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SPECIAL SECTION

*The* CHANGING WORLD of LONG-TERM CARE *in* RI

GUEST EDITOR

RENÉE R. SHIELD, PhD

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THE NATIONAL INSTITUTE ON AGING

The cover image is from a booklet on caregiving and is available on the National Institute of Aging's website. [Click to view.](#)

## The Changing World of Long-term Care in RI

RENÉE R. SHIELD, PhD  
GUEST EDITOR

The nursing home is a unique institution in American society that commonly elicits public and professional responses of dread and resignation, as well as brave efforts at reform. Nursing homes within the US long-term health care system have undergone major changes since I first began to study them in the early 1980s.

As guest editor for two themed issues on long-term care in RI for the *Rhode Island Medical Journal* (RIMJ), I am honored to dedicate them in loving memory of Dr. Stanley M. Aronson, my long-time mentor, collaborator and friend. As evident in his professional career and as editor *emeritus* of this Journal, the nursing home was of special interest to him for many decades; he was deeply committed to its improvement. I first met Stan in 1981 as a PhD student in cultural anthropology at Brown specializing in the study of aging. He had recently retired from his position as founding dean of the Medical School, and I asked if he would consent to be on my dissertation committee. In agreeing, he suggested I focus on the nursing home as a fascinating topic of rich history, complex individuals and high promise. I immersed myself in the culture of one nursing home for 14 months, going day and night for long hours at a time, trying to understand what it was like to live and work in this place. Each week I brought Stan my field notes, impressions and drafts about which we fervently argued and discussed. His red edits on my drafts were unsparing and clear-headed; his praise, when it came, was all the more precious. I later turned the dissertation into a book, *Uneasy Endings: Daily Life in an American Nursing Home* (Cornell, 1988). Years later, we co-authored *Aging in Today's World: Conversations between an Anthropologist and a Physician* (Berghahn, 2003), and we continued a deep and joyful friendship until his recent death. I owe profound thanks to Stan. What a huge loss for me, my family and for our community.

The authors in this and the next themed issue of RIMJ discuss important facets of long-term care in RI and the changes these institutions have undergone. This issue begins with Pelland, Mota and Baier's overview of long-term care services and costs situated within the demographic context of the aging population of our state. Nanda next provides a summary of the roles and responsibilities of the nursing home medical director, a role increasingly important given

the complex medical needs of the varied populations in our nursing homes. Kevin McKay, administrator of Tockwotton Home, describes his view of the culture change movement in nursing homes and chronicles on-the-ground details of how Tockwotton has worked to implement innovative, person-centered reforms. Sue Vinhateiro rounds out this issue by describing her personal trajectory as a long-term care nurse in one RI facility. Her perspective mirrors changes that nursing homes have undergone over the last decades as she has experienced them.

Dr. Bill Thomas, creator of the reform effort called the Eden Alternative ([www.edenalt.org](http://www.edenalt.org)), in attempting to explain the origins of this institution, said a hospital and a poorhouse got together to produce the nursing home.<sup>1</sup> This characterization embodies the contradiction that the nursing home is modeled after the hospital, is poorly reimbursed and is often a long-time last "home" for its residents. The predicament caused by its funding status and its split identity of hospital versus home creates challenges for reformers who want to ensure that competent and person-centered care is maintained in as home-like a setting as possible.

Stan Aronson was cautiously optimistic about the strides RI nursing homes were making to provide such care for our most frail and vulnerable Rhode Islanders. He wanted their care to be respectful and exceptional. In honor of his insistence on compassion and excellence, we offer these two issues. This issue provides an overview of the evolving nature of long-term care in RI, and the April issue will focus on transitions and end-of-life care. We hope they help inspire us to continue to improve and achieve the superb care that older Rhode Islanders deserve. Given the pressing demographic reality of our aging state, this goal must be our imperative.

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### Guest Editor

Renée R. Shield, PhD, is Professor of Health Services, Policy and Practice (Clinical) at the Center for Gerontology and Healthcare Research, Brown University School of Public Health.

# The Nuts and Bolts of Long-term Care In Rhode Island: Demographics, Services and Costs

KIMBERLY PELLAND; TERESA MOTA, BSN, RN; ROSA R. BAIER, MPH

## ABSTRACT

Nearly 8,000 people reside in Rhode Island's (RI's) 84 nursing homes at any single point in time. Many of these people are highly vulnerable because of illness or frailty. In this article, we describe the reasons that RI residents seek care from nursing homes, the associated costs (with a focus on Medicare and Medicaid payment), and different ways to assess nursing home quality. We also describe the home- and community-based services that can help people remain in the community. A resource list provides additional information for those seeking to better understand RI nursing homes and long-term care supports and services.

**KEYWORDS:** Economics, demographics, nursing home, skilled nursing facility, Rhode Island

## INTRODUCTION

Each year, tens of thousands of Rhode Island (RI) residents are admitted to a nursing home for skilled care following a medical event or hospitalization (post-acute care) or for custodial care on a more permanent basis (long-term care). Altogether, nearly 8,000 residents reside in the state's 84 nursing homes at any single point in time.<sup>1</sup>

## DEMOGRAPHICS

RI nursing homes are mostly independent facilities (60.7%), although a large minority belongs to a multi-facility organization (39.3%) (Table 1). Likelihood of admission increases with age, as well as among those with low income and low family and social support.<sup>2</sup> Residents are predominantly female (72.1%) and non-Hispanic white (93.4%) (Table 2).<sup>3</sup> More than half (55.5%) are aged 75 years or older.<sup>3</sup>

Locally, hospital patients are most commonly discharged to nursing homes for post-acute care as a result of septicemia, osteoarthritis of the hip or knee, hip fracture or dislocation, or

heart failure.<sup>4</sup> In contrast, long-term care residents' most-common health problems range from injury and surgery to the frailty and cognitive impairment that often accompanies aging (Table 3): many residents are dependent on staff for help with activities ranging from bathing (95.8%) to toileting (79.5%) and eating (43.2%); more than half are chair bound (57.2%), have cognitive impairment (moderate or severe, 64.6%), or dementia (52.4%); and nearly as many have depression (44.2%).

## COVERAGE AND COSTS

In 2012, RI nursing home costs averaged \$8,517/month for a shared room and \$9,277/month for a private room.<sup>5</sup> Expenses include skilled (nursing, therapy, and medications) and custodial care, as well as room, board, housekeeping, and other overhead costs. Most residents are covered by Medicare, Medicare Advantage, or Medicaid, or pay out-of-pocket.

Approximately one-third of RI Medicare patients have fee-for-service (FFS) Medicare and two-thirds have Medicare Advantage, a private health plan that furnishes Medicare benefits. Medicare Part A (hospital insurance) provides FFS Medicare patients with limited coverage for nursing home care (Table 4).<sup>6,7</sup>

**Table 1.** Rhode Island Nursing Home Characteristics, June 2014 (N=84)

Characteristic	
<b>Nursing Home Control, n (%)</b>	
Hospital-based	0 (0.0)
Independent	51 (60.7)
Multi-facilities	33 (39.3)
<b>Nursing Home Ownership, n (%)</b>	
For profit	66 (78.6)
Government	0 (0.0)
Non-profit	18 (21.4)
<b>Patients by Payer, n (%)</b>	
Medicaid	5,281 (66.4)
Medicare	732 (9.2)
Other	1,941 (24.4)

Source: American Health Care Association, 2014

**Table 2.** Rhode Island Nursing Home Residents' Demographics, 2012 (N=8,221)

Demographics	n (%)
<b>Age (Years)</b>	
≤64	715 (8.7)
65-74	929 (11.3)
75-84	2,014 (24.5)
≥85	4,563 (55.5)
<b>Female</b>	5,927 (72.1)
<b>Male</b>	2,293 (27.9)
<b>Race/Ethnicity</b>	
Black, not Hispanic origin	304 (3.7)
Hispanic or Latino	164 (2.0)
White, not Hispanic origin	7,678 (93.4)
Other	66 (0.8)

Source: Centers for Medicare & Medicaid Services Nursing Home Compendium, 2013

**Table 3.** Rhode Island Nursing Home Residents' Medical Conditions, June 2014 (N=7,953)

Condition	n (%)
<b>Mental Status</b>	
Behavior Symptoms	1,622 (20.4)
Dementia	4,167 (52.4)
Depression	3,513 (44.2)
Psych Diagnosis	2,314 (29.1)
<b>Mobility</b>	
Ambulatory*	5,065 (63.7)
Bedfast	108 (1.4)
Chair bound	4,549 (57.2)
Pain Management††	3,977 (50.0)
<b>Skin Integrity</b>	
Pressure Ulcers	387 (4.9)
Pressure Ulcers at Admission	190 (2.4)
Preventative Skin Care	6,797 (85.4)
<b>Special Care</b>	
Hospice	437 (5.5)
IV Therapy	103 (1.3)
Mechanically altered diet	2,362 (29.7)
Special Rehab	2,108 (26.5)
Tube feeding	167 (2.1)
<b>Total ADL Dependence</b>	
Bathing Dependent	7,619 (95.8)
Eating Dependent	3,436 (43.2)
Toileting Dependent	6,792 (85.4)
Transferring Dependent	6,323 (79.5)

\*Ambulate independently or with assistive devices  
 †Residents with a specific plan to control difficult to manage or intractable pain  
 Source: American Health Care Association, 2014

Medicare Advantage plan requirements vary by plan. Unless residents have long-term care insurance – and very few do – they must pay out of pocket for long-term care. Few can afford to do this for long; if their resources are exhausted, they turn to Medicaid. As a result, Medicaid is RI's largest payer for nursing home care, covering two-thirds (66.4%) of all post-acute and long-term care (Table 1).<sup>8</sup> In 2012, there were more than 1.9 million Medicaid bed days<sup>9</sup> among 7,978 residents; in contrast, there were 88,000 Medicare bed days.<sup>1</sup> Medicaid coverage is simpler, in some respects, because it is dictated by Medicaid eligibility (income and assets) and the clinical need for care (Table 4).

**ECONOMICS OF CARE**

Nearly eight in 10 (78.6%) RI nursing homes are for-profit (Table 1), although most are operating on a deficit. Why? As described above, the majority of RI nursing home residents are covered by Medicaid. Medicaid reimburses a flat daily rate that varies based on individual patients' acuity.<sup>10</sup> Although Medicaid reimbursement differs by state, on average it is lower than reimbursement by other payers and in some states, including RI, it can be lower than the actual cost of providing care.<sup>11</sup> In 2010, RI Medicaid patients accrued costs of, on average, \$212/day and facilities were reimbursed \$196/day, resulting in an operating deficit of \$16/day per Medicaid resident and a net loss of nearly \$30M in one year.<sup>12</sup>

In 2013, RI implemented a plan to constrain spending by enrolling long-term care residents with Medicaid into a health maintenance organization (HMO). Today over two-thirds of long-term care nursing home residents are enrolled in Neighborhood Health Plan of Rhode Island's Rhody Health Options.<sup>13</sup> However, Rhody Health Options receives Medicaid reimbursement rates and may therefore encounter similar operating deficits as Medicaid.

**Table 4.** Medicare and Medicaid Coverage

Eligibility	Fee-for-Service Medicare	Medicare Advantage	Medicaid
Overall	Based on age (≥65 years), end-stage renal disease diagnosis (any age), or certain disabilities (<65 years)	Based on age (≥65 years), end-stage renal disease diagnosis (any age), or certain disabilities (<65 years)	For certain population groups (children, pregnant women, parents, seniors, individuals with disabilities) or based on income/assets. Rhode Island has flexibility for coverage based on waivers.
Post-Acute Care	Medicare Part A (hospital insurance) provides limited coverage ≤100 days to patients who: <ul style="list-style-type: none"> <li>• Have a recent inpatient hospital stay ≥3 days,*</li> <li>• Be admitted to a Medicare-certified nursing facility &lt;30 days of the prior hospital stay, and</li> <li>• Be in need of skilled services such as nursing or therapy.</li> </ul> For the first 20 days, 100% of costs are covered; for days 21-100, patients pay a co-pay (in 2014, \$152.00/day) and Medicare pays the balance.	Requirements vary by plan; some may be exempt from the three-day hospital stay requirement, but most have higher co-pays	Covers inpatient, comprehensive services (e.g., post-acute and long-term care services) as part of institutional benefits. This includes state-licensed/certified nursing facilities for those in need of skilled services, such as nursing or therapy. Patients may need to meet level of care requirements
Long-Term Care	No coverage	No coverage	

Source: U.S. Department of Health and Human Services, 2014; Kaiser Family Foundation, 2012; Medicaid.gov, 2014  
 \*This requirement makes it important for hospital patients to understand whether they are being held for observation (a short-term treatment or assessment before a decision is made regarding a hospital stay or discharge) or admitted as inpatients.

## QUALITY OF CARE

Nursing home economics provide important context to the ongoing debate among nursing home providers, stakeholders, and researchers regarding the relationship between reimbursement rates and overall quality of care. There is a widely-accepted connection between reimbursement and resources, since reimbursement serves as nursing homes' primary source of revenue and their revenue, in turn, determines their ability to secure resources.<sup>14</sup>

Because Medicaid is the single-largest payer for nursing home care<sup>11</sup> and Medicaid reimbursement (as outlined above) can fall short of the actual costs of care,<sup>15</sup> researchers frequently use payer mix as a marker for overall quality of care. For example, investigators at Brown University's Center for Gerontology and Health Care Research found that facilities with the highest proportions of Medicaid residents — 85% or more — have fewer nurses, lower occupancy rates, and more health-related deficiencies.<sup>17</sup>

Nursing home quality is subjective and can include the physical environment, nursing care, clinical outcomes, relationships with staff or other residents, or other criteria. When choosing amongst facilities, experts suggest that people ask questions, visit in person to see how facilities look, sound, and smell, and use data to make comparisons. Both Medicare and the Rhode Island Department of Health (HEALTH) publish data to inform consumers.<sup>15,16</sup> HEALTH is also one of only four states nationwide to require all nursing homes to evaluate resident and family satisfaction each year,<sup>17</sup> with results published on HEALTH's website.<sup>19</sup>

HEALTH monitors nursing home quality by performing inspections. Most facilities also have programs to improve the quality of care and experiences they provide residents. This includes participating in local and national initiatives, such as the national *Advancing Excellence in America's*

*Nursing Homes* campaign,<sup>18</sup> and collaborating with Healthcentric Advisors, the New England Medicare Quality Improvement Organization (QIO). Healthcentric Advisors leads quality improvement initiatives that target national priority topics ranging from care transitions to patient safety, and is a national leader in improving person-directed care.<sup>19</sup>

## HOME- AND COMMUNITY-BASED SERVICES

For those unable to live at home, assisted living is a growing trend to provide the help or supervision necessary to remain in the community (**Table 5**). In RI, an assisted living facility is any residence for two or more adults that provides lodging, meals, and personal assistance.<sup>20</sup> In 2012, assisted living costs averaged \$3,898/month – less than half of the average nursing home costs (\$8,517-\$9,277/month).<sup>5</sup> However, residents usually pay out-of-pocket (assisted living is not a covered healthcare service) and these facilities do not substitute for nursing homes: they can manage medications, support activities of daily living, and provide social activities, but in most circumstances they cannot provide skilled nursing care for more than 21 days without HEALTH's approval.<sup>21</sup> Nationally, 69% of assisted living residents come from the community – not a hospital, rehabilitation center, or nursing home.<sup>28</sup>

When asked, most people will say that they prefer to stay at home. Home- and community-based services (HCBS) can help them do just that, by providing the wrap-around and supportive services necessary for disabled and elderly people to maintain independence (**Table 5**). The overarching goal of these programs is to “provide cost-effective services that will ensure that [patients] receive the appropriate services in the least restrictive and most appropriate setting.”<sup>22</sup> Reducing costs is a secondary goal, though some policymakers

**Table 5.** Rhode Island Home- and Community-Based Services

Programs/Services	Details	Coverage
Assisted Living	Residences with lodging, meals, and personal assistance, including medication management, support activities of daily living and social activities	\$3,898/month, usually paid for out-of-pocket by residents
Adult Day Services	Offer care during the day and can include assistance with personal care and medications, recreational and social activities, and meals	Services covered by Medicaid under Rhode Island's Section 1115 Waiver
Balancing Incentive Program	Designed to work separately or in concert, provides a network of HCBS services for seniors who want to remain in the community	Provided for patients with incomes up to 300% of the Social Security Income Federal Benefit Rate (in 2013, \$2,130/month for an individual)
Home Health Care	Provides assistance for seniors who cannot live alone, yet want to remain in the community. Includes assistance with activities of daily living, medication management, homemaker services, and meals.	Services covered by Medicaid under Rhode Island's Section 1115 Waiver
Money Follows the Person	Provides targeted support for nursing home residents who transition back to the community	
Program of All-Inclusive Care for the Elderly (PACE)	Serves frail adults ≥55 years who have chronic health needs and want to live at home. These adults are nursing home-eligible. Transportation is provided to a central site that includes medical care and other services.	Services covered by Medicaid under Rhode Island's Section 1115 Waiver

Source: Rhode Island Executive Office of Health and Human Services

acknowledge that HCBS costs can be higher than nursing home care, if people need significant support.

Although there are numerous HCBS available throughout RI, most are run by state agencies such as the Rhode Island Executive Office of Health and Human Services (EOHHS, which administers Medicaid) and its Division of Elderly Affairs (DEA). The DEA-led Aging and Disability Resource Center, THE POINT, is a referral service that maintains a comprehensive directory of services available throughout RI and connects people with available programs. THE POINT also helps people to apply for EOHHS or DEA funding assistance, which is awarded based on need, income, or Medicaid eligibility.<sup>23</sup>

Under RI's Section 1115 Waiver,<sup>24</sup> EOHHS may use Medicaid funds for programs that further state objectives, such as providing care in the least restrictive setting.<sup>25</sup> Under the Medicaid State Plan's core and preventative services programs, people can receive personal care (e.g., assistance with activities of daily living), home health services, and homemaker services, such as preparing meals and light housekeeping. Additional services may include comprehensive case management, assistance with transitional care, or referral to other HCBS, such as adult day services, assisted or shared living, or Program of All-Inclusive Care for the

Elderly (PACE, a program serving frail adults 55 and older who have chronic health needs and want to live at home).

EOHHS has two additional HCBS programs: Money Follows the Person and the Balancing Incentive Program.<sup>26</sup> Money Follows the Person provides targeted support for patients who transition from a nursing home back to the community. The Balancing Incentive Program provides new or expanded HCBS for patients with incomes up to 300% of the Social Security Income Federal Benefit Rate. These programs are designed to work separately or in concert, providing a network of services for seniors who want to remain in the community.

## IN SUMMARY

RI's nursing home population includes nearly 8,000 people, many of whom are highly vulnerable because of illness or frailty, and the aging population is expected to place increasing demand on nursing homes in the coming years.<sup>27</sup> Characterizing nursing homes and HCBS resources can help consumers and providers better understand the industry and available services. **Table 6** provides resources for those seeking to better understand RI nursing homes and HCBS.

**Table 6.** Helpful Resources for Long-Term Care in Rhode Island

Resource	Description	Contact
Aging and Disability Resource Center, THE POINT	Provides information, referrals, and help getting started with programs and services for seniors, adults with disabilities, and their caregivers	adrc.ohhs.ri.gov or 401-462-4444
Alliance for Better Long-Term Care	As the Rhode Island Ombudsman for Long-Term Care, helps to protect the rights of elderly and disabled persons who live in long-term care settings and those who receive home health or hospice in the home	www.alliancebltc.com
LeadingAge-Rhode Island	A membership organization for non-profit providers of aging services, including nursing homes and assisted living residences, which aims to promote policy and practice that empowers people to live fully as they age	www.leadingageri.org
Healthcentric Advisors	As the New England Medicare Quality Improvement Organization (QIO), provides data, education, and assistance to help providers in all settings, including nursing homes, improve the quality of care they provide to patients	www.healthcentricadvisors.org
Medicare's Nursing Home Compare	Publishes data to help consumers compare nursing homes based on the care and outcomes that their residents experience	www.medicare.gov/nursinghomecompare
Rhode Island Division of Elderly Affairs	Focuses specifically on preserving the independence, dignity, and capacity for choice for seniors, adults with disabilities, families and caregivers	www.dea.ri.gov
Rhode Island Department of Health's Healthcare Quality Reporting Program	Publishes data to help consumers compare nursing homes based on the care and outcomes that their residents experience; includes resident and family satisfaction	www.health.ri.gov/nursinghomes/about/quality
Rhode Island Executive Office of Health and Human Services	Provides consumers aged 65 years and older with information about services to help them get the right care, at the right place, at the right time	www.eohhs.ri.gov/Consumer/Elders.aspx
Rhode Island Health Care Association	A membership organization of for-profit nursing homes, which aims to provide its members with information, education, and tools that enhance residents' quality	www.rihca.com
The Economic Progress Institute's Guide to Government Assistance	Provides information about government assistance programs and community-based resources that help low- and modest-income Rhode Islanders meet basic needs	www.economicprogressri.org

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## Disclaimer

The views expressed herein are those of the authors and do not necessarily reflect the views of Healthcentric Advisors or the Brown University School of Public Health.

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## Authors

Kimberly Pelland is a Master's of Public Health student at the Brown University School of Public Health and a Research Assistant at Healthcentric Advisors.

Teresa Mota, BSN, RN, CALA, WCC, RAC-CT is Program Administrator at Healthcentric Advisors.

Rosa R. Baier, MPH is Associate Director of Brown University's Center for Long-Term Care Quality & Innovation and consulting Senior Scientist at Healthcentric Advisors.

## Disclosures

None

## Correspondence

Rosa R. Baier, MPH  
Brown University School of Public Health  
Box G-S121-6  
Providence, RI 02912  
401-863-3818  
[rosa\\_baier@brown.edu](mailto:rosa_baier@brown.edu)

# The Roles and Functions of Medical Directors in Nursing Homes

AMAN NANDA, MD, CMD

## ABSTRACT

The medical director is an important member of the healthcare team in a nursing home, and is responsible for overall coordination of care and for implementation of policies related to care of the residents in a nursing home. The residents in nursing homes are frail, medically complex, and have multiple disabilities. The medical director has an important leadership role in assisting nursing home administration in providing quality care that is consistent with current standards of care. This article provides an overview of roles and functions of the medical director, and suggests ways the medical director can be instrumental in achieving excellent care in today's nursing facilities.

**KEYWORDS:** Medical Directors, Nursing homes, Quality of care

## INTRODUCTION

Nursing Homes are an important site for individuals who cannot manage without substantial help to live and receive healthcare. In 1974, Medicare required skilled nursing facilities it certified, to have a medical director. The Omnibus Budget Reconciliation Act of 1987 (OBRA-1987)<sup>1</sup> extended this requirement to all nursing homes. Services medical directors provide to fulfill their obligations vary widely. Medical directors may remain relatively uninvolved or be highly involved in working closely with the facility administration to deliver high quality care to the residents. Similarly, the administration of a nursing home may employ a medical director just to fulfill the Centers for Medicare and Medicaid Services (CMS) requirement for a medical director, or to use as a referral source for maintaining high occupancy in their facility. On the other hand, the Administrator and Director of Nursing may involve and fully embrace the skills the medical director has to offer and utilize that expertise in improving many aspects of the residents' care quality.

According to CMS, medical directors are responsible for implementing resident care policies and coordinating medical care of all the residents in the nursing homes. In the early 1990s, CMS developed interpretative guidelines for the medical director's role: "to ensure that the facility provides appropriate care as required, monitors and implements

resident care policies; provides oversight and supervision of physician services and the medical care of residents; plays a significant role in overseeing the overall clinical care of residents to ensure to the extent possible that care is adequate; evaluates situations as they arise and takes appropriate steps to try to correct the root cause, if possible; consults with the resident and his or her physician concerning care and treatment, if necessary; and ensures the support of essential medical consultants as needed." These guidelines are broad and vague.

The 2000 report by the Institute of Medicine (IOM), "Improving the Quality of Long Term Care,"<sup>2</sup> urged that medical directors be given more authority and be held more accountable for medical services in nursing homes. In order to delineate the role and responsibilities of medical directors, the American Medical Directors Association (AMDA), the society for post-acute and long-term care medicine, has periodically revised and updated its policy statement. In its latest white paper in 2011, AMDA identified roles and functions for medical directors.<sup>3</sup>

## ROLES OF MEDICAL DIRECTOR

There are four major roles of the medical director outlined by AMDA:

### Physician Leadership

The medical director should be a role model, and is responsible for the overall clinical care of the residents in the facility. The medical director provides guidance for appropriate physician credentialing, coverage, and performance expectations.

### Patient Care-Clinical Leadership

The medical director should apply clinical and administrative knowledge to guide the facility in providing high quality care. The medical director should have a panel of residents under his/her care, and should set an example in seeing new admissions and follow-up visits in a timely manner. The medical director should be available to administration and other providers to answer any clinical questions on a particular resident. The medical director should assist in the development of specific clinical practices in the facility and ensure that they are resident-centered standard of practice.

### Quality of Care

The medical director should help the facility develop quality improvement projects. The medical director should assist the facility in providing a safe and caring environment and advise the administration on risk management.

### Education, Information, and Communication

The medical director should educate and provide information to the facility staff, and practitioners which helps in improving the care of residents. The medical director should act as a liaison with the community and assist in establishing appropriate relationships with other health care organization.

### FUNCTIONS OF MEDICAL DIRECTORS:

There are nine functions for medical directors, as stipulated by AMDA:

#### Administrative

The medical director should participate in developing and approving patient care-related policies and procedures. The medical director should meet periodically with the Administrator and Director of Nursing (DON) and discuss patient care issues.

Each facility is surveyed by state and/or federal surveyors once a year, or earlier if there are any complaints. The surveyors usually come unannounced. The medical director should be notified when the surveyors survey the facility. The medical director should make every attempt to go to the facility and introduce him/herself to the surveyors and answer any questions while the surveyors are on-site. During or after the survey, the medical director can help surveyors in clarifying any clinical questions. The medical director should try to attend the exit survey and should help the administration in resolving or correcting any citations in the correction plan.

#### Professional Services

Each facility should have a credentialing policy for the medical staff that includes physicians, mid-level practitioners and consultants. The medical director plays a lead role in developing this policy. The medical director ensures physician performance in the following activities:

- providing appropriate medical care to the residents
- performing timely admissions
- documenting care
- making scheduled and as-needed visits
- providing medical coverage 24/7

The medical director is responsible for covering the attending physician when the latter is unavailable. The medical director becomes the attending physician by default when

no other physician is willing to accept the new admission. The medical director may take over the care of another physician's patient under the following circumstances:

- request by resident/family; or,
- to address any concern in quality of care.

### Quality Assurance and Performance Improvement (QAPI)

Each facility is required to have a quarterly QAPI meeting, including the attendance of the medical director. The medical director can guide the committee about projects to improve quality of care. It is recommended that QAPI meetings be held monthly rather than quarterly, and all department heads should have a quality improvement project related to their discipline. Medical directors should maintain written records and e-mails documenting their relevant activities. There should be an agenda item in QAPI meetings regarding comments from the medical director. Activities conducted as part of the QAPI should be labeled as such, so they remain protected from discovery by the surveyors. This protection is intended to allow for more frank discussion to support the QAPI activities and overall a better care environment.

### Rights of Individuals

The facility is required to have policies in place for ensuring that the rights of residents are respected. The medical director can help the administration in developing these policies, for example, by identifying and reporting abuse, or honoring a resident's choice for a particular attending on staff.

### Person-Directed Care

The medical director should play a lead role in promoting person-directed care. Residents and their families should be actively involved in decision-making about treatment options. Residents should be offered choices; for example, regarding waking up and timing of medications administration. Residents should be treated with respect and dignity.

### Education

The medical director should participate in educating the nursing staff as well as physicians and mid-level practitioners. The medical director can play a pivotal role in providing clinical leadership regarding current standards of care in attaining optimal residents' outcomes in the facility.

### Employee Health

The medical director should participate in the development of policies for promoting employee health. The medical director is not expected to substitute for employees' primary care physicians. The medical director should approve policies that cover employee immunization programs, and address diagnosis and treatment of infectious illnesses that could be transmitted to residents or other employees.

## Community

The medical director should act as a spokesperson and advocate for the facility in the community. Nursing homes often have an undeserved poor reputation. The medical director can play a role in educating colleagues, public and hospital administration officials about the nursing home structure and its importance in our health care system.

## Social, Regulatory, Political, and Economic Factors

The medical director should have knowledge of social, regulatory, political, and economic factors that may have an impact on patient care. The medical director should have knowledge of important federal and state regulations, such as the responsibilities of attending physicians, the medical director, and pharmacy services.

There is wide variation in the involvement of medical directors in their facilities. In 2003, the Office of Inspector General released a report on a survey of medical directors in nursing homes. In this survey, 62% of responding medical directors reported visiting the facility once a week or less. Seventy percent reported that 1-10% of their overall medical practice is devoted to their medical director role. Eighty-six percent spend 8 hours or less per week at their facility.<sup>4</sup>

According to the IOM report<sup>2</sup>, medical directors are accountable for the overall quality of care in nursing homes, but have little authority within the facilities (e.g., hiring and firing staff, setting administrative policies), and little authority over the attending physicians. The report recommended that in order to improve the quality of care in nursing homes, facilities should give greater authority and responsibility to their medical directors.

In order to better define the medical director's role and expectations, CMS updated the guidelines for the medical director (F-Tag 501).<sup>5</sup> The facility will be cited for F-501 if there are deficiencies in quality of care; e.g., if the nursing home staff are not proactive in preventing and treating pressure ulcers. In some states, if the facility is cited F-501, the division of facility regulations may inform the physician licensure board of the respective state. In order to show their active involvement, medical directors should keep logs of their activities in the form of notes, e-mails, letters or minutes of the QAPI meetings.

The American Medical Directors Association offers a certification program for medical directors (CMD). Medical directors may improve their medical direction skills by attending the core curriculum for this certification program. In one study done in US nursing homes, the presence of certified medical directors in the nursing facilities was an independent predictor of good quality of care.<sup>6</sup>

Nursing homes are an important part of health care system in United States. Despite the limitations in their authority, the medical director can play an important role in helping the facility to provide good quality of care to the residents.

## Acknowledgments

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## Author

Aman Nanda, MD, CMD, is an Associate Professor of Medicine, Division of Geriatrics and Palliative Medicine, Alpert Medical School of Brown University, Providence, RI.

## Disclosures

None

## Correspondence

Aman Nanda, MD  
Division of Geriatrics, POB 428  
Rhode Island Hospital  
593, Eddy Street  
Providence, RI 02903.  
401-444-5248  
[ananda@lifespan.org](mailto:ananda@lifespan.org)

# A Nursing Home Administrator's Perspective on Culture Change: Tockwotton's Commitment to Resident-Centered Care

KEVIN MCKAY

## ABSTRACT

Tockwotton Home, a 150+-year-old long-term care organization reinvented itself by adopting the household model of management ("culture change") to enable residents to play an integral role in self-directing their care. Staff was cross-trained and cross-certified to be nimble in meeting resident needs. In addition to philosophical changes, the organization made a \$53.2M investment in a new building with architectural features that reflected the new focus. The process of change, the resources facilitating this change and our responses to challenges are described. Early indicators (and long-term studies at other institutions) have suggested that the new model of care is leading to fewer medications, falls and pressure ulcers and higher resident satisfaction.

**KEYWORDS:** Nursing home administration, culture change, resident-centered care, self-organized workplace

## INTRODUCTION

Sound business concepts turn into successful ventures when the owners listen to their customers and implement responsive plans. With more patient choices and increased competition for residents from for-profit entities, the 150-year-old Tockwotton Home took pages from textbook case studies and applied the same logic to our organization, thereby acknowledging that providing medicine alone simply isn't good enough for our residents. Through research of best-in-class practices, trial and error, and implementation, we've learned that patient care requires a holistic approach that responds to the full range of patient requisites, from spiritual to medical to daily activities. Successfully addressing resident needs at Tockwotton on the Waterfront means providing the kind of care they want, at a time they dictate and in a setting of their choice.

While healthcare organizations originally intended to provide personalized, attentive and professional care, oftentimes record keeping, billing, reimbursements, staffing quotas and government mandates place undue pressures on administrators and direct caregivers. By the 1990s, efficiency and efficacy were industry buzzwords used more frequently than compassion and choice. Like other healthcare organizations, Tockwotton Home in Providence was struggling to balance

cost containment with best-in-class care while tending to its aging physical plant. As our board considered its options, while keeping in mind its non-profit charter, President Elizabeth MacKenty challenged our directors, staff and residents to reimagine the perfect place to age in place. MacKenty was confident that she had a capable team and the right timing for Tockwotton to recreate its care and environment. Tockwotton had many factors in its favor – the economy was robust, we were a non-profit, and we were a small enough organization (90 employees and 66 residents) to be nimble.

## GETTING STARTED AND IMPLEMENTING CHANGE

Change and adapting to residents' needs had always been a top priority in our organization. Our structure and practices have been dynamic to meet the physical, social and mental health requirements of those in our care. However, industry "culture change"<sup>1,2</sup> was challenging us to think radically. Spearheaded by the Pioneer Network (<https://www.pioneer-network.net/>), our focus was redirected to resident-centered care. Simultaneously, the "greenhouse" concept ([thegreenhouseproject.org](http://thegreenhouseproject.org)) was inviting us to de-institutionalize the physical structures of nursing homes. Looking ahead, we understood the need to reinvent our protocols and practices to keep pace with the changing market and resident/family expectations.

When the board's collective vision was captured on paper, the picture of a perfect home for seniors had many of the same attributes that we all strive to achieve in our own, individual home. We pictured a place where people work together to get the task done that's comfortable and suits our physical requirements, and where individual needs and wishes are recognized and accommodated.

Looking for existing models to guide us, we visited Meadowlark Hills in Kansas where the "household" model had been successfully employed. Confident that it was a step in the right direction, we adopted this model in 2008 – the first organizational milestone in embracing culture change. By incorporating this model into our philosophy, we also made a commitment to a self-organized workplace to ensure that all employees would be responsive, adjusting their work priorities and tasks (oftentimes beyond their job description) to meet the changing needs of residents, i.e. making a different meal than what's on the menu. Working with realistic financial and logistic parameters, direct care staff in a

self-organized workplace accommodate residents' wishes to help them achieve their vision of how they'd like to live.

While a self-organized workplace appears to be simple, it's a significant switch from the traditional medical model in which nurses and doctors carry out their vision of "best-in-care" practices. This institutional model meant that meals were served at a specific time, lights were out two hours after dinner and bathing happened when it was most convenient for the nursing staff. We wished for residents to regain authority over their own lives in meaningful ways. Now, under the self-organized workplace model, if a resident has ambulatory problems and wants to go on a stroll, the risks are explained but they are not prevented from taking walks. If they want to sleep until 10 and skip breakfast, they do so. If they'd like a scoop of ice cream, it's given. We've discovered that little choices – and often even just the knowledge that one has the ability for self-determination – helps individuals retain their quality of life and boosts morale.

From an employee's perspective, the changes meant that we all had to adopt flexible job descriptions and be cross-trained and certified. A nurse, for example, could be needed to prepare a meal in addition to monitoring vital signs, measuring medication and administering therapies. As families ideally work together, so do members of the direct-care team. When a housekeeper's opinions are held in equal regard with those of an RN, traditional hierarchies disappear. Cynics might have expected that this dramatic change would be rebuffed; in actuality, it was a system researched and thoughtfully implemented elsewhere, and now it's embraced by our staff. An important innovation has been implementing "consistent care," in which staff members are assigned to a small group of residents. Being greeted by a familiar face allows residents to become well acquainted with their caregivers, and (in turn) allows staff to anticipate resident needs while working as a team. Minimal staff turnover occurred because of these changes. Those that stayed were committed change agents who embraced their new roles without prejudice or hesitation. Tockwotton is not alone in its findings. Research has demonstrated the value of a "household model." Staff satisfaction and markedly reduced turnover follow implementation ([artifacts.culturechange.org/Data/Documents/artifacts.pdf](http://artifacts.culturechange.org/Data/Documents/artifacts.pdf)).<sup>3</sup>

## OUR BUILDING

After adoption of the household model and self-organized workplace we soon recognized one insurmountable obstacle: the reality that our physical structure was still institutional. We had nursing stations, shared bedrooms, common bathrooms and long hallways. We needed a new building, but suddenly the 2008 recession hit and purse strings tightened. Donors who had taken a beating on the stock market had to reduce their personal giving. However, our board was undeterred. Strengthened by the community response from to initial changes, we forged on together.

Plans took shape for "Tockwotton on the Waterfront," a community that would resemble family households. Small gathering places were created both inside and out. Translating the concept of a household model into architectural amenities created a challenge to design intimate spaces, including private apartments, private baths, and residential kitchens. The architect, Diane Miller Dooley of DiMella Shaffer Associates, succeeded by ensuring that there are no visible signs of institutional care, such as commercial kitchens, nursing stations, long hallways or communal bathrooms.

Dooley left no detail to chance. To increase exposure to natural light, for example, she designed outdoor spaces to take advantage of the sun's path, angling the building to maximize sun exposure; created significant window area; and incorporated gardens and patios to increase residents' exposure and encourage outdoor exploration.

Unobtrusive technology was also incorporated into the Memory Care and skilled nursing households. Overhead paging was eliminated. Caregivers now use cell phones, texts and emails to communicate, and an electronic monitoring system was added to alert caregivers to potential problems behind residents' closed doors. No cameras are used; rather, motion sensors are placed on the bed and ceilings that track individual behaviors and issue a silent page if a resident's behavior deviates from normal patterns.

The medical community at large weighed in on the innovations we were proposing. RI Generations, a partnership formed to support patient-centered care, was in its infancy and embraced our plans. The Rhode Island Department of Health's Office of Facility Regulation saw the logic of our proposals, reviewed our proposal and worked alongside planners to refine designs.

Residents and their families also provided input during the design process. Family members of former residents voted to approve the changes and expenditures. Newsletters communicated resident-centered care philosophies and milestones. Families and residents who were ambulatory took hard-hat construction tours.

The \$52.3 million Tockwotton on the Waterfront rose on six acres along the East Providence waterfront. When completed, the five-story, 137,754 square-foot, Nantucket-style building featured five "households" and 156 individual apartments with assisted living, memory care, short-term rehabilitation and long-term care. Each micro community features its own kitchen where food is prepared and served, allowing each resident to choose what/when they want to eat. With a host of personal amenities, care is coordinated and enables residents to "age in place" while receiving personalized services. With the new building, even couples can now remain together regardless of their disparate care needs.

Fifty-six residents made the move from Tockwotton Home in Providence to Tockwotton on the Waterfront in East Providence in January 2013, and those residents applauded (and embraced) the changes that the new building has brought. While nursing stations used to be a meeting

place for residents, they've been removed. Now residents gather in the dining room, facing each other, often lingering and socializing over meals. Residents are waking up to tend to their gardens, taking walks and ending their day dining on waterfront patios, following the sun's path. Increased light exposure, private bedrooms and lack of overhead pages and vitals checks have translated into better sleep. Our medical staff has also noted that better quality sleep has led to fewer falls and quicker recovery in the rehab household where well-rested residents are also more eager and ready to actively participate in physical therapy sessions, thereby accelerating their recovery.

While the long-term results of this move and change-in-care philosophy at Tockwotton are still being measured, a two-year study of six nursing homes that employed the household model found reductions in pressure ulcers, number of residents taking five or more medications daily, number of residents taking anti-depressants and anti-psychotics, and number of safety restraints used.<sup>3</sup> We are confident that our analysis over time will yield similar results.

With the opening of this new building, we have embraced culture change while acknowledging hurdles along the way. The economics of building during a significant recession, the challenge of adding and training new staff on the principles of the self-organized workplace, and the addition of new residents coming from traditional care facilities have challenged us all. And we will continue to be challenged. The foundation of a resident-centered care organization requires continuous reinvention and adaptation to meet our residents' needs. New residents will arrive and current residents will continue to age. Creating strategic plans and blueprints for our organization as we move into the future will, therefore, continue to test us as those needs and desires continue to change, both individually and collectively.

We're proud of the results we've achieved along the path of this dynamic process and we're heartened by resident and family response. Recently, family member Eleanora Sordoni summarized our accomplishments best when she wrote:

*"My husband had a birthday party...last Saturday. We had flowers, music, wine, lots of food and laughter. We watched the sun set over the water. And when we escorted him to his apartment, it was to a private and comfortable refuge. This apartment is a place where Franco and I can sit together in comfortable silence or listen to music or watch TV. We are very much at home."*

At that moment, on that day, for that resident, Tockwotton on the Waterfront had achieved its goal of resident-centered care. Tomorrow, next week, and next year, that definition of success will have changed and we will be well prepared, both physically and philosophically, to address those dynamic needs.

Change is necessary to remain relevant to the people you serve. Real change needs to be initiated by top administrators who champion the concept, believe in the direction,

build a team to support their vision, persevere with the adoption of reforms and continuously re-evaluate, making adjustments to stay true to an organization's redefined mission. Based on our experiences at Tockwotton on the Waterfront, we believe that culture change is the adoption of a new philosophy to remain relevant and a commitment to adapt to meet individuals' needs to create a measurably healthier community.

#### Disclaimer

The views expressed in this article are those of the author and do not necessarily reflect the views of the staff or residents of Tockwotton on the Waterfront.

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#### Author

Kevin McKay is Executive Director of Tockwotton on the Waterfront, a CareLink partner.

#### Disclosures

The author has no financial disclosures to report.

#### Correspondence

Kevin McKay  
Tockwotton on the Waterfront  
500 Waterfront Drive  
East Providence RI 02914  
401-272-5280  
[kmckay@tockwotton.org](mailto:kmckay@tockwotton.org)

# The Changing World of Long-term Care in RI: One Nurse's Journey

SUSAN VINHATEIRO, LPN

## ABSTRACT

This paper presents a personal look at the changing world of long-term nursing care in one facility over the course of a 38-year nursing career. The paper reviews the ways the role of "nurse" has evolved and expanded due to changes in patient populations, industry standards, and technology advancement. Though the job has changed dramatically over the decades, the most integral parts of successful nursing remain the same: Connection to patients and their families, and a commitment to quality care and patient well-being.

**KEYWORDS:** Nursing care, long term care evolution, nurse case management

In 1976, I finished my freshman year of college and decided not to return to school. At my father's urging, I went on my first job interview for a nurse's aide position. There was no certification required to be a nurse's aide. The entire training consisted of watching procedural film strips followed by ten days of training with an experienced nursing assistant. After working as an aide for one year, my father encouraged me to attend nursing school. I enrolled in Rhode Island Junior College and graduated in 1979, while working part time as a third shift nurse's aide.

I got my first job as a licensed nurse at the same facility where I worked as an aide. I did not realize at the time that I would spend my career in that very building. In the years since, I've worked in many positions ranging from charge nurse to infection control nurse.

At that time, working in a nursing home meant taking care of frail elders exclusively. Generally, patients resided at the facility for end-of-life care. Typically a licensed nurse's day would involve medication administration, turning and repositioning, simple wound care, nutrition via gastric tube, nasal gastric tube, or hand feeding. Anything beyond the scope of nursing would be handled by contracted professionals. In the 1970s, patients conformed to the schedules of the facility. We didn't take into account their personal preferences and habits from their daily lives before they were admitted. Patients were bathed, dressed, and groomed according to set daily schedules. At the time, we thought it was best for patients at risk for falls to be restrained. There was little flexibility. Visiting hours were scheduled, nurses wore starched white uniforms, white hose and caps. I could

never have anticipated the changes that would come in the world of long-term care.

Although the way we cared for patients was rigid, I always felt personally connected to them, especially the first patients I ever cared for. Stanley was one of the patients I became fond of. Many staff would bring their children in for visits. I still have a photo of Stanley holding my daughter during a visit. He never had children of his own, but all of the nurses sensed that our children were treated as grandchildren by the patients. Today this is called intergenerational programming. At that time, we just knew our children brought such joy to the elderly.

Over the years, reimbursement changes, Medicare regulation, and evolving patient demographics have dramatically altered nursing and long-term care. The once privately owned facility where I work was purchased by a corporation. It has since been sold three more times to even larger corporations.

The nursing facility itself has also dramatically changed. In the early 1990s, we opened one of the first secured dementia specialty units in the state specializing in individualized care and a habilitation approach to dementia care. Culture change, a homelike environment, consistent assignments an extensive activity program, and a holistic focus on patients' prior lifestyles were integral to the success of the unit. Restraints became a thing of the past. Multiple industry studies revealed restraining patients actually caused more serious injury and were not effective in the prevention of falls. Staff became adept at developing creative solutions for falls prevention. The Activity Department had a vital role in developing interventions as well.

We tried to make life on the unit reminiscent of residents' prior lives. I will always remember the day we enacted a wedding ceremony for them. A nurse's aide wore her wedding gown, there were flowers donated by a local florist, music, wedding cake and dancing. And, of course, with lots of reminiscing and tears, residents were encouraged to share their words of wisdom. This was one of the most challenging yet rewarding positions I have held. I learned about behavior management, validation therapy and therapeutic activities, and these became tools in our toolbox of dementia care.

Not all of the changes we made were as lasting. There are many factors that have an impact on change. One of those factors is finances. At the same time we opened the dementia unit, we opened a Joint Commission accredited sub-acute

unit to care for short-term, medically complex patients. Initially the sub-acute unit cared for ventilator dependent patients with 24/7 respiratory therapists on staff. Changes in reimbursement later in the '90s made continuation of ventilator care unprofitable. Care for ventilator-dependent patients was discontinued, but the sub-acute unit is still thriving today. All these units required nurses to expand their areas of expertise.

Nurses in skilled nursing facilities are today caring for patients who once remained in the acute care setting for extended periods of time. They are administering intravenous (IV) meds, total parenteral nutrition (TPN), and doing advanced wound care; they are taking care of patients with new tracheostomies, patients with multidrug resistant strains of infections requiring contact precautions, poly trauma patients, and surgical patients. Consequently, units have become very fast-paced. It is not unusual to have 35-45 admissions and discharges per month. Gone are the days of the sleepy nursing home. Today's nurses are in scrubs and running shoes tending to beeping IV pumps, answering call lights, rounding with physicians, passing medications, and doing treatments.

Staff is no longer limited to nurses and outside contractors. Now, skilled nursing facilities have large complements of physical therapists, occupational therapists, speech therapists, and respiratory therapists. Nurses have more technology at their disposal: electrocardiogram (EKG) machines, automated external defibrillators (AEDs), pulse oximeters, crash carts, bladder scans, not to mention the recent requirement of electronic medical records. The clinical and technical expertise of nurses has greatly expanded. Nurses, particularly older career nurses like myself, have had to adapt from a setting that once cared for frail elders to the high-tech, medically complex nursing of today.

To meet the needs of the patients we now care for, many consultants have become a crucial part of the care team. These include palliative care nurses, hospice care clinicians, psychiatric consultants, and wound consultants. All of these changes created a need for nurse case managers to coordinate the delivery of care.

In 2010, I accepted the role of nurse case manager, a position which is becoming more popular in nursing facilities to manage the care and reimbursement for Medicare patients, managed care patients and insurance patients. Case managers act as a patient advocate and liaison with physicians and insurers. We do concurrent reviews for insurance companies to ensure timely care and proper reimbursement, and obtain prior authorizations. It is very rewarding to meet with patients and families, and work closely with the interdisciplinary team to coordinate care and set goals to ensure good outcomes and safe transitions home.

Today, performance is measured in outcomes. José (not his real name) was a patient who came to our facility from Boston following an extended and complicated hospital stay for a hip fracture, myocardial infarction (MI), and respiratory

failure. On admission, he had a tracheostomy tube and was unable to speak, a percutaneous endoscopic gastrostomy (PEG) tube for nutrition, and a peripherally inserted central catheter (PICC) line for IV antibiotics. Over time, through the collaborative effort of speech therapy and respiratory therapy, José began speaking with a passey miur valve, had a blue dye test and modified barium swallow test to assess abilities. He progressed from a puréed diet with nectar liquids to a regular diet with thin liquids. He was decannulated and the PEG tube was discontinued prior to discharge. José was able to return home at his prior level of function. I felt gratified to see this once debilitated person return for a visit with his wife carrying an enormous tray of homemade goodies.

I have always treasured the connection with patients and families. Receiving a Christmas card or a random phone call from a former patient just to say "hello" are the greatest rewards. I still meet with former patients' family members, and we have built lasting friendships.

As I near retirement, it is with great satisfaction and fulfillment that after 38 years, I still come to work in the same facility. Though the entryway has changed after several renovations and expansions, it's still comforting to come back to this place and try to make a difference every day.

As I was gathering my thoughts for this article, I realized the place my nursing career was born at the urging of my father was the same place where his life would end. Three years ago, I found myself on the other side, as a family member sitting at my father's bedside in the same room where I had cared for many patients. Now I was there as a daughter with my daughters and my mother telling stories about my dad's life. We sat for 2 days with dad until he passed away. Along with it being such an emotional time, the experience gave me a different perspective on what so many patients' family members go through. I have sat with families as their loved ones were dying, thinking I was saying just the right thing. Sometimes there are just no words.

#### Disclaimer

The views expressed herein are those of the author and do not necessarily reflect the views of Oak Hill Nursing and Rehabilitation Center.

#### Author

Susan Vinhateiro, LPN, retired in December, 2014 from her role as a nurse case manager at Oak Hill Health and Rehabilitation in Pawtucket, RI.

#### Disclosures

The author has no financial disclosures to report.

#### Correspondence

Susan Vinhateiro  
401-573-1924  
Svinhateiro77@cox.net