The experience of the person interacting with our healthcare system can have a significant impact on the outcome of that interaction.

Definitions abound but the commonalities are:
- a reaffirmation of the importance of the therapeutic relationship,
- a focus on the whole person and lifestyle — not just the physical body,
- a renewed attention to healing, and
- a willingness to use all appropriate therapeutic approaches, whether they originate in conventional or alternative medicine.

Institute of Medicine, 2009
How is Person-Centered Care Different than Quality Care?

Quality-Care Approach
Providing the right care in the right way at the right time.

Person-Centered Approach
Providing the care that the person needs, in the manner the person desires, at the time the person wishes. “Nothing about me without me.”

Roots of Person-Centered Care
460 BC Ancient Greek school of Cos, which was interested in the particulars of each patient
1950s Client-centered therapy (Rogers)
1970s Total-person approach to patient problems in nursing (Neuman and Young); disease- versus patient-centered medical practice (Byrne and Long); term coined by Tom Kitwood in England
1980s Biopsychosocial model (Engel)
1990s Patient-centered concepts applied to the hospital setting (Gerteis)
2000s Institute of Medicine (IOM) includes patient-centered care as 1 of 6 domains of quality

Dimensions of Person-Centered Care
- Empowerment
- Choice
- Voice
- Healing environments
- Community
- Dignity
- Privacy

What is the evidence for Person-Centered care?
- Improves patient satisfaction
- Improves clinical outcomes
- Improves quality and safety
- Reduces cost of healthcare

Challenge: Silos
- Proprietary Models
- Polarization by Acuity Level
- Multiple Small Advocacy Organizations
- Diversity of Focus
  - Direct care workforce
  - Patient/elder experience
  - Built environment
  - Family engagement

Challenge: Confusing Care Nomenclature
- Person-Centered
- Patient-Directed
- Relationship-Based
- Culture Change
- Family-Centered
Person-Centered Organizations

Challenge: Traditional View

Acute Care
Younger
Independent

Chronic Care
Older
Dependent

Today: Bridge Healthcare Continuum

“Institutional Acute Care”
“Non-Institutional Care”
“Person-Centered Care”

“We shape our dwellings, and afterwards they shape us”

Design Guidelines for Hospitals

Implementing Person-centered Design in Healthcare: Building Connections

2010 Edition
Past – 1976
Minimum Requirements

1) Maximum capacity shall be 4 patients
2) Minimum area:
   1) 100 sq. ft. in a single
   2) 80 sq. ft. per bed in multiple bed rooms
3) One lavatory in each patient room, omitted in a single or semi-private, may be shared with other rooms

And the miracle happens!

Present – 2010
Guidelines

Appendix
In new construction, single patient rooms should accommodate comfortable furniture for family members (one or two) without blocking access of staff members to patients.

Guidelines Development

- Revised every four years
- 130 person Multidisciplinary committee
- Public Process – everyone is encouraged to participate
- 2014 edition proposal period open until October 31, 2011
- Electronic submission – www.fgiguidelines.org

Challenges of the decision-maker

- Time it takes for new standards to be approved
- Time it takes for a new hospital to be created and delivered

Challenges of the decision-maker

- We buy new health care facilities all wrong
- Focused on first cost
- Very little thought during the planning phase
- Functional program not a focus of many organizations
- How do we change our bad habits?
- Fable Hospital 2.0 as an example
- More research that gets into the C suite
The 2010 Healthcare Environments Awards Professional Conceptual Winner Patient Room 2020

LTC Policy, Regulations, Codes & Guidelines: Steps in the Right Direction

History

OBRA Regulations
(OmniBus Budget Reconciliation Act or Nursing Home Reform Act of 1987)

Federal Standard to improve care:
US Code of Federal Regulations (42 CFR Part 483)

• OBRA Intent
  – Meant to represent minimum accepted standards of care
  – Changed focus of care from input to outcome based
    • Quality of care
    • Quality of life
  – Completing a written comprehensive resident care plan focused on well-being
    (provision of services & activities to attain or maintain highest practicable physical, mental, and psychosocial well being of resident)
• General OBRA requirements:
  – Nursing home responsible for resident safety
  – Medical orders coordinated and reviewed from primary care physician
  – Provide services to enhance resident quality of life to the fullest
  – Maintain resident dignity & respect
  – Conduct initial & follow-up comprehensive resident assessment
  – Freedom from chemical & physical restraints

Resource:
https://www.cms.gov/GuidanceforLawsAndRegulations/12_NHs.asp

• General OBRA requirements:
  – Prevent/reduce development of bed sores with proper treatment if does occur
  – Appropriate care for residents with urinary incontinence & restore bladder function if possible
  – Prevent accidents and facility acquired events: falls, medication errors, infection, etc.

Resource:
https://www.cms.gov/GuidanceforLawsAndRegulations/12_NHs.asp

• General OBRA requirements:
  – Prevent unnecessary weight loss through adequate nutrition
  – Maintain sufficient fluid intake to prevent dehydration
  – Maintain adequate quantity of trained staff
  – Resident Choice: rights to choose activities, schedules, health care, etc.
  – Medication services that meet the individual resident needs physically and psychologically
  – Maintain accurate, complete, & accessible clinical/health records

Resource:
https://www.cms.gov/GuidanceforLawsAndRegulations/12_NHs.asp

• Compliance
  – Residents must be assessed for not only medical conditions, but also for basic self-care activities as individuals
  – MDS (minimum data set) used to document assessment
  – Compliance for Medicare & Medicaid Reimbursement
  – Ensure compliance through state survey process
  – Penalties are weighed for non-compliance: fines, administrative consultants to run nursing home while deficiencies are remedied, and closure of a nursing home

Resource:
https://www.cms.gov/GuidanceforLawsAndRegulations/12_NHs.asp

F-tag (short for Federal Tag)
Provides Additional Guidance on CMS Regulations

F-tags & Person-Centered Care
  – 2009: CMS released revisions to 11 interpretive guidelines
  – Related to person-centered care, needs, and preferences

Resource:
http://www.pioneernetwork.net/Providers/PromisingPractices/CMSGuidelines/NursingHomes-IssuanceofRevisionstoInterpretiveGuidancePartofAppendixPP,StateOperationsManual
F-172 Visitation (24/7 access)
F-175 Married Couples (right to share room)
F-241: Dignity (signage, confidentiality, resident access to common areas)
F-242: Self-Determination & Participation (Choice over schedules)
F-246 Accommodation of Needs (providing adaptations to promote choice: furniture, access to supplies, etc.)
F-247 Notice Before Room or Roommate Change (roommate passes, allow grieving time, explain new room, introductions)

Resource: www.culturechange.org/resource/KarenSEducationalProgram_102408.ppt

F-252 Safe, Clean, Comfortable & Homelike Environment (defines intent of “homelike”, strive for elimination of institutional practices)
F-256 Adequate & Comfortable Lighting (minimum of glare, contrast between surfaces, adequate lighting design)
F-371 Sanitary Conditions (food procuring & handling)
F-461 Resident Rooms (Closet Portion) (residents to reach their own clothing)
F-463 Resident Call System (allows wireless call systems)


Present

Senior Living Sustainability Guide®
& Person-Centered Care

Resource: www.withseniorsinmind.org

MDS 3.0 (Minimum Data Set 3.0)
& Person-centered Care

• History of MDS: 1986 & Part of 1987

OBRA


– Functional impairment & co-morbidities not addressed:
  • Either not identified or
  • Attributed to “old age” or dementia.

– Report recommended shifting nation’s strategy for monitoring & improving NH care
  • Using structured evaluations with systematic and standardized assessments
  • Resident’s cognitive, functional, and emotional needs


• History of MDS: 1986 & Part of 1987

OBRA

– This information then utilized as basis for development of care plans and interventions.

– 450 item assessment: functional status, mood, and medical conditions of NH residents

– MDS is part of the longer Resident Assessment Instrument (RAI)
  • That includes Resident Assessment Protocols (RAPs)


• MDS 3.0 implemented October 1, 2010

• MDS 3.0 Updates:
  – Development of a Person-Centered Comprehensive Care Plan
  – Designed to include the resident within the assessment process
  – Increase the resident’s voice by including more resident interview items
  – Improve reliability, accuracy, and usefulness of the data
  – Enhance individual care planning & outcome measurement


• Comparable to MDS 2.0: National Trial

  – 81% More clinically relevant
  – 85% Help staff identify problems that might not have been noticed without the MDS
  – 79% items more likely help staff detect resident’s status changes
  – 84% Structured interview sections (cognition, mood, customary routine, activities, pain) improved staff knowledge of resident and their health condition


• Comparable to MDS 2.0: National Trial

  – 89% more accurate report of resident’s characteristics
  – 76% items better reflect clinical practice of standards
  – 85%: Questions clearer
  – 76%: Clarified several difficult items


MDS 3.0 Example Section: Customary Routine & Activity Items: Use of Preference Assessment Tool Response Scale

5/24/2011

MDS 3.0 Example Section: Customary Routine & Activity Items: Use of Preference Assessment Tool Response Scale

The remaining items in the Preferred Routine items set are:
- How important is it to you to leave your family or a close friend involved in discussions about your care?
- How important is it to you to take care of your belongings or things?
- How important is it to you to choose what clothes to wear?
- If you could go to bed whenever you wanted, how important would it be to you to stay up past 8:00 p.m.?
- How important is it to you to have a place to keep your things to keep them safe?
- How important is it to you to be able to use the phone as private?
- How important is it to you to have meals available between meals?


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MDS 3.0 Example Section: Customary Routine & Activity Items: Use of Preference Assessment Tool Response Scale

The remaining items also showed variation in responses. In Figure 8.4, activities are arranged from those with the lowest number of importance ratings to those with the highest. The mean for the activities are set as:
- How important is it to you to go outside to get fresh air when the weather is good?
- How important is it to you to keep up with the news?
- How important is it to you to participate in religious services or practices?
- How important is it to you to listen to music you like?
- How important is it to you to have books, newspapers, and magazines to read?
- How important is it to you to do things with groups of people?
- How important is it to you to be around animals such as pets?


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MDS 3.0 Example Section: Customary Routine & Activity Items: Use of Preference Assessment Tool Response Scale

Summary

A new Preference Assessment Scale (PAS) was designed to allow staff to obtain resident preferences unobtrusively. After the Department of Health and Human Services (DHHS) completed the draft, the PAT was completed by 10% of residents scheduled for MDS assessment, and findings or observations were compiled in an additional 4% of staff performed tests to the 320-3.0 company routine check list and reported passing new results into resident preference. Staff feedback identified a few items in the section as personally problematic. We addressed those items in a pilot evaluation. We recommend that the revised PAT be used for all residents capable of understanding their own behavior and that are capable of weighing their own preferences or those residents without a completed PAT.


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2010 Guidelines for Design and Construction of Health Care Facilities

Resource: www.fgiguidelines.org
Residential Health Care Facilities
& Person-Centered Care Initiatives

Resource: www.fqiguidelines.org

Part 4: No Longer "Patient" but "Resident"

4.1 - 2.2.6 Toilet Room
• Space Requirements
  • Private individual storage: personal effects
  • Doors
    • Hinged, sliding, folding: all permitted
  • Lifts & Transfers
    • Space for "double" transfer
    • Thresholds
    • Alternative grab bar configurations

4.1 - 2.2.6.6 Medication distribution locations
• Medication room
  • Task lighting
  • 50 square feet
• Self-contained medication distribution unit
• Medication storage in resident rooms
• Other approaches acceptable by AHJ

4.1 - 2.2.6.7 Resident food area
• Work Counter
• Refrigerator
• Storage Cabinets
• Sink
• Range, cooktop, and/or oven (with emergency shutoff) per the functional program
• Food warming
• Dishwashing
4.1: Common Elements Highlights

- 4.1.2.3.2 Resident Dining & Recreation Areas
  - 4.1.2.3.2.2 Dining areas
    - Support centralized or decentralized
    - Satellite Dining Areas
    - Number of Residents
      - Dining at a time based upon functional program

4.2: Nursing Facilities Highlights

- 4.2.1.2.2 Environment of Care

- 4.2.2.1.3 Layout & Care Model
  - Expanded appendix information on care models and design approaches
    - Clusters
    - Households
    - Small house

- 4.2.2.2 Resident Room
  - Performance Based Approach
  - Space Requirements
    - Multiple bed locations
    - Accessible window
    - Accessible storage
    - Accessible furnishings
    - Direct access for room entry to toilet room (NOT going through another Resident's living space)
    - Clearance for staff & utilization of lifts

4.2-3.5: Nursing Facilities: Resident Outdoor Area

Future
NFPA 2012 & Person-Centered Care

- NFPA 2012 & Pioneer Network
  - Allowing open kitchen to the corridor (maximum 30 residents)
  - Cooktop or range
  - Range hood with built-in fire suppression
  - Does not have to meet all commercial hood requirements
  - Venting not required, but recommended
  - Fire extinguishers
  - Locked switch (staff shut-off)
  - Smoke alarms at least 20 feet away

Resource: Life Safety Technical Committee: Tom Jaeger & Amy Carpenter

ADA & Accessibility Guidelines

- NFPA 2012 & Pioneer Network
  - Allows seating/resting areas in corridors (fixed and at one side)
  - Allows fireplaces in common spaces
  - Allows decorations (grandchild’s drawings can be hung on grandma’s door or bulletin board)

Resource: Life Safety Technical Committee: Tom Jaeger & Amy Carpenter

AIA Design for Aging (DFA) Knowledge Center & Rothschild
- ADA: Access Board
- Discuss appropriate guidelines for elders specifically
- Goal is to change/revise/add items such as the location of toilet fixtures, grab bar configurations, shower configurations, and other ADA criteria that does not support elders in long term care settings

2014 Guidelines for Design and Construction of Health Care Facilities

Resource: www.fgiguidelines.org
• 2014 Guidelines for Design & Construction of Health Care Facilities
  – Volume 2: Residential Health Care Facilities
  – Specialty Sub-group for RHCF
  – Part 1: Planning Design Construction & Cx
  – Common Elements
  – Nursing Homes
  – Hospice
  – Assisted Living
  – Adult Day Care

– In addition to expanding Environment of Care & Functional Program, looking at adding:
  • Expanding Nursing Homes (group homes, pediatric, etc.)
  • Independent Living Guidelines
  • Inclusion of Bariatric information

– Center for Health Design & Rothschild Workshops addressed specific issues:
  • Defining institutional setting, cluster/neighborhood, household, & free-standing house
  • Proposing Characteristic Chart
  • Address battery-operated ambulatory devices
  • Culture change: Environment of Care: considering terminology of “resident-centered”

– Rothschild Workshops to address specific issues:
  • Evaluation of examination room
  • Evaluation of isolation room
  • Outdoor Areas
  • Resident Room performance criteria (use of clearances to create minimums)
  • Specialty Care Populations
  • Wellness Centers

Thank You!

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Evidence Based Design That Reflects Patient Centered Care: A Journey From *Father Knows Best* to *Have It Your Way*
THE WAY THINGS USED TO BE

- Authoritarian
- Paternalistic
- Institutional schedules
- Rigid protocols
- Patient’s opinion unwanted
- Little access to information
- Families “get in the way”
- Patient as “prisoner”

Ulrich, Zimring et al. 2004

THE ADVENT OF PATIENT-CENTERED CARE

DO IT OUR WAY

Burger King

HAVE IT YOUR WAY®

EFFECTS OF STRESS

Can a less stressful experience lead to better post-surgical outcomes?

Physical and psychological comfort prior to surgery may result in less pain, use of fewer narcotic pain meds and fewer post-surgical complications.

Kiecolt-Glaser et al. 1998

EFFECTS OF STRESS

The healing process is a cascade: success in later stages of wound repair highly dependent on initial events. Immune function plays key role.

Kiecolt-Glaser et al. 1998

EFFECTS OF STRESS

- Mild stressors can delay wound healing 20-40%
- Pain adversely affects immune function
- Anxiety related to more severe postoperative pain
- Fragmented sleep results in higher cortisol levels (a stress hormone)

Kiecolt-Glaser et al. 1998

PATIENT-CENTERED CARE

ACCESS TO INFORMATION
COLLABORATION
RESPECT DIGNITY
FAMILY SUPPORT
COMFORT
HEALING ENVIRONMENT
EMPOWERMENT
**THE HOLY GRAIL**

All care options are tailored to the individual patient and care-giving activities revolve around providing comfort and emotional support to the patient with family and friends as active partners in the care process; inclusion of patients and families in care and decision-making. The physical environment is a vital component of the care provided.

Henrikson et al 2007; Saunders et al 2003; Macnab, Thiessen & Hinton 2000 as reported in Evidence for Innovation; NACHR/CHD 2008

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**SINGLE-BED ROOMS**

Overwhelming Evidence:
- Patient privacy enhanced
- Reduction in hospital-acquired infections
- Patient better able to sleep
- Reduction in noise
- Roommate often a source of stress
- More space for family
- Fewer patient transfers
- Fewer medication errors
- More candid conversations with physicians and nurses

Ulrich, Zimring et al. 2004

---

**BENEFITS OF SINGLE-BED ROOMS**

- Fewer nosocomial infections
- Fewer medication errors
- Better accommodation of family
- Higher patient and nurse satisfaction
- Better sleep
- Less use of pain medication
- More private conversations with physicians and nurses

Chaudury, Mahmood & Valente 2004
Ulrich & Zimring 2004

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**SINGLE-BED ROOMS**

The Business Case
- Higher first costs offset by higher occupancy rates, per diem costs
- Shorter length of stay
- Reduction hospital-acquired infections (addresses “Pay for Performance”)
- Easier to isolate infected patients
- Handwashing compliance higher
- Fewer patient transfers

Ulrich, Zimring et al. 2004

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**WHAT THE PATIENT SEES**

Minimal clutter; linen hamper and trash out of view

Indu & Raj Soin Medical Center, Beavercreek, OH
Jain Malkin Inc.
**EMPOWERMENT**

- Engage patients/families as partners in care
- Educate them
- Facilitate care after discharge
- Provide space for families in room
- Embrace technology

Dublin Methodist Hospital
Karlsberger/CAMA Inc.

**EMPOWERMENT**

Bedside computer for patient

Computer for family

Dublin Methodist Hospital
Karlsberger/CAMA Inc.

**EMPOWERMENT**

Shift-to-shift handoff done at bedside with patient as center of care team. More information is exchanged with patient and family participating. Increases time at the bedside.

Picker Always Event winner 2011

**HAVE IT YOUR WAY...**

Enhancing the patient’s experience

**CARE TEAM COLLABORATION**

Decentralized “perches” replace traditional nurse stations

Dublin Methodist Hospital
Karlsberger/CAMA Inc.

**CARE TEAM COLLABORATION**

Places for collaboration between nurses, physicians, case manager/social worker, P.T/R.T

Schuster Heart Hospital
Jain Malkin Inc.
ACCESS TO INFORMATION

Patient-care board

COMFORT

Positive distraction

COMFORT

Access to snacks

Positive distraction

TOP 10 LIST EBD FEATURES

1. Single patient rooms
2. Promote use of visible and accessible handwashing sinks and alcohol gel dispensers
3. Family areas within patient care spaces
4. Provide access to nature
5. Install HEPA filters and high number air changes

TOP 10 LIST EBD FEATURES

6. Provide access to sunlight
7. Install ceiling lifts
8. Promote visual access and accessibility to patient
9. Install sound-absorbing ceiling tile
10. Provide areas of respite for staff

ECONOMIC INCENTIVES RESULTING FROM EVIDENCE-BASED DESIGN

- Reduction nosocomial infections
- Decrease in medical errors
- Enhance nursing recruitment and retention
- Increase in market share
- Reduction absenteeism
- Increased customer satisfaction
- Reduction in narcotic pain meds
- Fewer patient complications
- Decrease in anger/violence
WHAT MATTERS MOST TO PATIENTS
- Connections to caregivers
- Care environment conductive to well-being
- Convenient and accessible
- Confidential and private
- Seamless transition across care continuum, including discharge
- Considerate of individual impairments
- Respect for family
- Access to nature, natural light

Restoring Home Initiatives
- Culture change
- Households
- Small House

Quality of Life Interventions
- Comfort
- Functional competence
- Autonomy
- Dignity
- Privacy
- Individuality
- Meaningful activities
- Relationships
- Enjoyment
- Security
- Spiritual well being

Home Environment
- Redesigning resident rooms for privacy, personalization, and individual needs
- Introducing plants, pets, children, and surroundings that are reminiscent of past lives
- Redesigning public and outdoor living spaces for stimulation and activity
- Developing neighborhoods or households with dedicated areas for dining and living

Home

Neighborhoods & Small Houses
Research & Outcomes
Resident Outcomes

Compared to the 2 control settings, GH residents reported a better quality of life and greater satisfaction.
GH residents equaled or exceeded standard quality indicators.

Family Outcomes

Compared to the 2 control settings, GH family members reported:

- greater satisfaction with their relative’s care and life.
- greater satisfaction with how they as family members were treated.

MOLONY

- Unanimous preference for new environment
- Trend to higher self rated ADL function
- Increased freedom was a strong theme

Access to Outdoor Space

Rated as very important by residents and staff.

Morgan

FOOD

More enjoyment
Less weight loss

Kane
Decentralized Home Like Design in Dementia Care

- Less exit seeking
- More observed manifestations of pleasure
- Lower levels of agitation

Cohen-Mansfield

Anecdotal/Participant Reporting

Needs

Research that examines:
- architecture/outcomes
- over time cost benefit of traditional/household/small house as it relates to the building
- improvements in resident function related to design.

Perspective:

Patient-centered Care Yesterday, Today and Tomorrow

Kimberly N. Montague, AIA, LEED-AP
Director, Design Consultation Services
Planer
e
EDRA Conference
May 25, 2011

History Lesson

How it all began...

“It may seem a strange principle to enunciate as the very first requirement in a Hospital that it should do the sick no harm.”
- Florence Nightingale, 1859

Royal Victoria Hospital (courtesy Norman Collection, McCord Museum).
“Health depends on a state of equilibrium among . . . the body and the mind . . . reached only when man lives in harmony with his external environment.”

- Hippocrates

“...the ideal hospital would combine the best of modern technologic medicine, with the best possible patient care experience to become a truly healing environment, where just being there is healing.”

- Angelica Thieriot

What does Patient-centered Care Mean to You?

- Massage
- Music
- Clowns
- Fish Tanks
- Cookies
- Dogs

Family Presence
Access to Information
Involvement in Decision Making
Effective Communication
Respectful Interactions...

In a nutshell...

- Providers partner with patients to anticipate and satisfy the full range of patient needs and preferences

- Staff are supported in achieving their professional aspirations and personal goals
Patient-Centered Care Today: Not Only “Nice,” But Essential

- Institute of Medicine
  - Identifies patient-centeredness as one of six national aims of health care quality
- Centers for Medicare and Medicaid Services
  - Public reporting of HCAHPS scores
  - Value-based purchasing on the horizon
- Joint Commission Standards
  - 24/7 access to family

Planetary Affiliate Profile: Domestic & International sites

- Hospitals & Medical Centers (162)
- Long Term Care Facilities (100)
- Clinics, Health Centers & Multi-specialty Groups (298)

Living Laboratories

- System-wide implementation
- Critical Access HCAHPS Leaders
- Ballyodge Award Hospitals
- Fortune 100 Best Companies
- VA Medical Centers
- Greater Los Angeles Healthcare System

VA Greater Los Angeles Healthcare System

**Planetree performance is significantly better than the national average at the 95% confidence level**

**Planetree performance is significantly better than the national average at the 90% confidence level**

HCAHPS Comparison of U.S. Planetree Designated Hospital Average and CMS National Average, 2009

- **Planetree** performance is significantly better than the national average at the 95% confidence level.
Asking the right questions

What would make your health care experience more healing?

- Access to family and friends
- Access to information
- Personalized care; more attention to the “little things”

Planetree Focus group data - 2000 to 2008

Quality and Safety — Preventing Physical Injury?

“Hi,
Last day before yesterday I was at the hospital. The R.N. were sweet and understanding. We just left today but my daughter talked to me and let me know that my mom is doing well and she is not in pain. I was sick as my mother was sick but I have never been so sick. I was in a state of shock. How do we want to be remembered?"

Laura Gilpin, RN, MFA

Patient-centered Designation

Growing
Integrated to apply across continuum
Evidence-based and Experienced-based
Evolving to address emerging issues
Global integration

Quality and Safety — Just about the Patient?

“...the family is going to remember what we do for the rest of their life. How do we want to be remembered?”

Laura Gilpin, RN, MFA
“Virtually any characteristic of the environment can have a supportive or detrimental effect on human performance and hence, on patient safety.”


“...establish a Hospital Value-Based Purchasing (VBP) program in Medicare that moves beyond pay-for-reporting on quality measures, to paying for hospitals’ actual performance...provide value-based incentive payments to acute care IPPS hospitals that meet certain quality performance standards beginning in FY2012...measures would focus on heart attack (AMI); heart failure; pneumonia; surgical care activities; and patient perception of care."

*Suggested transition from pay-for-reporting to pay-for-performance
† Current = 100% payment for reporting
‡ FY 2012 = Data Collection/performance year
§ FY 2013 = Hospital payments adjusted based on performance

† HCAHPS 20-40% of overall VBP score
‡ HCAHPS and related survey tools are becoming the industry focus

Holy Cross Hospital
Creating a Continuum of Care for Older Adults
Seniors Emergency Center

Bonnie Mahon RN, BSN, MSM, CMSRN, CNA-BC
Senior Director, Medical, Surgical and Senior Services
Mahonb@holycrosshealth.org
Holy Cross Hospital’s service area includes about 1.5 million residents of Montgomery and Prince George’s counties.

Seniors Growth

- In the year 2000 persons over age 65 represented 13.1% of the population or about 35 million persons
- By 2030 that number is projected to be over 70 million or 20% of the population.
- The fastest growing subgroups are the “oldest old” – a 28% increase in those >75 years
- Those >85 years are increasing at 3-4x the rate of younger cohorts
- At present utilization rates at least 25% of patients in the average ED will be geriatric based on population statistics alone
- In Maryland by 2030, 27.6% of persons >65 and 2.5% >85

Creating a Seniors Emergency Center

- CEO Vision
  Seniors who seek treatment at Holy Cross Hospital experience competent, comforting, and compassionate care in an environment that provides comfort and mitigates anxiety for the senior and his/her loved ones.

Current Emergency Room Models

- The current model of care in the United States was designed to treat the younger adult with a single acute illness or injury
- The needs of the older adult are more complex
  - Multiple co-morbidities
  - Polypharmacy
  - Functional and cognitive impairments
  - Social and psychiatric problems

Acute Emergency Center

Senior Focus Groups

- Overwhelming theme:
  - Keep me comfortable
  - Keep me warm
  - Keep me informed
  - I don’t mind waiting, if I know why
  - Don’t let me be alone!
Planning Team

- Leader – Senior Director – Seniors
- Physicians – Emergency Room
- Chief Nurse
- Nursing Director and Educator
- Case Management
- Project Planner

Sensory changes necessitate environment changes

- Vision and Hearing
  - Paint colors – warm brown and gold colors
  - Lighting – diffuse lighting with dimmer switches
  - Flooring – shiny white vinyl to faux wood grain vinyl with anti-glare and anti-skid properties

Noise Control

- Ambient loud noises lead to over stimulation and worsening of cognitive impairment and increase anxiety
  - Dedicated unit has doors at both entrances
  - Limited overhead paging
  - Wireless phones

Safety Issues

- Handrails in each room
- Open nurses station provides clear visibility into the patient rooms
- Hourly rounding
- Strategies to help with orientation
  - Large face clocks
  - Calendars
  - Wipe off boards
  - Telephone has large numbers and adjustable volume

Comfort Measures

- 4” tempur-pedic mattresses
- Comfortable side chair with arms
- Blanket warmer
- Bair Paws™ - a patient adjustable warming system
- Allow family/friends at bedside
- Nourishments / meals

Communication

- Translator phones in every room
- Magnifying classes
- Hearing amplifiers
- Spend more time with patients
**Results**
Seniors growth has significantly outpaced non-seniors growth

- Emergency Department Visits
- Ambulatory Surgeries
- Inpatients

**Patient satisfaction survey results are impressive**
- Would recommend = 97.8 percent
- Rate experience = 95.7 percent
23 percent said we had the best services for seniors (higher than for women’s services); the next highest percentage was 6 percent.

<table>
<thead>
<tr>
<th>Attribute</th>
<th>Holy Cross Hospital</th>
<th>Suburban Hospital</th>
<th>Washington Adventist Hospital</th>
<th>NMC Hospital</th>
<th>Shady Grove Adventist Hospital</th>
<th>Sibley Memorial Hospital</th>
<th>Montgomery General Hospital</th>
<th>George Town University Hospital Center</th>
</tr>
</thead>
<tbody>
<tr>
<td>The hospital trusted most to provide the best quality care for you and your family</td>
<td>20%</td>
<td>9%</td>
<td>2%</td>
<td>23%</td>
<td>13%</td>
<td>13%</td>
<td>14%</td>
<td>10%</td>
</tr>
<tr>
<td>Has the best reputation for meeting the health care needs of women</td>
<td>15%</td>
<td>14%</td>
<td>15%</td>
<td>15%</td>
<td>15%</td>
<td>12%</td>
<td>12%</td>
<td>19%</td>
</tr>
<tr>
<td>Has the best services for seniors</td>
<td>23%</td>
<td>21%</td>
<td>17%</td>
<td>29%</td>
<td>23%</td>
<td>22%</td>
<td>22%</td>
<td>23%</td>
</tr>
</tbody>
</table>

We wanted to build a reputation for seniors as we have for maternal child services – and we did!

* Statistically greater than any other hospital (p<.05)
• Resident Driven
  • Replacement Nursing Home
  • Resident Desire for Green Building (LEED™)
  • Resident Committee on Dementia Care
  • Resident Committee for Wellness Center
  • Introduced The Green House Project®
  • Small House Model & Culture Change
  • Workshops & Integrated Team

Wharton Care Center: Eden Alternative™ & Small House Care Model
Wharton Care Center: Eden Alternative™ & Small House Care Model
What is a Farrago?

An opportunity to come together: a motley assortment of things, a medley, a conglomeration, a hodgepodge of odds & ends.
Person-Centered Care: 
what does that mean?

By
A. Ray Pentecost III
DrPH, FAIA, FACHA, LEED AP
Director of Healthcare Architecture, Clark Nexsen

Thank You!

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Principal

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Person-Centered Care

Q: Who is the person?

Things to consider:

50% of patients in an exit interview said that they didn’t know:

A) What the MD said the problem was; or,

B) What to do to fix the situation.

Patients (5+) chronic diseases = 76% Medicare $
**Person-Centered Care – boomers?**

“They are three times more worried about a major illness (48%), their ability to pay for healthcare (53%) or winding up in a nursing home (48%), than about dying (17%).”

(1)

2030 “over 65” will be 20% of US (1 in 5)

31% non-institutionalized seniors live alone

65+ US population will grow 36% 2010-2020 (2)

7600+ turn 65 every day in 2011

1 Shannon O'Brien, How Baby Boomers will change retirement, About.com Guide
2 A Profile of Older Americans: 2009, DHHS, Administration on Aging
3 Melissa McNamara, Growing Old, Baby-Boomer Style, CBS News online, January 10, 2006

**Person-Centered Care – children?**

Traumatic childhood reduced life expectancy by 20 years (1)

Children today should expect a shorter life expectancy than parents: 1st in 200 years (2)

US life expectancy trails 20 other developed countries (3)

1 Ma, Jane Stevens, Traumatic childhood takes 20 years off life expectancy, The World Company, October 6, 2009
2 Pam Belluck, Children’s Life Expectancy Being Cut Short by Obesity, New York Times, March 17, 2006
3 Ms. Christina Leon, Link between Decreasing Life Expectancy and Childhood Obesity, LifeOrganizerse.com

**Q: Who is the person?**

A: There isn’t a person.

**Q: What is the care?**

**Person-Centered Care – medical?**

**Daily Medical Expenditures in the US**

1. Heart Disease $501,000,000
2. Cancer $430,000,000
3. Digestive Disorders $337,000,000
4. Obesity $320,000,000
5. Diabetes $273,000,000

And DEMENTIA: $1,000,000,000

RAND corp./ US NIH 2000
From the work of Mark Haynes, DC, Norfolk, VA, 2011.

**The United States is ranked:**

39th Healthcare Quality Index (WHO)(1)

46th Infant mortality (CIA World Factbook)(1)

50th Life Expectancy (CIA WF)(1)

72nd in Wellness (WHO)(1)

Last in a comparison of 19 industrialized nations for amenable deaths (preventable)(2)

1. From the work of Mark Haynes, DC, Norfolk, VA, 2011.
**CDC estimates 100,000 deaths per year from hospital acquired infections** (1)

The side effects of properly prescribed medications kill 106,000 per year (2)

Medicine is at best net neutral. *Kilo, Exploring the Harmful Effects of Healthcare* (3)

2. *JAMA*, July 26, 2000 – Barbara Starfield MD, Johns Hopkins
3. *JAMA*, 2009

“Architects, urban planners and transport engineers (among many others) can create environments in which healthy choices are easy choices.”

Christine Hancock, Founder, C3 Collaborating for Health

**Q: What is the care?**

A: There isn’t **A** care.

C3 Collaborating for Health

Design and Health Conference May, 2010

**3four50 message:**

1. 3 risk factors (tobacco, activity, diet)
2. Four chronic diseases (cardiovascular, type 2 diabetes, cancer, chronic lung disease)
3. 50% of deaths worldwide

Christine Hancock, Founder, C3 Collaborating for Health

30 Minutes of exercise each day can:

- Prevent 91% of cases of type 2 diabetes
- Prevent 50% of all cases of heart disease
- Prevent 50% of all stroke deaths
- Reduce site specific cancers by 50-72%
- Decrease all cause mortality by 67%
- Prevent up to 47% of cognitive impairment
- Decrease depression by 20%

Journal of Applied Physiology 2005

From the work of Mark Haynes, DC, Norfolk, VA, 2011

**Q: Where is the person?**
Person-Centered Care – Community?

Walmart in healthcare? (1)

- 400 clinics few years (extreme referral potential!)
- $4 generic drugs (shoppers saved $1 billion)
- Optometry centers: 6 million patients
- 130 million shoppers every week
- World # 1 retailer, 8,400 stores (2)

1 Ron Galloway, Wal-Mart and the Future of Healthcare, March 25, 2009
2 Answers Com, Wal-Mart Stores Inc.

Person-Centered Care – Community?

Walmart healthcare by the numbers (3)

- Goal: 400 clinics by 2011; 2000 by 2014
- Each store: 1.7 million shoppers per year
- Break even on clinic: 11,000 visits (7/10 x 1%)
- Volume: 2000 clinics @ 11,000 visits = 22 million
- Needing specialty referral: 10% (2.2 million)

Referral value: $1,000 = $2.2 BILLION

1 John Goodman review of Ron Galloway speech, What will Walmart Health Care look like?, Feb. 23, 2010

Kaiser Permanente (1)

- Garfield Center for Innovation
- Wii™ technology of interest

Intel (1)

- Digital Health Group
- Embedded chips in household items

1. The Future is Now: How 10 forces are changing health care design, Health Facilities Management magazine, March 2011, R. Pentecost and P. Bardwell

Person-Centered Care – Home?

Q: Where is the person?

A: Not just in the hospital.

Bundled Plan:
At risk for the care

Capitated Plan:
At risk for the population

Person-Centered Care – costs?

Q: Who cares about cost?
Person-Centered Care – costs?

This situation is time sensitive:

Economics lesson from the Cold War

The U.S. has a window of time to act.

Q: Who cares about cost?

A: We all should.

Person-Centered Care – issues...

Will person-centered care impact facility design codes for health?

Traditional medical facilities?
Community retail centers?
The home?

Will person-centered care help define a “good” national health system?

How? What must change?

Person-Centered Care – issues...

Will person-centered care influence researchers studying healthcare?

How? What will the goal(s) be?

Who is likely to take the lead in caring about a person-centered health industry? Why?

Who will be most threatened?
Will a person-centered care initiative thrive within or compete with a transaction-driven health system?

Are they compatible priorities?

Other questions?

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