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Jessica: Welcome everyone. My name is Jessica Brill Ortiz and I am the Program Manager at the National Consumer Voice for Quality Long-term Care. We're very excited that you've joined us for today's webinar titled "The Green House Model: Strengths and Weaknesses for Resident's Quality of Care and Quality of Life." Just a quick housekeeping detail I'm sorry for those of you that have heard this, but a reminder that you're lines are not automatically muted. So please do either press the mute button on your individual phones or dial *1 which will mute you through the system. And please try to avoid putting us on hold so that we don't received folks' hold music. So, I'll do a brief introduction of our organization. The National Consumer Voice for Quality Long-term Care is formerly the National Citizens Coalition for Nursing Home Reform, or NCCNHR, and we're a non-profit membership organization that was founded in 1975. We're the leading national voice representing consumers and issues related to long-term care; helping to insure the consumers are empowered to advocate for themselves. And we're a primary source of information and tools for consumers, families, care givers, advocates, and ombudsman to help insure quality care and quality services and support for the individual.

We're so excited for today's webinar on the Green House Project. Many folks in our network with you on the lines live and work in states where there are currently Green House Models, or models are in development, and you've expressed a great deal of interest on the topic. We're so pleased for this opportunity to learn more about the Green House Model, and to hear about and discuss some of the strengths and weaknesses, as well as some examples of advocacy related to the model. I'd like to thank Robert Jenkins and the Green

House Project for making today's webinar opportunity possible. A few logistical notes; the call is being recorded and will be available on the Consumer Voice website, which is www.theconsumervoice.org, within a week. In terms of the agenda of the call, you all do have a copy of the agenda. You'll see that there will be four speakers and time for questions and answers throughout the call. Today's first speaker is Robert Jenkins, who's the director of the Green House Project, with Community Solutions Group, LLC, of NCB Capital Impact. Next, we'll hear from Donnie Lee Young, who is a Michigan long-term care ombudsman with Upper Peninsula CAP services, Incorporated. And Dakima Jackson, a local long-term care ombudsman with Citizens for Better Care, also of Michigan. Finally, we'll hear from Robin Grant, Consumer Voice Director of Advocacy and Outreach. So at this time, I'd like to welcome our speakers and turn the call over Robert Jenkins.

Robert: Thanks, Jessica. It's nice to be with everybody. Thank you guys for joining us. Today we're going to go through a little bit of an overview of the Green House model. And then focus, in the last half of my time, on what we know about the model to date; the research, the performance, and the quality of the Green House Project. So I'm looking forward to the discussion that will come after that. Why don't we go ahead and start with the slides. (long pause) And if we go to the first slide... (long pause) Give us just a minute to get to the top of the presentation. There we go, great. (long pause) Can you advance the slides for me? Oh, here we go.

So; quick agenda for my forty minutes of presentation is a recap of the main principles and practices of the Green House model. Talk a little bit about the three major research projects we've had to date, and I'll mention a little bit of the research that is in planning right now. Talk to you, just briefly, about the financial viability of the model, because that's often on the minds of providers and policymakers that you all may talk to. I'll also talk about where we are with the Project across the United States. And then, very specifically, what people do to become a member of the Green House Project. And then what they also are

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expected to do to remain a part of our initiative; the responsibilities and the accountabilities they have for that.

So I wanna just start with a quote from Maya Angelo, and I think this is a really important quote for the Green House Project, and probably as well for everybody, for all the work that we do. And that is that, "We did the best we could with what we knew, and when we knew better, we did better." And that's really the purpose behind the Green House Project. We know that for many years people have been working very hard to improve the quality of life and clinical care in nursing homes; providers, advocates, elders, as well as family members of the elders. And we've learned an awful lot. We've certainly learned about how to provide good clinical care.
But we haven't always really understood was how to take what has been an institutional setting, a very medical focused setting, and add on top of that a really good quality of life where people have meaningful days, meaningful relationships, and control in their life. So as Bill Thomas designed the Green House Model in response to a number of his even alternative projects coming to him with a new construction plan to review. He really tried to think about how de we take all of the research, all of the best practices, all of the evolving practices, and rolled those together into a very tight mutually reinforcing model that would create the home that we've always expected as consumers and advocates and providers.

So let me give a very quick introduction of myself, the Green House Project, and then the non-profit that houses the Green House Project, NCB Capital Impact.

My background is working in long-term care innovations and creating alternatives to institutions since about 1984. I started as an architect. I thought you could do an awful lot to make a better model through the environment. And learned as I worked on that, that there were obviously very important issues that I couldn't impact as an architect. Namely some of the business issues, financing, reimbursement, policy, and regulatory issues. So after practicing for about 8 years as an architect in long-term care and other areas, went back to

school to focus exclusively on long-term care policy and also have a business degree in the area of real-estate. Once out of school I was able to really dive in to the policy side and then over the last 20 years have also been able to become very involved in the operating side. So my interest and my background is to bring all three of those areas together; policy, development, and operations. To create much better models and specifically for people with low income has been my focus.

The Green House Project for me was a perfect fit when the Robert Wood Johnson Foundation asked if NCB Capital Impact would partner with Bill Thomas on a national replication initiative. The Green House Project is a partnership, a very strong partnership, between the elders, the providers, and the advocates that we work with in the field, with Bill Thomas as the creator of the Green House Project. The Robert Wood Johnson Foundation has been a tremendous partner to us with very generous funding. NCB Capital Impact, the non-profit that the Green House is housed in...And then last, but certainly not least, the very important partnership with state and federal policy makers who, like you all are, are trying each day to make nursing homes a good place, and a safe place, and a safe place for people to live. NCB Capital Impact is a D.C. based not-for-profit. We focus on serving and partnering with low income communities to deliver innovations in healthcare, affordable house, economic development, as well as long-term care.

So the Green House redesign; a few things to note just as we go into the discussions, because they form, I think, an important foundation for the understanding of what we're trying to do. So the first is that our model, the Green House Model, the model that Bill designed, is designed very specifically to fit within the current regulatory and reimbursement systems. And this is important for two reasons. The current regulatory system is in place for a very important reason. It's a response to many quality issues and much thinking about how to provide good quality care and skilled nursing. And the Green House Model expects to meet the nursing home skilled nursing regulatory structure. It's also important for us to fit within the

current reimbursement system because we want to serve people with low incomes and the nursing home level, and the reimbursement associated, Medicaid reimbursement associated with that, is sternly the best reimbursement available to provide care for very significantly impaired individuals, whether physically or cognitively.

We are almost always (inaudible) skilled nursing home, and primarily because we want to guarantee the ability to age and place, as well as access to Medicaid funding. Sometimes we will license as assisted living. In a rare case we are license as an adult family home. But those are exceptions to our policy and can only happen actually only in states where they have a very good Medicaid and regulatory system that will allow aging in place under those licensing categories. All aspects of the model are designed to the goals, and, very importantly, to protect against institutional creep. So some of the pieces may not immediately make sense to you all on the surface. "Well why do you require the houses to be detached?" is the good question that we typically get. And almost always an aspect of the answer is that it's carefully designed by Bill Thomas to guard against the institution creeping back into the homes over time, and we'll get a chance to discuss those individual pieces.

And then finally the redesign is very focused on improving the quality of life for elders, not particularly the quality of clinical care. We think we know what type of clinical care needs to be provided and how to do that well. We don't always see that done well in skilled nursing. But Bill's innovation with the Green House Model was specifically to address quality of life in addition to the good clinical care that is available.

And then the other half of the Green House Model is really focused on creating better direct tier jobs for the CNA to really work hard every day in nursing homes, and are very much, or very often very much, underappreciated. So the CNA's, housekeepers, people in the laundry and the kitchen, who really end up with the relationship really deliver a lot of the meaning in care that people experience but often don't have much of a say in their jobs or in the way things are

delivered. And the Green House is very much designed to turn that around.

So we start with the philosophy that all people, no matter what age, or what level of need, are creative, resourceful, and whole. And that each of those people deserves a meaningful life in something that becomes a real home to them. So not home-like, not sort of a light institution, but a real home where people have shape, security, and control in their lives. So we know that meaningful lives require control, being well to each other, and to the staff, and then reciprocal relationships. Very important the ability to give as well as receive care. We also believe strongly that control require that decisions are placed with the elders. Not just that the elders are given some choices occasionally, or within their days, or in limited areas, but that the elders really have the ability to control their days and their lives.

For elders who are cognitively impaired, we believe that the best way to give them control is to place decision making as close to them as possible. So with them, when appropriate, with their families and with the director of staff who know them best, and can provide that for their needs as well as their preferences. We also believe that you really can't have control in your life without access to truly private space, so every Green House home is require to provide private bedrooms and bathrooms to everyone who lives there, regardless of the source of payment. So we know that people become well known in intentional communities and the Green House is designed carefully to create an intentional community. The organizational and physical structure of the Green House needs to foster those opportunities for reciprocity to make available opportunities on a regular and...on a regular basis. And then Green House homes and the operations are designed to foster control, knowing and those reciprocal relationships. So almost everything we do in the Green House meets those three tests together; fostering control, allowing people to get to know each other better, and develop relationships, and then to give opportunities for reciprocity. Where the elders can give back as well as receive.

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(long pause)

Hold on one second. I'm sorry we're having just a little glitch...

(long pause)

So moving in to...So the Green House changes three things pretty dramatically; the physical environment, the philosophy, and then the organizational approach. We've talked a little bit about philosophy; the next piece is the environment. The Green House environment is warm, smart, and green. Warm in small scale, small scale with residential finishes and details. Smart, because we use technology to support high-touch services. Not to replace high-touch services but to actually free the staff to deliver more in the way of high-touch services. And green in the sense of not only environmentally responsible, but particularly in the sense of supporting continued growth for the elders and people with disabilities who live in the Green House homes. The Green House environment provides, as I mentioned, private bedrooms and baths, regardless of ability to pay. Hearth, a hearth area which is an open living room, dining room. And then very importantly, an open kitchen within the common living space. The kitchen itself is a fully functioning kitchen where meals are prepared from scratch, not brought in and warmed, but actually cooked in the house. The Green House homes; all of them meet institutional building code standards, so they meet the same construction standards that any nursing home would be required to meet in the United States. And that's quite important for people's ability to age in place safely, especially when they are no longer able to self-evacuate. All areas of them home are open to elders through very specific safety measures. So we don't want an elder to come up to a locked door, in what we've told them is their home, and not be able to get into a space because you wouldn't experience that at home. But that does require that many of the rooms, for example, the kitchen, the laundry room, have some pretty clever and sturdy safety features to keep chemicals and anything that might be dangerous out of reach from an elder with any type of dementia.

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And then as I mentioned earlier the houses are fully independent from each other. When they're built as single family style Green House homes, this means that they actually are detached. There is no connection between one house and the other. And they're built in an urban area in apartment style; so a ten bedroom apartment rather than a ten bedroom house. They are then fully independent from each other in the sense that they don't share kitchens, laundry rooms, service spaces, office spaces. And each of the apartments has a locked front door that visitors and staff enter through as opposed to the unit, that you would be more familiar with in nursing homes, where anyone can actually come on to the unit and wander through the unit.

So the Green House types in rural and low-density suburban areas, they look very much like the rendering of our Legacy Village Project in Bentonville, Arkansas, this at the top of the slide. When they're in a denser suburb where garden apartments are a typical part of the housing stock and mix, they look like the middle graphic, which is St. Martin's in pines in Birmingham, Alabama. And then when they're in a high density urban area they're in high rise configurations. Rendering it at the bottom of the slide is Chelsea Jewish, the Chelsea Jewish Nursing Home Project called Leonard Florence Center for Living in Chelsea, Massachusetts. So our rule with the physical environment is that they should be familiar as a normal and regular housing type within the community that they exist in.

Moving into the Green House organizational redesign, we start at the house level. And the house itself is organized in a way that provides power and decision making by moving the elders into the middle of the organizational chart and then surrounding them with the direct care staff, the staff that we call "Shahbazim", who work in a team to support...in a flexible team, to support the needs and preferences of the elders, individually and collectively. And we understand that those needs and preferences will change on an almost daily basis. So the flexibility and empowerment of the self managed team to deliver that is very important. The Shahbazim are cross-trained CNA's, all of them qualified as

CNA's, they provide personal care, housekeeping, laundry, cooking, and enrichment activities to support the elders. To do that we've put a lot more time into the CNA position. We have four hours minimum per elder per day, compared to about 2.3 nationally. But we do ask them to perform those additional functions. The reason that we ask them to do that is so that we can put all of that time that is typically behind walls in the laundry department, the kitchen, housekeeping. We can put them in front of the elders in the form of a consistent staff member with whom they can develop a relationship and a really deep knowledge of each other. The Shahbazim teams are self-managed. And the flexibility that that self-management provides really allows the Shahbazim to continuously reorganize the house, the house's schedule, and the flow of the day to meet the elder's preferences that day individually. And again, as an intentional community.

The de-segregated staffing approach, as I mentioned, allows us to put an awful lot more time directly into the house while pulling it out of the department so that we can remain cost neutral in our operations, but really leverage what we're already spending in nursing homes today in a much smarter way. I'll talk a little bit more about that when we get to the financial slides.

Within the house we also have a new role which is called "The Sage" which is the volunteer from the community; somebody who's most likely been involved in counseling or conflict resolution in their lives or in their careers. And we asked them to partner with the self-managed team to help them through, especially the initial formation of that team, which can be a complicated period for people who have not worked in a self-managed team before. So they receive a lot of training from us, both the Shahbazim and the Sage. And then we provide them with a lot of support going forward to be successful in that new structure.

Outside of the house, obviously it's very important to have all of the clinical elements and administrative and leadership elements that you find in a typical nursing home. We have a clinical team that supports and partners with the

Shahbazim in the house, the nurses, the PT and OT Dietary, etcetera. They, the self-managed work team of Shahbazim, report to a guide and the guide's roll is to coach the self-managed team and also hold them accountable to policies, procedures, regulations, good practice. The self-managed team of Clinicians also report to the guide. So the guide is the person who is also able to mediate between the rhythm of the day, quality of life, as well as clinical, and the needs of the organization. The nurses actually still report up through the DON and the DON works with partners and then reports to the guide. So that they can, or the administrator if the guide is not the administrator... This really provides a very high level of accountability, but also a very good balance between the medical demands of the nursing home and then the demands of quality of life. Where those are both together, and also where they're in conflict.

One of the important pieces of that organizational structure then is transitioning from a top-down leadership style to a coaching-supervision structure and style. The benefits of coaching-supervision are to encourage collaboration, trust, problem solving to really bring in the creativity of the Shahbazim and others who have typically not been a part of that problem solving exercise, and then an ethical use of power. What we know from the research to date, as well as the theory is that this does improve the quality of care. It does improve the Shahbazim. Shahbazim have better jobs and a better, much better satisfaction with their jobs. And then also truly delivers control to the elder in the form of self-direction.

The research outcomes; all of this is great in theory. Also very good to see it anecdotally in any of the Green House homes. But the question, which is a fair question to ask, is does it really prove to be different in outcomes than a traditional setting. And what we know from Rosalie Kane's initial research at the pilot site in Tupelo, Mississippi, which was conducted with two matched comparison sites of over two years, is that there was a statistically significant improvement for elders and their quality of life with reports of sense of more privacy, autonomy, individuality, greater dignity, enjoying food more, better ability to form

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relationships, that was a really important finding for us, more meaningful activities in their days, and then more emotional well being. In quality of care Rosalie found that there was a lower incidence of decline in late loss, activities of daily living, fewer bedfast elders, fewer elders with little or no activity during the day, and then a lower prevalence of depression. She found a slight increase, although I'm not sure that it was at a statistical level in continence, we're not sure what the initial finding meant, but it has not been repeated in further research. And everything else, as far as clinical care, was equal to the traditional settings.

Second, as far as, staff quality of life and family quality of life, Rosalie also found that the staff indeed did feel more empowered to help residents; expressed much greater job satisfaction. Were more likely to remain, report that they would remain in their jobs, and we certainly see that anecdotally with a much lower CNA turnover rate in Green House homes. They were able to come to know the elders they care for in a much deeper and better way than they had in the traditional setting. And family reported not only being more satisfied with their family member's care, but also much more satisfied with how they were treated when they interacted in the homes with their family member.

Second research project which was conducted after a number of additional sites had been opened, so we were able to sample a larger set of Green House homes. We wanted to answer the question do Green Houses really deliver better quality of life, better care, without increasing the amount of staffing hours and therefore the cost at delivering that care. We asked Siobhan Sharkey and Susan Horn, two well-known researchers in this area, to put together a research project. That project was published and it's on our website. It was published in the Journal of American Geriatrics Society in 2010. And what they found is that there was no more staff time, in aggregate, in the Green House homes, when you put together all the different pieces, the Shahbazim, the nurses, and the leadership took over than in a traditional nursing home when you looked across those departments. But what they did find, and this was what we had expected, and it was very

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good to have this demonstrated in what was a very carefully constructed research project; was that the Green House homes deliver 1.72 hours more within the six hours that both settings used overall. Green House provided 1.72 more direct care and nursing hours compared to the typical nursing home. Because of that they were also able to deliver four times more periods of meaningful engagement by which we mean period where a staff person was able to be in a one on one conversation with the elder for more than two minutes. And the Green House homes were able to deliver four times more of that than traditional nursing homes. Again, not because the staff in traditional nursing homes don't want to do that, but the structure and the segregated job responsibilities just don't typically allow that. So then, as you might imagine, there was a corresponding two hour reduction in departmental support; outside of the homes, dietary, housekeeping, laundry, and activities because much of that work has been transitioned into the houses. And then Green House homes have the, importantly for this study, were found to have the same level of acuity as the traditional nursing home. And they had very similar, between the comparison sites and the Green House homes, very comparable organizational and locational characteristics.

And then finally we had the question about, "Can the nursing really be as good when you develop self-managed work teams of CNA's that are no longer supervised by the directly by the charge nurses. And we asked Barbara Bowers who again, is a very well known nursing researcher, to take a look at the question for us. And we asked her specifically, because she had been somewhat skeptical about the nursing model in the Green House Project. And she was able to spend a great deal of time observing Green House homes, staff and elders, looking through some interviews and some surveys. And what her finding, which should be published in The Gerontologist this summer, was that in fact Green House homes are able to do, if anything, a better job in the area of nursing than a conventional nursing home. Specifically because of how well the Shahbazim and the nurses are able to get to know the elders. And of course, if you're able to know somebody very well, you're much better able to provide good information to the clinician as well as identify emerging conditions and

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alert the appropriate clinician for the need for an assessment.

A couple of more slides, and then we'll stop for questions. Financial viability; so a question people often answer is, "Well if it's really this good..." or if people ask, "Well if it's really this good it's really got to cost more." And what we know from building on the work flow findings as well as the financial data that we've been able to collect from early adopters, is that, in fact, the Green House, as you would expect, does increase direct care nursing hours and that has a cost. But then when you put the salary figures to the hours that change; those that go up and those that go down, that in fact, the Green House homes are either equal in operating costs to traditional nursing homes with good quality, or, in fact, in some cases, they're a little bit less. Because we shift very expensive time out of the departments, especially departmental management positions, and into the CNA positions. We also know that this additional direct care, which is delivered without higher costs, is producing better results. And we're about to start some research on areas like reduced incidents of skin ulcers, reduced re-hospitalizations, which we have strong anecdotal reports about, but we don't yet have a research project. So we will be conducting that over the next one to three years.

The Green House homes are, however, bigger in their square foot, square feet per elder than what you would find in a traditional double occupancy, double loaded quarter nursing home. So there is an additional capital cost to Green House homes. And that is a challenge for our providers to cover within the limited reimbursement available through Medicaid. And because the Robert Wood Johnson Foundation as well as NCB Capital Impact are very focused on serving people with low incomes. This is a challenge that we're working very hard to develop additional resources for. The Green House homes are not bigger per elder per, in the total number of square feet than other culture change models, but we're definitely larger than traditional nursing homes, which are really close to 300 square foot gross per elder versus the 650 that we recommend.

And then we...and then finally on the financial side, we know that the construction costs for Green House homes per square foot are no greater than traditional setting. But because we do build more square feet, our capital costs overall per elder will be higher. The Green House Project itself, the roll that we play in this, is to provide very comprehensive consulting, or what we call technical assistance services, and tools to local organizations that want to implement the Green House Model and are willing to implement the full model with all of the core principles and practices. So we are able to help organizations with financial feasibility modeling, with the designing of the Green House homes, regulatory and policy review and assistance, the organizational redesign, project management, very extensive training on the new model and the new approach to care, and then post-occupancy consulting. And an important piece for projects that are called the Green House home, which means that they're officially part of the Green House organization and project, is if they also have access to ongoing education. And I know from the work that you all do, you will understand how important this is, so that staff, who are doing a good job, learning, but also needing refreshers on a regular basis have access to those educational resources. And then finally a peered network which allows all of our Green House adopters to share their successes, share their challenges, and support each other. Including this year, we're implementing an assessment process. It will allow each of our organizations to understand how well they're doing with all of our core practices and will allow us to better support them to meet the minimum standards that we set for our project.

As far as where we are today, and this slide is, each month the slides get a little bit out of date, we actually now have 97 Green House homes open and operating across 26 campuses in 16 states. We have another 130 homes in development across 24 campuses, which cover an additional 10 states. So in total, we have about 230 Green House homes open or in development, we're at 51 campuses and 26 states. So we're gaining momentum. Our mission is to be sure that Green House homes are a choice for elders in every community; not the only choice, but one of the choices that they have. And I

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think we're doing pretty well to get there. We need to solve the capital piece, as any nursing home that wants to rebuild needs to have solved. But we think we've got a model that really shows pretty significant results on a consistent basis across very diverse implementation.

So, if a provider or organization you work with wanted to become a Green House Project, the steps that they would take would be to attend a one day workshop that we offer at operating Green House homes quarterly. They'll learn about the philosophies, principles, and practices. We've made that a requirement because we want to be sure they know what they're getting into and that they're prepared to commit to the model. They would then apply to the Green House Project and we would assess their willingness and capacity to be successful. They would work with us, very intensively, across 11 cask areas. Typically they work with us for about 3 years to get the projects approved, designed, built, and opened. And then they complete the leadership courses in training as well as implementing all the required practices, and then they get to open, which is always a really exciting day. To remain a Green House Project, they must be prepared to provide us with required quality and financial data, which we monitor. Maintain membership in the Green House Peer Network, because that is where they will be supported and held accountable for the Model's core practices. And then also give back to the other organizations that are coming behind them, because this is a really a continuous learning process for us.

The last two slides; Jessica asked me to tell you what I thought the strengths of the Green House Model were and what also our challenges were.

So I would say our top five strengths that we see are truly creating better lives for elders and staff who choose to live and work in the Green House Projects. We know this is the case from research, from the increased engagement and satisfaction and quality of care that we see in that research. Very importantly I think strength of the Green House Model is that they don't have implementations and providers, don't have to be super-human or perfect to be very

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good. And that the Model itself, as Bill designed it, is very much designed to have redundancy systems so that if one piece is not working exactly the way it should it doesn't bring down or unravel the entire effort. We also know that research shows common improvements across very diverse providers; diverse regionally, diverse culturally, diverse economically. And I think that tells us that the model itself has a very strong core that is able to support people in being successful in many different situations. We also know that operations are cost neutral. That you can do, truly do more and better, without spending more. And then also that this can be done in an affordable way. Currently about 50% of the people living in Green House homes across the nation are eligible and enrolled in the Medicaid program.

Then finally, what are the challenges of the Green House Model? I would say that like any good innovative model that many of the implementations out there, many of our adopters and partners, have series' of tremendous strengths, but they also have areas where they haven't been as successful and will grow and improve over time. We often know that the Green House Model is not a silver bullet. It doesn't take a low performing organization and make it a high performing organization. You still have to be a very confident provider with strong regulations to back you up. And the role of advocates remains equally as strong in the Green House Project as it does in a traditional setting. We need that level of accountability. Staff resistance can often be a problem. Many staff who have worked in large institutions in segregated jobs prefer those jobs. They feel that they're more convenient. So it's...while it's a minority of staff who come to work in Green House homes, there are some staff who continue to resist the self-managed team, the self-directed care approach in the Green House homes. Family education can also be a challenge. Families themselves have sometimes become institutionalized. And they are often expecting to see something that looks like a hospital; not often, but sometimes, and that can be a challenge. And there's also, as you all well know often some very significant fraternalism from family members toward their elders, which robs these elders of control and choices in their lives. And our model, I think, does a good job of

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resisting and supporting the elders in that, but again, is not a cure for that. And then finally the capital costs, as I mentioned, are a real challenge. They're no more challenging for us than any good culture change model, but they are a significant challenge.

Jessica, why don't I stop there and let you take back the agenda and move us through it.

Jessica: Ok, great. So, I...Thank you Robert. At this time I think we'd like to open it up for questions...

(long pause)

Woman: Do the open living room, dining room, kitchen area hearth, do any of those areas have windows or are the windows in the individual resident's private bedrooms?

Robert: That is a great question and it's also a good illustration of what we've learned over the five years of assisting projects. So all of the common areas do have windows, but I have to say that it's in the early Green House Model. We didn't do as well with having the right number of windows for the size of the common space. And we did that, we made that mistake, I think for a good reason, but we've learned how to balance better. So the good reason was we wanted all of the bedrooms gathered around the hearth area and as you might imagine as you gather ten bedrooms around the living room, dining room, and kitchen, they tend to block out most of the possibility of an exterior wall with the window. We became very aware that the more sunlight you could get into the room and the more views you could get out of that common area, the more like a true home it felt. So we've developed additional floor plans and we've just introduced a prototype based on what we've learned that I think does a really wonderful job of getting very significant amounts of sunlight and exterior views into the kitchen, living room, and dining room area. And it's actually one of our quality standards that we require people adhere to, which is significant natural lights and views from the common spaces.

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Woman: When you talk about bedrooms around the hearth area, can you talk a little bit about how much privacy is afforded to each person in their own room?

Robert: Sure.

Woman: Is everybody just immediately in the immediate area?

Robert: Absolutely. So every bedroom is a private bedroom. It has a door to the common area, which the elders control. And then typically the bedrooms are organized so there's a small vestibule as you come into the bedroom, which generally allows you to pass, either to the bathroom or into the private area, the bedroom. So there's a little bit of buffer there as well. So an elder can choose to either be in their bedroom with their door closed, or they can choose to in their bedroom with their door either partially or fully open. And we see all of our elders making different choices in this area, which we support. And so some elders like to be in the common area. Some elders like to be in their bedroom but with their door open so they can keep track of what's going on in the hearth area. And then some elders, either all the time or at different times in the day want full privacy and they'll close their door to the common area. So very much the way, I think, for instance, house and apartments are designed today, with the bedrooms just off of the living space.

Woman: Except here you have what, like ten other people sitting in the common area who could potentially hear everything that's going on in a private room?

Robert: No, they shouldn't be able to hear everything because the bedroom doors are closed and they have, because of the life safety standards, they have gasketing around them, which would be a pretty effective sound barrier. And the doors themselves are typically fire rated so they're a good, solid door.

Woman: And the walls as well?

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Robert: Yes. Yeah, the walls are, you know, typical sheet rock walls...

Woman: Are they sound proof?

Robert: Which do a pretty good job with sound isolation. Just the way they would in your own home.

Woman: Uh huh.

Robert: And of course, you know, compared to what is typical in a current nursing home, the level of privacy is probably tenfold greater.

Woman: One of the concerns, Robert, we have in the urban high-rise concept, is there's one that's proposed for Manhattan, for instance, where I live, and it's proposed to be 20 stories. Which is the opposite of the small house model that Green House represents for us. And the concern is that it can pose a more restrictive environment for people and preclude their access to neighborhood and being able to get outside. The streetscapes that are just so important who live in cities. I wonder if you can comment on that, on the high-rise concept of 20 stories. It's against what we really want to see in the way of accessibility to neighborhood and community.

Robert: So, (inaudible), I'm very familiar with this controversy and I would say that I do not at all agree with the assessment that's been rendered by the neighborhood group that's opposed to the building. I will tell you very frankly I think the neighborhood opposition has to do with not wanting another building in their neighborhood and has little to do with the way people typically live in New York City. So I spent a great deal of time in New York, and I know that people live in a variety of housing types. But many older people live in multistory buildings. So, I think for me, the real question is, do the people...will the people who live in Green House homes, have immediate access to the outside, the way that most New Yorkers would actually like to have access to it. And that's in two forms. One is a terrace or a balcony, which each of the Green House homes will have in New

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York. But then also to being able to, as you say, get out into the street and more than just get onto the street, get into the community. And, of course, Green House homes, just like any apartment in New York, will have access to the street from their apartment through, in this case, high speed elevators. With a staff and activities program very focused on getting them not just into a street level garden, but truly out into the community. So for me I think I understand and appreciate the concerns, but in the discussions that I've had with the neighborhood groups, I haven't found their argument very compelling that this would be less good that what average people in New York experience.

Woman: We would differ because in our own homes there are just a few people at a high-rise who have mobility problems and are in wheelchairs. Whereas in a congregate setting with 454 residents proposed, it would be very difficult for them, even with staff help to be able to get outside. But, anyway, I don't want to dominate this discussion. We open it up to others, of course.

Robert: Sure. So just maybe stay in response to that is there are very few people who are lucky enough to live in a private home with immediate access to street level gardens and access. So, yeah I think we can argue what personal preferences; my preference would be to live on the 22nd floor and have a view. Others would be to live on the first floor and have a garden. Again, the Green House should be seen as one choice, or option, within a community for people to choose among.

Woman: I'd like to ask a question about the survey for the "In Being a Green House Home, Nursing Home." Does that have any of that on the survey, and if so how it's done.

Robert: You know, it certainly has an effect on how it's done, because it's...in the case of single family style Green House home they're ten individual houses with ten kitchens. But it doesn't have any effect or impact on the level of scrutiny or the documentation and observations that's required. So, like so much of culture change, it changes the way things look, but it doesn't change the, either the

regulatory standards or the typical process for ascertaining whether those standards are being met. So it does put a little, in some respects, it puts a little more pressure on the surveyors, because they have, again, for instance, ten kitchens rather than one. But I think they also have much more, much easier and more direct access to the elders and the direct care staff to really get their answers question...they're questions answered. But I think it is different, but I think it's probably, in some respects, as good if not better, a better environment for surveyors to operate with them.

Woman: Thank you.

George: Yes, George Leonard here...

Robert: Go ahead George.

George: Thank you. I'm just wondering where nursing homes are, for all intents and purposes, for profit? How do these larger chains, or what not, look towards creating these Green Homes?

Robert: George, that's a great question. And one that we've given a lot of thought because 70% of people who receive nursing home services through Medicaid subsidies live in for-profit nursing homes. So we are very determined to see for-profit nursing homes adopt the Green House Model. So that they can be a meaningful choice to people with low incomes. I would say that my experience right now is that large, for-profit chains are standing by to see how this goes. They are, obviously have an expectation from their investors to deliver a return, a specific return to their investment. And I think they're waiting to see if evidence shows that they'll be able to achieve that. My expectation is that as they understand the business results of Green House Homes, which are cost neutral operations, elevated capital costs from a standard double option, double quarter nursing home. But, correspondently greater occupancy and revenue, especially from private-pay and short-stay individuals, that they will see that this is a model that really helps them differentiate their services from

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competitors in the market and I expect...we are already beginning to see this and I expect to see that trend continue.

George: Thank you. I'm from Massachusetts and I live near Boston. I will definitely take the time to look into a location in Chelsea and see what's involved. One of the things that the Coleman Nursing Homes are getting themselves very involved in lately and that's a money making, which is a money making proposition; is temporary rehab, is the Green Houses getting involved in that at all? I'm not interested in the rehab aspect as my loved one has no need of it. I'm just interested in the comment.

Robert: Sure. So they are, and they're getting involved for the...well, maybe for a similar...maybe a slightly different reason than the general industry. So Green House providers who are focused on delivering services to people with low incomes have long had to cross subsidized between private pay and Medicaid to deliver the quality of care they seek to deliver. Obviously short-stay is an even richer reimbursement than private pay reimbursement. So many of our Green House homes do create a financially viable project, especially one that can support the death service of a new building have moved into, or increased the number of, short-stay cots or beds that they have. Chelsea is a good example. They...three of their ten houses are committed to short-stay care. And those three houses are able to contribute a great deal to the death service of the building so that the medicaid fund at long-term care houses don't have to pick up their equal share.

(long pause)

George: Very good, so...

Jessica: Hi. This is...I unfortunately am going to need cut our questions a little bit short. I want to make sure that we keep things on track and moving forward. Robert, thank you so much for your presentation. And just a reminder to folks participating, there will be additional opportunities at the end of the call for more questions and answers. So if

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we didn't get to you here hopefully we can catch you then. And if you're logged on to the webinar piece of this online, you can enter your question in there, and we can answer it after the call, through that format as well, so. At this...At this time I'd like to move forward and introduce Donnie Lee Young, who, as I mentioned, is a local long-term care ombudsman in Michigan. Donnie Lee...

Donnie: Afternoon (background voice). I'm actually the long-term care ombudsman for the Upper Peninsula of Michigan. In the Upper Peninsula we have two Green Houses that are on the main campus of a county facility, the...

(music hold playing to call - inaudible speech)

Donnie: The big issues about improving the quality of care and the quality of life for residents in these Green Houses from a consumer advocate point of view is, I think, is the relationships with the staff that the residents have. The staff are so much more personalized, and giving personalized care, they know so much more about the residents. And I see with the staff that work in the main facility, they're very much, or giving their residents, choices or control over their daily lives. You see a lot of the times the staff working with the residents preparing meals, assisting residents, sitting and eating with residents, sharing meals, and interacting a lot more with residents than the staff are at the main nursing home. It basically says they just have more time, and they're not as overworked as some of the staff report there up on the main campus home.

The residents are just overall, in the Green House, just figure to be more happy. They have more choices. Some of the things they're allowed to do is allowed to choose the color of their room when they move in and if the room is not something that they like; they get in there, they're able to, actually have their room painted, and have decor that matches with their taste as well. They also just...it's more of a home-like environment where they're able to interact with the staff more so like a family and with the other residents, they know a lot more about the other residents than the larger facility. And other residents just report that the

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impact on their life is great because they have so much more decision on their daily routines than they did when they were in the original nursing home. But these Green Houses, most of the residents that are in them now actually came from the main facility. And when the Green Houses were built then individuals were put on a waiting list to be able to go to these two homes that house twenty residents. Now that they're here, I haven't found one resident who had actually wanted to go back to the traditional nursing home setting. The setting of the Green Houses are just a lot more private. They have...each resident is being able to have their own room where they can go back in and have privacy, be able to retreat from the other residents if they don't want to interact, and...but then come out and participate in the living areas when they're wanting to. A lot calmer atmosphere as well than some of the hubbub and business of the bigger nursing homes. Most resident's all come back with positive feedback about the way the (inaudible), how much the staff know about them, and the interactions between the staff. I am far less com-...(inaudible) from residents that lived in the house and from their family members. And one of the reasons is because they feel so much more comfortable talking with their direct care workers if they have concerns, a lot of the residents in another facility, because they know them so much better.

And then just overall basically some weaknesses; some limitations of the Green House Model. Robert talked a little bit about rehab. The Green Houses up here do not have any rehab facilities in them. So I did work with one resident who would have liked to actually been able to access, go into the facility, and do some work on the parallel bars or what not. And that was not available to him, and unfortunately they don't do a lot of crossing between the nursing home and the Green Houses so he would have had to chose either move back up to the main facility or to just the restorative care in the Green House. Ultimately he just chose to do the restorative care; he didn't have access to rehabilitation services.

Some residents have voiced they do like to have a little more structured activities and these Green Houses don't provide

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the daily calendar of structure activities for residents. It's more so just their daily living activities; meal preparation or what not. And so they do have the opportunity to visit the larger nursing homes if there are things such as performers or what not coming to do things so they can do activities that way. And then just some other issues that we still see is regulation issues, especially for these nursing homes, or these houses are part of a larger nursing home. They still carry a lot of their(background noise)(inaudible) larger nursing homes provided for the houses then have to change as well to be in compliance to meet those federal regulations.

But overall residents who live in the Green Houses report a very, a higher quality of life, and are more out to stay that if they would be in a nursing home then that is where they want to be. So that's about all I have Jessica.

Jessica: Thank you very much. Dakima, are you there and are you prepared to speak a little bit about your experiences?

(long pause)

Jessica: Dakima Jackson, are you on the line?

(background noise - screaming)

Jessica: All right. Well, in the meantime, perhaps she stepped away, and we can catch her if she does come back but, at this point, I would like to move forward and invite Robin Grant to speak. She'll be sharing some examples of advocacy approaches related to Green House Models. So, Robin...

(background noise - screaming)

Jessica: I definitely can hear some background noise, I'm sure everyone else... Just a reminder that you are on the phone to please mute your lines either by pressing *1 or pressing the mute button on your individual phones. Robin, are you there?

Robin: I am Jessica.

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Jessica: Great.

Robin: Can you hear me?

Jessica: Yep. If you could speak up a little bit more...

Robin: Pardon?

Jessica: Can you speak a little bit louder?

Robin: Um, how's that? (crosstalk)

Jessica: That's good.

Robin: Is that good? Okay. Let me know if I need to speak any more loudly than that.

Jessica: Will do, thank you.

Robin: But, well, thank you. And there certainly are, you know, a lot of different advocacy approaches that can be done related to Green Houses. But in the time I have I want to share just a few ideas with you about advocacy at the individual level, the facility level, and the systems level. And again this is going to be very brief just to trigger some thinking hopefully on your part. In terms of individual advocacy, so, but, that I mean when you're helping to resolve a concern for an individual resident in house facility. So you might do this if you're an ombudsman, or you might do this if you are a citizen advocacy group that handles individual complaints, or you might do this if you're a family member. But you would certainly approach that complaint the same way you would approach a complaint in any nursing home. So your basic individual advocacy is not going to change. But there are a few things to think about that, will, or can, impact your advocacy work. And one of those things is, as you heard from Robert, the nursing assistants, and I hope I don't butcher this name, but, Shahbazim, are in power to handle a lot of the day-to-day life and care of the resident. So where in a traditional nursing home you might go to the charge nurse, or the director of nursing, or a

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department head for housekeeping or food services. In the Green House you would probably think about problem solving with one or more of the Shahbaz, or going even to the guide. So you might think about who you approach a little bit differently in a Green House setting.

In addition, we all know that when we do advocacy, we definitely rely on the nursing home laws and regulations because that's what says the nursing home is required to do. So, of course, as you heard, the Green House facility has to follow any state regulations. And if they accept Medicare and or Medicaid funding they certainly have to comply with schedule regs. as well. But might possibly have some extra tools. I'm aware of, that in at least one state, there was a law that was passed saying that staffing standards would be promulgated just for Green Houses. Now that state is Arkansas. I'm not exactly 100% sure where exactly they are with that process, but they do have a law requiring specific staffing standards for their Green Houses. So if you happen to be in a state that has extra regulations for Green Houses that would give you an additional place to turn to support your advocacy. I do recognize, probably, that most states do not have specific Green House standards. But one thing to think about in your advocacy that might be something you can use to give yourself a little extra leverage in problem resolution is to go back to the Green House philosophy itself and some of the principles that Robert did such a great job of explaining. So, for instance, and this is a very, very basic example. But let's say you have a complaint from a resident who wanted to help with doing the dishes and for some reason wasn't being permitted to do so. You could go back, obviously there are regulations that you have to rely on that have to do with chores, but you could also point out that that is in contradiction to the Green House philosophy. You know, that emphasizes resident participation and household activities and being involved in the daily life of the house. So it's just worth thinking about whether the Green House principles themselves can assist you in your advocacy work. And think about whether they can be an additional tool.

So those are just a few thoughts I had about advocacy on

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behalf of an individual. At the facility level, one example I wanted to put out there is you might be able to assist residents and families to advocate for a nursing home to transform itself into a Green House. And that would certainly be the most likely to happen if they were considering new construction or maybe remodeling. So in the situation you might work with resident counsel, family counsel, educate resident and families about the concept and help them in conveying their wishes to the administration and even to the corporate office as well. Knowing that residents and families are behind that change might help a corporation more likely to consider making that change. And you can even think about getting the community involved because those individuals who live in the community may be very interested in having a setting such as the Green House facility as a potential option for them and their long-term care needs. That's a brief idea on how you might advocate at a facility level.

But finally, you can also advocate at the systems level. So that could involve advocating for changes in law and regulations. That, for instance, could promote the creation of Green Houses or Green House-Like homes. So let me just give you a few examples of some of the changes that you could advocate for. So you could advocate for a demonstration project in your state in a project that might use the Green House principles. So that's what we've done in Wyoming. The state adopted a law that, among other things, created what they called an Alternative Elder Care Home. And that was modeled on the Green House principles. And then they also established a feasibility grant to fund the exploration of this Alternative Elder Care Home. So that was, you know, a way to try to kind of encourage the development of a Green House or a Green House-Like home in the state of Wyoming. And that could certainly be done in other states. You could advocate for waivers to state laws that might prevent the development of a Green House. Oklahoma did this, for example, in legislation where they gave their Commissioner of Health the authority to grant a waiver to support the creation...the waiver is necessary to support the creation of a residence in the community that would be designed like a private home and would house more than ten individuals. So

that waiver was crafted very carefully to apply only to homes that were small and like the Green House. I'm from Indiana, and right now advocates in Indiana are seeking a waiver to a moratorium that we have here on adding any new Medicaid beds. So if a complete moratorium were imposed, a Medicaid certified Green House that wanted to have new beds but not be opened. So advocates are seeking an exemption to the moratorium. Very...exemption for just a few number of beds. But it would allow a Medicaid certified Green House to open up.

So you can also advocate for enhanced standards for Green House homes. So that's what Arkansas did in the legislations they've passed that require staffing standards to be promulgated. So you can turn to, obviously, legislation or regulation, you know, as a way, if you have particular issues or concerns, as a way, to perhaps, address some of those at a systems level. And lastly, one approach that you could take that is sometimes an easier way to get your foot in the door, if you're trying to promote Green House development in your state, is to advocate for a legislative hearing or a study on the Green House principles. That's a way to educate legislators about the concept and also help to start building interest in Green House development. It's just a beginning step, but nevertheless it's a beginning.

So the laws that I mentioned, the majority of them, you will find on the NCB website under Regulation and Legislation. So there's a place where you can click on individual bills and you'll be able to see the actual language of the legislation. So that's very helpful. I hope that when we open up for question and answer again, if any of you have been involved in advocacy at any of those levels that you might also share your examples so all of us can learn from you.

Jessica: Great, thank you so much Robin. We do have about fifteen minutes left on the call, so I'd like to open things up again at this time for question and answer.

Robert: Jessica, this is Robert. I just wanted to, before we start with that, thank Donnie Lee and Robin for a really terrific overview. And to say that, the Green House Project,

one of our roles is to partner with advocates around, work to improve quality in nursing homes, as well as to drive policy change to support that. So we would be very happy to hear from any state coalition that you're involved with, and partner with you or support you and any information that you need for that. And just so that people know that the research legislation, and also the core practices and principles of the Green House Model, are available on our website, which is a very simple one it's just "TheGreenHouseProject.org".

Jessica: Thank you, Robert. So does anyone have questions at this time?

Nick: I have a question.

Robert: Go ahead.

Nick: I have a question for Robert. There was no mention about a level of medical necessity of...this is Nick (Monrail) in San Antonio... I have a question about what is the average level of medical necessity for a resident? Or do they all have to be ambulatory?

Robert: Nick; a great question. The Green House Project was, although it looks very much like your home or a really good assisted living project, it was designed specifically to care for the most impaired people living in nursing homes. Because it's our belief that those are the people who are often left out of the improvements and the community. So every Green House is designed to care for people with the highest level of need that's typically served in a nursing home. So that doesn't mean that every Green House has the capacity to serve people on ventilators or with very complex needs that would typically require a specialty care setting. But we expect our providers to go up to the very maximum you would typically find in a nursing home in that state. So the Green House, the people who live in Green House homes, look, on average, just like what you would expect to see in a traditional nursing home. You have people who come in, and come in with relatively low level of disability, as far as the nursing home spectrum. They age in place, they climb to

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a very high level of need. Some people come directly into the Green House homes after a pretty significant hospital stay or crisis at the home. So they come in with a very high level of need, and then often get better and look more average after that. So I think the thing to remember about the homes is that they are meant to, and their mission is, to provide services to anyone who qualifies at a nursing home level of need. And the people who live in them are...one of the core principles is aging in place. So if there's a Green House Project, a licensed Green House Project, the (June) you know of, that is only taking people in at the early levels of disability and then moving them out when they become more incapacitated, that is not at all meeting the principles of the Green House Model. And as Robin said, and is so important to us; they need to be held accountable for that. And we would appreciate knowing that if that's a concern. You could also bring it up directly with them. And certainly, in many cases, it would violate state regulatory requirements.

Nick: Thank you.

Woman: I had a quick question about the matching grant aspect of the Robert Wood Johnson Foundation for states that have not had a Green House come into the area yet. We're in North Carolina and we're looking in Ashland, North Carolina, at possibly bringing a facility in. Can you talk a little bit more about how that works?

Robert: Sure. So, unfortunately, as generous the Robert Wood Johnson Foundation funding has been, it's not sufficient to provide capital grants to individual Green House Projects because even at ten million dollars that would only build about four houses.

Woman: Mmm Hmm.

Robert: Well actually...six...four to seven houses, depending on your construction costs. So the way we typically work is that we will partner with a local organization that has demonstrated interest and capacity in developing a Green House Project. And then we will work as

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hard as you can imagine to help you figure out funding streams, grant applications, creative financing, and any type of state or federal support that would allow you to move forward. So the grants benefit to a project's capital side, capital needs, is that we will partner with you in advocacy around assembling those grants and lending products that you need.

Woman: Okay. So really it's a time factor rather than a monetary factor.

Robert: Exactly, yep.

Woman: Okay. All right, that's good to know, thank you.

(long pause)

Jessica: Do we have other questions?

Nick: Actually, Robert, this is Nick again, I've got a question...we'll it's not so much a question I have, but some information. We're very concerned about some of this talk about Medicaid being cut, and nursing homes closing down, and this and that. And one of the things that, I have a committee here in San Antonio, that what we're looking at is a possibility of looking to the diversified funding in this arena. And this is why I'm interested in the Green House Project. I've followed you for many years, from culture change and all. One of the recommendations that I'm making, you might look at it or not, or, but I think it fits well with the Green House, is the possibility of going to the Community Reinvestment Act with banks. And see if some of those funds can be used to create Human Service Entrepreneurial Funds for people to get into providing this type of service. If we start losing residents from nursing home closures we're going to have to look at everybody working together on this. So, I just wanted to throw that out for you. There's a good opportunity with CRA Funding out there, with all the banks.

Robert: Nick, thank you. That's...you know, I'm aware of CRA Funding, but I hadn't thought of it in that capacity and

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I think that's actually a terrific idea. And I think you're right on track with the approach of really looking creatively at what's out there. Because as... So I would agree with you. We are so terribly concerned about the Medicaid proposed and actual Medicaid cuts. It's very difficult to serve people eligible for Medicaid at a high quality level currently. It'll certainly become harder with cuts. And the more we can provide subsidies on the capital side, the less demand we have on the Medicaid program to finance debt. So I think you're thinking in exactly the right way. And I'd love to be kept abreast of what progress you make with the CRA approach, which is for those of you on the phone, the Community Reinvestment Act, which requires banks to contribute to low income programs and community programs in their market areas.

Nick: The reason that I really am behind this is that it does a number of things. It creates economic development, jobs, and in this case, it helps save many residents who can't go back home or don't have caregivers to look after them. Look, I welcome an opportunity to work with you and Dr. Thomas in trying to expand this idea.

Robert: Great. Let us know how we can help. Jessica, it looks like there's several questions on the chat box. Do you want us to go through a few of those?

Jessica: Sure. I know that Shriya's been responding to some of them. So I'm just gonna start with some of the most recent ones because I think she had gotten pretty caught up.

Robert: Ok, great.

Jessica: Would you like me to read them, or can you see them?

Robert: Go ahead, Jessica. Why don't you read them.

Jessica: So, question came in... "Has the Green House Model been used in assisted living facilities and what were the outcome with respect to residents, families, and staff?"

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Robert: Yes, the answer is yes. And I think the outcomes have been terrific. But we don't... So an important caveat is we do not typically work under an assisted living license. And we don't do it for two reasons. One is that generally the Medicaid reimbursement is not available for assisted living, or if it is available, it's often not sufficient to provide the level of care required to meet our aging in place requirement. Also, quite often, the assisted living regulations limit a provider or elders' ability to age in place once they're service needs advance beyond a certain point. So we will make exceptions to that under two circumstances. The first is... well three circumstances. The first is the state has to have a very progressive assisted living regulatory structure which will allow people to age in place with very advanced needs. The second is that they have to have a viable Medicaid program to support low income individuals. Or the provider has to establish a charity care program in lieu of Medicaid. And then the third is the provider, him or herself, has to be willing to go up to the highest level of care allowed under the Assisted Living Statute.

So we currently have assisted living projects in Arizona; two projects in Arizona. And those were very early projects for us. And they actually do not meet all those criteria, but they are grandfathered in. And they're very good projects, they just are not able to meet some of the aging in place requirements due to state regulations. We have a terrific program in Bentonville, Arkansas. And Arkansas has, in my opinion, very good assisted living regs. for their AL Level 2 and a very, very good program to finance services as well as subsidized capital costs for assisted living. We have a project that we've just accepted in Massachusetts that has a very good regulatory structure. And they have established a charity care program. And then we have a project in Winthrop, Washington, which is licensed as adult family care because their adult family care programs also have excellent regulatory structure for aging in place, as well as a good Medicaid program. And finally we have an assisted living Green House focused on Dementia care in Columbus, Georgia. And they will...they're trying very hard to build additional homes under a skilled nursing license because they want to be

able to meet the low income market that we all have a mission to serve, and have not been able to do that in Georgia under assisted living without a Medicaid...significant Medicaid program.

Jessica: Thanks. We've got still several questions coming in online and I know we're very close to the end time. I'm gonna pull one more and hopefully the rest of you that submitted questions to the web component can hear a response after the event is over. So this question is, "If you would still consider a place to be called a Green House if the houses were connected to a common area that would be like a city with a movies, coffee houses, hair salons, etcetera?"

Robert: So that's a really important question for us. So, of course, in the urban model where people are used to living in buildings or seeing people live in apartment buildings; that is possible. You know, you can have apartments above and then there's a, very often, a deli, a bookstore, a common area on the first floor, the same way you would expect to find in an apartment building. When the houses are built in the single family style, in a suburban or a rural area, we do not allow them to be connected. And we don't allow them to be connected for one very important reason. It's not that we don't believe that there are benefits to the commons building that you mentioned in the question, and being able to walk to that in a covered corridor, but we think that the potential negative impact outweighs the benefits. And the negative impact, in our mind, is that once you put a quarter to one of the houses from a central building, typically people think of those houses, not as individual houses, but as pods or units. And it's a really, very big back door for the institution to creep right back into the houses themselves, particularly around nursing and medication distribution, as well as food, and food carts, and food desk distribution.

So when I talked at the very beginning of the call about creating a model that resists institutional creep, one of the areas, we think, that the institutional creep is most likely to come through is a connected corridor to another, otherwise independent, house.

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Jessica: All right. Well, thank you so much. I am going to try and be respectful to everyone's time and close this webinar on time. I hope this has been useful and informative to everyone. I do encourage you to visit the Consumer Voice's website to learn more about ways you can get involved in advocacy and more about the Green House Project, as well as the Green House Project's website as well, which was also mentioned on the webinar. So to conclude, thank you to our speakers, and to the participants for all of your great questions. And again, thank you to the Green House Project for making this webinar opportunity possible today. Have a great afternoon everyone.

Robert: Thanks everyone.

END OF TRANSCRIPT

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