Department of Social Work and Social Administration
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Using Research Data to Drive Service Development

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March 4, 2024

Examples

- The Greenhouse Small group nursing homes.
- The Cash and Counseling Project.
- The Standardised Care Need Assessment Mechanism for Elderly Services (SCNAMES) and the Central Waiting List for Subsidised Long Term Care Services (CWL).
- Lessons Learned and Concluson.

The Greenhouse Nursing home project

History - Green House Project

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Green House Brings Intentionality to Eldercare

The Green House® Project's mission is simple. We believe that everyone has the right to age without sacrificing the joys of life. Since the beginning, Green House has worked to destigmatize aging and humanize care through the creation of deliberately non-institutional eldercare environments that empower the lives of those who live and work there.

The first Green House homes opened in 2003 in Tupelo, Miss., with the network growing significantly over the following years with initial support from the Robert Wood Johnson Foundation (RWJF).

When the pandemic descended upon nursing homes in 2020, elders and staff in Green House homes fared significantly better than their counterparts in traditional buildings. Research has since demonstrated that the Green House model is highly effective in preventing and mitigating the impact of COVID-19 and other viruses on elders.

Today, the Green House Project has helped organizations to build nearly 400 homes across 35 U.S. states and now Australia, redefining what it means to grow older with dignity. In partnership with our allies at Pioneer Network, GHP continues to develop and refine new ways of delivering eldercare services and supports with a focus on dignity, autonomy, and choice.


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SAY GRACE

The journey started here

Resident Outcomes in Small-House Nursing Homes: A Longitudinal Evaluation of the Initial Green House Program

Rosalie A. Kane, PhD, Terry Y. Lum, PhD,† Lois J. Cutler, PhD,* Howard B. Degenholtz, PhD,‡ and Tzy-Chyi Yu, MHA**

OBJECTIVES: To determine the effects of a small-house nursing home model, THE GREEN HOUSE® (GH), on residents' reported outcomes and quality of care.

DESIGN: Two-year longitudinal quasi-experimental study comparing GH residents with residents at two comparison sites using data collected at baseline and three follow-up intervals.

SETTING: Four 10-person GHs, the sponsoring nursing home for those GHs, and a traditional nursing home with the same owner.

PARTICIPANTS: All residents in the GHs (40 at any time) at baseline and three 6-month follow-up intervals, and 40 randomly selected residents in each of the two comparison groups.

INTERVENTION: The GH alters the physical scale environment (small-scale, private rooms and bathrooms, residential kitchen, dining room, and hearth), the staffing model for professional and certified nursing assistants, and the philosophy of care.

MEASUREMENTS: Scales for 11 domains of resident quality of life, emotional well-being, satisfaction, self-reported health, and functional status were derived from interviews at four points in time. Quality of care was measured using indicators derived from Minimum Data Set assessments.

RESULTS: Controlling for baseline characteristics (age, sex, activities of daily living, date of admission, and proxy interview status), statistically significant differences in self-reported dimensions of quality of life favored the GHs over one or both comparison groups. The quality of care in the GHs at least equaled, and for change in functional status exceeded, the comparison nursing homes.

CONCLUSION: The GH is a promising model to improve quality of life for nursing home residents, with implications for staff development and medical director roles. **J Am Geriatr Soc 55:832–839, 2007.**

Key words: nursing home; culture change; quality of life; longitudinal outcomes; quality indicators

After a critical 1986 Institute of Medicine report,[1] regulatory reform in nursing homes was launched, aimed at improved quality assessment, monitoring, and enforcement. A 2001 Institute of Medicine report noted improvements in overall health care but little reduction of societal dread of nursing homes[2] or improvement in quality of life.[3] The problems of maintaining a sense of well-being in a nursing home are well documented in decades of anthropological, ethnographic, and ethics studies.[4–9] Efforts to combat residents' learned helplessness with increased choices have resulted in measurable health benefits.[10–14]

A movement for culture change in nursing homes has gathered force since 1995, embracing transformed physical environments (e.g., smaller-scale, more-private rooms and baths and household-type neighborhoods for dining and occasionally cooking), transformed staff roles with more empowerment of line staff, and a philosophy of individualized care.[15,16] The "Eden Alternative," a set of principles overlaid on existing nursing homes to flatten hierarchies, invest decision-making in residents and frontline staff, and normalize nursing home life, addressed psychosocial problems of residents, such as loneliness, boredom, helplessness, and lack of meaning.[17] Eden training has been widely sought, but the few formal evaluations had unimpressive results,[18,19] suggesting that, without more-systemic changes

And here….

Effects of Green House® Nursing Homes on Residents' Families

Terry Y. Lum, M.S.W., Ph.D., Rosalie A. Kane, M.S.W., Ph.D., Lois J. Cutler, Ph.D., and Tzy-Chyi Yu, M.H.A., Ph.D.

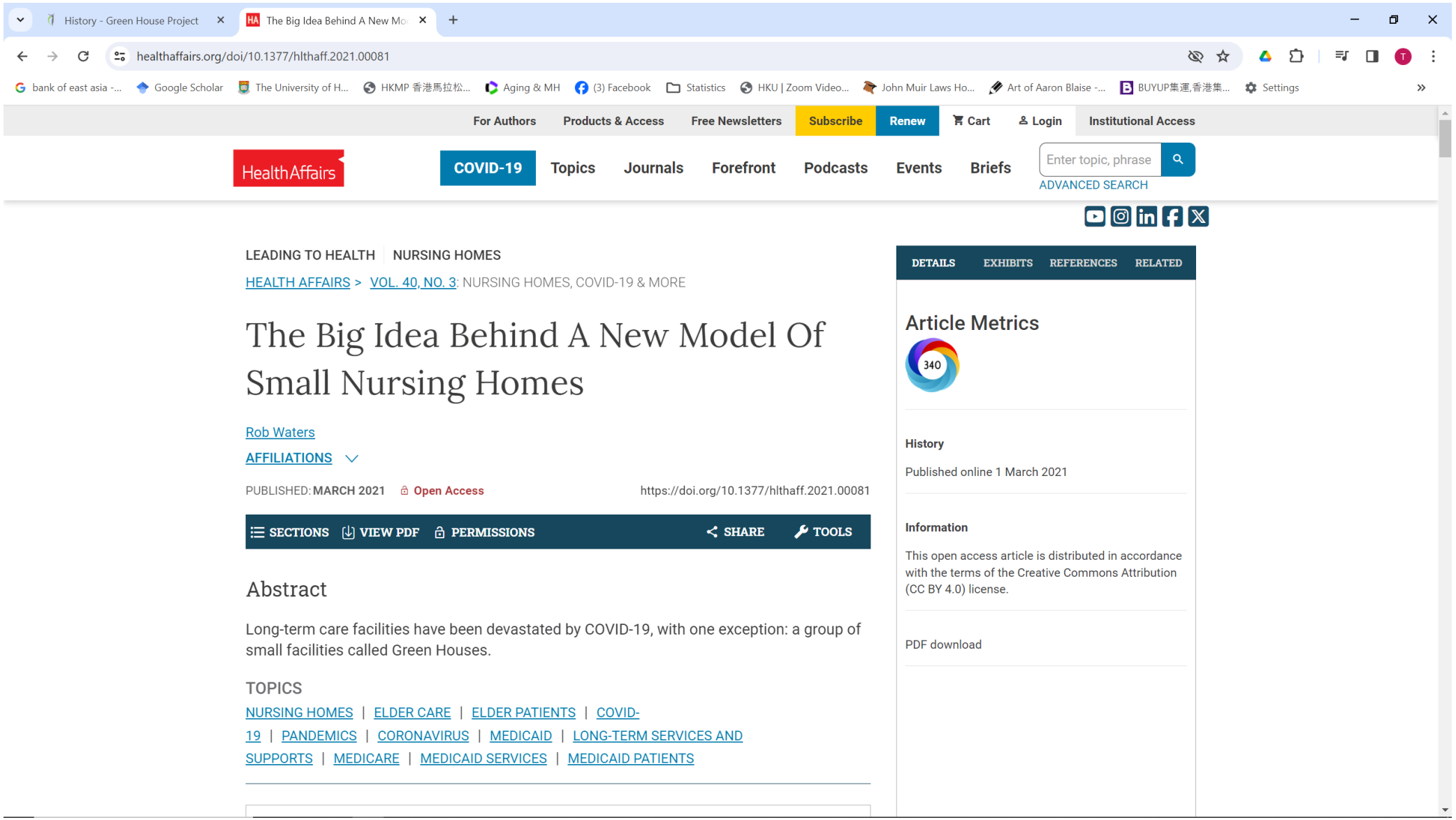
A longitudinal quasi-experimental study with two comparison groups was conducted to test the effects of a Green House (GH®) nursing home program on residents' family members. The GH®s are individual residences, each serving 10 elders, where certified nursing assistant (CNA)-level resident assistants form primary relationships with residents and family, family is encouraged to visits, and professionals adapted their roles to support the model. GH® family were somewhat less involved in providing assistance to their residents although family contact did not differ among the settings at any time period. GH® family were more satisfied with their resident's care and with their own experience as family members, and had no greater family burden. Issues in studying family outcomes are discussed as well as implications for roles of various personnel, including social service and activities staff in a GH® model.

EFFECTS OF GH® NURSING HOMES

opportunities and challenges for family members, and was expected to result in more positive family interactions with residents, and greater family engagement with and satisfaction with the nursing homes.

BACKGROUND

Family members are instrumental to the psychosocial well-being of nursing home and assisted living residents, and provide the major means for residents to retain their social affiliations and relationships outside the nursing home (Kane, 2004). Families typically are integrally involved in the decision of older people to move to a residential setting, and their choice of facility (Reinardy and Kane, 1999; 2003). If reformed models of nursing homes do not meet with family approval, they are unlikely to be chosen. Further, family members are also a major source of emotional support to elderly people receiving long-term care in all settings, including group residential settings such as nursing



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The Big Idea Behind A New Model Of Small Nursing Homes

Rob Waters

AFFILIATIONS

PUBLISHED: MARCH 2021 Open Access https://doi.org/10.1377/hlthaff.2021.00081

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Abstract

Long-term care facilities have been devastated by COVID-19, with one exception: a group of small facilities called Green Houses.

TOPICS

NURSING HOMES | ELDER CARE | ELDER PATIENTS | COVID-19 | PANDEMICS | CORONAVIRUS | MEDICAID | LONG-TERM SERVICES AND SUPPORTS | MEDICARE | MEDICAID SERVICES | MEDICAID PATIENTS

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- “Studies began to suggest solid outcomes. A 2012 comparison found that residents of Green House homes in Minnesota and Washington State spent less time in hospitals than a matched group in traditional homes, saving $1,300–$2,300 per resident in annual costs to Medicaid and Medicare.[11] A 2016 package of studies found, among other things, that residents in 15 Green House homes had lower rates of hospitalization than those in 223 traditional nursing homes. The Green House elders were also 45 percent less likely to need catheters, 38 percent less likely to have bedsores, and 16 percent less likely to be bedridden.[9]”

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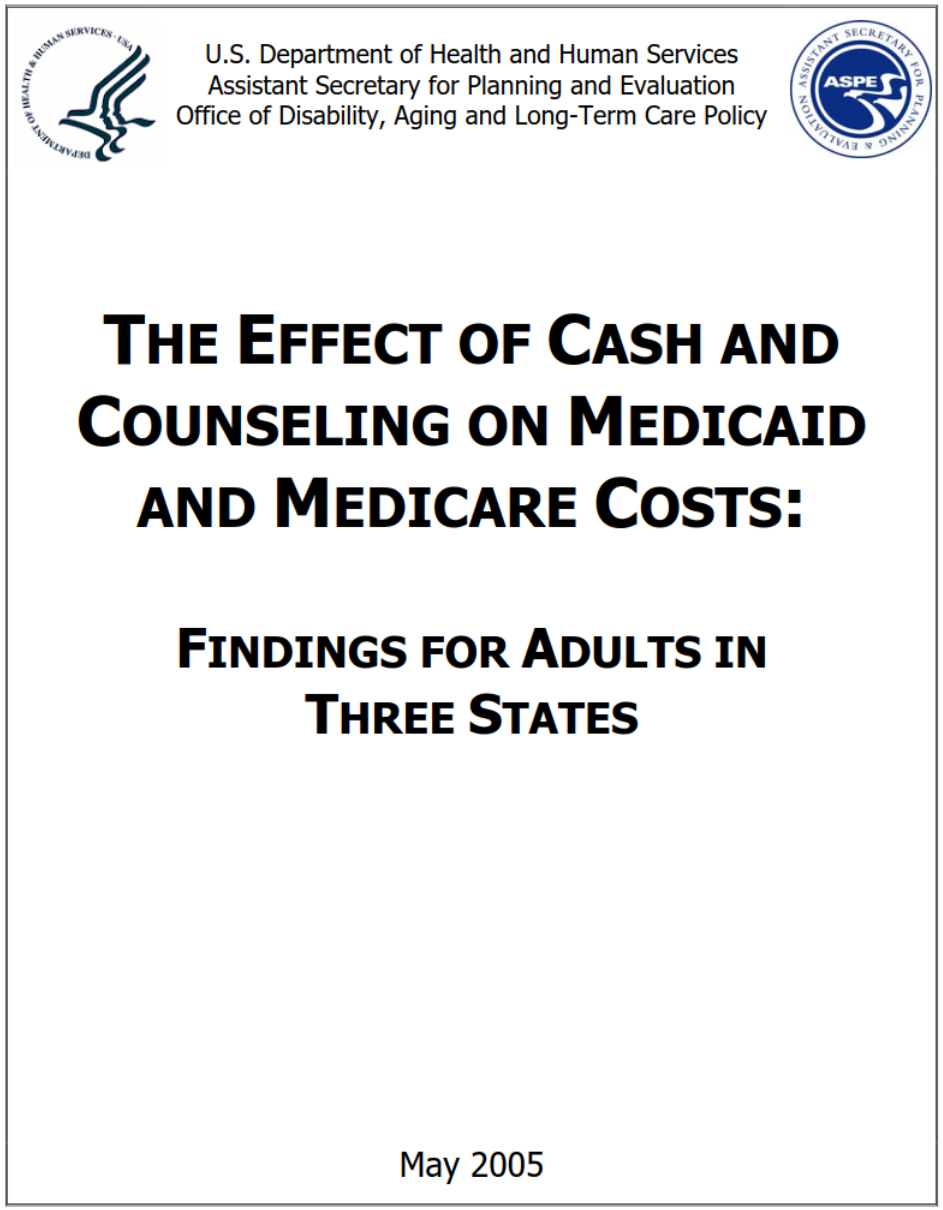
The Medicaid Cash & Counseling Program



U.S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Office of Disability, Aging and Long-Term Care Policy

THE EFFECT OF CASH AND COUNSELING ON MEDICAID AND MEDICARE COSTS:

FINDINGS FOR ADULTS IN THREE STATES

May 2005

TABLE ES.1. Effect of Arkansas's Cash and Counseling on Personal Care and Medicaid Expenditures

	Personal Care Expenditures (Dollars)			All Medicaid Expenditures (Dollars)		
	Treatment	Control	Difference	Treatment	Control	Difference
Year 1						
Nonelderly	5,435	2,430	3,005***	14,125	12,862	1,263
Elderly	4,313	2,292	2,021***	11,523	9,822	1,701***
All Ages	4,605	2,349	2,256***	12,219	10,688	1,531***
Year 2						
All Ages	3,852	1,839	2,014***	11,082	10,582	500

NOTE: Year 2 includes only those who enrolled in the demonstration before May 1, 2000.

***Treatment group mean different from control group mean at .01 level.

TABLE ES.2. Effect of New Jersey's Cash and Counseling on Personal Care and Medicaid Expenditures

	Personal Care Expenditures (Dollars)			All Medicaid Expenditures (Dollars)		
	Treatment	Control	Difference	Treatment	Control	Difference
Year 1						
Nonelderly	11,166	9,220	1,946***	26,863	26,049	814
Elderly	11,891	10,650	1,241***	20,236	19,407	828
All Ages	11,557	9,970	1,587***	23,370	22,509	861
Year 2						
All Ages	11,337	8,792	2,545***	22,033	19,653	2,379***

NOTE: Year 2 includes only those who enrolled in the demonstration before January 1, 2002.

***Treatment group mean different from control group mean at .01 level.

TABLE ES.3. Effect of Florida's Cash and Counseling on Waiver and Medicaid Expenditures

	Waiver Expenditures (Dollars)			All Medicaid Expenditures (Dollars)		
	Treatment	Control	Difference	Treatment	Control	Difference
Year 1						
Nonelderly	22,017	18,321	3,696***	27,433	24,106	3,327***
Elderly	10,496	10,063	433	15,971	15,833	137
All Ages	16,301	14,193	2,108***	23,745	19,973	1,772***
Year 2						
All Ages	18,354	15,978	2,375***	24,394	21,676	2,718***

NOTE: Year 2 includes only those who enrolled in the demonstration before October 1, 2001.

***Treatment group mean different from control group mean at .01 level.

The evidence

In all three states, the treatment group's use and cost of Medicare services was similar to that of the control group. Therefore, the program's effects on combined Medicare and Medicaid service use and costs are similar to the effects on Medicaid use and costs.

Policy Implications

In all three states, the program had large, overwhelmingly positive effects on the well-being of consumers and caregivers. In addition, in two of the states, costs for the treatment group did not exceed the costs the state would have incurred for delivering the approved baseline care plan services. In all three states, Cash and Counseling increased the likelihood that beneficiaries would receive paid services, greatly increased consumers' satisfaction with their care and their quality of life, and reduced their unmet needs (Carlson et al. 2005). It also reduced caregiver stress in all three states (Foster et al. 2005c). However, the higher initial costs of consumer direction under Cash and Counseling might discourage some states from adopting a similar program. Most states are having difficulty controlling their Medicaid budgets, so the effects of any new program on states' costs is likely to be an important factor in whether states adopt such programs. An important fact for states to consider is that this evaluation was conducted over a two-year follow-up period that started immediately after enrollment began. Since the evaluation, states have identified the sources of the higher costs for this innovative program and have implemented procedures to reduce these costs.

ask Medicare
Information to Help You Care for Others

TIPS AND RESOURCES FOR CAREGIVERS

What Caregiver Support Is Available In My Area?

Many local organizations provide materials, services, and support to assist caregivers—below you'll find information about and links to many of these helpful resources.

HOW DO I FIND LOCAL SENIOR SERVICES?

Eldercare Locator provides referrals to Area Agencies on Aging based on your zip code. Your local Area Agency on Aging can provide information about many eldercare issues and available services in your community. Go to www.eldercare.gov or call 1-800-677-1116 to find your local Area Agency on Aging.

Family Care Navigator is a state-by-state resource developed by the Family Caregiver Alliance. It includes services for family caregivers, as well as help for older or disabled adults living at home or in a residential facility. It also has information on government health and disability programs, legal resources, and disease-specific organizations. To find resources in your state, visit www.caregiver.org and select "Family Care Navigator: State-by-State Guide" under the "Caregiving Info & Advice" tab or call 1-800-455-8106.

State Units on Aging are agencies that administer, manage, and design benefits, programs, and services for the elderly and their families. Caregivers can learn about services and programs available to seniors living in their state. Visit www.nasuad.org and select "Contacting State Agencies" under the "About NASUAD" tab to look up your state agency.

ARE THERE FINANCIAL BENEFITS THAT I CAN ACCESS?

State Health Insurance Assistance Programs (SHIPs) offer free health insurance counseling in your community. Visit www.shiptalk.org and select "Find a State SHIP" to find a SHIP office near you.

BenefitsCheckup.org is a free, confidential service of the National Council on Aging. The site helps older adults find programs that may help pay for some of the costs of prescription drugs, health care, utilities, and other essential items or services.

Tax Benefits may be available if you provide care and financial support for an older adult. These benefits may include tax breaks or other financial help. You may want to look into any of the following:

- Exemptions and deductions if you are a qualifying relative (including a Multiple Support Agreement, if you jointly support your loved one with other friends or family members)
- Deductions for paying other's medical expenses, including long-term care insurance
- Dependent Care Credit for paid caregivers

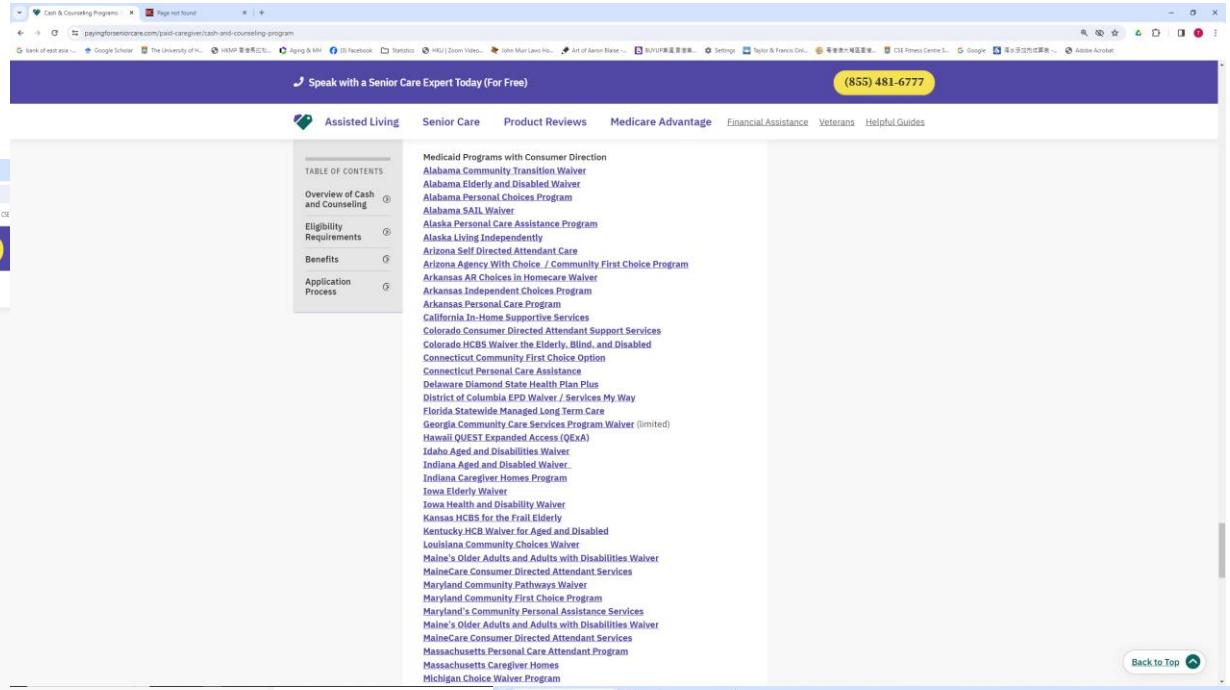
Visit www.irs.gov, or call 1-800-829-1040 to learn more about potential savings.

The Medicaid Cash and Counseling Program can provide direct payments that could be used to pay you for the time you spend providing care. To find out whether your state has a Cash and Counseling or similar program, contact your local Medicaid, human services, or social services office. Visit www.cashandcounseling.org, scroll down to the Project Overview section, and click "our program map" to see what programs are offered in your state.

For additional local referrals, contact any of the following:

- The social service department of your local hospital or clinic
- Adult daycare centers and faith-based agencies
- Your AARP State Office, www.aarp.org/states
- The local chapter of disease groups, such as the American Heart Association and Alzheimer's Association

Ask Medicare (www.medicare.gov/caregivers) also offers information on enrolling in Medicare, choosing a prescription drug plan, finding state and local resources to support caregiving tasks, accessing in-home services, and a free e-newsletter with the latest Medicare updates.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Alabama SAIL Waiver
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Alaska Living Independently
Arizona Self Directed Attendant Care
Arizona Agency With Choice / Community First Choice Program
Arkansas AR Choices in Homecare Waiver
Arkansas Independent Choices Program
Arkansas Personal Care Program
California In-Home Supportive Services
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Colorado HCBS Waiver the Elderly, Blind, and Disabled
Connecticut Community First Choice Option
Connecticut Personal Care Assistance
Delaware Diamond State Health Plan Plus
District of Columbia EPD Waiver / Services My Way
Florida Statewide Managed Long Term Care
Georgia Community Care Services Program Waiver (limited)
Hawaii QUEST Expanded Access (QExA)
Idaho Aged and Disabilities Waiver
Indiana Aged and Disabled Waiver
Indiana Caregiver Homes Program
Iowa Elderly Waiver
Iowa Health and Disability Waiver
Kansas HCBS for the Frail Elderly
Kentucky HCB Waiver for Aged and Disabled
Louisiana Community Choices Waiver
Maine's Older Adults and Adults with Disabilities Waiver
MaineCare Consumer Directed Attendant Services
Maryland Community Pathways Waiver
Maryland Community First Choice Program
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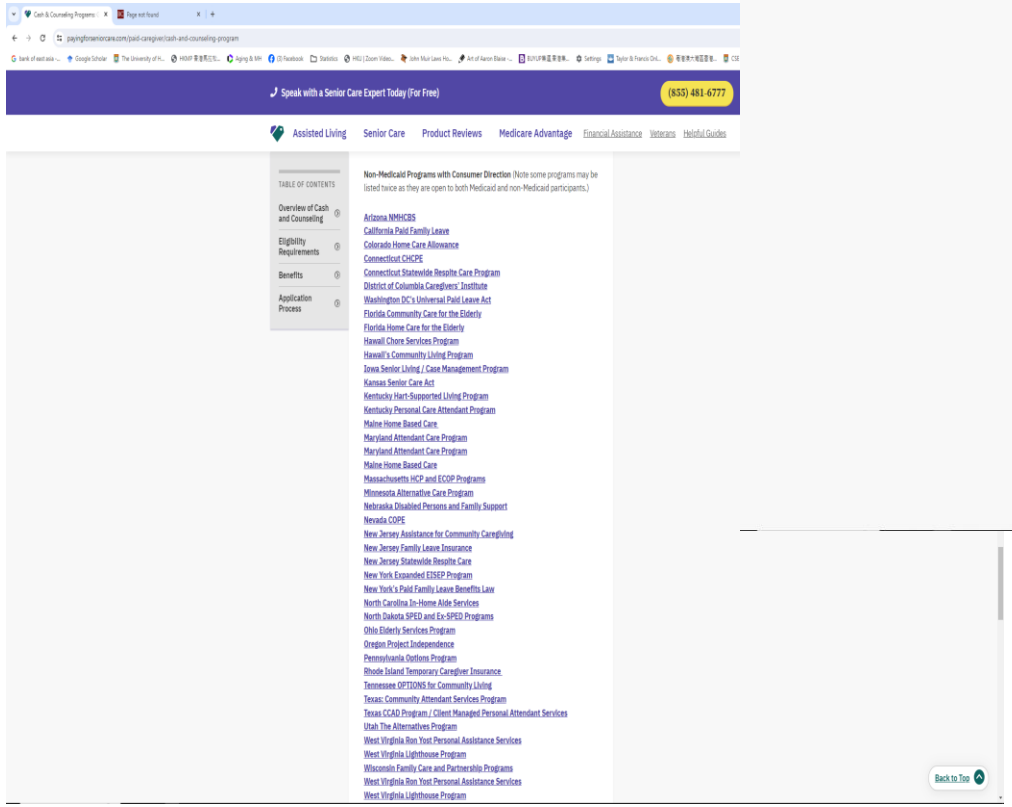
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Washington DC's Universal Paid Leave Act
Florida Community Care for the Elderly
Florida Home Care for the Elderly
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Maine Home Based Care
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Maryland Attendant Care Program
Maine Home Based Care
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Ohio Elderly Services Program
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Tennessee OPTIONS for Community Living
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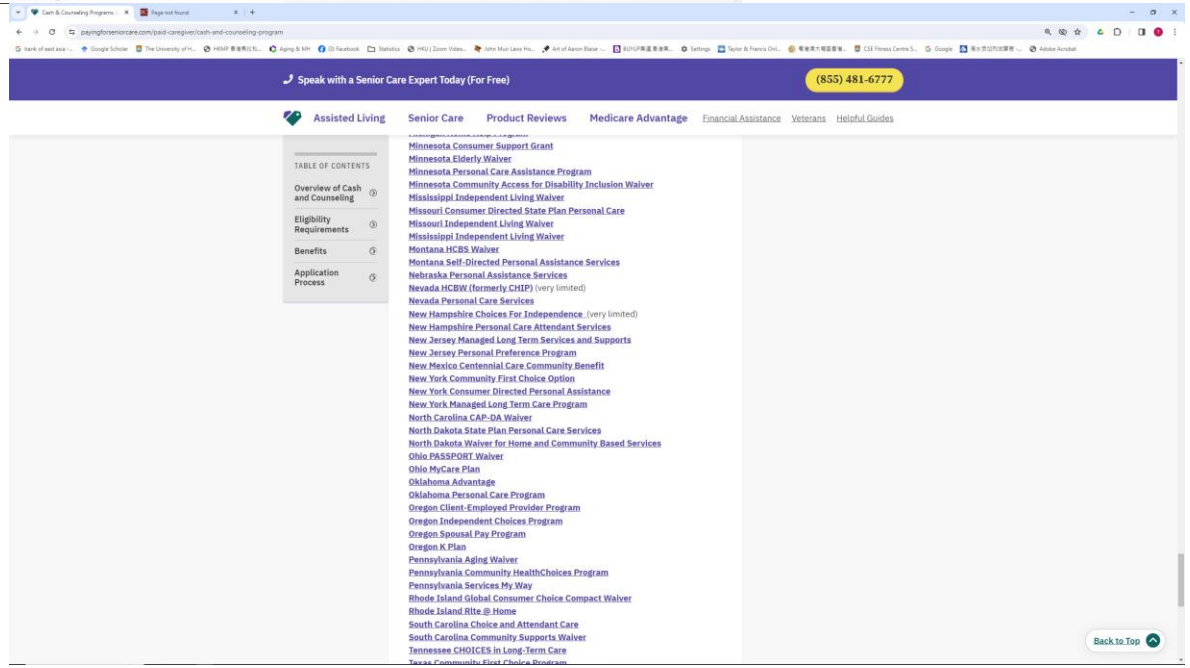
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Mississippi Independent Living Waiver
Missouri Consumer Directed State Plan Personal Care
Missouri Independent Living Waiver
Mississippi Independent Living Waiver
Montana HCBS Waiver
Montana Self-Directed Personal Assistance Services
Nebraska Personal Assistance Services
Nevada HCBW (formerly CHIP) (very limited)
Nevada Personal Care Services
New Hampshire Choices For Independence (very limited)
New Hampshire Personal Care Attendant Services
New Jersey Managed Long Term Services and Supports
New Jersey Personal Preference Program
New Mexico Centennial Care Community Benefit
New York Community First Choice Option
New York Consumer Directed Personal Assistance
New York Managed Long Term Care Program
North Carolina CAP-DA Waiver
North Dakota State Plan Personal Care Services
North Dakota Waiver for Home and Community Based Services
Ohio PASSPORT Waiver
Ohio MyCare Plan
Oklahoma Advantage
Oklahoma Personal Care Program
Oregon Client-Employed Provider Program
Oregon Independent Choices Program
Oregon Spousal Pay Program
Oregon K Plan
Pennsylvania Aging Waiver
Pennsylvania Community HealthChoices Program
Pennsylvania Services My Way
Rhode Island Global Consumer Choice Compact Waiver
Rhode Island RIte @ Home
South Carolina Choice and Attendant Care
South Carolina Community Supports Waiver
Tennessee CHOICES in Long-Term Care
Texas Community First Choice Program
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3-year Project on Enhancement of the Infrastructure of Long-term Care in Hong Kong

- Funded by the HKSAR Government.
- Started in Oct 2013 – April 2017

Project Objectives

1. To develop a standardized assessment system for better service matching and use of clinical data on care for the elderly in need of LTC services;
2. To develop Case Mix and Resource Utilization Groups (RUGs) systems for residential care and to better understand the care need of frail elderly in residential care setting;
3. To develop a set of outcome indicators for both community care services (CCS) and residential care services (RCS) based on the interRAI LTC assessment system.

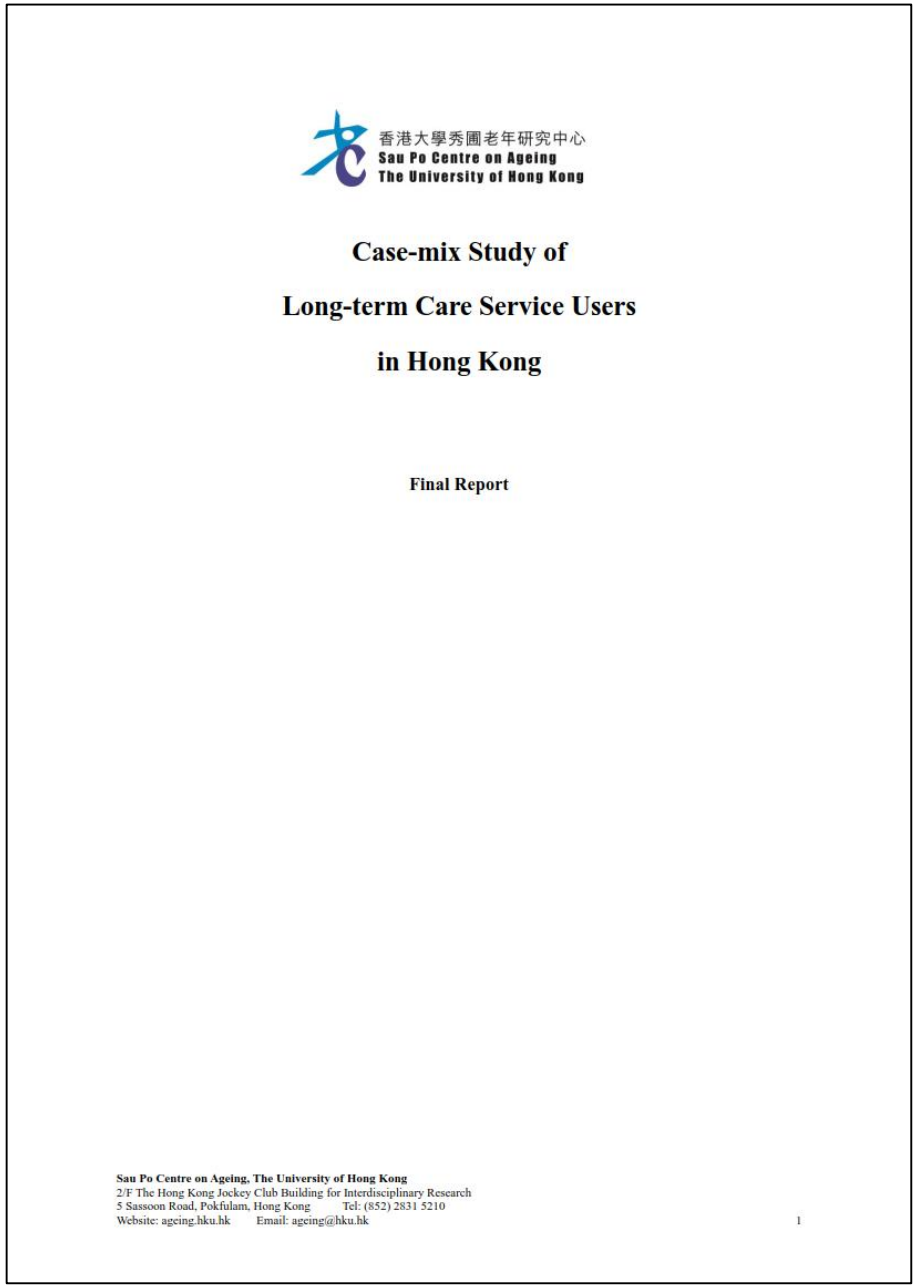
Methods: Case Mix & RUGs

- Review of overseas application of RUGs and local stakeholder opinions
- Quantitative study
  - Need assessment of 1,004 RCS & 1,012 CCS users, three times over 6 months.
  - Staff time measurement (STM)
- Qualitative studies
  - Focus groups
  - Case scenario studies

The research team combined and analysed information collected from the quantitative and qualitative studies in both CCS and RCS settings to develop a proposed RUG-HK. Test application of a case mix system for services matching in Hong Kong was carried out for reference.

Staff time measurement

- RCS: for each residents, we followed them minute by minute to record their services use over 24 hours for 7 days.
- CCS: for each services users, we used the billing records from providers to record their types and volume of services use over a month.
- We later converted all STM data into monthly data.



香港大學秀圃老年研究中心
Sau Po Centre on Ageing
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Case-mix Study of Long-term Care Service Users in Hong Kong

Final Report

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Website: ageing.hku.hk Email: ageing@hku.hk

Data Collection

3.4 CCS Sampling: As at March 2017, there were 73 DEs / DCUs providing subsidised centre-based care and support services, and as at September 2016, there were 34 EHCCS teams providing home care service for older adults in Hong Kong. Among them, 40 DEs / DCUs and 22 EHCCS teams participated in this study (operated by 22 NGOs), providing frailty level data from 1,047 CCS users (540 DE / DCU and 507 EHCCS, respectively). STM data were collected from 598 of these users.

3.5 RCS Sampling: As at February 2017, there were 156 subvented Residential Care Homes for the Elderly (RCHEs) providing subsidised places for elders in Hong Kong. These include 121 Care and Attention Homes (C&As), in which 120 were Care and Attention Homes Providing Continuum of Care (COC), 29 Contract Homes, and 6 Nursing Homes (NHs). Among them, 21 COC, 3 Contract Homes, and 2 NHs participated in the study (operated by 14 NGOs), providing frailty level data and STM data from 1,004 RCS users (835 COC and 89 Contract Homes and 80 NHs, respectively; see Table 3.1).

Proposal

Table 6.2 Criteria for proposed services

Case-mix score	Additional criteria	Proposed services
8	N.A.	Beyond nursing home
7	1. Dyspnea in daily life and require oxygen therapy, or 2. Hallucinations and physical abuse behaviour, or	Beyond nursing home
4-6		
2-3		
1		

*there are 7 levels (0-6) for each item, 0=independent to 6= total dependence, need supervision means the score is 2 or above

Figure 6.1 Proposed decision-making tree for elderly services based on a case-mix score.

Table 6.3 Agreement between the current and proposed LTC service recommendation protocols.

	Proposed service recommendation						
Current service recommendation	**Community Supportive Service**	**Home Support Services**	**Community Care Services**	**C&A Home**	**NH**	**Beyond NH**	**Total**
No service / IHCS / other service	4 (9.8%) (c)	22 (53.7%) (c)	15 (36.6%) (b)	0 (0%)	0 (0%)	0 (0%)	41 (100.0%)
CCS only	0 (0%)	4 (36.4%) (a)	8 (54.5%) (c)	1 (7.7%) (b)	0 (0%)	0 (0%)	13 (100.0%)
Dual C&A home and CCS	0 (0%)	38 (19.5%) (a)	89 (45.6%) (c)	67 (34.4%) (c)	0 (0%)	1 (0.5%) (b)	195 (100.0%)
C&A only	0 (0%)	25 (16.6%) (a)	56 (37.1%) (a)	59 (39.1%) (c)	6 (4.0%) (b)	5 (3.3%) (b)	151 (100.0%)
Dual NH & CCS	0 (0%)	0 (0%)	0 (0%)	6 (35.3%) (a)	10 (58.8%) (c)	1 (5.9%) (b)	17 (100.0%)
NH only	0 (0%)	0 (0%)	1 (1.6%) (a)	26 (40.6%) (a)	32 (50.0%) (c)	5 (7.8%) (b)	64 (100.0%)
Beyond NH	0 (0%)	0 (0%)	1 (5.3%) (a)	6 (31.6%) (a)	7 (36.8%) (a)	5 (26.3%) (c)	19 (100.0%)
Total	4 (0.8%)	89 (17.8%)	170 (34.0%)	165 (33.0%)	55 (11.0%)	17 (3.4%)	500 (100.0%)

IHCS = Integrated Home Care Services; CCS = community care services; C&A home = care and attention home; NH = nursing home (a) and (b) indicate discrepancy between the current and proposed service recommendation. See Table 6.5 for further elaboration. (c) indicates the concordance between the current and proposed service recommendation. The summary percentage in category (c) indicates the proportion of applicants recommended the same category of LTC service under the proposed protocol, while the summary percentage in category (a) and (b) indicate the proportion of applicants recommended a different level of LTC service.

Lessons learned & conclsion

- Strong academic – service providers partnership
- Government involvement from day one
- Long term funding support
- Scientific vigor – the importance of an control group
- Strong vision & strong science & political will

Thank You

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