CHSR Center for Health Services Research
Applying Research to Optimize Care©

What We Are Reading

Synopses of recent studies in health services research
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New Evidence on the Green House Model of Nursing Home Care: Synthesis of Findings and Implications for Policy, Practice, and Research

Take Away Points

- The findings of The Research Initiative Valuing Eldercare (THRIVE) studies have the following implications for practice, policy, and research for the Green House (GH) model of nursing home care as well as the culture-change movement toward more person-centered care:
  - Do not assume complete adherence to the GH model
  - Continue to model the quality of care
  - Take advantage of opportunities for communication and collaboration to provide good quality care
  - Actively include primary care providers in implementing the GH model
  - Expand the GH model to encompass use of evidence-based care practices
  - Support high-performance human resource practices and workforce training
  - Consider ways to better align Medicare's financial incentives to support the GH model
  - Promote equity as the GH model expands
  - Apply implications for culture change more broadly
  - Conduct further research on elements of the GH model

The Issue

The Green House (GH) model of nursing home care focuses on deinstitutionalizing the nursing home and includes several primary model components: no more than 12 residents, meals cooked in a central open kitchen, resident-directed living, resident control over time to wake, eat, sleep and access to activities in the broader community, and teams of self-managed certified nursing assistant staff. As of May 2015, 174 GH homes were in operation with 80% providing long-term nursing care. Nursing homes that adopt the GH model tend to be nonprofit, faith-based, part of a continuing care retirement community, have a special care unit, and a higher nursing assistant staffing ratio compared to other homes. Between 2011-14, the Robert Wood Johnson Foundation funded four project teams to independently evaluate GH nursing home processes and outcomes. These collaborative research projects are known as the THRIVE Research Collaborative. This article is a synthesis of results from the THRIVE evaluation and related suggestions for policy, practice, and research recommendations.

Source

Zimmerman, S., Bowers, B. J., Cohen, L. W., Grabowski, D. C., Horn, S. D., & Kemper, P. (2015). New Evidence on the Green House Model of Nursing Home Care: Synthesis of Findings and Implications for Policy, Practice, and Research. *Health services research*. http://onlinelibrary.wiley.com/doi/10.1111/1475-6773.12430/full

Study Methods and Design

The THRIVE Research Collaborative undertook a mixed methods evaluation approach. Primary data was collected from 2011-14 in 28 GH homes and 15 comparison nursing home units. Secondary data was collected from 2005-2010 from 15 GH homes and 223 comparison homes.

The findings of six published THRIVE studies examining the design and implementation, clinical decision making, quality, impact on Medicare spending and utilization, characteristics, perceptions, and satisfaction among staff, and sustainability of the culture change of the GH model are presented in summary.

Key Findings and Limitations

- GH homes were typically consistent with the model in that they had 10-12 private rooms, an open kitchen, and self-managed work teams. However, most differed from the model in practices supporting resident choice such as time to wake, bathe, and staffing changes.
- Direct care staff in GH homes varied in the interpretation of their empowerment.
- GH homes had 7.8 caregivers/resident/week compared with 10.6 in legacy homes. The amount of direct care worker time per resident per day was also higher in GH homes (4.2 vs. 2.2 hours/resident/day). As a result, staff reported being more familiar with residents and better able to detect change in their condition.
- The GH home staffing model presented barriers to sustainability. Staff had difficulty responding to survey citations, business challenges such as hiring, and daily routine. Leadership was challenging in that roles were unclear and direct care workers were often bypassed in decision-making and problem-solving.
- Residents in GH homes had fewer hospitalizations when there was collaboration and interaction among medical care and direct care staff, as opposed to homes where direct care staff interpreted their empowerment to mean they worked independently.
- GH home residents had a 31% decline in 30-day hospital readmissions and a 30% reduction in avoidable hospitalizations compared to legacy units.
- For residents in GH homes compared to legacy units within the larger GH organization, there was a 30%, or $7,746/resident/year, decrease in Medicare spending in GH homes ($p<0.06$).
- Limitations: Sufficient data to evaluate the GH model is difficult, due to the recent development of the model (2003) and the small number of residents (10-12) in each GH home. Another difficulty was identifying a true comparison group for study when comparing GH homes to a traditional nursing home or legacy homes. Patient-centered measures require further research.

"Among residents of GH homes, adoption lowers hospital readmissions, three MDS measures of poor quality, and Part A/hospice Medicare expenditures."

Final Thoughts

- Compared to traditional nursing homes, the GH model is a preferable model of care, however, other models of care that promote person-centered resident quality of life may prove of equal merit.
- In addition to traditional quality of care measures in nursing homes, indicators of collaborative care, resident-directed care, and other quality of life indicators should be included to better evaluate the environment and care provided.