

The Green House® Program

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Editors' Introduction

How does one care for older people in a society that does not respect or value age? Finding the answer to that question presents a major challenge, one that will only grow more difficult as the population ages. Already, 10 million Americans receive some form of long-term care assistance, and as many as 44 million relatives and friends are helping them. The cost is staggering, both in personal and financial terms: long-term care consumes more than \$200 billion a year in government spending—and this doesn't count the hundreds of billions of dollars families contribute in time and money.

An overwhelming percentage of seniors prefer to remain at home or live in their communities. This explains the great interest in home health care (now the fastest rising part of the Medicaid budget) and community-based care, such as adult day centers, congregate living facilities, and continuing care retirement communities.

Nursing homes are widely considered to be a last resort; they are often thought of as large, cold institutions where old people go to die. This stereotype is true to a great extent, but some aspects of nursing home care are changing. One of the changes is represented by Green House, a smaller and kinder sort of nursing home. Green House is the brainchild of a visionary pediatrician named Bill Thomas, who originally developed the concept with the support of the Fan Fox and Leslie R. Samuels Foundation. In 2002, the Robert Wood Johnson Foundation awarded \$305,000 to Thomas's organization to advocate for and test the Green House idea in Utica, New York. That test didn't happen, as this chapter explains, but the seed was planted. Steve McAllily, head of the United Methodist Senior Services of Mississippi, heard Thomas speak, experienced his own conversion, and decided to replace United Methodist's Cedars nursing home in Tupelo, Mississippi, with twelve Green Houses. The Green Houses were opened in Tupelo, Mississippi, in 2003. Since that time, the Foundation has awarded nearly \$12 million, primarily to NCB Capital Impact, to develop, test, and evaluate the concept,

which has received wide praise as an innovative approach to caring for the frail elderly.

In this chapter, Irene Wielawski, a veteran investigative reporter and a founder of the Association of Health Care Journalists, examines the Green House Program. She explores the beginnings and development of the idea, reports on visits to two Green Houses, and concludes by offering some thoughts on the viability of Green Houses as an alternative to traditional nursing homes.

Stanley Radzynski remembers the Army fondly, but not for the three years he served in the China-Burma-India Theater during World War II. Rather, it's for the day he reported for duty as a stenotype operator and caught the attention of the officer in charge. Like Radzynski, the officer was from a large Polish-American family, and in a subsequent letter home suggested that his sister, Edna, write to the "nice Polish boy" in his unit.

The letters were the beginning of a lifelong romance. The couple married in 1947 and, unable to have children, lived in singular devotion to each other. They bought a two-family house in Radzynski's hometown of Albany, New York and grew old together, secure in the routines of their long, shared life. That is, until the day Radzynski arrived home to find his wife lying unconscious in a pool of blood.

She had slipped and fallen, fracturing her skull, a shoulder, and both arms. Surgical repairs and six months in a rehabilitation facility enabled her to return home, and the couple, now well into their eighties, were able to manage for a while with the help of visiting nurses. But then Stanley and Edna both fell as they tried to unfold her wheelchair, and neither could get up. Rescue crews took them to the hospital, and from there they joined the ranks of some 1.5 million Americans living in nursing homes.¹

The Radzynskis' entry into residential care was fairly typical; experts cite injury, debilitating illness, and dementia or other cognitive impairment as the chief reasons for this transition from independent living to institutional care. At one time, the Radzynskis' accidents might have forced them into separate facilities specializing in their particular medical needs. (Edna developed dementia and had difficulty communicating.) But they remained together until Edna died in 2010, thanks in part to an innovative residential care model called Green House[®].

Green Houses, at first glance, seem to be a radical departure from the hospital-like fortresses most people associate with nursing homes. They're designed to look like suburban ranch houses. (The cluster of Green Houses in upstate New York where the Radzynskis live could easily be mistaken for a middle-income housing development.) Each Green House has no

more than twelve residents and operates to foster a sense of community among residents and staff, while also de-emphasizing the top-down hierarchy of traditional nursing homes.

Their charismatic founder, the geriatrician William H. Thomas, who calls himself a “nursing home abolitionist,” describes Green Houses as the antithesis of the “ageism and declinism” that permeate traditional long-term care institutions. Thomas sees old age, despite the infirmities and disabilities that accompany this stage of life, as simply another phase of human growth and development, which ought to be supported by the environments in which old people live. Skeptics, meanwhile, say Green House is a boutique concept that has yet to prove versatile enough to accommodate the spectrum of old people’s health and safety needs at reasonable cost.

In 2002, the Robert Wood Johnson Foundation began a series of grant-funded investigations into the viability of such small community-based nursing homes. By mid-2010, eighty-nine Green Houses were up and running, partly as a result of the Foundation’s support. But Green Houses remain very much a work in progress for early adopters, who have been propelled by Thomas’s vision into terrain with few scientific markers but many passions. Those passions reflect not only our unease with old age and impending death but also our unease with deficiencies in the status quo.

Who Wants to Live in a Nursing Home?

In a 2007 public opinion survey by the Kaiser Family Foundation, only 4 percent of respondents said they would opt for nursing home care. About 75 percent said they would prefer to remain in their homes with assistants or to move in with relatives if they could no longer care for themselves. Even more damning were responses to a question about whether they believed nursing home residents are better or worse off than they were before they left their homes. Only 19 percent thought people benefited from nursing home care, whereas 41 percent said being in the nursing home made people “worse off than they were before.”²

Pretty low marks for an industry that accounts for more than \$130 billion in state and federal expenditures alone.³ And it's not just lacerating polling data or the latest exposé of terrible conditions that has given nursing homes a bad name. Today's nursing homes have spent nearly a quarter century under an official cloud—ever since an Institute of Medicine (IOM) report in 1986 described a failed system of state and federal oversight and wide variation in the quality of care.⁴ The IOM report detailed widespread dissatisfaction with the status quo.

Congress responded with reform legislation, embedded in the Omnibus Budget Reconciliation Act (OBRA) of 1987. The Health Care Financing Administration (now called the Centers for Medicare & Medicaid Services) followed up in the early 1990s with regulations that were focused on residents. Among other things, nursing homes were required to develop individualized care plans with an overall goal of helping residents achieve their best possible physical and mental function.

OBRA 1987 routinely receives star billing when experts talk about improvements in the quality of long-term care. But although improved regulations and better oversight have helped, they're by no means the sole reason for a greatly improved and still transforming industry today. Market factors and an aging long-term care infrastructure combined with a growing *culture change* movement have opened the field to experimental and innovative ideas like Green House.

Perhaps the greatest stimulus (considering that for-profit companies operate most of the nursing homes in the United States) is the graying of the Baby Boom generation. This population bulge—demographers call it “the pig in the python”⁵—has loomed over every long-term care initiative since the first White House Conference on Aging in 1961. Baby Boomers were born between 1946 and 1964,⁶ meaning they'll begin to cross the threshold of old age in 2011. Demands on the nation's health and social welfare system are projected to increase steadily, even as there are proportionately fewer workers contributing to these largely tax-financed programs. In raw figures, the number of Americans aged 65 and older is expected to

reach 81 million by 2040, double what it is today.⁷ About 70 percent of Americans are expected to need some form of long-term care services during their lifetime.⁸

Of more immediate concern is the poor physical condition of many of the nation's ¹⁶,100 certified nursing facilities. Most were constructed in the decade following Congress's passage of Medicare and Medicaid in 1965—which included money for rehabilitation and convalescent care—and are due for renovation. This need has opened the door to new ideas in nursing home design and function. The older model was fashioned on hospitals, partly because of the dictates of regulations governing the construction of health care facilities. As a result, even though the idea was to build “homes” for frail or sick people who could no longer live independently, what emerged were big buildings that looked like hospitals. They also ran like hospitals, with semiprivate rooms, rigid schedules for residents' wake-up and bedtimes, meals, exercise, and so on, with many hierarchical layers of supervision and authority.

“Before the building boom in the 1960s and '70s, there were the old-fashioned rest homes for the aged, with overstuffed chairs, private bedrooms, and gang bathrooms,” recalls Monsignor Charles J. Fahey, a Catholic priest and scholar at Fordham University who chairs the National Council on Aging. “There were also private homes, often [owned by] a nurse and her husband, who took elderly people in for income.”

In scale and ambiance, new concepts like Green House aren't so different from this nineteenth- and early-twentieth-century model. But they're intended to go beyond simply a homey look to create an environment that supports residents' self-determination, dignity, and life goals, while also delivering twenty-first-century medical care. These environmental principles are the hallmark of the culture-change movement in long-term care. The people behind it are a diverse group that includes consumers, nursing home administrators, and medical professionals like Bill Thomas, who are loosely affiliated through an organization called the Pioneer Network, which was founded in 1997. Even an “abolitionist” like Thomas acknowledges the resulting improvements in traditional nursing homes.

“Institutional long-term care facilities are radically better than they were twenty years ago,” he says, noting a lag in public recognition, as evidenced by opinion polls like Kaiser’s, and also the influence of human psychology on poll results. “The results in every survey of older people are staggering. If you ask them what they are afraid of, death comes in third; the top two are being placed in a nursing home and loss of independence. People abhor and dread the prospect of institutionalization. The vast majority will say, ‘I want to live at home,’ even if that means living alone without the social opportunities of a well-functioning institution.”

Which is why Thomas wants the hospital-like structures replaced by Green Houses.

“There is no other way,” he says. “A nursing home is still an institution. There’s a deeply flawed view of humanity that occurs in those buildings. To be generous, it’s an asylum mentality that prevails in nursing homes, as in prisons or state psychiatric hospitals.”

The Green House Idea Takes Shape

In calling for the abolition of nursing homes and all forms of *institutionalization* of the aged and infirm, Thomas speaks to people’s highest aspirations for ailing loved ones as well as to their deepest fears about the setting and conditions of their own demise. He has written several books and has lectured widely on his vision of a more humanistic model of care for the frail elderly. His passion for this idea is described by many as compelling—and infectious.

Laurie Mante, an administrator on the nursing home side of Northeast Health, a not-for-profit health care organization based in Troy, New York, remembers being so mesmerized by one of Thomas’s speeches that she returned to her job determined to demolish the facility that employed her—which she has largely succeeded in doing.

“I’m a fidget, can’t sit still and just listen, so my usual thing at lectures is to plunk down on a chair in the back and go through my mail,” Mante recalls. “All I can tell you is once Bill

Thomas started talking, I never opened a single envelope.”

Thomas similarly captivated the Robert Wood Johnson Foundation. Longtime program officers still recall his first visit in 2001 to their staid Princeton, New Jersey, headquarters, where deferential grant applicants typically show up in business suits. Thomas, whose home is a working farm in upstate New York, wore jeans, a sweatshirt, and Birkenstock sandals. Recalling her first impression, Nancy Barrand, the special advisor for program development at the Foundation, recalls him as “completely unconventional” in appearance and manner, but a riveting speaker.

The purpose of this 2001 visit was to present Foundation staff members with the results of Thomas’s Eden Alternative, a precursor to Green Houses that also intended to overcome what Thomas calls the three “plagues” of nursing home life: loneliness, helplessness, and boredom.⁹

Launched in 1991, the Eden Alternative aimed at leavening the institutional feel of nursing homes by adding homelike touches such as indoor plants, pets, gardens for cultivation, and attractive and easily accessible outdoor spaces. Some nursing homes embracing Eden principles also experimented with day care centers so elderly residents could have contact with children. These tangible changes to the look and feel of nursing homes were accompanied by staff education and operational changes to encourage residents’ participation in decisions about their daily routine.

A study published in 1999 by the Texas Long Term Care Institute found nursing homes that adopted Eden principles (Thomas’s Eden Alternative Web site states that more than three hundred homes in the United States, Canada, Europe, and Australia participate¹⁰) saw decreases in the use of restraints and mood-altering drugs, improved mobility and fewer pressure sores among residents, and reduced staff absenteeism and injuries.¹¹ But Thomas believed the approach could be taken further, and toward the end of his presentation at the Foundation he offered up the Green House alternative: wholesale replacement of large institutional facilities with small community-based group homes.

Jane Lowe and David Colby, both Foundation senior program officers at the time, and Barrand were interested. The Foundation had considerable experience with efforts to make life easier so elderly people could remain in their homes and communities. These efforts included new ways to integrate coverage and reduce paperwork for low-income seniors who were eligible for both Medicare and Medicaid, to provide affordable housing for elderly people, and to develop home care alternatives for those who otherwise would be forced to live in a nursing home.

Colby, who now is vice president for research and evaluation, and Lowe, who currently heads the Foundation's Vulnerable Populations team, decided to do some field research to investigate Thomas's Eden accomplishments and his assertions about the state of traditional nursing homes. Accompanied by a Foundation financial officer, Colby traveled to upstate New York to see the nursing home where Thomas first tested Eden principles and to evaluate Eden principles' impact on the cost of operations. Then he and Lowe visited a traditional nursing home in Boston that was nationally renowned for its quality.

"We came out of there and both of us thought, 'Shoot me if I ever have to go into a place like that,'" Colby recalls. They returned to Princeton determined to give Thomas seed money. Barrand also was on board. "I said, 'Give him a grant,' and we ended up giving him three," she recalls.

The Foundation's first investment in Green Houses was a relatively modest one-year grant of \$305,000 in 2002 to Thomas's Center for Growing and Becoming, in Sherburne, New York, to develop a business and development plan for Green Houses. Among specific tasks, Thomas was asked to create educational materials to advance the Green House organizational culture, train workers, identify technology necessary to operate a house-sized skilled nursing facility, and build a prototype for the program.

Architecturally, Green Houses mirror the overarching vision of Thomas and many others in the Pioneer Network—that people unable to live independently should still be able to reside in a place that accords dignity and respect for their abilities, interests, and life styles while also

providing essential medical care and support. The dwellings are truly homelike in appearance, with private bedrooms and bathrooms, a central family room and hearth, and an adjacent open kitchen and dining area, just as one might find in a family home. At the same time, the dwellings reflect the prevailing architecture of the community, and new versions of Green Houses are in development, including a high-rise model suitable for urban areas. The first high-rise model opened in Chelsea, Massachusetts, in 2010, and another is in development in Baltimore. After all, if you've lived in an apartment all your life, a facility that looks like a suburban ranch house isn't the best substitute for home.

The food is cooked on the premises, making mealtimes not just an event on a rigid, institutional schedule marked by delivery of trays, but rather a congregating time of day signaled by bustle, kitchen clatter, and inviting aromas. Medical equipment typical of skilled nursing facilities, such as mechanized beds, medication and crash carts, and feeding tubes and oxygen jets, is deliberately tucked away in wall closets or, in the case of the beds, made up with residents' own familiar quilts, pillows, and linens. A hoist to help staff move physically disabled residents from bed to wheelchair or bathroom is hidden in bedroom ceilings and doorway arches.

Many long-term care facilities have adopted homelike touches, but Thomas and other Green House advocates assert that the scale and the organizational structure of traditional nursing homes create substantial barriers to culture change. Private rooms are rare, and staff duties are so task-oriented (for example, food service, laundry, housekeeping, transport, clinical care, therapy, social service) that it's hard for residents to form relationships. This is not the case in Green Houses, which is perhaps the model's most significant contribution to culture change.

Green Houses reverse the traditional hierarchy of staffing in nursing homes, in which those who spend the most time with residents—certified nursing assistants (CNAs)—have the least say and the least pay. This isn't a great formula for job satisfaction, as evidenced by annual industry-wide turnover rates for CNAs of 71 percent.¹² In Green Houses, the CNAs are charged with running the house in consultation with residents, nurses, other medical specialists, and a

house manager, but minus the extra supervisory and administrative layers of a traditional long-term care facility. This frees up money to pay the certified nursing assistants more.

To emphasize the CNAs' enhanced hierarchical status, Thomas came up with new professional titles, semantically underscoring the break from the old ways. A CNA, who, in the Green House system receives an additional 120 hours of training, earns the title of *shabbaz*, the name of a compassionate falcon in a mythical kingdom invented by Thomas (the plural is *shahbazim*).¹³ The administrator or manager of the Green House was now a "guide." And residents became "elders," echoing folkloric connotations of wisdom. These titles were of a piece with the Green House mission to support the dignity and the capabilities of residents.

"The Green House rests on a foundation of human growth and development," Thomas says. "And if that is appropriate for the elders, it is appropriate for the staff. When it works optimally, it becomes a reciprocal relationship between the staff and the elders that produces vastly more psychic income than a CNA gets operating in a traditional nursing home, and frees the creativity that's tapped from having a decision-making role in the house. Also, by eliminating the middle management structure, you free up dollars to pay [staff] better for work that goes beyond simply following orders."

Implementing the Vision

The Robert Wood Johnson Foundation embraced Thomas's vision wholeheartedly. As presented in the Foundation's grant documents, Green Houses were an alternative to traditional nursing homes—described in these documents as "cold, sterile organizations" where seniors are "isolated from the community, lack dignity, and lose self-worth and independence." The original idea was to test the Green House concept in New York State, but the Foundation's authorization of the first grant to Thomas's Center for Growing and Becoming, Inc. came on the heels of the 9/11 terrorist attacks. More than 2,700 people perished in New York City alone; in the tumultuous aftermath, obtaining the necessary approvals from health officials in New York to develop a Green House prototype proved more difficult than

anticipated.

An alternate site was established in Tupelo, Mississippi, where Stephen L. McAlilly, president and CEO of Mississippi Methodist Senior Services, which owns and operates a faith-based nonprofit retirement complex, embraced the concept and made a commitment to replace its traditional nursing home with a cluster of Green Houses. In February 2003 and February 2005 the Foundation authorized two more grants to Thomas's Center for Growing and Becoming, partially to support the work in Tupelo.

Even as the Tupelo Green House was progressing, Foundation staff members say they became convinced that the Center for Growing and Becoming did not have the organizational capacity to manage national replication of the concept. Accordingly, when in November 2005 the Foundation authorized \$9.5 million to expand the Green House approach nationwide, it named NCB Capital Impact as the national program office. NCB Capital, a Washington, D.C.-based organization specializing in providing financial services and technical assistance to organizations seeking to create quality housing, education, and health care services for low-income people, had gained the Foundation's trust by effectively managing an earlier Foundation-funded housing program called Coming Home. The Foundation found a willing, albeit business-minded champion for Green Houses in NCB Capital's Robert Jenkins, now the Green House national program director, whose career has focused on creating an array of alternatives to institutional nursing home care for people with low incomes. NCB Capital engaged Thomas's expertise through a contract as well as through a license agreement for use of the trademarked name Green House.

The Foundation has authorized a total of more than \$12 million (including the \$9.5 million in November 2005) to NCB Capital to develop a business plan, recruit and provide technical assistance to long-term care organizations around the country, and build fifty Green Houses. The program has surpassed this goal, with eighty-nine Green Houses now operating in sixteen states (see Exhibit 2.1).

Beyond supporting NCB Capital in getting the houses built and occupied, the Foundation invested additional millions in research studies. The studies, many of them still ongoing, include inquiries into psychosocial aspects of Green Houses, such as: Are residents and their families happier? Are workers? Do the small size, amenities, and staff reorientation result in improved health status among residents? And—of critical importance as the nation grapples with excessive costs and service gaps in the larger health care system—are Green Houses affordable?

“This is not just a concept for touchy-feely types,” says David Morse, the Foundation’s vice president for communications. “You actually have to be pretty hard-nosed about what you can do practically and what is affordable.” Morse notes that views of Green House have evolved at the Foundation over nearly a decade of discussion and experimentation and that not everyone agrees. “There are still a lot of questions,” he says, noting that the Foundation wants Green Houses to be an option for all elderly people, not just the well off. This means factoring in the relatively low reimbursement rates of state Medicaid programs—a challenge to Green House administrators no less than to their colleagues in traditional nursing homes.

There are also quality benchmarks for medical and supportive care that must be reached. As more Green Houses come online, providing a larger pool of residents from which to capture data, they will be put to this test. Early studies of the first Green House complex in Tupelo identified positive trends. A study published in 2006 found generally positive self-reports from residents, staff, and families, but some administrative difficulties in flattening hierarchical relationships between CNAs, registered nurses, and other clinical professionals.¹⁴ The study concluded, “early experience suggests that Green Houses are feasible and that outcomes are likely to be positive.” An evaluation published in 2007 found that Green House residents rated their overall quality of life higher than that of traditional nursing home residents, had a lower prevalence of depression, were more likely to participate in activities, and had longer retention of independent living skills such as bathing, dressing, and using the toilet. On the negative

side, they had a higher prevalence of incontinence.¹⁵ A 2009 study also found greater satisfaction among residents' families, especially with the physical environment of Green Houses and with residents' privacy and autonomy.¹⁶

These studies offer a generally positive initial assessment of the Green House Program, albeit one that is based on the experience of a single site in Tupelo, Mississippi. The studies identify issues that need to be explored in greater depth as more old people, families, and long-term care professionals make use of and test the Green House model. In the meantime, early adopters of the model press on. Following are two snapshots from the field.

Martin House Tabitha Health Care Services, Lincoln, Nebraska

Keith Fickenscher, the former president and chief executive officer of Tabitha Health Care Services (he left Tabitha for another position at the end of 2009), vividly remembers the initial response of his directors to the idea of building a Green House. The nonprofit health care company, which operates skilled nursing homes and provides home care, hospice services, respite care, and adult day care services, had just sunk \$3.5 million into adding a rehabilitation center to its main nursing home in Lincoln—an investment that was starting to pay off, but not so heartily that Fickenscher's board was keen on more spending.

“They just kind of smiled and said, ‘Well, you know it sounds nice, but it’s just not practical,’” Fickenscher recalls. “It took a long time to persuade them, and there was skepticism even after they voted yes.”

The result of this debate is Martin House, a graceful, red-brick one-story house on a residential street half a block from Tabitha's traditional nursing home. Built and furnished for nine residents at a cost of \$1.4 million, the facility opened in May 2006, and in 2007 and 2008 generated surplus revenue over costs with six out of nine residents covered by Medicaid, according to Joyce Ebmeier, Tabitha's Green House champion and vice president of strategic planning. The company is planning construction of three more Green Houses even as it

continues to work out the bugs in Thomas's theoretical model.

Most of the problems are on the operational side. The Tabitha system was already well grounded in nursing home culture change from having implemented Eden Alternative principles in 2002. But transferring these principles from an institutional setting to a small, homelike facility proved more complicated than expected, leaving staff at Martin House and management at Tabitha to fill in the gaps through trial and error.

Notably, the original model placed so much emphasis on improving certified nursing aides' status and autonomy that it gave short shrift to important operational questions such as how to integrate nurses and other specialized staff into the care team for Green House residents, most of whom were very sick. The new titles for workers—*shabbaz* and *guide*—that Thomas created to underscore the philosophical underpinnings of culture change further obscured day-to-day roles and duties, as did the emphasis on nurturing residents' autonomy, staff members say.

“The model said elders had to have a choice every morning of when they wanted to get up,” says Angie Peterson, a shahbaz at Martin House and former certified nursing aide at Tabitha's traditional nursing home. “But that didn't exactly work, because we have some elders who if you gave them a choice, they'd never get out of bed, and others who'd never take a shower. We realized we had to have some structure.”

Nurses say they also had to adjust the model to insure timely and appropriate clinical care of residents because it wasn't clear to shahbazim when they had to call for nursing support. The issue of nursing supervision and quality of care has come up in many Green Houses and was the focus of a Foundation-funded study by Barbara Bowers and Kim Nolet at the University of Wisconsin-Madison School of Nursing. In a survey of eleven Green House sites, researchers found that clinical quality was not compromised by vesting greater authority in the shahbazim except in houses where nurses were seen as outsiders. In the latter case, researchers found lapses in communication of important clinical information. But in houses where the duties of shahbazim and nurses were well integrated, Bowers and Nolet concluded that clinical quality

potentially was better than in traditional nursing homes. Interestingly, the study found significant differences in the shahbazim-nurse relationship from site to site and even from shift to shift.¹⁷

Michelle Hunter, Tabitha's director of nursing for long-term care, said she was able to compensate for deficits in the training model by handpicking nurses from the "mother ship"—a term widely used by Green House staff members to refer to the traditional nursing homes with which they're affiliated. "The staff nurses that went over to Martin House were the cream of the crop, so I knew they'd figure out how to work out the new relationships with the CNAs," Hunter says, noting that her twenty-five-year tenure at Tabitha was a great asset in selecting seasoned nurses who could adapt to the flattened hierarchy without budging on patients' clinical needs. "But as this gets bigger and we have to hire into this model, we're going to have to develop more processes for communication and divisions of responsibility."

Martin House nurses and shahbazim say they have managed to craft relationships under the Green House collaborative model to make sure no one feels either over her head or underutilized. This teamwork has led to innovations that many acknowledge would not have been possible in the rigid staff structure of a traditional nursing home. One of these innovations is an enhanced electronic medical record for each resident that shahbazim, nurses, physicians, and other specialists contribute to.

This, Hunter and others say, leads to more comprehensive and potentially better quality of care than is possible in most medical facilities where access to patient records is restricted to clinical professionals. The shahbazim's close relationships with elders enables them to contribute "rich psychosocial content" that helps an episodic worker, such as a physical therapist, understand the patient's specific needs in a broader and more humanistic context. These daily caregiver notes, particularly on patients who can't talk or who have dementia or are otherwise cognitively impaired, can also alert clinical staff to behavior changes (such as unusual fatigue, irritability, or disorientation) that can signal infection or other medical trouble in frail old people. Thomas's theory of "psychic income" plays out as well in the satisfaction

shahbazim say they experience knowing they've contributed not only to elders' comfort but also to early detection of illness or injury.

Shahbazim say the Green House setting makes it easier for them to get to know residents and share their insights with fellow staffers than was possible in Tabitha's traditional nursing home, where the job emphasis was on accomplishing specific tasks—turning a bedridden patient to avoid bedsores, changing linens, assisting with personal care, and so on. These tasks are still part of the job at Green House, but the charge to shahbazim is to figure out how to work together to complete tasks efficiently so time is freed up to socialize with residents.

“I really think it helps that the elders don't have to put their trust in a hundred different employees rotating through on three shifts,” says James Williams, a shahbaz who previously worked as a CNA in Tabitha's rehabilitation unit. “There are only twelve of us here at Martin House, and because the elders see us regularly, it helps them open up and feel more like a person, not just a room number.”

Green Houses also smell great. No off-putting antiseptic, medicinal, or body odors here. At Martin House, visitors step into the aroma of fresh-baked chocolate chip cookies, cinnamon buns, or tangy spaghetti sauce. Recipes are often chosen for their pungency. The idea is to stimulate residents' appetites (weight loss is a significant problem in the very old) and create anticipation of a convivial gathering around the dining room table.

Videos and marketing brochures about Green House key in on these mealtime gatherings as a way to illustrate the homelike ambiance of these small-scale facilities. But staff and residents say the promotional materials tend to exaggerate the degree of interaction at meals or any other time. After all, Green Houses are licensed and reimbursed as skilled nursing facilities. Their residents suffer from the same serious physical and cognitive problems as residents of traditional nursing homes, which include stroke, dementia, swallowing, digestive and motor disorders, cancers and other acute illnesses, and chronic afflictions of the heart, lungs, liver, kidneys, and metabolism. A significant number of Green House residents cannot feed

themselves or communicate well and require assistance from shahbazim or family members.

They're also, by virtue of age and infirmity, short-timers in the Green House family, which can be very hard on staff. The death of a beloved resident—one of the first to die at Martin House—revealed significant deficits in the preparation of shahbazim for losing people they'd been trained to bond with so personally. Reacting protectively, as is their duty under the Green House model, shahbazim closed the house to new admissions for an indefinite period of mourning, recalls Fickenscher, Tabitha's former president and CEO.

"I'm hearing this as an administrator who knows the finances don't allow for unfilled beds," Fickenscher says. "It really surprised a lot of us, and it took a lot of explaining to persuade them that to stay viable we have to do some things that may not seem too sensitive but they're necessary. It was a very tough situation."

The experience illuminated the need for hospice-type training as part of the orientation for new shahbazim, according to Jeremy Hohlen, Martin House's guide. There's now also a "celebration of life" ceremony with refreshments, spontaneous storytelling, and even PowerPoint slide shows to mark an elder's passing—and clear the way for a new resident. Harsh as that may sound, Green Houses are businesses no less than nursing homes. This aspect of long-term care facility management is harder to disguise in a small, homelike setting than in a large institution.

On an evening last fall, Martin House residents and shahbazim gathered for dinner and welcomed some visitors to their table, among them Gregg Wright, a physician and former director of the Nebraska Department of Health, who had stopped by after work to visit his ninety-seven-year-old mother, Marian, one of Martin House's first residents when it opened in 2006. Marian Wright initially was in the middle of the group in terms of independence, according to her son, but now she's one of the most disabled. As his mother slumps in her wheelchair, eyes half-closed, Wright gently strokes her hand and tries to coax her into swallowing a spoonful of pudding.

Across the table is Margaret Hall, wheelchair-bound but fully able to handle her own knife and fork and converse amiably with residents and visitors alike. For most of her adult life, Hall worked as a librarian in Chicago, serving on the prestigious Newbery Medal committee of the American Library Association. She was a committee member when the novel *Charlotte's Web*, by E.B. White—destined to become a classic of children's literature—was nominated for the prize. "I voted for it—I didn't think any other nominee even came close," Hall recounts. "But I was in the minority and the medal went to another book."

Hall continues to be an avid reader and participates in the house book group, which sounds like just the sort of resident-sponsored activity Green Houses were conceived to nurture. But the book group's organizer, former schoolteacher Helen "Mike" Holmes, eighty-three, says her experience has been disappointing, illuminating a downside of small group living; it is difficult to find companions with similar interests and abilities.

"We haven't been able to get very far with everyone reading the same book," says Holmes, who'd just finished a biography of Eleanor Roosevelt and wished she had someone to discuss it with. "People forget to show up or when they do they haven't read the book or didn't like it so just quit reading. So now we just read our own book and share the stories if enough people show up for a meeting."

Holmes, though, is quick to put these observations in context, namely her decided preference for Martin House in favor of the life she had at Tabitha. She cites amenities like private rooms and bathrooms as well as greater personal freedom.

"I was on the second floor over there in the nursing home and my care plan said I couldn't go outside without an attendant," she says. "But now when the weather's good, I just wheel myself outside anytime I want. I can read on the patio or on the front porch all day long."

Family members like Greg Wright significantly extend the appreciative constituency of Green Houses. Indeed, they may be the model's strongest proponents—even after their loved ones have passed on. Zoe Holland still visits Martin House from time to time in gratitude for her

late mother's experience there.

Holland has testified on behalf of the Green House model before the Senate's Special Committee on Aging,¹⁸ eloquently describing the contrast between the four years her mother Mary Valentine spent in a traditional nursing home and her final year in Martin House. Valentine died three weeks after a grand 101st birthday party at the house, but during the year she spent there, recovered the spirit she'd lost sharing a cramped nursing home room with only a curtain for privacy and no place for personal mementos. And Holland says her own spirits rebounded with her mother's.

"We dreaded going to the nursing home to visit; the environment was just so depressing," Holland recalls. "But at Martin House, we could visit my mother in her room or on the porch or in the living room. Granddaughter Liz could play the violin for the whole house where before, at the nursing home, she had to play standing in the hall—the room was that small!

"Once I could see that my mother was happy and secure in the Green House, it was easier for my husband and me to travel, knowing we could call anytime and talk to caregivers who really knew her. The value of that peace of mind is hard to overstate."

Eddy Village Green Northeast Health, Cohoes, New York

Like her administrative counterparts at Tabitha, Jo-Ann Costantino, executive vice president of Northeast Health in upstate New York, had a bushel of logistical and financial variables to sort through before she could commit to constructing Green Houses. Scale was the overriding variable.

Northeast Health is like Tabitha in that it operates many health care businesses besides long-term care facilities. Northeast Health also ranges more widely than Tabitha, running hospitals, rehabilitation services, and primary care facilities, in addition to nursing homes and other services for the elderly. Its territory covers twenty-two counties surrounding the state capital of Albany. Its long-term care network is known as "The Eddy" after the founder of its first nursing

home, Elizabeth Hart Shields Eddy.

The Green House proposal dovetailed with an urgent need for renovation of two traditional nursing homes located at The Eddy's complex in Cohoes, New York. "Basically we had twenty-five- to thirty-year-old buildings that needed \$25 million in repairs—plumbing, electric, everything," says Costantino, who is also chief executive officer of the Eddy. For an estimated \$40 million, The Eddy could construct a village of Green Houses, move in the nursing home residents, and tear down the old buildings. This is the route The Eddy eventually chose, albeit with significant modifications to the Green House model. When completed, Eddy Village Green will feature sixteen ranch houses for twelve residents each, for a total of 192 skilled nursing beds. Laurie Mante, The Eddy's project manager, says the facilities' small size makes them easy to adapt to the clinical needs of a wide range of people—a flexibility that's important in the ever-shifting health care market and that helps justify The Eddy's construction investment.

"We're a nonprofit organization, but we have an obligation to operate in a fiscally sound manner," Costantino says. "What I'm saying is I'm not taking a bath on an idea, however appealing, that can't be justified by the numbers."

Bumping up the number of residents from ten (the optimal number for Green Houses, according to Thomas) to twelve was the first change to the model. "We simply couldn't make ten work financially," Costantino says. (Ten residents is the maximum for use of the trademarked Green House name, except in cases of demonstrated hardship, according to Jenkins, the national program director.) Staff training also differs from the original model, thanks in part to test runs by early adopters like Tabitha. The first houses at Eddy Village Green opened in December 2008, more than two years after Tabitha's Martin House. Administrators attended educational sessions offered by the Green House National Program office, but also visited the Tupelo project and consulted with frontline workers and managers elsewhere.

As a result, shahbazim and nurses at Eddy Village have been trained together from day one—and there’s no fuzziness about their mutual and separate responsibilities. “We saw a concept that went so far out of its way to elevate the shahbazim that it made the nurses outsiders,” says Diana Lloyd, director of nursing. “What we basically said about the model on this point is, ‘You blew it.’ Shahbazim have twelve extra days of training over traditional certified nursing assistants, which is very laudable, but it does not qualify them to do nursing work or make licensed practical nurse- or registered nurse-level clinical judgments.”

To delineate when shahbazim must hand off responsibility to nurses, Lloyd devised a two-hour course to help shahbazim recognize so-called emergent clinical situations requiring immediate medical response. The shahbazim are also equipped with call pendants; if one of them pushes the button, the nearest nurse must drop everything and rush to her aid.

Another departure from the model is the higher nurse ratio at Eddy Village—an adaptation to what administrators believe are sicker residents than at other sites experimenting with Green Houses. Most of the experimental sites function as satellites of traditional nursing homes and share the same campus. This enables them to be selective in who qualifies for the Green House. Eddy Village, in contrast, is designed to be freestanding with no institutional backup. Already, 85 percent of the elders in the sixteen completed houses have dementia, and some houses have no patients who are able to walk on their own or feed themselves or talk, according to Cheryll Schampier, guide (manager) of three of the houses. This contrast between the promotional image of Green Houses as convivial, interactive communities and the manifest acuity of illness and disability at Eddy Village fired up debate when a production company sought permission to film at Eddy Village for a video about Green Houses. “Across the board, the feedback from staff was, ‘OK, but not if they’re just going to focus on residents who can talk and smile for the camera,’” said Lloyd.

Shahbaz Tracy Price agrees the inspirational Green House message can obscure the reality of this final stage of life. The first resident under her care died three days after arriving in the

house. “It is not the utopia that they try to sell it as,” Price says. “We have elders with all kinds of personalities, attitudes, problems, and psychological states. It’s hard some days, and not everyone can be happy.”

But Price, a one-time nursing student who shifted to shahbaz training because of its emphasis on “hands-on personal caring,” also sees many pluses in the small-scale environment and many opportunities to be creative. “We have found that intergenerational mixing delights the elders,” she says. “My kids sometimes stop by to visit me here after school and the elders all know them. Pets are also very big. And we also see progress, which is very rewarding. A new resident came in with late-stage Alzheimer’s who we were told didn’t talk. Well, after a month here, she was talking.”

Conclusion

Stanley Radzynski is matter-of-fact about the circumstances that made it impossible for him and his late wife Edna to continue to live independently in their home. He accepts this stoically, with the understanding of every Green House resident interviewed for this chapter that their best years are most definitely behind them. There’s not a lot of talk about happiness or personal growth and development. Residents’ conversations tend to be about practical concerns and tangible, even if small, successes.

For Radzynski, a success was getting the Green House staff to rearrange the furniture in his and Edna’s assigned rooms so they could continue to share a bedroom and convert the other bedroom to a parlor. For Holmes, a success was being able to roll her wheelchair out onto the patio without needing permission or an attendant. For Eddy Village resident Frederick Britting, ninety-six, it’s the relief of having a private room after sharing one “at the big house” with a man whose wife hollered and threatened divorce every time she came to visit.

Because Green Houses are still relatively new, most of their current residents previously lived in traditional nursing homes. The elders’ comparisons are strikingly judicious in contrast to the rhetoric of nursing home reformers like Thomas. Green House residents go out of their way to

point out that their nursing home caregivers were good people, too, and some mention advantages of the large facilities such as more activities and a greater variety of people.

To position Green Houses as radically different from nursing homes, Thomas invented new language and a mythological story line to inspire nursing home workers to think differently about their jobs. He gave new titles and authority to frontline workers and special training to imbue them with a sense of mission. The idea of improving residents' lives by increasing monetary and psychic rewards for the people most involved in their care seems like Management 101, except that virtually no one did anything about the industry's shocking CNA turnover rate until Bill Thomas came along.

That said, evidence from the Green House field suggests that the long-term care reform movement would benefit from plainer speech about the realities of frail old age. Decisions at Eddy Village and Martin House to more closely integrate nurses into the care team were forced by deficiencies in a staff training model that failed to adequately account for the severity of illness and disability in people who require skilled nursing care. Additional training is now being done. "I think we underestimated how important it was to also train nurses to work in a Green House environment because we had changed so many elements of the traditional nursing home organizational model," says NCB Capital's Robert Jenkins.

Green House sites continue to work through operational issues such as these, while also keeping a close eye on costs so Green Houses can remain an option for people dependent upon Medicaid.

The Green House concept is unquestionably an attractive one, and there is sure to be push from families of the frail elderly attracted by the appeal of a homelike setting where an aged parent can receive sophisticated medical care and social support. Moreover, the long-term care industry has shown itself to be receptive to innovation, especially now as it girds itself for major investments to replace or remodel deteriorating facilities while also expanding capacity to prepare for baby boomers.

Time will tell, however, whether Green Houses and other congregate living models replace more institutional nursing homes or exist alongside them as one of many residential care options. Better knowledge about clinical, operational, and financial results from studies of Green House and other reform experiments will provide much-needed anchors for long-term care policy.

Notes

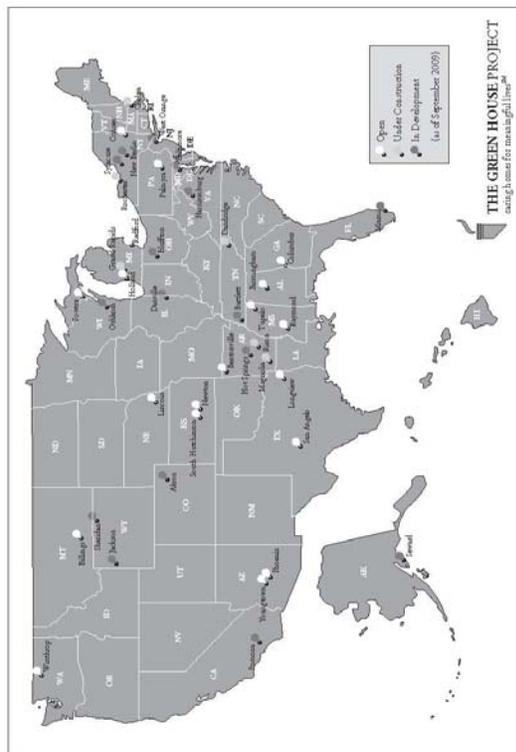
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Appendix: The Green House® Project Site Map



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