institution to individualized focus/home/community living.
Generally speaking, the lack of specificity of federal or state regulatory language serves innovation well as it allows for innovative approaches such as the requirement for a nurses station to receive calls but not how, for example, leaving the door open for such technology as wireless call systems.
Reserve Federal standards to areas where it is clear states are unlikely to act, e.g. a private room standard or an enlarged room standard.
Develop new documentation systems so the focus can be on the care that is given, not documentation to maximize reimbursement. Set up wireless Electronic Heath Records.
Develop an approach to nursing home self-assessment of the physical environment. Such as the SAGE POE.
Within care environments where residents are assisted with transfers, research should determine the optimal range, as opposed to extreme range, of use to determine the required size and location of grab bars. Extension of side grab bars from the back wall should be reduced to allow shorter, fold down bars and rear wall grab bar requirements should be eliminated.
Consider expressing maximum distances that residents should need to traverse from X to Y such as from resident bedroom to dining room.
Suggest the use of Automatic Emergency Defibrillator for cardiac arrest be adopted.
Recommend educating HUD insurers, and lenders. Health care is a special field they don't understand. Most are trained in apartment inspection not nursing homes.
Examine the possibility of new regulation/code/reimbursement to fit new and emerging culture change residential models.
Facilities need to make resident-centered care principles a core value, include this in training for all staff, and incorporate them into job descriptions and evaluation tools. Similarly, direct care workers should be given more training and support for implementing resident-centered care principles.
Celebrating individual diversity and encouraging this diversity is a critical part of any regulations that CMS may develop. We can no more prescribe a household configuration as equally appropriate for any ethnic, religious or lifestyle group than we can legislate any home or apartment design. The definition of 'home' is different to each of us and is informed by our ethnicity, our beliefs, our lifestyle and our socio-economic situation. To regulate away

creativity and sensitivity to these issues is no more or less than to embrace a revised, but modernized, set of existing regulations which stereotype those individuals who live in long term care settings.
Recommend state regulators attend such a symposium.
In order to truly bring about a cultural change, we have to include residents and their families at all levels of care. Recommend including residents and families on advisory committees, architectural/design committees, on a lighting committee, in education committees, in advisory committees.
Residents and staff need to get together and talk about what it is we need to do at whatever facility they are at and then try to improve it. You can't improve it if you don't talk about it.
Need inclusion of the regional and local ombudsmen in the discussion of resident needs – they have an overall vision and practical application experience of best practices that may be successful; they also have the voice of residents that are unable or unwilling to be put "on record" for fear of reprisal if they speak up about new ideas.
Recommend use of the Low Cost Practical Strategies by Rosalie Kane and Lois Cutler (available on the Pioneer Network website).
When creating an environment, consider the residents' experiences and what they bring to the table such as urban dwellers growing up in a different environment than rural, suburban, etc.
Recognize that the population is not only the elderly resident.
The culture change community has made wonderful changes in their physical environments that have also produced very positive impacts and outcomes with the workforce. And I'd like to see those interventions and those innovations added into the discussion as the dialog continues.
Recommend that culture change, including the environment, expands to and is inclusive of short stay residents and extends beyond the nursing home into the community.
We talked about building homes but I think first we need to recognize we're building a house to be a home. You can put the walls up but until you put it in your heart, until you walk in and give you're cell number as an administrator to your residents, until you're willing to be a resident for some period of time and see what an immobilizer does to your knee in about four hours.
Recommend eliminating even institutional clothing such as scrubs as a very important part of environmental growth in the culture change process.
Recommend we listen and find out from staff what's important to them regarding the clothing they wear.

Recommend the same quantum energy on what we do in the states with the people who are struggling, the poor performers to even comply with the old model and we'd be really happy if they could get to the old model.
Because there is a major correlation as to how CNAs score the quality of their work life and how residents score their quality of their life, if we are not taking care of our CNAs everything here is for naught.
Recommend that we no longer minimize people to beds by saying "I work in a 120 bed facility" and instead refer to the people that live in our nursing homes.
Suggest there be another national symposium and it be called "Completing the Home." Maintaining our relationship to the outdoor environment the "room" that all too often gets ignored in the nursing home is the outdoors. Patios, gardens, walking paths, raised planters, fish ponds, bird watching and many other elements are <u>all</u> a part of everyone's lives – and missing from nursing homes. America's number one hobby is gardening and number two is bird watching. The holistic focus must be connecting the building to the patio, the garden, the yard and the community thus creating the house. We need to create universal access for elders to the real authentic natural environment.
Current systems and design solutions focus more on how to fit personal belongings into residents' rooms. However, more attention needs to be paid to how residents use and connect with those belongings. For instance, some residents told me that "I don't have any space for plants," although a deep windowsill was provided in their rooms. The problem is typically that they are not able to reach and water plants on the windowsill from wheelchairs because their bed would block access which can be easily fixed if we understand how residents live their life in their room every day.
Auditory privacy should be taken into account in order to create comfortable living environments. Even if one has a private room, various noises from outside the room seem to constantly irritate residents such as a resident who lives next room screams all night long. Rooms also need to be made sound proof.
There is a danger when rewriting existing standards/regulation that their history comes with them. The language of the recommendations or documentation that arises out of this is very important and I would encourage you as you move forward to strip language that directly or even perhaps unintentionally suggests old medical models and ways of doing things. Even by inference this type of language can do much to undermine what has been talked about today by miring us in the past instead of pointing us to the future.
We need to put together "mini conferences" around the country sponsored by CMS and Pioneer Network to present what we talked about today.
Support the fact that dental hygiene is a routine part of care.

To fully embrace culture change and to offer more homelike environments, we need to change more than just the Life Safety Code. We would need to consider building codes, health codes, AIA guidelines, and state licensure requirements to name a few.

Residents should be consulted about environmental preferences. Discussions in resident and family council meetings would help administrators and other staff to identify the best environmental plans for that facility.

We're all convinced but how do we get from the current concrete situation into a new era? Management guru Peter Senge says that, "Systems deliver what they are perfectly designed to deliver." And if you don't like the outcome of what you have today you can't simply go back in and simply change symptoms you've got to rethink your system. Our current nursing home delivery system is based on a model driven by capital, by episodes of illness and an extension of a hospital. And there are thousands of these places built today like that. So, a lot of people in this audience today would say close them down. Easy to say. Hard to do. Needs still need to be met. So, as we move to a system that is consumer driven and quality of life driven therein lies the next ten years of major capital changes that have to occur. That means we need to move from a compliance philosophy with regulation to a quality improvement philosophy of management and regulation. We need to begin to define quality of life. Environment communicates what we expect out of people doesn't it, it is a truism. So if you expect sickness, you get sickness and we train staff to deal with people when they get sick. As opposed to what Pioneer Network, Eden Alternative, Wellspring, the Green Houses, how do we change the whole paradigm? Changes need to be made in capital, treating staff as culture change partners as well as partners in care, and patience with the regulatory side of it. Government, providers, consumers, researchers and supportive people like architects are going to have to work better and differently together than we ever have.

To ensure environmental competency, clinical and administrative disciplines must receive formative and continuing education and be held accountable for conceptual learning through proficiency testing and implementation in the practice setting:
Education curricula must include a conceptual awareness and appreciation for the impact of environmental light on vision and quality of life and its photo-biologic benefit for older adults.
The development of clinical skills must incorporate the importance of conducting a comprehensive, individualized assessment of each person served to identify vision needs that are impacted by the presence and absence of adequate light.
The interdisciplinary plan of care must address all environmental factors, including the impact of lighting on vision, that affect the delivery of individualized, person centered care. Lighting adaptations must be individualized and include, but are not limited to ensuring that:

- light is appropriate to meet the visual acuity needs of the individual served;
- lighting levels in bathrooms is sufficient to support independence;
- illumination is sufficient to reduce the risk of falls, especially for individuals with dementia;
- there is visual contrast in the environment to help individuals adapt to a reduced contrast sensitivity;

- there is a reduction of glare (dimmers, blinds, anti-glare screens, low gloss floor care, window filters, etc.);
- there is sufficient time for individuals to adapt to changes in lighting;
- vision health is addressed, including low vision rehabilitation, the diagnosis and treatment of underlying age related eye diseases, and barriers to vision care;
- adaptive eye wear (glasses, contact lenses, visors) is available, accessible, labeled with name, and in good condition;
- there is environmental adaptation for reduced color discrimination and color sensitivity;
- Supervisory and managerial staff must coach and mentor staff and monitor the environment of care to ensure appropriate/sufficient lighting is available *and* utilized and that vision care is embedded in the culture of care;
- Administrative staff makes lighting accommodations in the work areas of older workers who may also be experiencing visual problems. Remedies might include:
- Provide well-lit work surfaces and task lights;
- Remove fluorescent tubes;
- Use diffuse or coated lamps to reduce direct glare; reduce indirect glare by proper positioning of luminaries in relationship to the task or surface and low surface brightness of the luminaries.