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LONG-TERM LIVING LEADERS OF TOMORROW 2014

2014 LEADERS OF TOMORROW AWARD

Meet and celebrate four rising influencers in long-term care

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Long-Term Living recognizes its 2014 Leaders of Tomorrow for their outstanding contributions to the senior care industry

BY THE LONG-TERM LIVING EDITORS

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Defining leadership

By Pamela Tabar, Editor-in-Chief

This month's highlight was another successful Environments for Aging (EFA) conference (hosted by our sister publication, *EFA*), with its invigorating energy-fest of collaborative ideas that architects, designers and providers bring to this conference each year. The conference dovetails perfectly with this *Long-Term Living* issue, where we showcase our 2014 Leaders of Tomorrow.

What does it mean to be a true leader in the senior living industry? Being a game-changer isn't an easy job. It takes a willingness to believe in ideas no one else believes in—yet. It takes a willingness to face dragons, argue hard, be your own proof-of- and change policy.

Leadership means taking good ideas and making them happen—just because they will benefit residents' quality of life. It takes questioning policies and then stepping up to change the ones that don't make sense. It takes encouraging the various silos of the senior care industry to erase barriers and work together under the common mission of culture change. And, it takes being willing to stand on the front lines of the senior care quality movement, showing by example what can be done if we all try.

So much of our industry is overshadowed by regulations (especially in skilled nursing), almost encouraging us to stand idly by and change only when it's mandated by the Centers for Medicare & Medicaid Services or other bodies. But true leaders will say, "What can I do to improve quality care and quality living spaces, even though it's not a rule?"

Sadly, the passion to lead is often trampled by bureaucracy, or—even worse—lies dormant and untapped because no one is looking for it. True leaders will insist on leading, despite obstacles. As Nina Willingham, executive director of Life Care Center of Sarasota (Fla.) says in this month's nursing leadership feature article, "To be a good leader means that I am responsible to develop other leaders." One of the best things a leader can do is inspire others to take up the reins, champion the next idea, or share a great solution.

At the EFA conference, we gave heartfelt tribute to David Green, the founder of the Society for the Advancement of Gerontological Environments (SAGE) and the former CEO of Evergreen Retirement Community in Oshkosh, Wis., who died in March. When he first launched SAGE 21 years ago, it was the first organization of its kind in the United States—an organization dedicated solely to improving the design of senior living spaces. May we all grow into better leaders by following his example.

Next year, we're opening up our Leaders of Tomorrow awards to nominations from our readers. Watch for our announcement on our website, and share with us the people you think are true leaders in your community.

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Sexuality in SNFs: Balancing resident rights and resident safety

By Alan C. Horowitz, RN, JD

There's too much sex and craziness that's going on. Now they're bringing it to the nursing home, and it don't [sic] belong there," according to the son of a nursing home resident who recently filed a suit against the facility. The lawsuit stemmed from the nursing home's decision to have a male stripper visit the facility and perform as if he were a Chippendale.[1] Apart from the merits of the case, that incident forces us to consider a growing concern among nursing home administrators—how to handle residents' sexuality. Is there, as the plaintiff states, "too much sex" going on in nursing homes? The answer: It depends.

The need for love, intimacy and companionship is a basic human need that people share, regardless of age. But prejudicial and stereotypical views are not uncommon regarding sexuality among nursing home residents. Until fairly recently, the sexual needs—and rights—of nursing home residents have not garnered the attention they deserve.

REGULATORY BACKGROUND

Federal regulations provide that married couples in nursing facilities may share a room when both spouses consent to the arrangement [42 C.F.R. § 483.12(m)]. Further, on June 28, 2013, the Centers for Medicare & Medicaid Services (CMS) issued a directive stating that residents have a right to visitors on a 24-hour basis, including same-sex spouses and domestic partners.[2]

The applicable regulations require facilities to accommodate residents' "individual needs and preferences" so long as other residents are not endangered [42 C.F.R. § 483.15(e)]. If two residents, legally married or not, want to be together, they have that right. Whatever those residents choose to do, as long as both have the

capacity to consent and there is no risk of harm to either resident or a violation of a regulation, it is their right to be together and to have privacy.

The exact number of residents in nursing homes who are sexually active is unknown. What is known is that approximately 1.6 million residents live in nursing facilities. While studies reveal that the prevalence of sexual activity generally declines with age, the elderly population has certainly not abandoned normal sexual intimacy. Sexuality is a basic human need that normal people carry throughout their lives. The sexual needs of the elderly population are similar to the needs that they had when younger, although the frequency, intensity and manner of expression may vary with aging.[3]

According to a recent study in the *New England Journal of Medicine,* the following percentages of age groups engaged in sexual activity: 57-64 years of age 73 percent; 65-74 years of age, 53 percent; and for the group aged 75-85 years old, 26 percent.[4] Clearly, a significant proportion of nursing home residents remain sexually active.

THE RIGHTS VS. SAFETY CONUNDRUM

The challenge for nursing facilities does not concern situations where competent, consenting adults choose to be sexually active. However, when residents with significant cognitive impairment want to engage in sexual intimacy, facilities must be hypervigilant. Note: Cognitive impairments do not necessarily preclude a resident from engaging in sexual activity. However, facilities must often determine whether a potential situation involving a resident's sexual intimacy might create an opportunity for abuse.

Serious problems on multiple levels may occur when residents with diminished decision-making capacity (DMC) or cognitive impairment are sexually active. Such a quagmire is illustrated by a recent case where two residents with dementia were observed engaging in sexual intercourse. The administrator was charged with professional incompetence, negligence and violating a regulation or law regarding the practice of nursing home administrators.[5] The director of nursing and the administrator were terminated from the nursing home. The facility was cited by surveyors with "immediate jeopardy" and fined. And, the family of one of the residents sued the nursing facility.

At a hearing involving the former administrator, an experienced geriatrician testified that both residents were capable of consenting to sexual activity. The State's Board of Nursing Home Administrators concluded that the sexual exchanges were consensual. To avoid a situation such as the one described above, the author suggests that all facilities take a proactive approach and develop reasoned and appropriate policies and procedures that respect resident's rights while ensuring their safety, including the area of sexuality.

For those residents thought to be actually or potentially sexually active, facilities should consider having the resident's

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physician and interdisciplinary team perform a multidisciplinary assessment. Based on that assessment, an individualized care plan should be developed, implemented, monitored and revised as needed.


Alan C. Horowitz, RN, JD

RECOMMENDATIONS

Be proactive as a facility. Develop, implement, monitor and revise, as needed, policies and procedures regarding sexual intimacy among residents, including procedures for determining a resident's ability to consent to sexual intimacy.

- Remember that "competency" is a legal determination (by a court) and "capacity" is a clinical determination.
- Educate all staff concerning resident rights and resident safety in general and in regard to intimacy issues.
- Educate staff that a resident's DMC may wax and wane, and should be re-evaluated by the resident's physician and interdisciplinary team as needed.
- Recognize that some staff and others may have conflicting religious, cultural and moral values regarding sexual intimacy among nursing home residents, and be sure to provide education of residents' legal rights and provide a forum for discussion.
- Contact the State survey agency *before* a problem arises, for guidance.
- Provide resources to empower your staff: Two good ones are
- AMDA's Clinical Practice Guidelines on Decision-Making Capacity and *Intimacy, Sexuality, and Alzheimer's Disease: A Resource List*, National Institute on Aging, Alzheimer's Disease Education and Referral Center. Available at: **www.nia.nih.gov/alzheimers/intimacy-sexuality-and-alzheimers-disease-resource-list**.

Do a cognitive ability assessment. Where a resident's cognitive ability may be impaired, ensure that the attending physician, medical director and/or psychiatrist make a clinical determination regarding a resident's ability to consent to intimacy whenever DMC may be an issue.

Should a problem or question arise concerning a resident's sexuality activities:

- Document all pertinent information in timely way.
- Engage the QAPI or Quality Assurance committee and compliance committee (both committees, being required, should be in place).
- Involve the facility's Ethics Committee, if one exists.
- Seek input from the State Long Term Care Ombudsman and the State survey agency, where appropriate.
- Consult counsel as appropriate.

CONCLUSION

A paramount concern when respecting residents' rights is to ensure the safety of the resident. A facility's obligation is to take all reasonable measures to do so while respecting the resident's right to make choices, including the choice to safely enjoy intimacy. The federal regulatory scheme provides that residents have autonomy and choice, to the maximum extent possible, about how they wish to live their everyday lives and receive care, subject to the facility's rules, as long as those rules do not violate a regulatory requirement.

In all instances involving conflicts between resident's rights and resident's safety, the facility should engage in an interdisciplinary team approach and strive to involve all stakeholders in the decision-making process. The question isn't whether conflicts between resident's right and resident's safety will occur. The only question is, "When will they occur?" Therefore, the facility should establish and implement appropriate policies and procedures proactively in order to have guidance when conflicts arise. For those situations that do not lend themselves to relatively straightforward solutions, the facility should seek the involvement of the State Long Term Care Ombudsman's office, the State survey agency and counsel, as appropriate. LTL

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2014 LEADERS OF T

Each year, *Long-Term Living* honors select individuals who are engaging in groundbreaking work in the fields that impact the quality of life and care for tomorrow's older adults—be it in small towns or on a national scale. This year, we welcome four new honorees as our Leaders of Tomorrow, researched and selected by the *Long-Term Living* editorial staff. Each one is helping to raise the bar for the quality of senior care and senior living environments.

Next year, we're opening up the process to nominations from our readers. So watch for the upcoming announcement on our website, and get ready to nominate a noteworthy person who is creating the waves of tomorrow.

OMORROW AWARDS

Amy Carpenter, AIA, LEED AP, BD+C

Senior designer/project manager, SFCS
Philadelphia, Pa.
By Pamela Tabar, Editor-in-Chief

Amy Carpenter, AIA, LEED AP, BD+C, may have started out as a residential architect, but when she got her first senior living project 15 years ago, she never looked back. The dementia care-centered project was being adapted for three different states, just the kind of challenge she loves. "I had to figure out how to make this building work under three different sets of building codes," she says. "Then, the more I researched and learned about designing for dementia and the microsocial aspects required of the design, I saw how the design could improve the quality of life or make people miserable. When I realized the type of carpet or wallpaper you choose can drastically alter someone's life—that's the moment I was hooked."

In 2004, she attended a conference session presented by the Society for the Advancement of Gerontological Environments (SAGE), a group she promptly joined and has been a member of ever since—including serving at different times as its vice president and secretary. Now a senior designer and project manager at SFCS in the firm's new Philadelphia office, Carpenter is firmly ensconced in groundbreaking designs for senior living. "I love it all, but I gravitate toward the end of the care spectrum—end-of-life care and skilled nursing."

Carpenter isn't shy about her other passion—She's crazy about building codes and has spent the past four years changing some of them for senior living communities. Her work with the Life Safety Task Force, an initiative launched by the Pioneer Network and funded by Hulda B. and Maurice L. Rothschild Foundation, resulted in important code changes for kitchens and dining spaces in buildings with fewer than 30 residents. The changes helped pave the way for open-view cooking, a model where residents can order a meal and have it prepared to order right there, like a restaurant. "It's a big part of person-centered care—to have meals that you can see and smell being prepared."

The changes were approved by the 2012 edition of the 101 Life Safety Code under the National Fire Protection Association, and the Centers for Medicare & Medicaid Services followed suit by approving the code for Medicare-funded communities. Later, the code changes also were adopted for the 2015 edition of the International Building Code.

The new codes opened up a host of possibilities for residents and dining staff, including more creative menus, time-flexible dining and exhibition cooking. The model also provides new activity opportunities for residents, where food smells can entice appetites or a cooking class might create greater interest in nutrition, she adds. "We're even seeing some families bringing in a resident's favorite recipes to share."

From the business side, the person-centered dining model isn't as convenient or as economical as preparing dozens of identical meals and serving them all during a designated meal time, she says. "The challenge for communities will be, how will they staff that kitchen? How do you designate the jobs of cooking? Who on your staff has the desire and aptitude to prepare the food under this model?" The new model may have communities seeking gourmet chef skills and experts in preparing menus with plenty of choice, she adds.

As the national demographics change, design that supports memory care is moving beyond skilled nursing and into all levels of long-term living, including independent living, she says. "We have to think about every design decision and filter it through the lens of what works for those with cognitive decline. That doesn't mean there isn't a place for dedicated memory care centers, since many people benefit from being in those specific, controlled environments. But we need to think about design for supporting memory like the way we think about how lighting affects the elder eye and how the type of furniture chosen can support accessibility," she says. "All design for senior living spaces needs to be about designing for resident dignity."

Beverley Laubert, MA

Long-term care ombudsman and head of the Elder Rights Division, Ohio Department of Aging, and **chair,** Advancing Excellence in Long-Term Care Collaborative
Columbus, Ohio
By Lois A. Bowers, Senior Editor

Beverley Laubert credits her Great-Aunt Hazel with her entry into the long-term care (LTC) field. "I have a degree in gerontology, and that was prompted by caring for an elderly aunt in our home when I was in high school," she says.

After graduation, Laubert worked as a social worker in home health and nursing home environments before accepting a position with the ombudsman program at the Ohio Department of Aging (DOA), where she had completed a practicum during college. She's now been with the department for almost three decades, 20 of them as the state's LTC ombudsman, a position overseeing 80 staff members, 12 regional programs and about 300 volunteers, all advocating on behalf of seniors.

"There's just so much in their daily lives that people just sort of accept as the best that they can get, and a big part of our ombudsman work is helping people to elevate their expectations," she says.

Bonnie K. Burman, ScD, director of the Ohio DOA, believes that Laubert and her colleagues are succeeding. "Beverley Laubert works tirelessly on behalf of Ohio's long-term care consumers and is recognized nationally as an innovator and leader," she says.

Laubert's descriptions of programs and services back up Burman's claim. For instance, the state conducts surveys of nursing home and assisted living residents every other year, querying family members in "off" years, and publishes the results online for consumers.

And the state is one of 13 in which the LTC ombudsman plays a role in home- and community-based services—and Ohio, unlike some of the others, provides funding to enable that work. "Ohio has been very good to the ombudsman program, recognizing the need for consumers to have an advocate wherever they may live, and has supported us very well to be able to provide that service," she says. Also, through July Ohio is launching a demonstration project, which Laubert's office helped design, to provide managed care for those dually eligible for Medicaid and Medicare.

And the ombudsman program finds creative ways to use the civil monetary penalties collected in the federally required resident protection fund accumulated from nursing home deficiencies. Projects have included training new volunteers, developing resident and family councils in nursing homes, preventing involuntary discharges from nursing homes, implementing a music program in conjunction with memory care and educating nursing homes on how to use the Centers for Medicare & Medicaid Services Artifacts of Culture Change tool to assess the care they are providing.

"As an ombudsman and an advocate, we're best known for hearing complaints from people and investigating those and working with facilities and home care agencies to resolve problems," Laubert says. "So it's really nice to be able to say, 'Let's look at the root cause of issues and start from the beginning so we can make sure that people are receiving the care that they need and facilities are equipped to provide person-centered care to prevent some of those problems.'"

During the four years she spent as president of the National Association of State Long-Term Care Ombudsman Programs, she also became involved with the Advancing Excellence in Long-Term Care Collaborative, a national not-for-profit organization that is leading the Advancing Excellence in America's Nursing Homes quality initiative. She is 2014–2015 board chair, the first non-physician to serve in the role.

"The Advancing Excellence campaign really brings people together with a common goal of quality," she says, adding that state policy has helped Ohio be a leader in data collection and campaign involvement. "We developed a quality incentive system from the Medicaid reimbursement system—sort of a pay-for-performance part of Medicaid—and one of those measures is involvement in the Advancing Excellence campaign. So nursing homes can get a point for it, and they're doing a great job of getting data entered and being real participants in the campaign."

And just as family led Laubert to pursue a career in LTC all those years ago, family members also help her continue to be successful, she says, acknowledging her husband, Michael, who is an attorney at the Ohio DOA, and two high school-aged children, Jeff and Libby. "This role I have isn't just a job to me but a way of life," Laubert says. "My husband and children are supportive and see how important it is to be an advocate."

Bernadette Ledesma, MPH, LNHA

Administrator, Pearl City Nursing Home
Pearl City, Hawaii
By Sandra Hoban, Managing Editor

Even in paradise, people grow old, frail and in need of care to add quality to their days. For the past 15 years, Bernadette Ledesma, MPH, has been the administrator at Pearl City Nursing Home, a 122-bed Medicare/Medicaid-certified skilled nursing facility in Pearl City, Hawaii. Since childhood she has held a special place in her heart for the elderly.

"My great-grandmother came from the Philippines to Hawaii. In the 1930s, older women took the lead as caregivers—especially in adapting to life in a foreign country," Ledesma says. Hawaii is a composite of many cultures: native Hawaiian, Filipino, Japanese, Chinese, Samoan and Micronesian, to name a few. "In most of these cultures, the elders are significant family members and multigenerational family living arrangements were common," she adds.

After earning her master's degree in public health, Ledesma became a healthcare trainer at Kuakini Medical Center and was promoted to supervisor at a 100-bed care home facility. She transitioned this wealth of experience in long-term care as Pearl City Nursing Home's administrator. Its multicultural population can present some challenges, however.

"It makes for interesting work. We have to enlist families to help staff understand the customs of our residents. If language presents a challenge, we ask families to provide a directory of words that staff can use to communicate," she explains. Staff must be prepared to deal with family values regarding healthcare and end-of-life scenarios. "Some cultures insist that everything be done to preserve life regardless of the futility of these efforts," she adds. Bringing better targeted care to her multicultural residents, she feels, is her biggest achievement.

Pearl City Nursing Home employs a staff of more than 200, with the majority of the nurses being Filipino. "In the Philippines, many were licensed nurses, and they are working here to use their nursing home experience as a stepping stone to passing the American licensing exam," Ledesma says.

Culture change is evident at Pearl City. "The Aloha Spirit is the way we carry out our day-to-day care," Ledesma explains. For native Hawaiians, "aloha" is a lifestyle and part of their culture. It embodies concepts like patience, honesty, caring and teamwork. "Aloha Spirit is not much different from what long-term care is all about," she says. It's a person-centered philosophy that ensures residents receive a caring respect for their individuality.

Preventing readmissions and infection prevention is high on the list of missions at Pearl City. "We need to really work with acute care to make sure that we know everything possible about the new resident. We continually probe to find out everything we can about the resident's condition to care for that resident and keep other residents safe."

All of Ledesma's work is not confined to the nursing home building. She is out in the community and working with other facilities to improve care for seniors. "Most administrators belong to the Healthcare Association of Hawaii (HAH) so we have a lot of opportunity to share, collaborate and support each other," says Ledesma, who is also a member of the HAH Government Relations Committee.

Hawaii is one of a handful of states where infection prevention reporting is mandated. "Right now, it's in the acute care area, but I believe it will be required of long-term care soon," she says. In preparation for this eventuality, Pearl City has used an infection preventionist to enable nurses to submit appropriate data. "It helps to understand how important it is to make sure your case-mix is done properly, so infection is contained," she remarks.

"Long-term care is a work in progress," Ledesma notes. And she should know. She's been involved with the Minimum Data Set (MDS) regulations since they began in 1990 through the current MDS 3.0 version and has continued to keep informed and train her nurses in its requirements. "Basically, the challenge is to adapt to the many changes and images of long-term care while staying focused on the resident," she reflects. With her many years of involvement in the geriatric field—15 at Pearl City and 20 years at Kaukini Medical Center—Ledesma quips, "I certainly am aging in place, too."

Anna Ortigara, MSN

Organizational change consultant, Paraprofessional Healthcare Institute Coaching and Consulting Services
Chicago and New York City
By Lois A. Bowers, Senior Editor

Anna Ortigara, MSN, confesses that she didn't start working in long-term care "with any great passion." "It was sort of happenstance" that she began conducting education in nursing homes in the early 1980s after working as a nurse in surgical and pediatric areas, she says.

But, spending time with residents and staff, she quickly fell in love with the field. "It really became clear to me, when I was in a nursing home, doing this education, doing this work—I felt like this is where I belonged," Ortigara says.

Since that time, long-term care has seen many changes. Clinical care has improved to address health issues that can occur—but don't have to be inevitable—with aging. Residents' rights increasingly are acknowledged and encouraged, improving their quality of life. A social model of treatment for those with dementia has emerged as an alternative to the medical model.

And recognition is growing that valuing direct care workers helps improve their ability to honor the wishes of residents, as evidenced by the increasing use of practices such as consistent assignment (Ortigara prefers the terminology "consistent relationship"), team huddles to improve communication, peer mentoring and self-management of teams. "Not that we've gotten all the way" with culture change, she adds, "but in so many areas across the country and across the world, you see organizations doing highly innovative things." Ortigara has been there through all of those improvements—leading efforts to ease and hasten their adoption through her work, which has included speaking, writing and participation in professional organizations in addition to her other roles.

In one of those roles, as vice president of the Campaign for Cultural Transformation for Life Services Network (now LeadingAge Illinois), she helped create the LEAP—Learn, Empower, Achieve, Produce—program, "an evidence-based model…to empower nursing assistants and nurses to be in more effective relationships with each other" to make LTC settings more person-directed. The LEAP program was implemented and tested in 600 nursing homes, and a Mather Institute of Aging evaluation found it effective. (One Mather LifeWays community's use of LEAP won *Long-Term Living's* OPTIMA Award in 2010, and the program has earned other accolades as well.)

In another role, as director of residential care services at the Rush Alzheimer's Disease Center of Rush University Medical Center, she developed an intensive training program called Preparing Leaders for the Future of Dementia Care, which is still being used.

More recently, she spent more than six years with The Green House Project as resource development director, where she helped adapt the Paraprofessional Healthcare Institute (PHI)

Coaching and Consulting Services coaching model for use by the small-house nursing home model. And early this year, she moved to PHI Coaching and Consulting Services as an organizational change consultant, via which she is helping a range of service providers learn and implement proactive communication and team-based problem-solving skills.

"I've come to really believe that using a coaching approach to leading change as the model or framework creates the capacity, the possibility of all the rest of the transformation for the organization," Ortigara says. "You can build the most beautiful building, you can have the most wonderful dining, you can not wake people up in the morning, but at the end of the day, it's really about these relationships, changing the organizational culture, and PHI is really supporting organizations to do that."

Outside of PHI, Ortigara is encouraging broader adoption of culture change through work with the Pioneer Network, a leader in the movement. She currently is the organization's board president and has been active with the group for about six years.

"I feel so lucky to have come into our field when I did, at a time where we have truly been a part of trying to profoundly change it," she says.

Wanted: Qualified nurse leaders

Today's directors of nursing have expanded their roles from clinicians to LTC leaders

BY JULIE THOMPSON

Michael Bobbit has one of the most demanding jobs as the director of nursing (DON) at the busiest nursing home in the Dallas metropolis. His schedule is anything but typical, but on average he manages to oversee staffing issues, budget concerns, clinical matters and sporadic complaints among the 75 admissions and 30 discharges that come in and out of the facility during his 50-hour work week.

It's a jam-packed schedule that might drive many people crazy, but for Bobbit it's simply what he loves. "I worked for hospice shortly after becoming a nurse and then made my way into long-term care (LTC). That is where I found my true love," said Bobbit, MSN, RN, who now works at Presbyterian Village North. "This really is a calling that sticks with you and is something that is in your gut."

Those who surround Bobbit love him as well. It's an admiration that extends beyond the residents, each of whom is personally given his cell phone number on the day they arrive. Bobbit is also indispensable to the top tier decision makers within his community. In his role, Bobbit has helped lead Presbyterian Village North to receive numerous regional and national awards. The community has been recognized by *U.S. News & World Report* as one of the best senior-care communities for the past two years and recently Bobbit himself was named the Nurse Administrator of the year by the National Association of Directors of Nursing in Long Term Care (NADONA/LTC).

Bobbit's awards are impressive, but his day-to-day accomplishments are not isolated. Increasingly, LTC nurses are becoming valued resources beyond passing medications and are being groomed by the communities that understand the rich resources they have in their nurses. They are being encouraged and educated for leadership—whether that be on the frontlines or in the boardroom. Nurses are no longer people who merely carry out orders, but are instead key participants who engage in collegial relationships with both clinicians and administrators.

RESHAPING THE JOB DESCRIPTION

Nurses comprise the largest proportion of LTC employees. Residents at senior care communities require nursing care more than any other service provided in these settings. However, nurses have not always had a strong voice in decision making or have been provided the opportunity to learn how to lead properly, said Robin Arnicar, RN, president of NADONA/LTC. "When I first became a director of nursing 17 years ago, the role was more like that of the head nurse of the facility," Arnicar said. "I became DON literally because I was the nurse in the building they liked and they thought had potential. So, they tapped me on the shoulder one day and said they would like me to be their director of nursing. I love to share the story about how one day I was a nurse like everyone else and the next people were coming up to me and asking me questions like somehow magically overnight I knew something more."

Slipping into the DON role was daunting for Arnicar as a 27-year-old nurse. However, she was blessed that the role simply involved staffing. "The majority of my role was making sure there were enough nurses to help run the facility," she said. "I had to figure out leadership skills on my own through trial and error."

The DON position has drastically changed over time, along with the industry. The complexity of running an LTC community has increased to include new areas of focus such as regulatory demands, compliance issues, MDS and surveys. Likewise, a DON's responsibilities have expanded from just staffing concerns to in-

clude risk management, infection control, staff education, customer satisfaction and budget and finance.

Arnicar will quip that she isn't the best clinician in her community called Charlestown, an Erickson Living Community in Maryland. However, she believes the DON's expanded responsibilities have served the LTC community for the better. "You see the bigger picture," she said. "You are no longer just looking at your department, but you are looking at how nursing impacts dining and rehab and programming and how nurses impact the bigger team. As a result, all the teams within the community are starting to work together more."

In his role as DON, Bobbit has fostered significant change among the training of his nurses. The first thing he noticed when he arrived at his community three years ago was that training was not up to par for the level of acuity coming through the facility's doors. His first initiative as DON was to increase training for nurses so that they could adequately handle these cases.

Bobbit has also helped foster communication between different areas of the community in order to increase resident satisfaction, said Dr. Mary Bean, associate executive director at Presbyterian Village North. "Mealtime is very important for residents because it is not only a social time, but it's also a time for them to maintain a certain level of health through the food they take in," Bean said. "But from an operational standpoint, mealtime can also be challenging because the food service may set a time that doesn't always work with the staff and residents. So, Michael worked very intimately with the dining director to establish a time that would work best for everyone."

PROVIDING A FOUNDATION TO LEAD

Strong nurse leaders are a growing need, but nurses need a framework in which they can learn how to do it—something that isn't always provided in their academic settings. In 2013, Life Care Center of Sarasota won the nurse leadership award from the Florida Health Care Association. It was an honor that came on the heels of an intense focus to train and educate nurses.

> **"Nurses need to come to the table and have a voice for what is right in the profession of nursing in LTC."**
>
> *Lori Guiterrez*

The previous year, the community was a beneficiary of a $145,000 county grant, of which it decided to pour a significant amount into training its nurses. A large portion of that money was used to hire a career coach who came in every other week—at the cost of $1,500 a session—to train nurses. These nurses not only had the privilege of learning on the job, but getting paid their usual salary while doing it.

"They received conflict resolution training, teamwork training and they learned how to empower their staff and how to delegate," said Nina Willingham, executive director at the community. "We did an assessment of their leadership skills before the training, after it and then six months later. What it showed is that they learned a great deal and were able to retain it."

Life Care Center of Sarasota used additional money from the grant to pay 100 percent of the tuition for 10 of its nurse associates to further their degrees. It also paid for 40 hours of training for each nurse who would work in a new cardiac rehab unit, which was created to reduce readmission rates. Willingham believes her community's keen focus on training is why it enjoys its 83 percent retention rate.

"I believe that as an administrator, my most important job function is to be a good leader," said Willingham. "And to be a good leader means that I am responsible to develop other leaders."

STILL MORE ROOM TO GROW

Unfortunately, there is still significant room to grow in both how nurses are perceived in the LTC setting and what type of training they are receiving. Lori Guiterrez is the clinical development specialist for Chamberlain College of Nursing as well as an LTC consultant and clinical educator. Guiterrez said nurse participation in leadership at LTC facilities has increased over time, but still has a way to go.

"As I travel and work with LTC nurses, the pendulum is swinging in that direction, but very slowly," she said. "LTC needs to recognize and increase the number of nurse leaders. Nurses need to come to the table and have a voice for what is right in the profession of nursing in LTC."

Guiterrez said there is still a misperception that nurses in LTC settings are less knowledgeable as nurses working outside of LTC. This is something she has not only viewed in her work, but also experienced firsthand. "I have had people say to me in the past, 'You look like you're smart and you have been a nurse for a long time. Why are you working in long-term care and not in a hospital?'" she said. "We need to change the landscape of LTC by encouraging young nurses to look at this area as a specialty."

Guiterrez said nurses need to be encouraged to achieve higher education as well as completing American Nurses Credentialing Center (ANCC) certifications. She said LTC needs to utilize more evidence-based practices and give nurses more tools to be successful. "LTC nurses are working with a vulnerable population with many comorbidities and diseases processes," she said. "The nurse needs to have the critical thinking, financial and leadership skills to meet the needs of the changing landscape of LTC." LTL

Julie Thompson is a freelance writer based in Dayton, Ohio.

Embracing QAPI: Part 3

Steps 5 and 6 provide fundamentals for developing and communicating your QAPI plan

BY NELL GRIFFIN, LPN, EDM

Editor's note: This is the third article of a series offering advice on successfully implementing Quality Assurance Performance Improvement in your organization.

As people, we plan for everything we do in life. A plan is a project or a scheme. It's the extent of an idea in writing, in the spoken word or in thought. Even if a person says that he or she will do nothing all day, that's a plan.

In humans, planning begins from infancy with the most basic accomplishments. As soon as a child realizes something as simple as how to make his or her parents smile, on a subconscious level that child begins planning the next occasion to experience that pleasing outcome. When a toddler begins to pull up on furniture, the environment is prepared for the unplanned falls and tumbles the toddler will experience. Parents plan for toddlers to fall while navigating the wonders of ambulation. This analogy spotlights the fifth step of the 12 Quality Assurance Performance Improvement (QAPI) implementation steps—Develop Your QAPI Plan.

Healthcare is founded and dependent on the completion of prerequisites, which requires planning to be integrated into every healthcare component. Physicians examine before prescribing treatment. Nurses assess before administering care. Physical and occupational therapists evaluate before determining a therapeutic course of action.

The same is true for nursing homes (NHs). The prerequisite for writing the QAPI plan is to develop a vision, mission, purpose, guiding principles and scope of QAPI. Articulating these prerequisites provide the foundation to help NHs integrate these components into the staff's behaviors and into the written QAPI plan, which guides the quality efforts and supports QAPI implementation.

STEP 5: DEVELOP YOUR QAPI PLAN

One of the fundamentals of QAPI is to gather staff, resident and family input on all aspects of care and care processes from planning through sustainment. NHs that revert to complacency and have leadership write the plan without this input are delaying the embedding of this concept. NH leadership tends to focus on meeting the requirements of the regulation, while staff, family and residents focus on the practicalities of day-to-day tasks. Their input increases compliance by bridging the chasm between the idea and the reality. With all-inclusive input, the written plan is more likely to be known, accepted and practiced by all, meeting the requirements of the QAPI regulation.

Writing the QAPI plan is a function of the QAPI Steering Committee. As stated in Step 1, this Steering Committee must learn to use system thinking. Representatives from direct care staff, residents and family, should actively work with leadership on this steering committee.

The implementation guide, *QAPI at a Glance* (**go.cms.gov/Nhqapi**), states: "The written QAPI plan guides the nursing home's quality efforts and serves as the main document to support implementation of QAPI. The plan describes guiding principles that will be used in QAPI as well as the scope QAPI will have based on the unique characteristics and services of the nursing home."

NH organizations and corporations may have a QAPI plan for the collective. To meet the essences of QAPI, however, each NH must have a plan that works for its unique services and residents. In the appendix of *QAPI at a Glance* the Centers for Medicare & Medicaid Services (CMS) has included a "Guide for Developing a QAPI Plan."

Like all the CMS-provided tools, this downloadable guide is intended to lead NHs through their performance improvement efforts and the writing of their QAPI plan.

USING THE CMS DEVELOPMENT TOOL

There are nine sections in the "Guide for Developing a QAPI Plan." The written plan details how the NH will achieve the purpose, guiding principles and scope identified in that prequel tool. Here's is

an overview of the nine sections to refer to when developing your plan:

Section I. Set QAPI goals for your organization. A Goal Setting Worksheet is included in the tools located in the appendix of *QAPI at a Glance* to help NHs specific, measurable, actionable, relevant and time-bound goals.

Section II. Scope describes how QAPI will be integrated into all of the NH's care and services. This section describes an NH's plan for data-driven person-centered care while infusing QAPI in clinical care, quality of life and resident choice. Element 1 of the 5 Elements of QAPI is at the foundation of this section of the written plan.

Section III. Guidelines for Governance and Leadership relates to the first of the 12 QAPI implementation steps (Leadership Responsibility and Accountability) and the second of the five QAPI elements. This part of the written plan details how leadership will provide resources, education and the time for staff to participate in QAPI and how all staff, services, departments, as well as residents and family will participate in the planning, implementing and sustaining of QAPI. The NH's plan for team building and communicating between meetings and within the organizational structure is also detailed in this part of the plan.

Section IV. Feedback data systems and monitoring is the third the five QAPI elements and the portion of the plan that outlines the overall system for monitoring the care and services provided. Here is where the sources of data are identified, the process for collecting and analyzing data, the process for sharing data with performance improvement project teams and the frequency of information dissemination.

Section V. This section of the written plan, provides guidelines for aligning performance improvement projects (PIPs) with the fourth QAPI elements. This section that details the overall plan for chartering PIPs.

Section VI. Systematic analysis and systemic action addresses the fifth QAPI element, where nursing homes document their plan to become proficient at root

cause analysis, proactivity and sustaining improvements.

Section VII. Communications is the part of the written plan that outlines the audience, frequency and format for sharing information.

Section VIII. The evaluation portion of the written plan describes the process for assessing QAPI on an ongoing basis. NHs can state the frequency of the reviewing and updating of the QAPI Self-Assessment tool to document how QAPI will evaluated.

Section IX. The final section in establishing a plan determines the dating, scheduling and documentation of how revisions will be tracked and updated in the written plan.

All NHs will be required to write and submit a QAPI plan to Medicare. Quality improvement organizations (QIOs) are providing NHs with tools and resources as well as webinars to assist them with this part of QAPI. Every state has a QIO that is ready and willing to assist nursing homes. A list of state QIOs (**www.qualitynet.org**) is available. Telligen (**www.telligen.com**), the Medicare-contracted QIO for Illinois, has presented several QAPI webinars. In addition to being a requirement, the written plan can be an instrument for to assist in "Conducting a QAPI Awareness Campaign"—the sixth QAPI step.

STEP 6:
GENERATE QAPI AWARENESS

Commitment, proficiency and awareness are words sprinkled throughout *QAPI at a Glance*. Words like these were chosen for this guidebook because they accurately depict the depths and theme of QAPI. Words like these are coaxing QAPI to life in America's NHs. Dedicated leaders inspire employee loyalty and loyal employees tend to stay. Proficiency with a particular skill builds confidence, which can motivate continued building of expertise. Awareness is knowledge and knowledge is power. The sixth QAPI action step is: Conduct a QAPI Awareness Campaign.

EMBED QAPI IN NH CULTURE

This sixth action step focuses on communicating with two focus populations—caregivers and residents/families. There are seven guidelines for communicating with all caregivers. A guideline for conducting a QAPI awareness campaign is to frequently let everyone know about QAPI using multiple strategies. People receive information in various ways. Reading, listening, and watching are all viable ways for communication with caregivers. Newsletters, flyers, information brochures and even texting are ways for conveying information by written media. Videos, webinars and face-to-face meetings are other ways information is conveyed by watching and listening.

Nell Griffin, LPN, EdM

To conduct an awareness campaign for caregivers, *QAPI at a Glance* suggests NHs let everyone know about the QAPI plan often and in multiple ways, conveying the message that every caregiver is expected to raise care concerns and think about systems. Download copies of *QAPI at a Glance* and place throughout the facility for residents, visitors and employees to access.

QAPI updates, progress reports and next steps should be on the agenda of every meeting, included in every huddle and stand up, on the agenda of every resident council meeting and every department or team meeting. For QAPI to become ingrained into the nursing home's culture, every employee, every caregiver, every resident and every family member should develop a taste for QAPI. It must be talked about, heard about and seen every day. It should be thought about and felt in every service that is provided and all care that is delivered. QAPI is a lot of new information requiring learning new skills as well as implementing changes in daily practices. Change has to be introduced incrementally, allowing one part to be embedded before introducing another. The same is true about QAPI.

High-quality care is dependent on the care delivery system. Each resident's care depends on groups of caregivers across disciplines and in various roles. For all this variation to come together into a high-functioning system that does what it is designed and intended to do requires strong commitment, unwavering dedication and unambiguous effective communication. There are numerous ways to improve the care delivery system, including interdisciplinary brainstorming sessions focusing on improving how each discipline influences the care delivery system. This is also a good forum for a caregiver awareness campaign.

In addition to residents, family and care staff, any consultants, collaborating agencies, contracted care providers and contracted services need to be aware of the NH's QAPI plan and agree to practice accordingly. This means the NH's hospice provider, supplemental staffing agencies, any contracted care suppliers must practice the same protocols as hired staff. The NH's awareness campaign and training strategy has to include contracted care providers.

Although there may be some overlap between the awareness campaign for caregivers and the one for residents and families, special attention has to be given to the resident-centered focus of the NH population. In every NH, resident voice must be a living component of QAPI. This requires NHs to know and understand the residents they care for and their families. Knowing the audience is a key component for any campaign and the same is true about the QAPI awareness campaign.

Be creative and come up with fun and imaginative ways to spark and maintain QAPI awareness such as QAPI festival days. A QAPI festival, similar to a school science fair, is an event with QAPI displays for staff, residents and their families to learn and play games as they stroll from display to display. NHs that have had successful awareness campaigns or are planning a creative event can share ideas with their QIO. The Illinois QIO, Telligen (**www.telligen.com**), invites NH teams to share its awareness campaign.

The awareness campaign is how nursing homes communicate their written QAPI plan with caregivers, resident and families. The written plan includes the nursing home's strategy for collecting and using QAPI data. LTL

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Beyond Bingo

Perhaps no other role in long-term care has changed as much over time as that of the activity director

BY RON RAJECKI

Living in a long-term care (LTC) facility does not mean that the joys and experiences of life have ended. There's a memorable scene in the 1975 film *Rooster Cogburn* in which United States Marshal Cogburn, played by John Wayne, is "celebrating" by tossing biscuits into the air and shooting at them. When an alarmed Eula Goodnight (Katharine Hepburn) asks him what he's celebrating in this unusual manner, the drunken Cogburn joyously shouts, "Bein' alive, sister, bein' alive!"

Although the movie is fictional, it represents part of the reality for activity directors in LTC communities. The days of simply keeping residents occupied are over, and the focus has turned squarely on making sure that meaningful, person-centered activities contribute to a life worth living—and celebrating. As always, LTC communities and their activity directors are rolling up their sleeves and taking the challenge to heart.

LIFE ENRICHMENT

Percell Smith, vice president of resident loyalty at CHE/Trinity Senior Living Communities, says he feels strongly that there needs to be a transformative philosophy that moves away from the old paradigm of activity programs and toward life enrichment, and facilitates a community life that embraces everyone within it. The Livonia, Mich.-based healthcare system includes skilled nursing, assisted living and independent living communities.

"We believe an activities program should be more than diversional," Smith says. "It should be a vehicle for enriching the lives of all the residents within our communities. It should recognize and affirm them as a whole person."

To successfully meet this goal, CHE/Trinity Senior Living Communities realized that it would need to incorporate more people into administering life-enrichment experiences at its communities. This led to an increased role for nursing assistants in activities. "We recognized that, given the way most communities staff their activity departments, there was no way they were going to be able to cover enough ground to meet the interests of each and every resident," Smith says. "So we made a decision that the regularly scheduled caregivers—the nursing assistants—were going to work with the activity director."

As Smith explains, the activity director still does all the traditional tasks that he or she was doing, such as assessments and the creation of a calendar. But now the nursing assistants, who are often the individuals closest to the residents, can help arrange the community into "neighborhoods" of shared interests, or even advise the activity director about specific one-on-one pursuits residents would like to enjoy.

"That's a fundamental change we find quite exciting," Smith says. "It has been exciting for the activity directors because now they don't feel overwhelmed by having a small department that's called to serve people with many interests, and it's really enriching for the nursing assistants—who we now call care partners—because many of them learn things about the residents that transform them from a resident that they're caring for into a person who has a life history and has intellectual interests and things they want to pursue."

PROVIDE MEANINGFUL PURSUITS

Knowing your residents is the easiest way to meet their needs with activities, and the best way to know residents is to learn as much about them as possible when they enter your facility, says Kendra Howard, LPN, RACCT, Country Lane health coach at Evergreen Community of Johnson County, a 112-bed skilled nursing facility in Olathe, Kansas.

"If you know what a resident's profession was, what his or her hobbies were, what he or she enjoyed doing, you're going to be able to meet that person's needs activity-wise," Howard says.

Although Howard feels that group

activities are important because they bring people together, the most import aspect of activities is ensuring that people have a purpose. "We've really had good success by giving people the opportunity to do things they're still capable of doing that gives them the sense of purpose they had their whole life," Howard says.

She cites the example of a gentleman who had been a maintenance worker. "You could tell that when he got here he just didn't feel like he had a purpose," Howard says. "He would walk around checking the handrails to make sure they were sturdy, checking chair legs, things like that. So we set him up with our maintenance department when they did their rounds in the morning. He'd be with them to make sure everything looked good and was working properly, and he'd go with the maintenance workers to storage to pick up supplies." An added bonus, according to Howard: The more engaged and more purposeful the residents are, the less likely they are to fall and be injured.

BLENDING FUN AND THERAPY

Terri Occhionero, ADC, activity director at Avon Oaks, an assisted living and skilled nursing facility in Avon, Ohio, agrees with Howard: The key is keeping residents involved in meaningful activities that they did at home and still enjoy doing now.

One activity that Occhionero is eager to share with others is Avon Oaks' choir. "Our music therapist discovered that one thing many people had done in the past was to have been part of a choir," she says. "So we put together a choir and it has been very popular. At any given time we have between 20 and 30 residents participating." Occhionero notes that singing not only is enjoyable, it also helps residents breathe better.

In addition, each choir concert features four or five residents who are selected to perform a solo, which is tremendously popular with the soloists and their families.

"It's not just about singing, it's about participating in something as a group and being involved in something they can share with their families," Occhionero says.

Many LTC facilities have found that intergenerational activities are particularly enjoyed by their residents, and Avon Oaks has the benefit of being a rare nursing facility that also has a day care center on site. Occhionero realizes not every nursing home will have this arrangement, but she highly recommends finding ways to bring youngsters from the community into the long-term care facility for visits. "The residents just love the kids, and we do everything together," she says.

YOUNG AND OLD GROWING TOGETHER

One intergenerational activity—and one that is especially timely with summer just around the corner—is to set up a community garden. An excellent example of this can be found at the Lynnwood Senior Center in Lynnwood, Wash., where the intergenerational garden project won a 2013 Program of Excellence Award from the National Council on Aging's National Institute of Senior Centers.

Participants and volunteers ranging from 4- to 90-years-old constructed 30 garden boxes and filled them with just about anything that it's possible (and legal) to grow in Washington, including flowers, squash, corn, sunflowers, tomatoes, spinach, kale, swiss chard, radishes, carrots and potatoes. The boxes were raised to be easily accessible to older individuals in scooters or wheelchairs.

Mary-Anne Grafton, MSW, recreation supervisor for senior programs, tells *Long-Term Living* she wanted to set up a garden for a number of reasons, including providing seniors in the city with an enjoyable activity and a source of fresh fruits and

Resources abound for activity directors in LTC

Why do activity professionals do what they do? Perhaps that is summed up best by Lisa Ost-Beikmann AC-BC, ADC, CDP.

I personally love the people," says Ost-Beikmann, who is in charge of education outreach for the National Association of Activity Professionals (NAAP, **www.naap.info**). "You meet so many different kinds of people, and these individuals raised families and did all they could, and now they need us to help them. There is tremendous satisfaction that comes from helping people who can't help themselves anymore."

Ost-Beikmann adds, however, that the role is filled with challenges—often multiple challenges in the same day. That's why she suggests activity professionals rely on each other for help. "There's no greater resource than another individual who does the same thing you do," she says. "They know it, they've lived it, and I think you really need peers who are in your same situation to be able to help you."

To get that peer-to-peer interaction, as well as opportunities for training and continuing education, Ost-Beikmann encourages activity directors to consider becoming members of NAAP. The website includes information on becoming a board-certified activity professional or activity consultant.

In addition to NAAP, there are a number of other resources of interest to activity professionals, including:

- Activity Connection, **www.activityconnection.com**
- Activity Director.com, **www.activitydirector.com**
- Activity Directors Network, **www.activitydirector.net**
- Activity-PALS, **www.marylandactivityprofessionalsresourcenetwork.com**
- National Center for Creative Aging, **www.creativeaging.org**
- National Certification Council for Activity Professionals, **www.nccap.org**
- Not Just Bingo, **www.notjustbingo.com/articles-and-resources.html**

An article in the *Annals of Long-Term Care*, "Promoting Personhood in Men in Nursing Homes: The Role of Activity Directors" **www.annalsoflongtermcare.com/article/promoting-personhood-men-nursing-home-activity-directors - sthash.6Hd3ylAS.dpuf**

Is your "Movie Night" legal?

"Movie Night" screenings at long-term care (LTC) and senior living facilities are considered "public performances" that require a license, even if the facility rents or buys the films. The Motion Picture Licensing Corporation (MPLC) has forged a partnership with the National Association of Activity Professionals (NAAP) to make the compliance process easier.

MPLC, a copyright licensing agency, is offering an Umbrella License to NAAP member-facilities for a discounted rate. Those who acquire the license will secure public performance rights to show films from more than 650 different studios and film producers without the need for further reporting.

The partnership makes sense, noted Sal Laudicina, president of the MPLC Licensing Division, in a press release about the deal. "In virtually all facilities, the activity professional is the person who organizes the movie event, and this agreement will provide the assurance of comprehensive copyright compliance."

MPLC, which handles film licensing at more than 250,000 facilities in the United States alone, has already partnered with other major LTC member organizations, including LeadingAge, the American Health Care Association/National Center for Assisted Living and the National Certification Council for Activity Professionals.

Read more about the motion picture licensing process for retirement and senior living communities at **www.mplc.org**.

—Pamela Tabar

vegetables, and also to allow them to share their knowledge with younger generations.

"Many older adult lose their ability to garden—either through downsizing or physical ailments such as bad knees—after a lifetime of experience," Grafton says. "I think it does the whole community a disservice to put older adults in a corner and say, 'Now we've provided for you.' It seems like an unnecessary loss to me."

Grafton also saw the community garden as an opportunity for high school students to perform community service projects. "It allowed us to pair up students with older adults, so the students could learn and the adults could engage with people of different ages from the community," she says. "It's a simple thing to do, and it brings people together and builds community. There has been no downside to this project. It has been all benefit."

Grafton's advice on starting your own community garden: Seek out others who are willing to get behind it.

"I couldn't get this project off the ground until I found another coworker who was willing to help out, and then we received enormous help from community partners who engaged local businesses that were willing to support the project," she says. "We had businesses that went out of their way to get us really good materials at discounted prices."

The payoff, according to Grafton, was well worth the effort. "We had one elderly gentleman who had loved gardening but he hadn't been able to garden for more than 10 years," she says. "He came by every day, sometimes just to put his hands in the soil and just connect with something that he loved and that he wasn't able to get elsewhere in his living environment. That really moved me. The impacts from this kind of community effort can last for a long time, and can really affect a lot of people."

ACTIVITIES ADD MEANING

As Howard sums up, "I think offering activities is one of the most important things we do in an LTC setting. They keep people happy and make life worth living." And although you might prefer that individuals don't shoot biscuits á la Marshal Rooster Cogburn, in today's person-centered care environment the activities that it is possible to create to make your residents' lives worth living are limited only by your imagination. LTL

Ron Rajecki is a freelance writer based in Cleveland, Ohio.

Intimate by design

Do your facility's spaces, furniture and care culture support or deny resident intimacy and sexuality?

PAMELA TABAR, EDITOR-IN-CHIEF

Intimacy and sexuality are important to human identity and well-being at all stages of life, including the years long after age 65, and designers are obligated to create spaces that foster the health, safety and well-being of the people who use them, noted Migette Kaup, PhD, IDEC, IIDA, associate professor, Kansas State University, in an educational session at the 2014 Environments for Aging conference held earlier this month in Anaheim.

Kaup and Gayle Doll, PhD, director of the K-State Center on Aging at Kansas State University, researched sexual activity in Kansas nursing homes, and found plenty of it. They also found many nursing homes that considered many sexual activities to be "inappropriate," although 59 percent of the nursing homes surveyed said they didn't actually have a policy on sexual activity. The researchers found the lack of assured privacy in nursing homes and the lack of spaces designed for intimacy surprising. "Maybe sexual activity is deemed inappropriate only because there is no appropriate place to have it," Kaup said.

Culture change is beginning to take root, Doll said. Some states, including Kansas, are starting to develop person-centered quality initiatives that include higher reimbursement for communities that respect and support resident intimacy. Nurses are being trained to wait for a response when they knock on a resident's door, instead of knocking and walking right in.

Some facilities are incorporating conjugal visit rooms onsite for couples to use. Others are reconsidering everything from room floor plans to furniture, discovering new ways to provide more privacy, even in semi-private rooms. "Privacy is not only visual, but auditory," Kaup said. "And a curtain separating two semi-private spaces isn't going to cut it."

The low-hanging fruit for providing more resident choice may be in the furniture, she said. Administrators need to pry themselves away from assumptions, including the idea that all residents will welcome the same kind of furniture, or that everyone will want the chair next to the TV. "Who says every resident will want to sleep in a twin bed?" Kaup noted.

An EFA attendee raised the issue of "single-serving" furniture—single beds, single chairs—noting that most furniture found in resident rooms and common spaces makes it difficult or impossible to sit side by side. With all single chairs, single beds, there is no way to sit next to someone.

Giving residents the ability to rearrange the furniture also can enhance their ability to share intimacy, she added. Kaup related a story about a woman who pulled the recliner chair right next to her bed. Nurses said the woman had trouble falling asleep unless she was physically touching her husband. So he sits next to her and holds her hand until she falls asleep. "It was the moment I realized, 'Wow, there's a big piece we're missing about person-centered care design,'" Kaup said.

Designers still face tight limits on square footage and even tighter budgets. Kaup issued a call to action for designers to rethink the "privacy curtain," giving residents in semi-private rooms a greater sense of privacy while adding as little square footage as possible. She also encouraged vendors to develop furniture and products that are versatile and can be rearranged or converted for resident wishes.

"It's not just about living longer," Kaup said. "It's about enjoying it more while we live it." LTL

Giving residents the ability to rearrange the furniture also can enhance their ability to share intimacy….

‘Active shooter’ events: 4 steps to keep staff, residents safe

Part 2 of a series on how to protect everyone in your facility from armed intruders

BY JAMES MINNINGER AND STEVE WILDER

Editor’s note: Read Part 1 in this series, “Preparing for lockdown events,” Long-Term Living*, March 2014, p. 16, or at ltlmagazine.com/blogs/steve-wilder/preparing-active-shooter-events-lockdowns.*

One of the most overlooked components in an “active shooter” response policy in a healthcare facility also is the main focus of your day-to-day routine: the care and well-being of your residents. The traditional suggestion to survive an active shooter event, as outlined by the U.S. Department of Homeland Security, is the “run, hide, fight” doctrine, an approach that is sound but does not address a big challenge within the realm of long-term care: the well-being of the residents.

The mission statement and core values of your facility probably contain wording and ideology related to compassionate resident care. The active shooter policy for your facility also should consider that care. Although your active shooter response policy cannot dictate that staff members remain in the midst of an active shooter event to care for residents, leaving the residents to fend for themselves while staff members evacuate is not a sound idea either. So what are your options to balance staff and resident safety?

The change in active shooter tactics because of rapid police intervention will help you survive an event.

NEW TACTICS

After the Columbine High School shootings in 1999, where one teacher and 12 students were killed, police response and tactics in active shooter events changed nationwide. Police officers no longer surround the scene and wait for specialized units such as SWAT to arrive. They immediately enter the facility and look for the shooter, to stop the action. This newer strategy had two effects: (1) the quick response to the threat has helped the police save lives, and (2) an active shooter now has changed his or her tactics in response to the police officers’ rapid response.

An active shooter now needs to move rapidly through a facility, looking for targets of convenience and opportunity, because the shooter knows that police officers are coming. This action is evident in the surveillance video that the FBI released of shooter Aaron Alexis at the Washington, D.C., Navy Yard. Alexis moves rapidly, doesn’t stop to try to enter doors, and at the end of the video, quickly moves toward people he sees at the end of a long hallway.

The change in active shooter tactics because of rapid police intervention will help you survive an event. Let’s see how. Your active shooter response needs to contain several layers dictated by the shooter’s location and actions. But what does that mean? Let’s look at the concept of “use of force” used by law enforcement officers.

Formerly, an officer’s use of force choice was guided by a clearly defined continuum: It started at the lowest level and progressively went up. For example, one of the lowest levels of force an officer

could use was his or her mere presence in uniform. The police uniform and badge are recognized as symbols of authority and, by that officer being present, show a low level of force.

Force then progressed up from that—verbal, hands-on, pepper spray, Taser, strikes and so on—until the highest level, deadly force, or the use of an officer's firearm. A progression of force application existed.

In the past decade, however, law enforcement has shifted the way it thinks about use of force and the continuum. Think of all law enforcement use-of-force options as tools. The action of the perpetrator dictates what tool a law enforcement officer uses (as long as it is reasonable and necessary).

For example, if a "bad guy" (or gal) is firing a gun at a police officer, should the officer start at the lowest levels of force, relying on mere presence and verbal commands, or can the police officer reach into his or her "toolbox" and go right to the force level of using a firearm? The obvious answer is to bypass all the lower levels of force and proceed to deadly force. The perpetrator's actions have dictated the use of force used by the officer.

The same theory can be used in an active shooter response in long-term care. When the bad guy's actions and location dictate your active shooter response, don't overthink the concept. If the shooter is in the facility, away from your location, and the sound of gunfire is faint, what would your response be? If the bad guy is in eyesight but not close to your location, how would you respond? If the active shooter comes through the front door of your facility and you are in the lobby, what would you do? Remember that concept as we discuss the development of an active shooter safety action plan and the Safety Transition Adjustment Formula Protocol (STAF-P).

ACTION PLAN: PERSONAL SAFETY

In an active shooter event, we slightly modified the run, hide, fight approach. For ease of remembering, we call our active shooter safety action plan "the four outs."

1. Get out: This step is the equivalent of "run" in the run, hide, fight approach. If you can, quickly evacuate the facility. Leave personal belongings behind, and encourage others to go with you. Call 911 when you are in a safe location. Follow this course of action if the active shooter is not in your direct sight.

2. Hide out: Hide in an inconspicuous area. Remember, the active shooter is looking for targets of convenience and opportunity. He or she does not have the time to search, because of the rapid and impending police response.

3. Keep out: We added this step to the run, hide, fight protocol. It sounds simple and is based on common sense, but if you do not have training and an advance plan, it may not occur to you. If you need to hide because the active shooter is nearby or blocking your egress, keep the shooter out of your hiding spot by barricading it. Doing so may be as simple as locking the door or pushing a piece of furniture in front of it.

Preparedness protected residents, Village Shalom chief says

By Lois A. Bowers, Senior Editor

One person was shot and killed outside an Overland Park, Kan., senior living community on April 13, but the outcome could have been worse had staff members not been prepared for such an event, the community's president and CEO says. "We are extremely proud of the way our staff and residents reacted during the crisis," Village Shalom's Matthew E. Lewis wrote on the community's Facebook page the day after the shooting. "Due to the policies, procedures and emergency preparedness training that Village Shalom has in place, our staff responded appropriately to the crisis, ensuring the safety and security of our residents. We are thankful to them and the first responders who made sure that our campus was locked down and secure until the immediate crisis was over."

Terri LaManno, 53, was killed in the parking lot as she arrived to visit her mother at the assisted living section of Village Shalom. A 14-year-old boy and his grandfather also were killed outside a nearby Jewish community center shortly before LaManno was shot.

Frazier Glenn Cross, 73, who also has used the last name Miller, has been charged with murder for all three crimes; the Associated Press described him as "a well-known white supremacist and former Ku Klux Klan leader." Despite being killed outside of Jewish facilities, all of the victims were Christian.

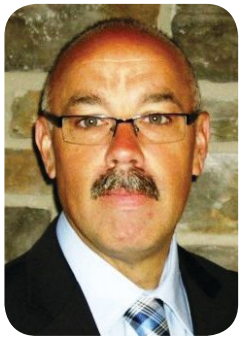
LaManno had been an occupational therapist for eight years at the Children's Center for the Visually Impaired in Kansas City, which, in a statement on its website the day after the shooting, described her as a "gracious, generous, skilled and deeply caring individual who made a great difference in the lives of so many children and their families."

In the wake of the shootings, Village Shalom posted this Helen Keller quote on its Facebook page: "The world is full of suffering. It is also full of overcoming." The overcoming, Lewis wrote, would take the form of grief and trauma counseling being made available to residents, families and staff members.

The facility also planned to increase its security for the foreseeable future, he added. "As saddened as we are by this event, we will continue to provide quality care and support for our residents and their family members," Lewis said.

4. Take out: This course of action is your last resort for survival in an active shooter event. "Take out" corresponds to the "fight" in the run, hide, fight doctrine. Use it when you can't evacuate or hide. If you have to interact face-to-face with the active shooter, use weapons of opportunity, diversion and a committed action to attack him or her. Remember, there are no rules when it comes to fighting someone intent on killing you. In such a case, you truly are in a fight for your life.

Steve Wilder, CHSP, STS



James Minninger

BALANCING RESIDENT, STAFF SAFETY

Use STAF-P to balance the safety of both staff members and the people for whom they are tasked to care—the residents. Make, or have someone make, a facility-wide announcement at the beginning (or at the moment of recognition) of an active shooter event. Early recognition of an event, combined with a clear, concise announcement of the shooter's location, will save lives. Staff members then will decide on a resident safety action plan or a personal safety action plan based on the shooter's location. Visual confirmation and auditory clues—for instance, the sound of gunfire—will aid in the decision-making process.

If an announcement is made that the shooter is in the area of the main entrance and your personal care wing is on the second floor, several hundred feet from the last known location of the shooter, how many residents could you safely evacuate or hide? As the sound of gunfire gets louder and it is apparent that the shooter is ready to enter the personal care wing, transition from resident safety to personal safety (remember the four outs).

To whom do you attend first when focusing on resident safety? Use the same priority you would for fire evacuation:

- ambulatory residents,
- those with assistive devices,
- residents in wheelchairs, and then
- those who are bedridden.

Consider hiding immediately those who cannot evacuate due to the shooter's location or the fact that they are bedridden or have other ailments or physical maladies.

Your facility must adopt a well-thought-out and thorough active shooter response policy that considers the safety of both residents and staff members. Everyone needs to understand the policy and be trained on through drills and exercises. Additional training considerations in active shooter response are crisis decision-making and stress inoculation.

CRISIS DECISION-MAKING, STRESS INOCULATION

If your facility has the misfortune of being the site of an active shooter event of any magnitude, lives will be lost unless you have provided staff members with training and tools. Active shooter training in long-term care must focus on rapid recognition of an active shooter event, stress inoculation and decision-making skills for staff, facility-wide communication and an announcement of the event, and the implementation of a safety action plan based on the movements of the offender.

Why are crisis decision-making skills and stress inoculation so important? If you have been working in the healthcare field for any amount of time, chances are high that you have participated in a cardiac or traumatic code or some other medical crisis that without immediate attention would have meant the imminent death of a patient or resident.

Do you recall how you reacted and performed during your first code? Without repetitive didactic and practical training in code response, chances are you would not have performed well; stress, anxiety and the chaos of the moment would have jeopardized the life of the victim. But because of proper repetitive training, you more than likely responded appropriately during the code. The same can be said during an active shooter event. It will be chaotic, and it is your responsibility to control chaos for your safety and the safety of your residents.

It will be chaotic, and it is your responsibility to control chaos for your safety and the safety of your residents.

NO MARGIN FOR FAILURE

The likelihood of an active shooter event your facility is slim, albeit possible. As with every other possible crisis scenario, you must address an active shooter event in the phases of planning, response, mitigation and recovery. Much the same as fire plans, weather emergency plans, utility failure plans and other crisis plans, your active shooter plan must be exercised, evaluated, revised and retested to ensure that it serves your goals and that your staff members develop the needed competencies and proficiencies. Putting faith in the belief that "it won't happen here" and allowing that mind-set to replace planning and training reminds me of this well-known emergency preparedness adage: "Failing to prepare is preparing to fail." Unfortunately, in an active shooter scenario, no margin for failure exists. LTL

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A small house can mean a big difference

Model affects design, care delivery and overall senior living

BY LOIS A. BOWERS, SENIOR EDITOR

Brian Gruber has fielded more than one telephone call from someone who has driven by new homes being constructed by Ridge Stone General Contractors, of which he is president. People request additional information about the "condos," he said, including their price.

The catch? The new homes, built in clusters on cul-de-sacs, actually are skilled nursing and rehab neighborhoods for the non-profit Otterbein Senior Lifestyle Choices. "These are 7,000-square-foot homes, but they are really designed to look like houses or condos," Gruber said, adding that the scale of the neighborhood, the pitch of the roofs, the front doors and the building materials help the houses blend into the surrounding residential area. The exteriors of the homes have common elements—all roofs are black, all trim is white—but they don't look identical. "People are amazed because it's not what they're used to seeing from a traditional nursing home."

Gruber and Susan McConn, MSN, LNHA, vice president of small house neighborhoods for Otterbein, discussed the small house model and its challenges at the recent Environments for Aging Conference in Anaheim, Calif. The small house model is "one of the most exciting models for skilled nursing that exists today" and represents the future of long-term care, McConn said. She described Otterbein, based in Lebanon, Ohio, as the country's largest provider of small house care, with five skilled nursing and rehab neighborhoods in the western part of the state—the oldest is seven years old—and four more are being developed. The company also offers continuing care retirement communities as well as home health and hospice services.

Houses have common elements—all roofs are black and all trim is white—but are not identical.

"The whole small house model is to get away from that institutional nursing home and provide something better," McConn said. An Otterbein small house neighborhood consists of five homes (one for rehabilitative stays of fewer than 30 days, and the others for long-term stays), each with 10 occupants, in a residential setting. Each small house includes private, customizable suites for residents (all of which can support ceiling lifts, and two with lifts already present) as well as a common living room and dining, kitchen and spa/salon areas. (The "great room" concept means that residents have short walks to wherever they'd like to go, Gruber said.)

Elders are free to use the fenced-in back patio and backyard—complete with gas grill, patio furniture and a garden area—whenever they wish. Care delivery is person-centered; residents determine their own schedules, and their preferences are honored.

"The houses probably are not as efficient as an institutional nursing home, but that's OK for us," McConn said.

WHOLE APPROACH TO LIVING

The small house model is not just a design; it is a whole approach to living as well, with a language of its own. Residents are referred to as elders, and staff members—working in an organizational structure that McConn said is "very flat" and "not a bureaucracy"—have unique titles.

In every Otterbein home, two elder assistants work during the day, two work in the evening and one works at night. They are state-tested nursing assistants employed under the "universal worker" model and so are involved with dining, housekeeping, caregiving and other tasks. All elder assistants carry smartphones to receive

messages, as needed, from pendants worn by the elders. Also, they use email as one way to communicate with administrators and other staff members.

Each neighborhood also has nurses—two during the day, two in the evening and one at night. They move from house to house, each carrying a bag with a blood pressure cuff, stethoscope, glucometer and other items. The nurses administer medication (usually twice a day) that is kept in locked cabinets in the elders' rooms, eliminating the need for a medication cart.

Each neighborhood also includes a guide (administrator), a coach (usually a newly licensed administrator) to whom all elder assistants report, a healthcare coordinator (director of nursing), a quality-of-life coordinator who performs social services and activities duties, a housing coordinator who performs admissions functions, a business office coordinator, a maintenance person and a chaplain, since Otterbein is a faith-based organization. These employees (Otterbein refers to employees as partners) also move from house to house, taking their computers with them and working in the office located in the houses (one per house), none of which is assigned to any particular person or purpose, McConn said.

RESIDENT CHOICE

Dining is one way that resident choice is manifested, McConn said. (See the sidebar to read about another experience with household dining.) Once a week, she explained, the elders meet with the elder assistant to talk about the menu for the next two weeks. The elder assistant enters food choice information into a computer, and a diet technician or dietitian subsequently reviews it. The elder assistant orders the food online, and it is delivered to the home. At mealtime, the elder assistant prepares the food, which could mean a different meal for each resident.

CHALLENGES

"People want to live where they've lived all their lives," McConn said. "That's part of why we decided to build in a residential neighborhood."

Delivering skilled nursing in a residential area can pose challenges, however, she and Gruber said. Those challenges center on changing public perceptions of skilled nursing.

For instance, going through the zoning process can be difficult, Gruber noted, at least the first time a small house neighborhood is constructed in a geographic area. The process can ease somewhat after the first grouping of homes is built, he added, because government officials and residential neighbors gain a better understanding of the small house concept.

All houses must comply with the applicable codes and regulations related to construction of a commercial facility as well as the provision of nursing and rehabilitative care and safety and security, Gruber said. "You have all the things you have in a nursing home. It just doesn't look like it when you first look," he added.

The condo-like appearance of the homes also means that the organization's marketing department works hard to help potential residents locate the neighborhoods and understand that skilled nursing can be delivered in such settings, McConn said.

Another challenge relates to contracted services, which for Otterbein include therapy and lab services.

"Therapists have to understand that we don't wake people up, so you can't come in and get everybody out of bed to do therapy at 8 o'clock in the morning. It doesn't work that way," McConn said. Similarly, lab workers initially want to arrive at 6 a.m. to conduct all of their work and then leave, she added. So the service providers with whom Otterbein contracts need to be retrained to align their efforts with the small house concept.

The model itself is designed to support therapy in the houses and neighborhood, McConn said. For instance, occupational therapists can use the actual kitchen to work with elders on their kitchen skills; elders can practice walking in hallways and, outside, via trips to the mailbox and stepping off and on curbs; and a drive-up area in front of the house allows for practice entering and exiting vehicles.

The small house model is not just a design; it is a whole approach to living as well, with a language of its own.

The short-stay house has more therapy equipment, such as weights and mats, she added, but elders in the long-term houses typically receive therapy services in their own homes.

A final challenge of the small house model is trying to avoid what McConn called "institutional creep." "A lot of times, we just say, 'So, would you do that at your house?' If the answer is no, then we don't do it here, either," she said.

But the challenges are worth it for everyone involved, McConn said. Otterbein's small house neighborhoods exceed state and federal quality benchmarks for antipsychotic drug and physical restraint use, rehospitalization and pain management, she said. The neighborhoods also experience lower staff turnover and higher family, resident and staff satisfaction, McConn said, and occupancy of the small houses is 95 percent compared with a state average of 86 percent for skilled nursing.

And McConn and Gruber said they welcome the chance to help others implement the model successfully. Otterbein, she pointed out, learned the ideal elder/elder assistant ratio to "keep it more like a family," as well as other information, from a Green House community in Tupelo, Miss. "We share information freely. …I want to get to the point where, someday, somebody says, 'What was an institutional nursing home?'" McConn said. LTL

The household dining room with satellite kitchen in Vetter Health Services' Brookstone Meadows community offers residents an improved dining experience. (*Photo by Tom Kessler*)

Household dining yields lower costs, higher satisfaction

BY LOIS A. BOWERS, SENIOR EDITOR

A household dining model using satellite kitchens results in lower net costs for communities and an improved dining experience for residents, according to Mitchell Elliott, AIA, an architect and chief development officer of Vetter Health Services.

The Omaha, Neb.-based privately held owner and operator of 30 long-term care communities—primarily skilled nursing—in the Midwest has been experimenting with dining options since 1998, Elliott said. Those options have included traditional dining; household dining with serving kitchens, with most food prepared in a central location and delivered to serving lines; and household dining with satellite kitchens, with more food being prepared closer to the living spaces. At an Environments for Aging Conference session titled "Household Dining: A Bad Aftertaste or a Succulent Delight?" Elliott and Ed Rowswell, culinary coordinator, and Mary Ann Thurman, MAM, RDN, LMNT, CDP, dietary services coordinator, shared the company's experiences.

Satellite dining facilitates resident choice by enabling items to be prepared to order, Thurman said. Also, because food is prepared closer to where it is eaten, it is more nutritious, more attractive and served at a more ideal temperature, resulting in increased consumption and a reduction in weight loss among residents, she added.

When planning dining rooms that have satellite kitchens, Vetter makes them big enough to accommodate 20 percent more people than resident capacity, Elliott said; because the food is better, more resident family members dine in the communities.

When it comes to staffing under the model, Thurman said, "We consider eating an ADL. It's 'all hands on deck.'" Nurses are "very engaged" in the process, working with dietary staff members to see that all residents are served, she added.

Some employees won't like the changes—for instance, a dietary staffer may not welcome participation by nursing staff, or nursing staff may not wish to participate in serving meals. That's why it's important not to measure the success of a household dining model based on staff turnover, Elliott said. "You're going to lose people. Some people just can't make the transition" from a traditional dining model, he added.

Research telling

Vetter researched its food costs and surveyed residents and their families and found that the increase in food costs associated with a satellite kitchen was "more than offset" by a decrease in staffing costs—and quality improved, Elliott said.

Specifically, Vetter found that offering household dining with a satellite kitchen resulted in a 16 percent increase in food costs compared with using a central kitchen. Rowswell attributed the cost increase to increased inventory to enable resident choice as well as the higher number of family members eating at the communities.

Dietary staffing costs under the satellite kitchen model, however, were 72 cents per patient day (ppd; meaning that if a resident's charges were $100 per day, 72 cents of that amount goes toward staffing) compared with 80 ppd under a central kitchen model. "Multiply that by 365 days per year by 120 residents and you start to see some benefits," Elliott said.

Benefits are more than financial, he added. Vetter surveyed residents of one community and their family members and found that 80 percent and 45 percent, respectively, "strongly agreed" that the community offers a quality dining experience under the household dining model, compared with national averages of views of overall dining experiences of 31 percent and 30 percent, respectively. When asked about the quality of meals, 100 percent of residents and 52 percent of their family members said that the quality of meals was "extraordinary" under the household model, compared with national averages of the views of overall meal quality of 29 percent and 33 percent, respectively.

"Everyone has an opinion about food, and we are serving a generation of good cooks," so the results are encouraging, Elliott said.

Design considerations

When moving to a household dining model, Elliott said, several design considerations are important to ensure that the spaces not only are beautiful but also are functional. Among them:

- the distance between where the food is prepared and where it is served (which has efficiency, visual, nutritional, food safety and housekeeping ramifications);
- ergonomics for staff members (for instance, use of an under-the-counter dishwasher may result in back problems);
- safety issues, including all applicable laws, regulations and codes;
- the size and layout of the kitchen and dining areas to enable efficient and resident-friendly serving as well as socialization;
- location of commercial equipment in a way that maintains a home-like atmosphere while accommodating the needs of staff members; and
- placement of areas for ice so that everyone needing to access it has it.

Collaboration is vital so that all considerations are included in the design process, he said.

Cognition assessments under fire

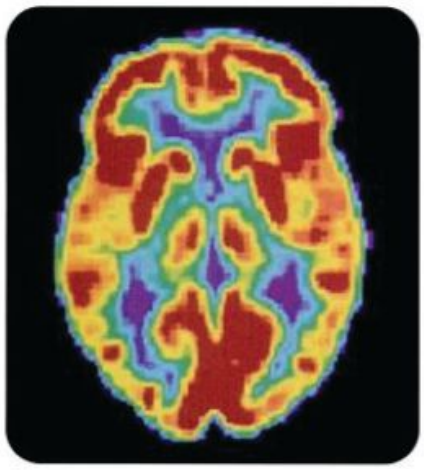
A new report says there's no clear case for or against cognition screening in symptom-free adults—ruffling the feathers of screening proponents

BY PAMELA TABAR, EDITOR-IN-CHIEF

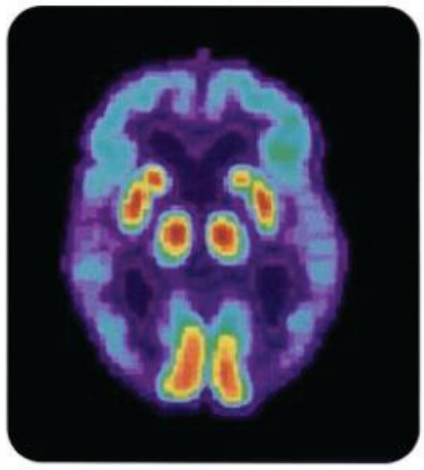
The case for cognition screening for symptom-free older adults came to a boil again following a report questioning the efficacy of screening tools. The report, released by the U.S. Preventive Services Task Force (USPSTF) and published online March 25 in the *Annals of Internal Medicine*, concluded that no clear value case exists for the benefits of screening older adults who have no signs of impairment and, in some cases, screening results may lead to more harm than good.

The task force found "inadequate" evidence to support the benefits of no-cause screening and evaluated whether the screening process delivered enough benefits to outweigh possible issues with early drug therapies.

"Evidence shows that several drug therapies and nonpharmacologic interventions have a small effect of cognitive function measures in the short term for patients with mild to moderate dementia, but the magnitude of the clinically relevant benefit is uncertain," the report concluded. In addition, the report warned of problematic situations that can arise when drug treatments are enacted because a screening test was positive: Many of the drugs approved for dementia have dangerous possible side-effects, including liver damage, slow heart rate and falls attributed to fainting.



PET Scan of Normal Brain



PET Scan of Alzheimer's Disease Brain

The recent report echoed the statements in the USPSTF's 2003 report on cognition screening, a disappointment for organizations that have developed new tools for cognition testing, early interventions and brain stimulation exercises in the 10 years between reports.

The Alzheimer's Foundation of America (AFA) voiced its frustration at the report's findings, saying that the report seems to dismiss the new advancements in screening and devalues the role of a positive screening result to "raise a red flag" for older adults who may not have shown prior symptoms of cognitive decline.

"Early detection of Alzheimer's disease can empower individuals and their families to take a more proactive approach to care planning and treatment and thus help improve quality of life," said AFA CEO Charles J. Fuschillo Jr. in a foundation statement. "Individuals can take advantage of available treatments when they are most helpful, before symptoms have progressed. There is a substantial benefit to identifying a 65-year-old with mild cognitive impairment who is currently in a stage in which FDA-approved medications can slow progression of symptoms and postpone costly nursing home placement."

Some also fear that the report's findings could be misinterpreted, causing all dementia screening tools to be devalued and possibly discouraging people from participating in clinical trials. "Identification of those with pre-symptomatic dementia is

Some also fear that the report's findings could be misinterpreted, causing all dementia screening tools to be devalued and possibly discouraging people from participating in clinical trials.

8 effective screening tools

The USPSTF report examined various screening tools and deemed the following eight tests as effective for detecting mild cognitive impairments:

- Clock drawing test
- Informant Questionnaire on Cognitive Decline in the Elderly
- Memory Impairment Screen
- Mini-Cog
- Abbreviated Mental Test
- Short Portable Mental Status Questionnaire
- Free and Cued Selective Reminding Test
- 7-Minute Screen

Source: USPSTF report, March 2014

critical for participation in clinical trials as research into promising drug therapies is taking place earlier in the disease progression," Fuschillio added.

The report is also seemingly at odds with the Centers for Medicare & Medicaid Services' Annual Wellness Visit initiative. The program, instituted in 2011, provides those with Medicare Part B benefits for longer than one year an annual, deductible-free visit to review personal health risk factors, including the "detection of any cognitive impairment."

The USPSTF report serves as a recommendation and does not mandate the use or disuse of screening tools. The report also identifies eight screening tools deemed to be effective [see sidebar].

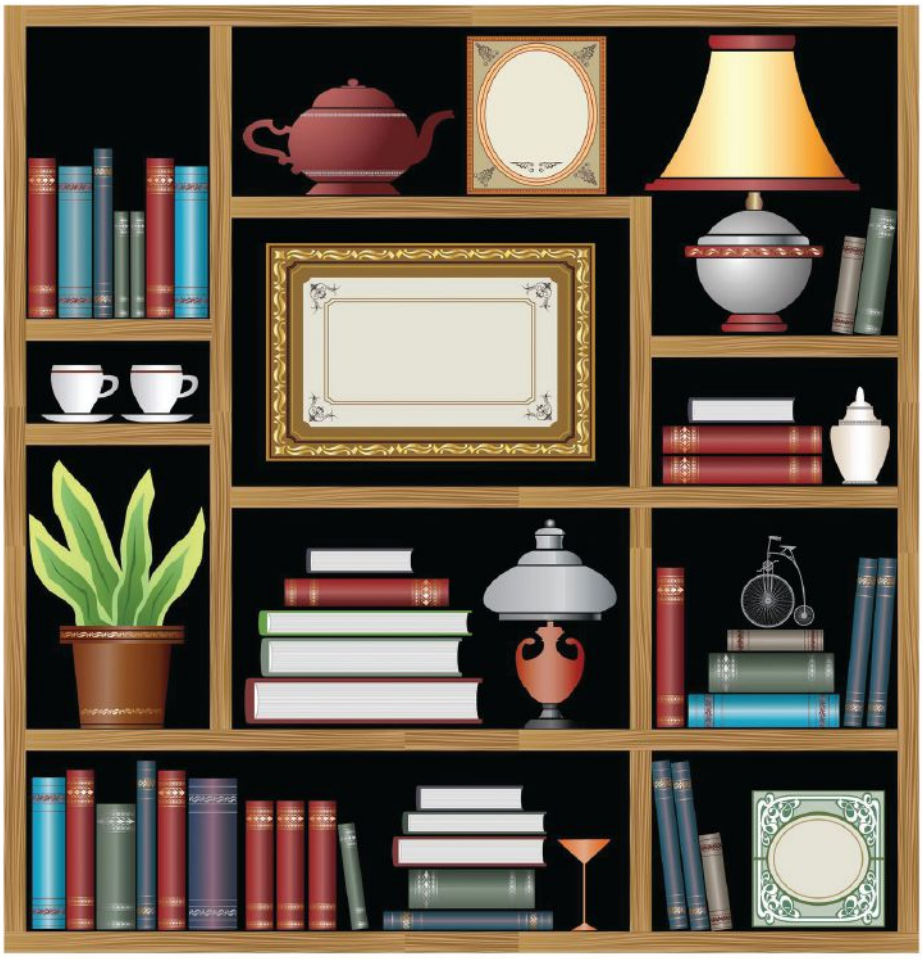
But the report has re-opened the discussions on cognitive screening, including the need for physicians, residents and families to discuss the efficacy of screening tools, increase education on what the test results mean and discuss any drug treatments carefully.

The American Geriatrics Society included the topic in its February "Choosing Wisely" List, noting that certain drug trials and treatments for dementia should be discussed at length: "Clinicians, caregivers and patients should discuss cognitive, functional and behavioral goals of treatment prior to beginning a trial of cholinesterase inhibitors. Advance care planning, patient and caregiver education about dementia, diet and exercise, and non-pharmacologic approaches to behavioral issues are integral to the care of patients with dementia, and should be included in the treatment plan in addition to any consideration of a trial of cholinesterase inhibitors." LTL

Memory boxes? Forget about them

Long-term care communities are moving away from using memory boxes as cuing tools for residents

BY LOIS A. BOWERS, SENIOR EDITOR



It's an awful lot of money to invest, and a lot of my clients don't have that money anymore," said Julie Bessant Pelech, BES, C. Gerontology. Pelech, of Bessant Pelech Associates, facilitated a workshop titled "Juggling Act: Design Solutions for Person-Centered Care" with Jane Rohde, AIA, FIIDA, ACHA, AAHID, principal of JSR Associates; Sandra Harris, principal of S Harris Interiors; and Elizabeth "Betsy" Brawley, AAHID, IIDA, CID, a healthcare interior designer with Design Concepts Unlimited.

The issues with the boxes—often built into walls at the entrances to resident rooms to indicate to residents that they have reached their personal spaces—go beyond cost, however, Pelech added.

"I can tell you of all the buildings I've worked on, where the vast majority do have those memory boxes, when you go back [to visit], they actually kind of underscore who has a caring family and who does not. So it can be really very depressing," she said. "And if they're not used, then why are they there?"

Some families are active in residents' lives, Pelech said, but they do not realize that it is their responsibility to fill the boxes with mementos. "If they're not used appropriately, with real cuing tools for the resident, then they are useless as a landmark or a cue," she added. Communities with buildings that incorporate memory boxes into their designs should improve education of staff and family members so that the boxes are filled with appropriate items, Rohde said.

A family photo "might be more effective than spending a whole lot of money on a memory box...."

Research on the effectiveness of the memory box as a cuing tool is limited, the speakers noted.

"For 20 years, this has been a standard practice…and I can tell you that we're actually migrating away from the memory box as long as we have some other things at the door," such as a permanent frame, Pelech said. A family photo "might be more effective than spending a whole lot of money on a memory box that we're not 100 percent sure that your staff are going to help families know that that's their responsibility to bring that memory box alive," she added.

Harris suggested alternatives such as individualized mailboxes or doorknockers. LTL

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VENDOME HEALTHCARE MEDIA

Effort seeks new name for CCRCs

Ideas due June 13; recommendations to be announced in fall

BY LOIS A. BOWERS, SENIOR EDITOR

It's about the 'R' word—retirement, says LeadingAge President and CEO Larry Minnix. And the 'C' word—care, he adds.

Those two words and older adults' perceptions surrounding them are leading the association of not-for-profit aging services providers to partner with one of those providers, Mather LifeWays, to spearhead an effort to develop a new name for continuing care retirement communities (CCRCs). The "CCRC NameStorm" initiative featured three in-person events in late April and early May, and communities also can conduct their own idea-generating activities with administrators, staff, board members, residents and prospective residents and submit them online by using brainstorming exercises and other resources at **leadingage.org/namestorm/**.

All ideas are due June 13. Results from all efforts will be shared with focus groups and LeadingAge members to determine finalists. Minnix says he expects that some conclusions and recommendations will be announced this fall at the LeadingAge annual meeting, which will have the theme of "Redefining Age."

The undertaking "was prompted by the multiple signals we were getting from members and consumers that our language is becoming outdated,"

Larry Minnix

'ANTIQUATED' LANGUAGE

The undertaking "was prompted by the multiple signals we were getting from members and consumers that our language is becoming outdated," Minnix tells *Long-Term Living*. "If you go into a modern [CCRC] and ask the people living there, 'Do you think of yourselves as retired?' many will say, 'Well I guess I am, but I'm still on three boards, and I'm still making stuff for underprivileged children,' so the 'R word' is becoming antiquated."

Mary Leary, president and CEO of Mather LifeWays, says her organization realized that issues with the term CCRC existed 10 years ago when it announced plans for a new community in Evanston, Ill.

"We sought to attract the next generation of older adults, and I felt that the term CCRC would not necessarily appeal to a younger age group because the name tends to emphasize a downward spiral in terms of age and health and ability," she says, noting that consumers in the Chicago area are quite familiar with the terminology because of the many communities in the area. "We developed other ways to describe what

it was intended to be—such as a lifestyle community, or a forward-thinking solution, or a single retirement choice offering a continuum of living choices, or a retirement option—and then, when we had to respond to questions regarding what the new community would encompass, people would then say, 'Oh, so you're planning a CCRC.' So we were back to using CCRC as a primary descriptor, and we realized we needed to go back to the drawing board and rethink how best to approach this to achieve a new name that would resonate with older adults and one which could be accepted and used by others in the industry."


Larry Minnix

'SHOCKING' RESEARCH

Leary says that Mather LifeWays' subsequent market research—focus groups and telephone surveys—has revealed additional issues with the term.


Mary Leary

"We learned that a CCRC can carry a strong negative connotation for those who are unfamiliar with the concept, and also we heard that the 'continuing care' aspect of the name implies that somebody already needs care, so it often doesn't have immediate relevancy for those who are still active and independent," she says. "And further, we learned that in older adults' minds, they have a perceptual map of the continuum, and they actually see a CCRC as being further along the continuum, toward the end of life, than a retirement community, which was shocking to us.

"So the terms 'continuing care' and 'retirement,' we heard, are not aspirational in the eyes of prospects, and people felt that they tended to imply that people who live in a CCRC are less engaged, less connected or less capable," Leary says. "And we learned that prospects connect better with words that reference things like being productive, connected and engaged."

So Mather LifeWays approached LeadingAge about partnering in the effort to develop new terminology, she says.

"So the terms 'continuing care' and 'retirement,' we heard, are not aspirational in the eyes of prospects, and people felt that they tended to imply that people who live in a CCRC are less engaged, less connected or less capable," Leary says.

NEW NAME CRITERIA

A new name resulting from the rebranding process, Minnix and Leary say, must focus on the consumer experience versus services provided—connecting with prospective residents on an emotional level, must not contain words that limit consumer perceptions of what is offered or limit what communities actually offer, must be able to be trademarked (meaning that the terminology isn't already in use, Leary says), must be memorable and easy to say, and must "seamlessly complement and correlate to CCRC brands."

"It could be both an expansion of what is currently offered or changing up what is offered," Leary says. "I think right now, the phrase [CCRC] makes an assumption that all communities offer a continuum of care, and…there are lots of different, new concepts afoot that are changing what that continuum looks like and how it's provided."

The renaming process, she predicts, may force providers to think about the services they offer now and how they might want to change in the future.

USING THE NEW TERM

It will be up to the more than 1,800 individual CCRCs across the country to decide whether they will use whatever new name arises from the process, Minnix says.

"We don't necessarily want to get into having people change their financing documents or going back to their state legislatures to get a legal name changed, although perhaps it could come to that," he says. "But what we think this will be is the start of what the brand of CCRCs really is. For example, I can see one outcome of this is us changing the name category among our membership. So CCRCs would no longer be the category of membership for us, but it would be whatever this new label is."

Leary says she hopes that state and federal regulators ultimately will use the new term.

And a chance—albeit perhaps a small one—exists that the terminology won't change, Minnix adds. "We just have to see what comes out of it and what really resonates with people," he says. "We may not make a change at all, but the marketplace is really very subtly challenging us to come up with new language." LTL

See the results of a 2011 survey of families of those living in CCRCs, conducted by Mather LifeWays, Brecht Associates and Ziegler, at matherlifeways.com/archives/458.

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One-on-one with… Shawn Bloom

The Programs of All-inclusive Care for the Elderly (PACE) serves 42,000 nursing-home eligible seniors who receive clinical care and daily living support within their communities as an alternative to skilled nursing care. Utilizing a bundled payment structure, PACE's model brings together teams of physicians, nurses, social workers and therapists to devise and implement individualized care plans for seniors in a community setting.

Shawn Bloom has been the president and CEO of the National PACE Association for 14 years. He is responsible for the association's strategic direction and operational activities. Previously, Bloom served as executive director of the Missouri Association of Homes for the Aging and also worked in the Policy and Governmental Affairs Department at the American Association of Homes and Services for the Aging (now, LeadingAge). He recently shared PACE's story of success and the organization's plans for the future with *Long-Term Living*.

PACE recently expanded to 103 programs. What were the challenges along the way?

While the National PACE Association does everything it can to support the growth of PACE, the credit for reaching 103 programs really goes to the sponsors who have a vision to create a program that can help families and older people in their communities. Once they have that vision, then they have to create a PACE organization.

There are a few common challenges to getting PACE started. Because it is still not well known, generating community support can be a challenge. Also, before we enroll the first person, the PACE organization has to build the PACE center, develop a transportation system, and employ all the members of the interdisciplinary team. So there is large upfront invetment before the program is paid the first dollar. Currently, only not-for-profit organizations can start PACE programs.

How does the program model work, including provider networks, reimbursements and outreach?

We are community-based providers that directly employ an integrated team of doctors, nurses, social workers and others that provide all needed medical care and long-term services and supports, including transportation, adult day care, physical and occupational therapy and even meals if needed.

While care and services are delivered across settings, the team is based in a PACE center. We are paid a set amount each month, adjusted some by the diagnoses each person has. From that amount of money we are totally responsible for that person's healthcare from emergency room access to hospital and nursing home care.

Because the program is responsible for all necessary care and services, PACE has the incentive to provide high-quality primary and preventive care and services to avoid in-patient utilization costs. In PACE, the clinical and financial incentives are perfectly aligned. Because team members are primarily responsible for providing care and services each day, they can detect and address changes in a participant's needs very quickly. That is a key reason the program can keep more than 90 percent of its enrollees out of nursing homes.

Who is the typical PACE client?

To enroll in PACE, a person must be 55 years old or older, certified to meet the state's nursing home level of care, live in the PACE service area and be able to live safely in the community with the help of PACE services at the time of enrollment. Our typical enrollee is a 79-year-old woman who lives alone, has difficulty with three of more activities of daily living, and just had a setback that is causing her to look for increased access to services at home so that she can avoid moving to a nursing home.

How has the ACA affected PACE?

Many of the principles and goals of the Affordable Care Act have been embraced by PACE for many years—bundled payments, fully integrated care, medical homes…. With an aging population and a renewed emphasis on serving those eligible for both Medicare and Medicaid, we see tremendous potential for growth. PACE is a complement to health plans because the model is able to integrate not only different funding streams, but also, more importantly, completely integrate the delivery of care and services. The focus is on what is best for the care of the person, not what is covered by Medicare, Medicaid or insurance.

What's next for PACE?

We think the principles that make PACE a successful model for older adults who need access to care and services would also make it a successful model for serving other populations with similar levels of needs: for example, younger adults with physical or intellectual disabilities or people with multiple chronic health needs. As states look to enroll more, if not all, of their Medicaid-eligible individuals into managed care plans, having a managed care option with a fully integrated network of caregivers like PACE is very attractive to them.

We hope that as PACE grows, more people will become aware of the type of care PACE provides and will work to have it available in their community. LTL

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