



Home Is Where the Hearth Is: New Models for Nursing Homes

Introduction

This issue brief describes several nursing home models that feature significant changes to the traditional physical environment. In these models, the structural layout and amenities support the best in elder care, including maximizing opportunities for socializing, activities, and family involvement. They also support more consistent staffing so that residents and caregivers can form relationships.¹

While this issue brief highlights the Green House model as an example of positive change occurring in nursing home design, providers are also creating other types of small homes across the country by making both physical and operational changes to existing facilities.

The History of the Nursing Home

After its creation in 1964, Medicaid established a licensing system for nursing facilities and a reimbursement program for residents with limited resources. With an emphasis on delivering health care efficiently, the look and feel of most facilities mirrored that of hospitals — with nursing stations, double-loaded corridors, pre-plated meals served on trays, overhead paging, and medication carts. While that initial focus on health care and efficiency helped bring some structure to an unlicensed and unregulated environment, the trappings of the hospital structure created dreary models for nursing homes.

While there has been substantial change over the last 50 years in how and where health care is delivered, very little has changed about the physical environment of the vast majority of nursing homes in this country.

In addition to improving the quality of life and care for residents, providers that have established these alternative models report an added benefit: It makes good business sense. Those adopting change reported marked improvements in staff retention, competitive position, occupancy rate, and operational costs.²

Alternatives That Deliver

Licensed as skilled nursing facilities, the Green House and small home residences generally include the following features:

- A series of self-contained residences, similar to private homes in design, offering each of the 10 to 12 residents a private bedroom and bathroom
- A common space — referred to in the Green House model as the “hearth” — including a living area, an open kitchen, and a single dining table accommodating both residents and staff for recreation, meetings, and meals
- Specially trained certified nursing assistants who are empowered to work in self-managed teams to provide direct care
- A support team of licensed nurses, therapists, the medical director, and social services, activities, and dietary specialists working in partnership with the direct care staff

Unlike most culture change models, the Green House project is implemented all at one time, crafted to support both initial success and long term sustainability.

Although the Green House and small home models are geared to a small structure size, even large nursing homes are achieving some of the benefits of more homelike environments by grouping small numbers of residents together in a “household” within the larger facility. Each household includes a living room, dining room, and a kitchen serving a variety of food and meals upon request.

Proponents of the household model share a core set of principles:

- Cross-functioning staff working in teams who report to the household instead of up a departmental chain of command
- Resident-directed care, where the rhythm of each individual’s life is dictated by personal desires
- A sense of community shaped and designed by those living there

A Look at the Legal Controls

Local, state, and federal laws and regulations dictate the physical environment of a nursing facility. Nursing home culture change innovators report that regulations at each of these levels can hamper the physical changes necessary to create more homelike environments.

The legal structure of nursing homes begins at the federal level with regulations enforced by the Centers for Medicare and Medicaid Services (CMS).³ CMS has created a minimum set of health and safety standards, but states may pass and enforce regulations that are more restrictive.

In addition, CMS requires new and existing nursing facility structures to comply with the Life Safety Code, a standard established by the National Fire Protection Association. Important vehicles for creating change at the state level, waivers are granted by CMS to code provisions that would result in “unreasonable hardship” to the facility, as long as the residents’ health and safety would not be adversely affected.⁴

Finally, state government agencies oversee licensing for nursing facilities and contract with CMS to monitor those providing care to Medicare and Medi-Cal recipients.

California’s Procedure for Change

In California, applicants must secure approvals for both major renovations and new construction of nursing facilities from three different agencies:

- 1. The Office of Statewide Health Planning and Development (OSHPD)**, one of 12 departments within the California Health and Human Services Agency, is responsible for approving and overseeing all aspects of general acute care hospital, psychiatric hospital, skilled nursing home, and intermediate care facility construction in California.
- 2. The Department of Public Health Licensing and Certification Program (L&C)** licenses, regulates, inspects, and certifies health care facilities in the state. Responsible for ensuring that health care facilities comply with state laws and regulations, L&C works in tandem with CMS to confirm that facilities accepting Medicare and Medi-Cal payments meet federal requirements.⁵
- 3. California’s Office of the State Fire Marshal** proposes fire and panic safety requirements for skilled nursing facilities.

OSHPD preempts the local building department in enforcing building codes and also alerts L&C in writing once it begins working on a project.

Both agencies enforce provisions of the California Code of Regulations, but there are disconnects in the code provisions. Instituting new nursing home models in some states has required securing changes to the controlling regulations — and the amendment processes these two enforcement agencies follow are quite different.

OSHPD is able to alter Title 24, which concentrates on safety and construction, in approximately 18 months — allowing it to keep current with changes in the field, as evidenced by the recent code revisions creating a household model for skilled nursing facilities.⁶

Title 22 of the L&C Code, which focuses on services, staffing, and care, commonly takes more than a decade to change. While Title 22 has not been updated in years, staff members at L&C have made efforts to both understand and embrace culture change and new models, including the Green House. The code gives L&C the option of allowing flexibility, which specifically includes “alternate concepts, methods, procedures, techniques, equipment, personnel qualifications, or the conducting of pilot projects.”⁷

As noted, the Office of the State Fire Marshal also proposes fire and panic safety requirements, though it tends to be guided by OSHPD enforcement decisions. Local fire inspectors are also given a great deal of autonomy in their decisionmaking, which can be challenging for applicants.

Finally, California has an additional regulatory layer not found in other states: The Department of Public Health, Department of Environmental Health must approve the design and construction of the kitchen. While small home and Green House kitchens are designed to be residential, they fall under the regulations for retail food facilities.⁸

Supply, Demand — and Money Troubles

The majority of nursing homes in California are 30 to 40 years old, built according to the traditional institutional model. Many are in need of some level of renovation, while others are hopelessly outdated.

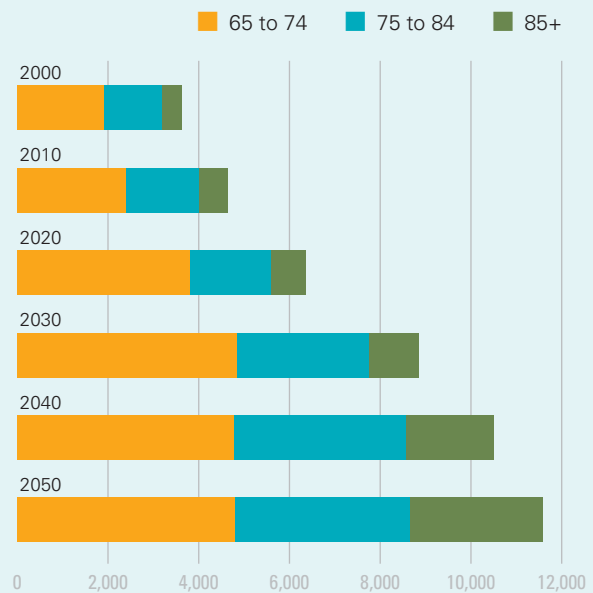
Many plans for renovation and building are hampered by the state’s high construction costs. California’s nursing homes also suffer from the current budget shortfalls, including:

- A recent 10% reduction in Medi-Cal payment rates for nursing homes
- A significant reduction in funding for home- and community-based services likely to increase the number of Medi-Cal recipients and add to the shortfall of Medi-Cal funding of \$3.34 per nursing home resident per day⁹

At the same time, demand for long term care services is slated to reach unprecedented levels in California in the coming decades as the state’s population ages.

California’s Aging Population, 2000–2050

PROJECTED* NUMBER OF RESIDENTS, BY AGE GROUP (IN THOUSANDS)



*Data for 2010 to 2050 are projections.

Chart Source: State Population Projections and Population Projections Program. Population Division: State of California, Department of Finance, Race/Ethnic Population with Age and Sex Detail, 2000–2050. Sacramento, CA, 2007.

Salient Features for Change

Common physical features in Green House, small home, and household models present both challenges and opportunities to providers during the regulatory approval process. Following are examples.

Kitchens

In states in which culture change models have been adopted or contemplated, the kitchen has been the primary source of many of the regulatory challenges. Most state licensing agencies view kitchens as potential fire hazards — in addition to raising operational issues of ensuring food safety, controlling infections, and protecting residents from harm.

In contrast to institutional nursing homes, small home kitchens resemble the kitchens in a residence. Elders who can see and smell food being prepared generally have better appetites and increased interest in this important aspect of living. And some residents are able to help staff prepare food, adding to their quality of life.¹⁰

Historically, nursing homes have been allowed to have “warming kitchens” with noncommercial appliances that allow for heating of prepared food and limited cooking. The fire marshal refers to this type of cooking as an “activity” and refers to the space as an “activity center” rather than a true kitchen.

The licensing challenges have been directed at facilities in which kitchens are used to prepare daily meals. Such fully functional kitchens are essential in the Green House model in particular, since all meals are prepared on-site.

A number of solutions have been shown to reduce risks in Green House kitchens — including installing induction cooktops that transfer heat from the element directly to a pot or pan and gas shut-off valves when appliances are not being used. In addition, safety devices can be placed on stovetops if staff members need to leave the kitchen while food is cooking. Retractable gates prevent entry

into the kitchen, and locked cabinets and drawers keep chemicals and sharp utensils out of reach.¹¹ To meet the evolving interpretation of current codes, Green House homes are built with fire shutters or similar devices to fully separate the open plan kitchen from the rest of the home. And all new homes include a commercial hood above the stove with full fire suppression systems.

The National Fire Protection Association recently approved amendments to regulations allowing kitchens to be open to other spaces and the corridor as long as they adhere to other specific guidelines:

- Serve no more than 30 residents
- Are within a smoke compartment and serve only residents in that compartment
- Have fully sprinkled smoke compartments
- Contain range hoods with a fire suppression system, grease clean-out capability, and a 500 CFM fan that vents to the exterior or recirculates
- Provide local smoke alarms that need not be tied into the fire alarm system¹²

Access to Corridors

The Green House model strives to remove institutional corridors. But this structural change can also raise the issue about bedrooms having direct access to exit corridors, as mandated by CMS regulations.¹³

The regulations were based on the traditional style of nursing home construction requiring passage from one room into another to reach the corridor. States have gotten around this concern in existing structures by defining a corridor as any passageway having a wall on one side.

In a Green House home, resident rooms open onto an eight-foot-wide corridor surrounding the hearth area — an open space much larger than what would normally be designed for a residential home.

The Hearth

Many states, including California, prohibit fireplaces that are open to resident rooms in the common areas. However, the National Fire Protection Association recently approved a regulatory amendment allowing gas or electric fireplaces to be used in smoke compartments that contain sleeping rooms, but not within individual sleeping rooms. Controls must be locked, and a sealed glass front provided to block outside objects from the flames.¹⁴ These modified fireplaces achieve the same effect as a hearth, a central feature of the Green House model.

Staff Space Needs

In traditional nursing homes with more than 60 beds, regulations often require bathrooms designated as female and male for the public and separate bathrooms for staff. While a unisex bathroom may be allowed by codes depending on staff size, separate facilities for staff members are necessary for infection control.

State regulations often call for defined office space for dietary and administrative staff to be located within the dietary service space. In the Green House model, staff members are housed outside of the home, so no such space is required within the home itself.

In traditional nursing homes, the nurses' station serves as the control center, but its physical structure can create a barrier that separates staff from residents. Green House homes and many small home models do not include nurses' stations. Staff members sit at the dining room table or in the living room while charting and interact with residents while monitoring their conditions.

Since there are no federal guidelines for nurses' stations, these requirements fall under state regulations. While many states do not require nurses' stations in nursing homes, some states require a specific desk for caregivers, and some require a room designated for file storage and private meetings with family members and residents.

Signs of Progress

In most states, nursing home culture change began with providers that were willing to seek waivers or amendments within the state regulatory structure to implement a more resident-centered physical environment.

In California, some recent regulatory changes have helped ease the way to establishing Green House, small home, and household models:

- OSHPD approved regulations aimed at creating household models within an existing facility or building new units in that format.¹⁵ These regulations encompass many of the culture change principles espoused by Green House and other small home developers.
- The California Department of Public Health Licensing and Certification held educational sessions for its senior management focused on the Green House model and the implications for operations.
- The Green House Replication Initiative targeted California as a key state for replication.
- The California State Senate Select Committee on Aging held hearings to clarify the barriers to creating Green House homes in the state.
- The Care Delivery and Design Improvement Committee, which provides a forum for clarifying California's regulations, created a subcommittee to examine the issues around changing the physical structure of nursing homes, make recommendations for changes, and provide technical guidance to providers seeking to make changes.
- An all-day conference, "Changing the Physical Environment of Nursing Homes: Addressing State Regulatory Hurdles," coordinated by Chi Partners and funded by the California HealthCare Foundation, brought together providers, regulators, and other interested parties to seek collaborative solutions for bringing about change in California.

Lessons Learned from Other States

Arkansas, Michigan, and Tennessee have successfully implemented Green House and other small home models. While each state took a different path, much can be learned from their challenges — and especially, their successes.

Common Themes

A number of similar factors emerged that were pivotal in instituting change in these states.

Advocates for change. The Green House model has struggled in states that lacked an advocate and flourished in states with a committed advocate at the director level within the state regulatory structure. Many of these advocates began their culture change journey with the Eden Alternative, a philosophy introduced in the early 1990s aiming to deinstitutionalize long term care.¹⁶

Seeing became believing. Once providers and regulators saw a Green House model in action, talked with staff, and interacted with residents, they grew to understand the process and appreciate the outcome. Regulators and providers from these three states visited Green House homes prior to making any changes.

Experience with the Eden Alternative. Just as regulatory advocates were committed to the Eden Alternative, providers and regulators who were active in the movement to deinstitutionalize long term care were also early proponents of the Green House model.

Flexible regulations. States with a dynamic regulatory process — one that is updated regularly to keep pace with changes in long term care — were in the strongest positions to adopt small home models and implement elements of resident-centered care.

Dedicated controls. States that created a small home section within the regulatory structure were well-positioned to encourage the growth of that model. Some providers were not comfortable using waivers due to the uncertainty of their longevity.

Motivated providers. States did not create change without the encouragement of committed providers. Advocacy efforts by industry trade associations, skilled nursing facility providers, and state culture change coalitions were also crucial to encouraging states to embrace change.

Small beginnings. In many states, incremental change preceded full implementation of models such as Green House. Operational changes originally promulgated by the Eden Alternative led to more substantial changes that opened the door to small home models.

Arkansas

- A committed individual within the Office of Long Term Care served as an advocate and facilitator.
- Rather than change existing regulations, the state simply added new sections to the regulatory structure that acknowledged Green House and small home models.
- There was ample support at the legislative level to create statutory change.
- Civil Money Penalty (CMP) funds were used to offset development costs to create new facilities.
- Enhanced Medicaid reimbursement provided incentives for providers to engage in culture change and new models such as Green House.

Michigan

- The director of the Bureau of Health Systems at the Michigan Department of Community Health took an Eden Alternative training and was also an advocate of the Green House model.
- Michigan was one of the key leaders in the nursing home culture change movement in the 1990s.
- There is a vibrant Eden Alternative movement in the state. Grants were available to providers pursuing quality of care and culture change through the Eden Alternative.
- A number of providers embraced the small home movement and were willing to make the transition.
- Implementing a Green House model did not require statutory changes, only regulatory changes.
- There was some level of involvement by the legislature in encouraging the model's adoption.

Tennessee

- Though not the driving force for change, there was an advocate within the state long term care hierarchy.
- The state was very involved in the Eden Alternative, forging strong partnerships within the industry associations. CMP funds had been used for nursing homes that sought education about the Eden Alternative.
- Waivers from the Board for Licensing Health Care Facilities were relatively easy to obtain, and board members were amenable to change.
- An early Green House review of the state building standards revealed only minor challenges around the kitchen and a few other areas.
- Implementing the Green House model required only regulatory changes, not statutory changes.

California Works in Progress

While most providers in California have been hesitant to take on the challenge of implementing these new models, two nursing home renovation projects are currently making their way through the state regulatory process: Mount San Antonio Gardens in Pomona and Mercy Retirement and Care Center in Oakland.

Mount San Antonio Gardens

Mount San Antonio Gardens is a continuing care retirement community owned and operated by Congregational Homes Inc., a nonprofit corporation.¹⁷ The Gardens, located on a 30-acre campus spanning the border of Pomona and Claremont, has been operating since 1961 and currently has more than 470 residents in independent living, assisted living, memory care, and skilled nursing.

The Gardens began working on a group of Green Houses in 2009. While the Green Houses were intended to fit into a residential neighborhood, there were significant challenges for the Gardens and its residential architect. OSHPD viewed this as a new model of care without corresponding code language, and the complicated project site spanned two local fire jurisdictions. Additionally, the project presented a new open kitchen concept, and there were significant communication difficulties between OSHPD and the sponsor.

One major issue was the distance of more than 780 feet between the proposed Green House homes and the existing nursing facility, raising a question of whether the new Green House homes would fall under the existing nursing home license. If a separate license was required, then the project would not be viable. Having a separate license with only 20 units (two houses) would not be possible given the staffing requirements for nursing facilities. Title 22 states that facilities acting under one license must be on the same grounds. While the Gardens would be on the same campus, that campus is divided in two by the city limits of Claremont and Pomona; the Green House homes would be in one city, while the

traditional facility would be in the other. L&C granted a waiver for this issue tailored to these circumstances.

While small homes and Green House homes are designed to be residential, their kitchens are classified under the regulations as “retail food facilities.” Health department codes require a “full partition separating the kitchen from living and sleeping areas with no doors or openings (windows).” In this scenario, food must be carried outside the building and then back into the dining area to be served. This rule was intended to stem the flood of homes in Los Angeles that were being converted into small eateries, but has no real relevance to skilled nursing facilities. Environmental Health granted a waiver to resolve this issue.

Some challenges have required an application for an alternative method of compliance, including:

- Reducing the size of the clean and soiled utility, which serves only 10 residents
- Arranging for the dietician to share a desk area in the nurses’ station rather than the kitchen due to space constraints
- One unisex staff locker and general dressing room for both dietetic staff and general employees
- Administrative and staff work areas in the main skilled nursing facility rather than in the Green House home
- Wheelchair storage limited to two wheelchairs
- Changing the linen storage and laundry services so that soiled linens are kept in each resident’s bathroom, and clean linens in each resident’s room

As the final kitchen drawings have not yet been approved, it is anticipated that there will be issues raised about the open kitchen. Code does not allow and OSHPD will not approve any type of heat-producing hearth, so the hearth will be an artificial fireplace.

Mercy Retirement and Care Center

The Mercy Retirement and Care Center, established in 1872 by the Sisters of Mercy in Oakland, offers assisted living, memory care, and skilled nursing.¹⁸ The Center includes 59 skilled nursing beds, two dining rooms, and a therapy room. Since 1997, Mercy has been a part of the Elder Care Alliance (ECA), a regional organization operating two skilled nursing and four assisted living facilities.

In contrast to the Gardens, which is building only two houses, Mercy hopes to completely replace their existing skilled nursing facility with six Green House homes built in a high-rise style in keeping with the neighborhood.

Mercy has taken a very conservative approach to its relationships with both OSHPD and L&C. It hired an architect experienced in working with health care facilities and brought together all regulatory participants for an early review of the project.

This project may not be challenged in the kitchen area as it will have a full commercial kitchen dietary service in the building in addition to the kitchens in each of the Green House homes.

Conclusion

Homelike alternatives to traditional nursing facilities — Green House, small home, and household models — have been shown to improve residents' quality of care and satisfaction, and offer the added boon of reducing providers' operational costs.

Recent regulatory changes, including a comprehensive new code section on household models as well as focused attention from local legislators, have created a more accepting environment in California for these alternative nursing home models. But many state providers are still leery about forging ahead with changes in these relatively untested waters.

The experiences of early adopters in other states — particularly Arkansas, Michigan, and Tennessee — offer blueprints for overcoming roadblocks and regulatory challenges to alternative models. Ready advocates within the system, especially those familiar with the Eden Alternative, which sets out culture change specifics, are key to motivating providers to embrace the changes.

California nursing facilities can also learn from two state pioneers: Mount San Antonio Gardens, which is constructing a Green House model, and Mercy Retirement and Care Center, which is planning construction.

The hope is that these alternative models will encourage the spread of culture change within the nursing home community, enhance the physical environment of nursing homes, and facilitate improved qualities of life and care for residents.

ABOUT THE FOUNDATION

The California HealthCare Foundation works as a catalyst to fulfill the promise of better health care for all Californians. We support ideas and innovations that improve quality, increase efficiency, and lower the costs of care. For more information, visit us online at www.chcf.org.

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Chi Partners is a health care consulting firm focused on innovation in long term care and service-enriched housing for seniors. It works with state units of government and the private sector on public policy, market research, and strategic and business planning. Visit them at www.chipartners.net.

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ENDNOTES

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