

The Green House Project

New Research and the Future of Small Homes

Introduction

For over a decade, Green Houses have provided elders with person-centered elder care in a small, homelike environment. Green Houses are designed in opposition to the traditional medical model-- where care is provided in a way that is convenient for doctors and staff-- with little to no consideration for residents' preferences. The homelike feel of the Green House is accomplished by the Green House Project's reinvention of the physical environment and culture of the nursing home to maximize elders' independence, dignity, and well-being. Today, 185 Green Houses operate in 27 states across the U.S. (The Green House Project, 2016). This issue brief describes the Green House Project and summarizes the latest research on the model.

The Green House: Designed with Elders and Staff in Mind

One of the most important features of a Green House is its architecture. Each Green House houses between 10-12 elders who are given their own private bedroom and bathroom. Green Houses have a hearth area with fireplace, a dining room where residents and staff eat together, and a homelike kitchen that is open to residents. Each house provides

access to green spaces or gardens. Green Houses look and feel much more like home than the traditional nursing home.

The Green House Project also accomplishes its goal of creating a home by fostering person-centered care. Residents are treated with respect and dignity-- they make decisions about when they want to get up, what they want to eat and when, and how they want to engage in social interaction. Medical equipment is stored out of sight and residents help to administer their medications and treatments, reducing the medical, patient-model of care.

The Green House model reworks the traditional hierarchy that exists in nursing home staffing. In the traditional model, Certified Nursing Assistants (CNAs) report to and take direction from a head nurse. CNAs in Green Houses (called Shahbazim) coordinate care with Guides (Green House administrators), nurses, and other members of the health care team. In addition to health-related tasks, Shahbazim shop for groceries, cook, clean and engage in worthwhile activities with elders (Rabig, et al., 2006; The Green House Project, 2013). The intended result of this type of organization is to empower Shahbazim to provide quality care and a more meaningful life for residents.

All of these factors--small, homelike design, person-centered care, and staff empowerment--place the focus on elders and their quality of life and initial results from studies on Green Houses reflect this. Results revealed, for example, that Green Houses provide quality care in a home-like environment that is on par with the cost of care in traditional nursing homes (Horn et al., 2012). Residents and their families report high levels of satisfaction with care (Lum et al., 2009). The research also shows that staff in Greenhouses--especially frontline workers--find empowerment, meaning, and satisfaction in their work (Loe and Moore, 2012).

Care in a Green House costs about the same as a traditional nursing home--\$199.13 per resident day in Green Houses compared to \$197.51 per resident day in the traditional nursing home (Jenkins et al., 2011). Furthermore, total Medicare and Medicaid costs per resident in Green Houses have even been estimated to be \$1,300 to \$2,300 less than traditional nursing homes (Horn et al., 2012).

The Latest Research on Green Houses

Two recent studies have focused on Green House staff. Bowers and colleagues (2015), in their study of 28 Green Houses in 6 states, found that staff who had previously worked in a traditional nursing home had greater familiarity and increased interaction with residents, their families, and with other care

workers in the Green House. Another study (Brown et al., 2015) that compared 13 Green Houses to 8 traditional nursing homes in 11 states found that Green Houses had higher staff retention than traditional nursing homes. Interestingly, they also found that although staff in Green Houses were providing twice the normalized hours per resident, there were no differences between the two settings in terms of stress, perceptions of safety, or job satisfaction.

Other recent studies that examine variation within the Green House Model reveal important nuances in how the Green House model is implemented and their outcomes. One study (Bowers et al., 2015) that focused solely on differences in hospital transfer rates (a measure of quality of care in which higher transfer rates indicate lower quality) found that Green Houses with higher interaction between staff, residents, and other care workers had lower hospital transfer rates. Also, having better access to just a few primary care physicians and better communication among staff about subtle changes in residents' behavior or health were associated with lower transfers. Green Houses with staff who interpreted empowerment to mean "responsibility" rather than "authority" had lower hospital transfer rates. Another study of 11 Green Houses found that maintaining the original Green House principles and using them to problem-solve is important (Bowers et al., 2015). Another report (Zimmerman et al.,

2015) synthesized research findings from several studies and found that Green Houses that adhered closely to the model had lower Medicare Part A expenditures, lower staff turnover, and better care.

Conclusion

Small care settings like Green Houses could become the preferred residential long-term care providers which makes finding best practices more important than ever. Recent research comparing the traditional nursing home to Green Houses indicate that quality of care does not have to be sacrificed in order to provide quality of life. Studies comparing different Green Houses show that adherence to the model is key. Future research on what works, successful implementation, and maintenance of the model will continue to make Green Houses places where elders thrive and staff is empowered.

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