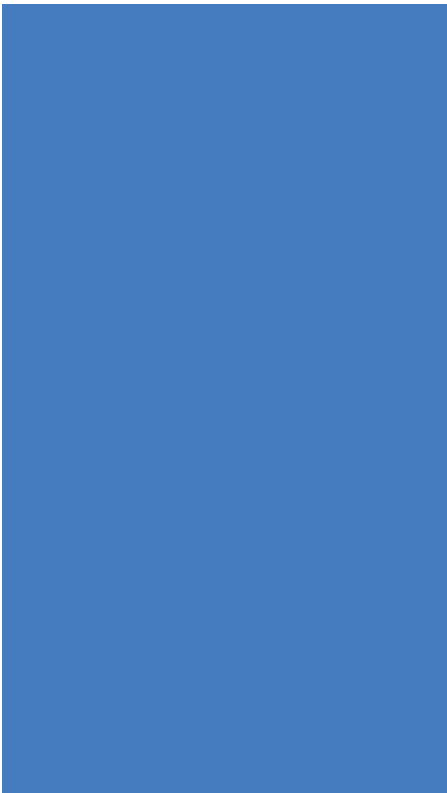


Changing the Physical Environment of Nursing Homes

Addressing State Regulatory Hurdles



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PREPARED BY

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Traditional nursing homes don't look much like a home.

They closely resemble the institutional hospital setting,

as indeed that was their model. However, a hospital

is not designed to be a home, but rather a place where

one stays temporarily in order to get acute medical care

for the short term. This has been the most common

model for nursing home construction since the 1950s.

“There is no theoretical underpinning for designing nursing

homes in this manner — no theory that dictates that this is

supportive of either good care or positive quality of life”

(Calkins, 2005).¹



INTRODUCTION

The purpose of this Issue Brief is to explore the regulatory issues and challenges inherent in the development of small home models like Green House^{® 2}. It is hoped that the development of alternative models will encourage the spread of culture change, enhance the physical environment of the nursing home, facilitate a higher quality of life and provide the setting for a higher quality of care in nursing homes. While many providers are desirous of environmental change, the regulatory environment and licensing process often provide a myriad of regulatory challenges. This brief will examine how those regulatory issues have been overcome in other states, explore changes that are in process in California and seek to bring “lessons learned” from other states to California.

The creation of a more home-like physical environment is one of the hallmarks of culture change in nursing homes, and facilities that have implemented culture change practices have shown an increased quality of care.³ While high quality care can certainly be provided in an older, more conventional style nursing

home, full implementation of resident-centered care practices often requires physical changes including private rooms with private bathrooms, and smaller self-contained residences that are designed like homes with working kitchens and consistent staffing. It is anticipated (and demonstrated in early research) that these homes may:

This brief will examine how those regulatory issues have been overcome in other states, explore changes that are in process in California and seek to bring “lessons learned” from other states to California.

- ▲ Provide a more meaningful experience for the residents with higher quality of life and social participation
- ▲ Allow residents to maximize their functional capacity because of the smaller scale of the environment and freedom from institutional routines
- ▲ Encourage family members to participate more actively, contributing to greater satisfaction for elders and families
- ▲ Provide consistent staffing that allows direct care staff to know the residents better, to have a greater sense of their ability to positively affect residents’ lives and to experience increased job satisfaction and productivity

THE PHILOSOPHY

It is important to examine the philosophy under which nursing home regulations are both promulgated and enforced and to understand the process by which those regulations are adapted to keep pace with the changing culture of long-term care. Discussions with regulatory staff in California at both the Office of Statewide Health Planning and Development (OSHPD) and California Department of Public Health Licensing and Certification (L&C) suggest that their foremost concern is safety and, while they acknowledge the residential nature of skilled nursing facilities, they also acknowledge that the model was originally conceptualized to be hospital-like. As such, they view nursing homes primarily as health care facilities first and residences second.

In 1964, when Medicaid was created, unlicensed, unregulated and unsupervised facilities for frail seniors were rampant and quality of care in these facilities was often questionable, if not blatantly poor. Medicaid created an entitlement program that licensed nursing facilities and provided a level of reimbursement for those with limited financial resource. The physical structure and the regulatory structure of the nursing home mirrored the hospital with nursing stations, double-loaded corridors, pre-plated meals served on trays, overhead paging, medication carts and a model that was designed for “efficient” delivery of health care services. That initial focus on health care and the quality of that care helped to bring some structure and quality to what had been an unlicensed and unregulated environment.

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. The trappings of the hospital and industrial efficiency — med carts, overhead paging, shared rooms and nursing stations — are still the standard for 95 percent of the nursing homes in the country.

Today, culture change proponents suggest that nursing homes should be first and foremost a residence and, within that residence, quality health care is delivered and quality of life is supported. Additionally, care practice over that time has changed dramatically. Long-term care does not have to be delivered in an institutional setting in order to be high quality and many frail, nursing home-eligible individuals are receiving high quality care in their own homes. Today, quality of life is now acknowledged to be as important as quality of care. In 1987, the Omnibus Budget Reconciliation Act (OBRA) codified in Federal law that residents in nursing facilities have the right to live in the least restrictive environment possible, that they have the right to control their care and that they have a say in the environment in which that care is delivered. Institutionalization was no longer the legal standard. Yet many of the vestiges of the institutional environment still exist in state nursing home regulations.

It is the intent of this document to examine the ways in which many providers and regulators throughout the country have implemented environmental modifications that allow nursing homes to create more residential environments, like Green House®, and how the regulatory agencies in those states have both responded to and facilitated changes. It is also hoped that this document will assist in bringing those “lessons learned” to California.

BACKGROUND

GREEN HOUSE®/Small House

Licensed as a skilled nursing facility, the Green House® small home model goes beyond “home-like” to what truly feels like “home” through fundamental changes to architecture, organizational structure and philosophy of care. Key aspects of the model are:

- ▲ Each facility is a series of self-contained residences, each designed like a private home while meeting institutional health care construction standards. Multiple Green House® homes on a campus are designed, like a residential subdivision, to make a community and provide economies of scale. With a maximum of 10 to 12 elders per home, each resident has a private bedroom and bathroom. The common space in the house, referred to as the “hearth,” includes a living area, a single dining table that accommodates all of the residents (and staff) for meals and an open kitchen.
- ▲ Green House® home implementations range in size from one home on a long-term care campus to a neighborhood of 16 homes. A 24-home high-rise project has been developed in an urban setting. Multiple homes on a single campus are licensed and certified as a single skilled nursing home provider.

The Green House® project is implemented all at one time, in a carefully crafted method designed to support initial success as well as long-term sustainability.

- ▲ Specially trained workers (with core training as certified nursing assistants) staff each residence as a self-managed work team providing personal care, activities, meal preparation and service, light housekeeping and laundry.
- ▲ Partnering with the direct care staff is a clinical support team of licensed nurses, therapists, medical director, as well as social services, activities and dietary specialists.

Unlike most culture change models, the Green House® project is implemented all at one time, in a carefully crafted method designed to support initial success as well as long-term sustainability. While this Issue Brief highlights Green House® as an example of the type of positive change happening in nursing homes across the country, providers are also making both physical and operational changes to existing facilities in order to make them more home-like and creating other types of small home models.

Household Model

There are a number of changes to national and state codes that acknowledge the movement from the nursing home as a large institutional environment to the creation of smaller households within the nursing home. A household is a place where a small group of residents live that is their home. It includes a kitchen (with a wide variety of food accessible to residents 24/7 including breakfast-to-order and upon request), a dining room and a living room. It encompasses renovations to an existing building, new construction of households within a building or single households in the form of cottages, houses and similar structures. Along with these physical components households are committed to:

- ▲ Cross-functioning staff, permanently assigned to a household (consistent assignment).
- ▲ Integrated organizational functions rather than oversight provided through separate departmental services. Staff reports to the household instead of up a departmental chain of command.
- ▲ True resident-directed care where the rhythm of each individual's life is dictated by his or her own desires.

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- ▲ A genuine sense of community where the flow of household life is intentionally shaped and designed by the life pursuits of those living in the household. All residents have opportunities to participate in the daily life of the household in the manner and to the extent they choose.
- ▲ Self-led work teams of staff that move along a continuum of empowerment and team autonomy.⁴

REGULATIONS

Federal, state, local, and life safety code regulations dictate the physical environment of a nursing home. Culture change innovators report that regulations at each of these levels can hamper their ability to make changes that would create a more home-like environment. Thus, many providers, who wish to pursue innovative ideas, become discouraged by requirements they believe to be unreasonable and/or by concerns that what they build could subsequently be found to be out of compliance.

Federal — Centers for Medicare & Medicaid Services

The nursing home regulatory structure begins with regulations promulgated at the Federal level and enforced by Centers for Medicare & Medicare Services (CMS).⁵ CMS is the component of the Federal government's Department of Health and Human Services that oversees the Medicare and Medicaid programs. A large portion of Medicare and Medicaid dollars is used each year to cover nursing home care and services for the elderly and disabled. State governments oversee the licensing of nursing homes and have a contract

with CMS to monitor those nursing homes that want to be eligible to provide care to Medicare and Medicaid beneficiaries. CMS has created a minimum set of health and safety standards, but states may pass and enforce regulations that are more restrictive.

While the majority of the nursing home regulations in Title 42 are focused on the delivery of services, CMS also requires nursing homes to conform to the 2000 edition of the Life Safety Code (LSC). The LSC is a set of fire protection requirements designed to provide a reasonable degree of safety from fire, smoke and panic. The LSC is a publication of the National Fire Protection Agency (NFPA). As waivers are an important vehicle to create change at the state level, it is important to acknowledge that CMS also has the right to grant waivers to the code: "After consideration of state survey agency findings, CMS may waive specific provisions of the NFPA Life Safety Code which, if rigidly applied, would result in unreasonable hardship upon the facility, but only if the wavier does not adversely affect the health and safety of the patients."⁶

Federal Support for Green House® and the Culture Change Movement

CMS has been exceptionally supportive of the culture change movement and the Green House® model in particular:

APRIL 2006: CMS released the Artifacts of Culture Change, a tool for providers to assess the readiness, implementation and sustainability of person-directed care. The Artifacts tool fills the purpose of collecting the major concrete changes homes made to care and workplace practices, policies and schedules, increased resident autonomy, and improved environment.

DECEMBER 2006: CMS sent a letter to all State Survey Agency Directors clarifying compliance with the long-term health and LSC requirements in nursing homes that are changing their cultures and adopting new practices.

FEBRUARY 2007: CMS responded to an inquiry by the Mississippi Senate and House delegations regarding the Green House® Project. Leslie Norwalk, Acting Administrator of CMS stated that CMS is supportive of the culture change movement and “believe[s] these innovations more fully implement the Nursing Home Reform provisions of the Omnibus Budget Reconciliation Act of 1987, from which our nursing home regulations are derived.” Additionally, CMS offered its contribution to the movement by stating, “It is our goal to have State agencies assist innovative providers in determining how changes they wish to make to improve the lives of their residents can be compliant with the Federal regulations that protect all residents.”

APRIL 2008: CMS cosponsored with Pioneer Network a national symposium, “Creating Home in the Nursing Home I: A National Symposium on Culture Change and the Environment Requirements” to promote discussion, dispel barriers and coordinate action that supports culture change in nursing home environments. The symposium and follow-up efforts discussed in detail at Creating Home Symposium were groundbreaking efforts to broaden and deepen discussion of the linkages between person-directed implementation and the regulatory environment.

JUNE 2009: CMS released revisions to eleven Interpretive Guidelines to redefine nursing home culture by revising guidelines that specifically related to person-centered care, needs and preferences. The revisions include both environmental and systemic nursing home components and require institutionalized nursing homes that have not yet adopted person-directed nursing practices to create the look and feel of a real home in which dignity and respect are presumed and are further promoted by striving to accommodate individual resident choices and needs.

MAY 2010: CMS partnered with the Pioneer Network to sponsor an online symposium entitled “Creating Home in the Nursing Home II: A National Symposium on Culture Change and the Food and Dining Requirements.” The symposium addressed dining initiatives that promote culture change in nursing homes and explored the potential and perceived regulatory barriers to making such transformations.

California Regulatory Structure

In order to understand how California differs from other states, it is important to understand the process that an applicant must go through to construct, renovate and license a skilled nursing facility. There are three key approvals needed for both major renovations to nursing homes to implement the household model, or create Green House® homes in California:

- 1) Office of Statewide Health Planning and Development (OSHPD),
- 2) California Department of Public Health Office of Licensing and Certification (L&C), and
- 3) California State Fire Marshall (fire and panic safety)

Office of Statewide Health Planning and Development

OSHPD is one of 13 departments within the California Health and Human Services Agency. OSHPD's Facilities Development Division (FDD) reviews and inspects health facility construction projects. FDD 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 under Title 24⁷ of the California Code of Regulations (CCR). This responsibility includes: establishing building standards which govern construction of these types of facilities; reviewing the plans and specifications for new construction, alteration, renovation or additions to health facilities; and, observing construction in progress to ensure compliance with the approved plans and specifications. FDD is also a regulatory agency authorized to develop building standards

adopted in the California Building Standards Code for hospitals and skilled nursing facilities, as well as correctional treatment centers and licensed clinics.

CCR Title 24 is reserved for state regulations that govern the design and construction of buildings, associated facilities [skilled nursing] and equipment. These regulations are also known as building standards. Cities and counties may adopt ordinances making more restrictive requirements than provided by CCR Title 24, because of local climatic, geological or topographical conditions. Additionally, cities and counties may adopt ordinances requiring fire suppression sprinkler systems and other fire protections that are more restrictive than the adoptions in CCR Title 24 by the Office of the State Fire Marshal.

California Department of Public Health — Licensing and Certification

Health care facilities in California are licensed, regulated, inspected, and/or certified by the California Department of Public Health Licensing and Certification Program (L&C) under CCR Title 22⁸ and the U.S. Department of Health and Human Services' CMS. These agencies have separate — yet sometimes overlapping — jurisdictions. L&C is responsible for ensuring health care facilities comply with state laws and regulations. In addition, L&C cooperates with CMS to ensure that facilities accepting Medicare and Medi-Cal (in California, Medicaid is referred to as Medi-Cal) payments meet Federal requirements.⁹ L&C also oversees the certification of nurse assistants, home health aides and the licensing of nursing home administrators.

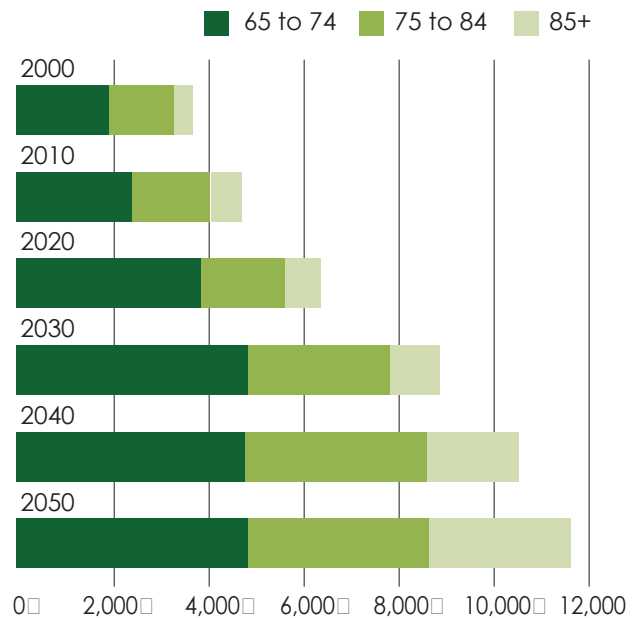
The California Nursing Home Landscape and Regulatory Progress

California has approximately 1,296 nursing facilities, the vast majority (1,244) in urban settings and the vast majority for profit (80 percent). Most homes are freestanding — only 160 are hospital-based nursing facilities.¹⁰ California’s nursing home supply and utilization rates are below the national average. The state has 123,920 nursing home beds — 32 for every 1,000 people age 65+. This is lower than the national average of 46 beds for this age group. For the 85+ population, the bed supply is equally low. California’s ratio of 241 beds per 1,000 age 85+ is the ninth lowest in the nation and 30 percent below the national average of 345.¹¹ California’s nursing home occupancy rate is equal to the national average (86 percent).

The majority of nursing homes in California are 30 to 40 years old, are built according to the traditional institutional model (hospital-like), many are in need of some level of renovation, while others are hopelessly outdated. Providers’ ability to make renovations to outdated facilities and/or make structural modifications to facilitate culture change is challenged by California’s higher than average construction costs and California’s budgetary challenges. This budgetary shortfall creates two challenges for California’s nursing homes: 1) the Governor has imposed a ten percent reduction in Medi-Cal payment rates for nursing homes and 2) there has been a significant reduction in funding for home and community-based services, which may increase the number of Medi-Cal recipients in nursing homes. With a Medi-Cal per diem shortfall of \$3.34 per resident per day¹² (before the current ten percent reduction), an increase in Medi-Cal residents accessing nursing homes will certainly contribute to a less robust financial

picture for nursing homes throughout the State. These low margins and unstable financial scenarios make nursing home owners more risk adverse and less willing to make environmental changes, particularly substantial changes like Green House®. While the financial picture is challenging, it may be exacerbated by demand for long-term care services in the coming decade, both institutional and home and community-based, which will reach unprecedented levels in California driven by the high growth rate of the 65+ population.

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.

Positive Changes in the California Environment

While most providers in California have been hesitant to take on the challenge of these new models, Mt. San Antonio Gardens (Gardens) in Pomona and Mercy Retirement and Care Center (Mercy) in Oakland are moving through the process of developing (Gardens) or evaluating (Mercy) how the Green House® model can be implemented given California's regulatory environment. The process of change in the vast majority of states has begun with a nursing home providers willing to seek waivers or changes within the state regulatory structure to implement a more person-centered physical environment.

While these two providers work through the regulatory issues, some changes have made that path easier to travel:

- ▲ OSHPD has approved regulations that pave the way for a more home-like model with regulations that define "households." These regulations provide a platform for future changes that further define the small home/household model.
- ▲ CA DPH Licensing and Certification held educational sessions for its senior leadership focused on the Green House® model and the implications for operations.
- ▲ The Green House® Replication Initiative has targeted California as a key state for replication.
- ▲ The California State Senate Select Committee on Aging held hearings to clarify the barriers to creation of Green House® homes in California.

Providers' ability to make renovations to outdated facilities and/or make structural modifications to facilitate culture change is challenged by ... higher than average construction costs and budgetary challenges.

- ▲ The Care Delivery and Design Improvement Committee (CDDIC)¹³ has created a subcommittee to examine the issues around changing the physical structure of nursing homes and will make recommendations for changes and provide technical guidance to providers as they seek 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 interested parties to examine "lessons learned" from other states and seek collaborative solutions for California.

OSHPD and L&C — Process and Approach

Creating a new nursing facility or making substantial renovations to an existing facility begins at the local planning department for the jurisdiction in which the facility will reside. Once the applicant gains some understanding of the local issues and requirements, they approach OSHPD. OSHPD enforces Title 24 of the CCR and that regulatory structure preempts the local building department for the enforcement of all building codes. It is important that the applicant's architect have familiarity working with OSHPD and designing skilled nursing facilities. The process can be complex as the construction of a health care facility can be very different from construction of other building types. While it is assumed that the applicant will be in contact with L&C early in the process, when OSHPD begins work on a project, it provides L&C with a letter alerting them to the project. At least at the Sacramento level, it appears that OSHPD and L&C have a good working relationship. Staff acknowledged challenges and disconnects between the regulatory structures of Title 22 and Title 24, but they work to eliminate or ameliorate these challenges on a project-by-project basis.

Both OSHPD and L&C are working under somewhat challenging staffing conditions. While the required furloughs for staff that were in place during California's budget crisis have been replaced by a defined number of personal leave days per year, this still reduces staff's ability to meet its workload. Additionally, there has been a 15 percent reduction in the work force for OSHPD, and a 25 percent vacancy in staff positions at L&C. During these challenging times, the amount of work has not lessened and both organizations have had to do "more with less." Additionally, many of the more experienced staff

While program flexibility can work well to institute change, program flexibility for one project does not guarantee that same program flexibility for another project.

have left both organizations, resulting in a reduction in the quality of the work that is being completed and longer timelines to complete that work.

OSHPD works under CCR Title 24 and L&C works under CCR Title 22. While both codes are part of the California Code of Regulations, the process for altering the two titles is quite different. OSHPD is able to alter Title 24 with a process that takes approximately 18 months, while alterations to the Title 22 of the L&C code may take over a decade.¹⁴ OSHPD's process for altering the code allows it to keep more up to date on changes in the field as demonstrated by the current code changes (revisions) that have created a "household model"¹⁵ for skilled nursing facilities that seeks to acknowledge the industry's move to a more residential model of care. L&C's process does not allow it to keep up with changes in health care practice, resulting in a set of regulations that are out of date, particularly in light of changes in the industry as a result of the culture change movement.

While Title 22 has not been updated in years, staff at L&C has made efforts to both understand and embrace culture change and new models like Green House®. Under Title 22, L&C does have the option to allow “program flexibility”: “All skilled nursing facilities shall maintain compliance with the licensing requirements. These requirements do not prohibit the use of alternate concepts, methods, procedures, techniques, equipment, personnel qualifications or the conducting of pilot projects, provided such exceptions are carried out with the provisions for safe and adequate care and with the prior written approval of the department. Such approval shall provide for the terms and conditions under which the exception is granted. A written request and substantiating evidence supporting the request shall be submitted by the applicant or licensee to the Department.”¹⁶ While program flexibility can work well to institute change, program flexibility for one project does not guarantee that same program flexibility for another project.

While Title 22 and Title 24 both govern skilled nursing facilities, the Titles are very different in their approach. Title 24 is all about construction and physical structure safety, while Title 22 focuses on services, the staffing of the facility and the provision of health care. There are very clear disconnects between the two Titles.

The Office of the State Fire Marshall has the responsibility for proposing the fire and panic safety requirements in Title 24 for skilled nursing facilities, though they tend to take guidance from

the decisions made by OSHPD through their enforcement actions. Much of the regulatory structure of the International Building Code (and Title 24) is based on the National Fire Protection Association 101 LSC. Additionally, there is a great deal of autonomy given to the local fire inspectors, which can pose challenges to applicants.

California has an additional layer of regulatory approval not found in other states, approval from the California Department of Public Health, Department of Environmental Health for the design and construction of the dietary component (kitchen).¹⁷ While small homes and Green House® are designed with the kitchen to be residential in nature, it has been determined that they fall under the regulations for retail food facilities (restaurants). Though it appears that this issue has been resolved in the case of Mt. San Antonio Gardens, it may present challenges to others in the future.¹⁸

In July of 2011, the California Building Standards Commission approved OSHPD’s changes to the Building Standards for Skilled Nursing and Intermediate Care Facilities that create a new category within Chapter 12 – Interior Environment called “1225.5.2 Household Model.” These Household Model regulations are meant to encompass many of the culture change principles espoused by Green House® and other small home developers. These draft regulations will take effect in 2012, but providers like the Gardens and Mercy may cite them as alternate design criteria now.

THE ISSUES

While some regulators have simply struggled with the philosophical nature of small homes (staffing model, role of clinical support team, service model, etc.), most have had specific issues with the following:

Kitchen

The residential scale and character of the [small home] kitchen resembles the kitchen that residents had in their own homes, thus making them feel at home. The kitchen is usually the most utilized room in one's home both to prepare meals and to eat and as a gathering place so an open residential looking kitchen is an important way to "create home" for residents. The food can be prepared in full view (and smell) of residents, staff and visitors resulting in an increased appetite and interest in this important aspect of everyday life. Some residents, depending on cognition and physical frailty level, may be able to participate in food preparation activities with the staff.¹⁹

In most of the states where Green House® (or small homes) has either been adopted or contemplated, the kitchen is at the heart of most of the regulatory challenges. In California and in most other states, those who license skilled nursing view the kitchen as the greatest threat to safety in the nursing home. It is the single place where "fire" is needed, tolerated and tightly controlled. Additionally, the kitchen brings up operational issues of food safety, infection control and the safety of residents around fire and heat.

Historically, nursing homes have been allowed to have "warming kitchens," outside of the commercial kitchen, with non-commercial appliances that allow the facility to heat pre-prepared food or for limited cooking. The cooking done in this type of warming kitchen is often referred to as an activity and the kitchen as an activity center rather than a true kitchen by the Fire Marshal. These warming kitchens are usually not licensed kitchens and, as such, the facility needs to also have a fully licensed commercial kitchen to prepare and serve daily meals.

The licensing challenges around the kitchen is directed at those facilities where the kitchen is used to prepare meals on a daily basis. Fully functional kitchens are crucial to the Green House® and small home models, as they are used to prepare all the meals for the house and are an important area for resident engagement and

activity. Based on the specific state regulatory environment, Green House[®] has crafted measures to lessen the risk including using induction cook tops (stove tops that do not get hot because heat is transferred from the element directly to the pot or pan) and gas shut-off valves when cooking appliances are not in use. Additionally stove guards can be available to be placed on the top of the stove if staff needs to leave the kitchen while food is cooking. Retractable gates can prevent entry into the kitchen if necessary, and locked cabinets and drawers keep chemicals and sharp utensils out of reach. These precautions are a means of preventing potential accidents and eliminating hazards while making it possible to live in a home instead of an institution.²⁰

To meet the evolving interpretation of current institutional life safety and related codes, Green House[®] homes are now built with fire shutters (or a similar device) to fully separate the open plan kitchen in case of an emergency. All new Green House[®] homes also include a commercial hood with full fire suppression systems above the stove.

Generally any time this full-service kitchen has an open cooking appliance, additional fire suppression systems (Type 1 commercial hood) and/or physical separation of this appliance from exits is needed. Currently a task force from the

Pioneer Network has received approval from NFPA for the following changes to the regulations for kitchens:

- ▲ Kitchens will be permitted to be open to other spaces and the corridor as long as they meet all of the following criteria:
 - May use either residential or commercial stoves or cooktops.
 - Kitchen cannot serve more than 30 residents.
 - Kitchen must be within a smoke compartment²¹ and must only serve residents in that smoke compartment. A building with multiple smoke compartments may have an open kitchen in each smoke compartment.
 - The smoke compartment where the kitchen is located, whether in a new or existing building, must be fully sprinkled.
 - A range hood must be provided with a fire suppression system, grease clean-out capability and a 500 cfm fan.
 - Hoods may be vented to the exterior or re-circulating, but does not need to meet full commercial hood requirements.
 - Local smoke alarms that are not tied into the fire alarm system may be provided in the area of the open kitchen.

Nurses' Stations, Staff Offices and Space Needs

As nursing homes were patterned after hospitals, nurses' stations in nursing facilities are similar to nurses' stations in hospitals. They are often located at the entry to the nursing facility and are the first thing that one sees as one walks through the door. The nurses' station simply reinforces the concept that this is an institution, not a home.

In most nursing homes, nurses' stations are the control center for the nursing facility. The physical structure of the station is often a barrier that separates staff from residents and, in some facilities, that station is so high that residents in wheelchairs cannot see over it. Requirements for nurses' stations fall under state regulations, as there is no Federal requirement. As such, some states require nurses' stations, while others do not. Select state regulations require that the nurses be able to see down each hall from the nurses' station even though nurses are not sitting at a nurses' station at all times — the majority of their time should be in caregiving.

Green House® homes and many small home models remove the nurses' station, allowing nurses to sit at the dining room table or in the living room while they do charting. This allows for interaction with residents and additional observation and monitoring of resident conditions. This also reduces the barrier between

residents and staff created by the imposing nurses' station. In the Green House® model, nurses travel between houses and are not embedded in each house, further reducing the need for a defined “station” for them.

Some states have struggled with the removal of the nurses' station and still require some semblance of a station, albeit often only a desk. Ohio has softened language in its state regulations that require a nurse area rather than a nurses' station. Several states where Green House® has been adopted require a “room” where nurses can safely store files and have private meetings with family and residents. As some state regulations also require defined space for dietary, administration, social work and others, this space may also serve that function.

In the traditional nursing home with 60+ beds and often over 100 staff, there are space needs that don't manifest themselves in small homes like Green House® homes. Plumbing regulations often require male and female bathrooms for the public and separate bathrooms for staff. While a unisex bathroom to accommodate staff may be allowed by codes depending on the number of staff, separate facilities accommodating staff are necessary for appropriate 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, these staff are housed outside of the home and so don't need space within the home itself.

Resident Rooms

“It’s the same deal over and over again of having old regulatory language and needing to decide how it relates to something new that was not thought of when it was written. For example, our Federal regulation that bedrooms must have direct access to an exit corridor was developed to eliminate the practice of having one bedroom located behind another, which is a fire safety issue that was encountered in old buildings that were turned into nursing homes long ago. Now the issue is resurfacing in Green Houses® that are built to look like homes and do not wish to have the institutional look of a corridor.”²²

There is another regulatory issue that has come up with the design of Green Houses® regarding the arrangement of bedrooms around the central living space and whether the bedrooms have direct access to an exit corridor as required by CMS regulation²³. Currently, CMS has no authority under current regulations to approve a variation to this requirement. This requirement grew out of the old-style nursing home where you often had to pass from one room and into another to reach the corridor. States have gotten around this issue by considering a corridor as only

having a wall on one side. In the Green House®, the resident rooms open onto an eight-foot-wide corridor which surrounds the open hearth area. This causes that open space (eight-foot corridor) to be much larger than what would normally be designed in a residential home, forcing this institutional feature even in the small home model.

The Hearth

Although the hearth, which includes a fireplace, is the heart of the Green House®, there are a number of states where the Fire Marshall and the regulatory authorities will not allow that hearth to produce heat. While there are a number of issues here, the fact that resident rooms open onto the hearth area seems to be at the heart of the issue, though there are states where the concept of having a fireplace in a nursing home is simply not code compliant. In many states, California included, there cannot be a fireplace in the common area open to resident rooms, yet there are a number of nursing homes in California with fireplaces.

Currently a task force from the Pioneer Network has received approval from NFPA for the following changes to the regulations for fireplaces:

- ▲ Allows 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 must be provided to prevent anyone from throwing objects into the flames.

STATE LEGISLATION

While many states have granted individual waivers (alternate means of compliance) that make the Green House®/small home model possible, other states wanting to create a more

permanent environment for the this model and encourage its spread, have passed legislation to amend statute or regulatory language. If Green House® and small home models are going to grow exponentially, this legislative strategy will be important.

Arkansas

In March 2007, Arkansas House Bills 1363 and 1364 were signed into law. They provide Arkansas' Office of Long-Term Care the ability to provide support, staffing flexibility and specialized reimbursements to organizations interested in creating a Green House® project or implementing an Eden Alternative program. House Bill 1363 amends Arkansas' Long-Term Care Trust Fund, an account funded by nursing home's civil monetary penalties, to allow the Director of the Office of Long-Term Care to use funds from the trust to create programs supporting Green House® projects or Eden Alternative Programs. Discussions with the Office of Long-Term Care indicate that planning grants for Green House® adopters are one such program. House Bill 1364 amends Arkansas' Code relating to nursing home staffing standards to allow the Office of Long-Term Care to create separate staffing standards and reimbursement categories for Green House® projects or Eden Alternative homes as determined necessary.

Oklahoma

In 2007, Governor Brad Henry signed House Bill 1510, which helped to bring the Green House® Project to Oklahoma. The legislation gave the Commissioner of Health the ability to waive certain provisions of the Oklahoma Nursing Home Care Act if necessary to restore "individuals to a self-contained residence in the community that is designed like a private home and houses no more than 10 individuals." While the Green House® Project does not typically need waivers to operate under state guidelines, the added flexibility is an excellent tool to have available.

Wyoming

In 2007, Wyoming adopted the Long-Term Care Choices Act (SF89). The Act covers several items relating to long-term care, including creating an "alternative elder care home" category (modeled on the Green House® Project principles) and a feasibility grant to fund the exploration of one Alternative Elder Care Home. The Elder Care Home must provide a "residential home environment" to Medicaid supported residents, including private bedrooms and baths, a den, an open kitchen (implied), an office for a nurse, open access to all areas of the house and a secured patio during waking hours, overhead lifts, a restraint-free environment, and self-managed work teams of direct care and nursing staff.

Massachusetts

In July 2006, Section 116 of Chapter 139 of the Acts of 2006 became law in Massachusetts, providing a Certificate of Need for 100 new skilled nursing beds to be developed using the Green House® model of care by Chelsea Jewish Nursing Home. This is the first approval for new nursing beds to be granted in the state in the past 10 years.

LESSONS LEARNED FROM THREE STATES

The following three states (Arkansas, Michigan and Tennessee) have all implemented Green House® and other small home models. Each has taken a different path to implementation, though there are common themes that can be drawn from all of the states:

1. *It is important to have a highly placed and committed advocate within the State regulatory structure.* Green House® has struggled in those states without a state advocate and flourished in states where there is an advocate at the “director” level. Many of these advocates have begun their culture change journey with the Eden Alternative.
2. *“You have to see it.” A common theme is that providers and regulators must see a Green House® in action, talk to staff and interact with residents to truly understand the process and appreciate the outcomes.* Regulators and providers from these three states all visited Green Houses® prior to making any changes.
3. *Those states (providers and regulators) that were committed to and active in the Eden Alternative were also early proponents of the Green House® model.*
4. *States with a dynamic regulatory process* – one that is updated regularly to keep pace with changes in long-term care – are much better positioned to adopt small home models and implement elements of person-centered care.
5. *States that carve out or create a “small home” section within the regulatory structure are better positioned to encourage the growth of small homes within their state.* The use of waivers and Alternative Means of Compliance (AMC) is a disincentive to some providers and creates a level of uncertainty around the longevity of the waiver.
6. *States don’t create change without the encouragement of committed providers.* Select members of the skilled nursing provider community and the state trade associations representing skilled nursing and state culture change coalitions are crucial to “pushing” states to make change.
7. *In many states, incremental change has been a successful path to full implementation of models like Green House®.* Once again, operational changes originally promulgated by the Eden Alternative have led to more substantial changes that have opened the door to small home models.



Key Lessons

- 👍 Arkansas had a committed individual within in the Office of Long-Term Care who served as an advocate and facilitator.
- 👍 Rather than change existing regulation, the state simply added new sections to the regulatory structure that acknowledged Green House® and small home models.
- 👍 There was enough support at the legislative level to create statutory change.
- 👍 Civil Monetary Penalty (CMP) funds were used to offset development costs to create new facilities.
- 👍 Enhanced Medicaid reimbursement incented providers to engage in culture change and new models like Green House®.

The Process

Arkansas' route to Green House® began with the establishment of affordable assisted living as a more person-centered alternative to skilled nursing care. The process to create a regulatory framework for AL helped regulators in the Arkansas Department of Human Services²⁴

to see the benefits of a more home-like, non-institutional model of care. Additionally, the same organization that worked on the state's assisted living program (Coming Home Program) and established its credibility through that work also worked with the State to establish Green House®. Both programs were funded through the Robert Wood Johnson Foundation.

Arkansas' skilled nursing regulations were written in 1984, are some of the most highly prescriptive in the country and had not been significantly altered since their inception. As written, they hindered any state or provider efforts at culture change, and their prescriptive nature precluded the creation of small home models like Green House®. Any attempt to completely rewrite these regulations would have encountered significant opposition from the industry.

As with other states that had successfully implemented the Green House® model, there was an advocate within the state hierarchy, Carol Shockley, the Director of the Office of Long-Term Care at the Department of Human Services. Ms. Shockley had been impressed with the Eden Alternative and taken the Eden training. She subsequently traveled with members of her staff to visit the first Green Houses® in Tupelo, MS. While desirous of creating an environment in Arkansas that would allow Green House® to flourish, she knew that a complete rewrite of the nursing home regulations to allow for Green House® would be challenging and, possibly, unsuccessful. To institute the Green House® model in Arkansas required both statutory and regulatory changes. The statutory change would allow facilities to use universal workers (Shahbaz/CNAs) and the regulatory change would create two new sections in the

current regulations (Section 700 – Green House[®] and Section 800 – HomeStyle) that allowed select providers to adopt this new model.

The new regulations for Green House[®] homes are brief and place the responsibility of vetting new projects with the Green House[®] staff.

Under “Designation,” Green House[®] staff must approve new projects and those projects must remain in good standing with the Green House[®] organization to continue to be in good standing with the state.

700 GREEN HOUSE[®] Facilities²⁵

701 Intent

Green House[®] facilities are an attempt to enhance residents’ quality of life through the use of a non-institutional facility model resulting in a residential-style physical plant and specific principles of staff interaction. The Green House[®] model utilizes small, freestanding, self-contained homes surrounding or adjacent to a central administration unit, each housing between ten (10) and twelve (12) private rooms, each with full bathrooms. The residents’ rooms are constructed around a central, communal, family-style open space that includes a hearth, dining area and residential-style kitchen. All residents’ room entrances are visible from the central communal area. Each home is built to blend architecturally

with neighboring homes. The intent of these regulations is to create a framework that encourages the construction and operation of Green House[®] facilities.

702 Designation

To be designated by the Office of Long-Term Care as a Green House[®] facility, the facility must meet the minimum standards, and have approval to use the Green House[®] service mark, issued by the Green House[®] Project and NCB Capital Impact at the time of designation and at all times thereafter.

703 Staffing

Facilities designated by the Office of Long-Term Care as Green House[®] facilities shall employ the same staffing ratios and otherwise comply with Section 520 of these regulations; provided, however, that CNAs utilized in Green House[®] facilities may act as universal workers. For purposes of this regulation, universal worker means a Certified Nurse Assistant (CNA) who, in addition to performing CNA duties, performs dietary, laundry, housekeeping and other services to meet the needs of residents.

While the Green House® regulations rely heavily on the Green House® Project for monitoring of compliance with the Green House® model, the HomeStyle regulations are very prescriptive. This model is described in regulation as a “pilot” and, as such, will be monitored for resident quality of care and quality of life improvement:

“Facilities participating in the project will be required to maintain detailed medical and social records of residents. The records will contain an initial assessment of the medical and social conditions, and needs of residents at the time of admission, which will form a baseline measure. The baseline will be compared by the Office of Long-Term Care or its designees with subsequent records maintained by the facility to determine the level of functioning, social interaction and medical conditions of residents to determine whether HomeStyle facilities result in improvements in those areas, including but not limited to the type and dosage amounts, and frequency of medications. Further, facilities will be required to maintain detailed financial records.”²⁶

In addition to Federal and state regulations regarding staff training, CNAs in the HomeStyle model must take an additional 80 hours of training focused on person-centered care and the HomeStyle model. This training was based on the training that the Green House® Project provides to the Shahbaz.

In order to encourage the spread of Green House® model, the Legislature passed Act 193, which amends Arkansas’ Long-Term Care Trust Fund, an account funded by nursing home’s Civil Monetary Penalties, to allow the Director of the Office of Long-Term Care to use funds from the

trust to create programs supporting Green House® projects or Eden Alternative Programs. These planning grants were limited to \$500,000 per project and could be used to offset the increased costs of building this new model. Additionally, the State worked with CMS to create a state plan amendment (subcategory of nursing home) allowing an enhanced Medicaid daily rate for nursing homes that implemented Green House® and HomeStyle models. The Legislature also passed Act 192 that allowed for a universal worker model for staffing of both Green House® and the HomeStyle.

THERE ARE THREE GREEN HOUSE® PROJECTS IN ARKANSAS AND A NUMBER OF HOMESTYLE MODELS:

Green House Cottages of Southern

Hills, owned by Summit Health Resources, a for-profit provider in Rison, is operating six 12-unit elder homes that replaced a 50-bed traditional institution.

Wentworth Place of Magnolia is also owned by Summit Health Resources and is operating four 12-unit homes.

Green House Homes at Legacy Village in Bentonville is owned by the local nonprofit Northwest Arkansas Senior Services, Inc., and is licensed as assisted living. They currently operate three 10-unit homes with an additional three homes in the planning stage.

It is important to note that Arkansas is one of the few states to implement a Green House[®] model under an assisted living licensure category. Arkansas' assisted living level two category allows residents to remain in assisted living despite frailty that might force them to move to skilled nursing in other states. The challenge with this model is the reduced reimbursement (less than SNF) provided by the assisted living waiver.

Arkansas has made every effort to ensure that the small home model will not be “anecdotal” or enacted based on an alternative means of compliance. The state believes in the model, and has created regulations and reimbursement to encourage its spread. They hope that those who don't actually transition to Green House[®] will aspire to take on the attributes of Green House[®] and provide a higher quality of life and quality of care to its residents.



Key Lessons

- 👍 Tennessee had an advocate within the state long-term care hierarchy, though that person was not the driving force for change.
- 👍 Tennessee was very involved in the Eden Alternative, and Eden had strong partnerships within the industry associations. CMP funds had been used for nursing homes that sought education about the Eden Alternative.
- 👍 The process for change (waivers from the Board for Licensing Health Care Facilities) was less onerous than in many states and the Board members were amenable to change.
- 👍 An early Green House[®] review of the state building standards surfaced only minor issues, though challenges, around the kitchen and a number of other areas arose during the approval process.
- 👍 Implementation of Green House[®] model did not require statutory changes, only regulatory changes.

The Process

While changes necessary for Green House® homes came easy in Tennessee, the groundwork for this was in process for some time. Providers in Tennessee have been involved with culture change since the early days of the Eden Alternative. The Tennessee Eden Alternative Coalition (culture change coalition) has strong partnerships with industry associations and the Department of Health. They were instrumental in passing a state law to provide annual Eden grants, using CMP funds, to homes to support their need for Eden education and other resources for their journey. The coalition has also established regional support groups for the Western, Central and Eastern sections of the state.

The Tennessee Health Services and Development Agency is responsible for regulating the health care industry in Tennessee through the Certificate of Need (CON) program. The CON program serves as a growth management and cost savings tool since it requires certain health providers to establish the need for new services and facilities before the providers will be allowed to build facilities, become licensed or conduct certain business.

It is interesting to note that the Tennessee CON application only requires very basic architectural drawings and does not comment on structural type.²⁷ Architectural plans are then submitted to the Plans Review Section of Health Care Facilities, which performs a similar function to OSHPD in California, and reviews and approves the plans. Approximately 30 to 45 days prior to

completion of the construction, applicants send a letter to the Bureau of Health Licensure and Regulation Regional Office to request a survey of the facility.

As in other states, the Tennessee Department of Health, Bureau of Health Licensure and Regulation and Division of Health Care Facilities struggled with a number of concepts around the Green House® model, including the open kitchen; the fireplace (hearth); a covered drop-off area and pedestrian entrance at grade level for inclement weather; separate dining areas for staff and residents; physical therapy equipment in each house; an administrative/public lobby area for reception and information; and administrative office(s) and multipurpose rooms. To resolve these issues, Green House® staff made presentations to the Board for Licensing Health Care Facilities and Board members were impressed with both the physical structure and the operating model. As a result, the Board adopted the following one-time waivers from existing state regulations:

- ▲ With the open kitchen area a focal point in the Green House® model as a means to stimulate the residents appetite through smell, and the location of a fireplace in the gathering area will add to the home atmosphere, the following code references, Standard Building Code Table 409.1.5 and NFPA 101 18.5.2.3(a), may be accomplished by providing one-hour rated, smoke-tight, separation from the building core at the resident room wall. Resident rooms shall have 20-minute rated doors and frames. Door closers are not required on resident room doors.²⁸

- ▲ Kitchen cooking appliance(s), if residential type, must have a UL 300A suppression system. All fuel sources (gas and/or electric) for the kitchen or fireplace shall be controlled through the fire alarm control panel using solenoid valves or shunt trip device, respectively. A carbon monoxide detector shall be located adjacent to gas fire appliances to detect possible gas leaks and also be tied into the fire alarm control panel.
- ▲ A vehicle drop-off and pedestrian entrance at grade level, sheltered from inclement weather and accessible to the disabled, shall not be required.
- ▲ Separate dining areas for staff and residents shall not be required.
- ▲ Equipment for carrying out each type of Physical Therapy that may be prescribed may be stored in a space at an adjoining nursing home and brought to the Green House® for resident therapy.
- ▲ An administrative/public lobby area for reception and information shall not be required. Access to telephones and public toilet(s) shall be provided in the facility.
- ▲ Administrative office(s) and multipurpose rooms may be located in an adjoining on-campus facility/building.

THERE ARE TWO GREEN HOUSE® PROJECTS IN TENNESSEE:

Ave Maria Home, a nonprofit health care provider in Bartlett, is under construction on four 10-unit homes to replace 35 traditional skilled beds on their existing campus.

Jefferson County Nursing Home in Dandridge has built three Green Houses® to bring their total nursing home bed count to 160.

ADDITIONALLY, THERE IS A SMALL HOME MODEL:

Uplands Retirement Village, a nonprofit health care provider in Pleasant Hill, has constructed four homes that serve 15–16 individuals each. While larger than the conventional Green House®, they have many of the same characteristics.



Key Lessons

- 👍 In the case of Michigan, the Director of the Bureau of Health Systems at the Michigan Department of Community Health was both an Eden Advocate (took the Eden training) and an advocate of the Green House® model.
- 👍 Michigan was one of the key leaders in the culture change movement in the 1990s.
- 👍 Michigan was a state with a vibrant Eden Alternative movement.
- 👍 Grants were made available to providers pursuing quality of care and culture change through the Eden Alternative.
- 👍 Michigan's provider community embraced the small home movement with a number of providers willing to make the transition.
- 👍 Implementation of Green House® did not require statutory changes, only regulatory changes.
- 👍 There was some level of involvement by the Michigan legislature in encouraging the model's adoption.

- 👍 As one of the first implementers of the Green House®/small home model in the country, regulators, providers and legislators encountered challenges for which there were no existing precedents. As such, they were not able to fall back on lessons from other states.

The Process

Michigan is an interesting example of the role of politics, innovation and enlightened partnerships between regulators and providers. Michigan was at the forefront of the culture change movement in the late 1990s with a vibrant culture change coalition and state agencies focused on both culture change and quality improvement in nursing homes. In 1998, the state provided \$10 million in grants to providers pursuing quality improvement and culture change through the Eden Alternative. Bringing the Eden Alternative to Michigan (BEAM) was formed in 2000 and the state soon became a frontrunner in the national culture change movement. Michigan providers embraced Green House® homes, LEAP and the household model and, to this day, Michigan has the most Eden Alternative registered homes and small house projects in the country. What made Michigan successful was the collaboration among advocates, regulators and providers and, once again, an advocate in a highly placed position in state government who championed the change.

To open a new nursing home in Michigan, the process begins with an application for Certificate of Need. The architectural plans must be reviewed and approved by Health Facilities Engineering Section of the Division of Health Facilities and Services. This Division has a role that is similar to OSHPD in California. Michigan uses the International Building Code²⁹ and NFPA 101 LSC. When the plans are approved, the

applicant must notify the Division of Nursing Home Monitoring for assignment of a Licensing Officer. At the conclusion of construction, the Bureau of Fire Services and the Health Facilities Engineering Section staff must inspect the facility. A recommendation for approval for occupancy will be made to the Licensing Officer after the construction project has been inspected and found to meet all requirements.

The process for opening the first Green House® in Michigan was challenging. While a careful review of the regulatory structure by the provider did not originally indicate any issues, the regulatory agencies struggled with many of the same issues that other states had identified: the open nature of the kitchen, proximity of the Green House® to the traditional facility, the nature of the new staffing model that incorporated much of the daily tasks to the Shahbazim, lifts in the ceiling and a host of other issues. Additionally, other than the original Tupelo Green House (Tupelo) site, the Village at Redford (Village) was one of the first Green House® projects in the country, and many of the regulatory questions around the physical environment had not been explored at either the state or national level. Much like Tupelo, the Village had to break new ground to open their Green House®. The Village took a very different route in seeking to meet the challenges of the regulatory process. They convened a meeting with key health care regulatory and licensing department heads and key members of the Michigan legislature in order to educate all concerned about the benefits of Green House® homes and to assess the regulatory challenges that lay ahead.

Some of the additional issues were:

- ▲ Requirement to have a commercial hood, rather than a residential hood, for the kitchen. Additionally, providers needed

a manual pull station in case of fire at least 10 feet from the kitchen in the direction of egress.

- ▲ The nursing office (not a station) must have windows that look out onto the living area and be in sight line for all the rooms.
- ▲ Because the Shahbaz spend a considerable amount of time in the kitchen, the kitchen needed to be designed so resident room doors are visible from the kitchen.
- ▲ Received waiver for a unisex toilet because they had fewer than 15 male/female staff.

THERE ARE FOUR GREEN HOUSE® PROJECTS IN MICHIGAN AND MANY SMALL HOME MODELS (NOT LISTED):

Pinecrest Medical Care Facility, a nonprofit health care provider in Powers, is operating two 10-unit homes. Pinecrest is owned by the counties of Delta, Dickinson and Menominee.

Porter Hills, a nonprofit provider with eight campuses in the Grand Rapids area, is operating two 10-unit homes.

The Village of Redford, a nonprofit provider in Redford, is operating two 10-unit homes on a large, multi-level campus.

The Resthaven Care Community, a nonprofit alliance of churches in Holland, operates one 10-unit home at one of its five housing and health care locations.

CALIFORNIA GREEN HOUSE® PROJECTS PENDING

Currently, there are two projects making their way through the regulatory process – Mt. San Antonio Gardens (Gardens) in Pomona and Mercy Retirement and Care Center (Mercy) in Oakland. The Gardens has been working on Green House® for about two years and has encountered considerable challenges. Given that they are first project in the state, that is to be expected. Mercy is examining the benefits of Green House®, studying the financial implications and working with the state to flesh out issues around implementation.

Mt. San Antonio Gardens

Mt. San Antonio Gardens is a nationally accredited continuing care retirement community owned and operated by Congregational Homes, Inc., a nonprofit corporation. The Gardens, located on a 30-acre campus in the towns of Pomona and Claremont, has been serving older adults since 1961, and currently has more than 470 residents in independent living, assisted living, memory care and skilled nursing. The nursing facility at the Gardens has a five-star rating from CMS and a “superior” rating from CalQualityCare.org.

The Gardens began working on Green House® in 2009 and, very quickly, discovered that there were a number of significant roadblocks to implementation. The Gardens chose a residential architect to design the Green House® buildings, which created issues for both OSHPD and the Gardens. While the Green House® is meant to be a residential structure that fits into a residential neighborhood, there were significant challenges for that architect and the Gardens as they came

to grips with the complex processes of OSHPD and the complex health care building type. Additionally, OSHPD viewed this as a new model of care without corresponding code language, with a complicated project site that spanned two local fire jurisdictions and two cities. Additionally, the project presented a new open kitchen concept and there were significant communication difficulties between OSHPD and the sponsor.

One of the major issues was the distance (780+ feet) between the proposed Green Houses® and the existing traditional nursing facility. This brought up issues of a second license and whether or not the new Green Houses® would be licensed under the existing nursing homes 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 operationally 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 line runs right down the middle of the campus and the Green Houses® would be in one city, while the traditional facility would be in the other. L&C did grant a waiver for this issue (program flexibility under Section 72213), which would not create a precedent for other projects. Using program flexibility would also allow L&C to deny other applicants if they weren’t in a similar campus type situation as the Gardens.

The next major issue was the involvement of Department of Environmental Health. California has an additional layer of regulatory approval not found in other states, requiring approval from the local health department, Los Angeles County Department of Environmental Health, for the design and construction of the kitchen. While small homes and Green House® are

designed to be residential in nature, it had been determined that they fall under the regulations for retail food facilities (restaurants). Under the California Food Code, licensed medical facilities must adhere to the Code though Residential Care Facilities for the Elderly (assisted living) have been excluded. Health department codes require a “full partition separating the kitchen from living and sleeping areas with no doors or openings (windows).” In this scenario, in order to serve the food, it has to be carried outside the building and then back into the dining area. This rule was implemented to stop the large numbers of homes in Los Angeles that were being turned into small eateries, but has no real relevance to nursing facilities. Every nursing facility in the country has doors (openings) that allow food to be transported from the kitchen into the dining area that is often adjacent to the living areas. A waiver has been granted from Environmental Health to resolve this issue.

The following are challenges that have required the application for an alternative method of compliance:

1. Reduce the size of the clean utility and the soiled utility, as these rooms only serve 10 elders.
2. Rather than having a desk for the dietician in the kitchen (the Green House® residential kitchen has no room for a desk), dietician will share a desk area in the nurses’ station.
3. Lockers will be provided in one unisex staff locker and general dressing room for both dietetic staff and general employees, as there are not separate dietary staff in the Green House®.

The Gardens began working on Green House® in 2009 and, very quickly, discovered that there were a number of significant roadblocks to implementation.

4. An employee dressing room with toilet, lavatory and lockers will be in one unisex room. As there are fewer than five employees, separate male and female staff toilet rooms are not required.
5. Administrative and staff work areas will be provided in the main SNF, rather than in the Green House®, as administrative staff are not located in the Green House®.
6. Wheelchair storage will be limited to house two wheelchairs only, as there are only 10 residents.
7. Combine the clean linen storage and laundry services as one unit. Combine the soiled linen storage and laundry services as one unit. Soiled linen will be kept in each resident’s bathroom in a hamper. Clean laundry will be taken directly back to resident’s room for storage.

As the final kitchen drawings have not been approved, it is anticipated that there will be some challenges about the nature of 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, CA, offers assisted living, memory care and skilled nursing. The Care Center includes 59 skilled nursing beds, two dining rooms and an in-house therapy room. Since 1997, Mercy has been a part of the Elder Care Alliance (ECA), a regional organization that operates two skilled nursing and four assisted living facilities. Mercy is a five-star rated facility with few deficiencies. It was rated by Newsweek magazine as one of the highest quality facilities in the country. Mercy has a five-star rating from CMS and a “superior” rating from CalQualityCare.org. Currently the payer mix at Mercy’s nursing facility is 70 percent private-pay, 27 percent Medicaid, and 3 percent Medicare. All of the rooms are semi-private, with the exception of three private rooms.

Mercy has plans to completely replace their skilled nursing facility with six 12-unit Green House® homes built in an urban high-rise style (four stories) that is in keeping with the Oakland Fruitvale neighborhood where Mercy is located. Mercy’s foray into Green House® has been exceptionally methodical. In contrast to the Gardens, which is only building two houses,

Mercy has plans to completely replace their skilled nursing facility with six 12-unit Green House® homes built in an urban high-rise style that is in keeping with the Oakland Fruitvale neighborhood where Mercy is located.

Mercy is replacing their entire facility and moving from a debt-free environment to a larger facility that will carry a substantial level of debt. As such, Mercy has been very focused on the financial viability of the proposed project.

Mercy has also taken a very conservative approach to the relationship with both OSHPD and L&C. They have hired an architect that has an exceptional history with health care facilities, and have brought together all of the necessary regulatory participants for an early review of the project in hopes of targeting any potential challenges in the schematic drawing stage and creating continuity throughout the design review process. Mercy may not be as challenged in the kitchen area, as they will have a full commercial kitchen dietary service in the building in addition to the kitchens in each of the Green Houses®.

The Mercy project (and the Gardens) is able to take advantage of a new set of regulations that was passed in 2011 but won't go into actual use until 2012: Title 24, Part 2, Volume 1, 1225.5.2 Household Model. These new regulations are designed for providers who wish to create a Household Model within an existing facility or build new units designed in a small home/household design. The new regulations make some important changes:

- ▲ Rooms may hold no more than two residents, and they must be visually separated from each other by a “full height wall or a permanently installed sliding or folding door or partition, and shall provide each patient with direct use of and direct access to an exterior window at all times.”
- ▲ One toilet room shall serve no more than two residents, and residents should not have to enter a corridor to use the toilet.

- ▲ Dimensions and arrangement of resident rooms shall be designed to accommodate at least two bed positions to provide patient choice of bed placement.
- ▲ Rather than specific areas for staff (dietary, administration, nursing, social work, etc.), there can be one centralized work area.
- ▲ An outdoor area must be provided for the use of all patients and includes walking paths, benches, shaded areas and visual elements like sculptures or fountains.

While Mercy will still need a number of waivers using alternative means of compliance, these new regulations provide a step forward in the efforts to create a regulatory structure that works for both small homes and neighborhoods.

History of Environmental Changes

1987	The passage of the Nursing Home Reform Act of OBRA 1987, called for care provided “in a manner and in an environment that promotes maintenance or enhancement of each resident’s quality of life.”
1990s	Pioneers like Charlene Boyd of Providence Mount St. Vincent in Seattle, Pauline Brecanier of Teresian House in Albany, Garth Brokaw of Fairport Baptist Homes in Fairport, NY, and Steve Shields of Meadowlark Hills in Manhattan, KS, create facilities designed as neighborhoods and small homes.
1992	Dr. Bill Thomas’ work on the Eden Alternative leads to the vision for “Green House [®] as the Eden Alternative made real.” Thomas envisioned freestanding residential homes, licensed as skilled nursing residences, that look like any person’s home.
1993	First Green House [®] homes built in Tupelo, MS.
1997	The Pioneer Network, formed in 1997 to transform the culture of aging, identified “environment” as one of the core values and recognized the need to transform the traditional institutional environment of skilled nursing facilities.
2006	CMS issues a detailed document to state survey agency directors explaining how the Green House [®] and similar culture change models fit into the current Federal survey requirements.
2007	<p>CMS issues a letter indicating that culture change models, such as Green House[®], “more fully implement the Nursing Home Reform provisions [OBRA 1987], including quality of life goals.” CMS stated that no Federal regulatory barriers exist for the model and similar culture change approaches.</p> <p>Wyoming, Arkansas and Oklahoma all enact legislation to facilitate and/or support the spread of Green House[®] within their state.</p>
2008	CMS convened a symposium on the implications of traditional nursing home physical environments and the LSC on culture change and identified strategies to meet LSC requirements while embracing culture change principles related to the physical environment.
2011	<p>The Green House[®] concept spreads to more than 99 Green House[®] homes operating on 43 campuses in 27 states.</p> <p>The Pioneer Network’s National Long-Term Care Live Safety Task Force receives approval from NFPA on changes to regulations for kitchens, seating in corridors, decorations and fireplaces.</p>

About the Foundation

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

About Chi Partners

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 Chi Partners at:
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ENDNOTES

- ¹ “The Environmental Side of the Culture Change Movement: Identifying Barriers and Potential Solutions in furthering Innovation in Nursing Homes,” Carmen S. Bowman, 2008.
- ² See “Background” for a description of Green House[®], small homes and households/neighborhoods.
- ³ “Outcomes in Small Nursing Homes: A Longitudinal Evaluation of the Initial Green House[®] Program,” Dr. Rosalie Kane, PhD, June 2007, and “Effects of Green House[®] Nursing Homes on Residents’ Families,” Dr. Terry Lum and Dr. Rosalie Kane, Health Care Financing Review, Winter 2008–2009, Volume 30, Number 2.
- ⁴ Association of Households International, <http://www.ahhi.org/Householddefinition.html>
- ⁵ Code of Federal Regulations, Title 42, Part 483, Subpart B.
- ⁶ Code of Federal Regulations, Title 42, Part 483.70(a)(2)
- ⁷ Title 24 is the 24th title within the California Code of Regulations (CCR). State regulations should not be confused with state laws enacted through the legislative process. State regulations in the CCR are adopted by state agencies as determined necessary to implement, clarify and carry out the requirements of state law.
- ⁸ Title 22 is the 22nd title within the California Code of Regulations (CCR). CCR Title 22, Division 5, Chapter 3 is reserved for state regulations that govern the licensing of skilled nursing facilities.
- ⁹ Nursing homes that participate in the Medicare or Medicaid programs must comply with the regulations for Federally certified nursing homes that are contained in Title 42 of the Code of Federal Regulations (42 CFR), Parts 483.1 through 483.75. These regulations can be found at http://www.access.gpo.gov/nara/cfr/waisidx06/42cfr483_06.html
- ¹⁰ “Snapshot: The Changing Face of California’s Nursing Home Industry,” California HealthCare Foundation, 2007.
- ¹¹ “Rethinking the Nursing Home: Culture Change Makes Headway in California,” California HealthCare Foundation, 2008.
- ¹² “A Report on Shortfalls in Medicaid Funding for Nursing Home Care,” BDO Seidman, LLP, 2007.
- ¹³ CDDIC, hosted by Aging Services of California and the California Association of Health Facilities, provides a forum for those seeking clarification and changes to California’s regulatory environment.
- ¹⁴ L&C has been in the process of updating Title 22 for over a decade already with no significant progress to date.
- ¹⁵ Final Express Terms for Proposed Building Standards of the Office Statewide Health Planning and Development regarding proposed changes to California Building Code, California Code of Regulations (CCR), Title 24, Part 2, Volume 2.
- ¹⁶ California Health and Safety Code, Section 1276(b)
- ¹⁷ California Retail Food Code, Part 7 (“a place where food is stored, prepared, packaged, transported, salvaged or otherwise handled for dispensing”).
- ¹⁸ See sections on Mt. San Antonio Gardens and Mercy Retirement and Care Center.
- ¹⁹ Pioneer Network, National Long-Term Care Safety Task Force, <http://www.pioneernetwork.net/Policy/NFPA/>
- ²⁰ The Green House[®] Project Guide Book, 2007.
- ²¹ A smoke compartment is “a space within a building enclosed by smoke barriers on all sides, including the top and bottom.”
- ²² Karen Shoeneman, Pioneer Network.
- ²³ 42 CFR §483.70 (d) (1) (iv)
- ²⁴ Arkansas Department of Human Services licenses skilled nursing facilities.
- ²⁵ Rules and Regulations for Nursing Homes, Arkansas Office of Long-Term Care
- ²⁶ Section 801, Pilot Project, Rules and Regulations for Nursing Homes, Arkansas Office of Long-Term Care
- ²⁷ Tennessee Certificate of Need (CON) application: “Attach a floor plan drawing for the facility which includes legible labeling of patient care rooms (noting private or semi-private), ancillary areas, equipment areas, etc., on an 8 1/2-inch x 11-inch sheet of white paper. Do not submit blueprints. Simple line drawings should be submitted and need not be drawn to scale.”
- ²⁸ Tennessee uses the American Institute of Architects (AIA) Building Codes.
- ²⁹ The International Building Code (IBC) is a model building code developed by the International Code Council (ICC). It has been adopted throughout most of the United States.

