

Elder Care in Chile and the US: Two Models of Culture Change

by
Sarah Jane Robinson

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Approved by

Advisor: Dr. Sarah Moses

Reader: Dr. Kate M. Centellas

Reader: Dr. Douglass Sullivan-Gonzalez

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ABSTRACT

SARAH JANE ROBINSON: Elder Care in Chile and the US: Two Models of Culture Change
(under the direction of Sarah Moses)

This project examines two long-term care models: the Green House Project model and the Little Sisters of the Poor Home for the Aged in Viña del Mar, Chile, under the lens of the long-term care culture change movement to explore what can be learned from each of these models to allow elders to grow in dignity and autonomy. The research methods used were primarily participant and non-participant observation, informal interviews, and review of social scientific and gerontological literature. Elements of culture change were found to be present in each model, both of which aim to provide person-centered care to elders. The Green House Project succeeds in providing holistic resident directed care through the execution of deep culture change but faces some obstacles in widespread adoption due to systematic obstacles. The Little Sisters of the Poor Home for the Aged in Chile provides person-centered care with less thorough implementation of deep culture change and faces obstacles in sustainability and replicability due to its nature as an organization run by a religious order.

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Chapter One: Introduction

Aging is a reality that everyone faces. Hopefully we are all lucky enough to reach old age, but with that hope comes the question of how society is going to support the ever-growing aging population. Over the next 35 years or so, the global aging population, those over 60, is expected to more than double in size from where it was in 2015, reaching nearly 2.1 billion people (United Nations, 2). Despite this staggering statistic, I have found through my experiences visiting the elderly in a nursing home in Oxford, MS that the aging population continues to be a largely forgotten group of people. This is in large part due to structural issues within long-term care. It was because of my work with the elderly in Oxford that I wanted to study elder care within another organization in Chile during my time abroad there, seeing that the aging population is a global reality. In fact, the aging population is expected to grow most rapidly in Latin America and the Caribbean over the next 15 years, as compared to the rest of the world (United Nations, 2).

While in Chile, I worked in a home for the elderly run by the Catholic religious order, The Little Sisters of the Poor. There I observed once again the issues present with the long-term care system, but also many positive aspects of their model for delivering care to the elderly in such a way that respects the dignity and autonomy of the person. Driven by these findings, I wanted to look at another model of elder care in the United States that seeks to combat the problems faced in

the long-term care system: the Green House Project model. Therefore, this paper will explore each of these two models of long term care and look at them through the lens of the culture change movement which seeks to provide more person-centered long term care and allows elders to grow in dignity and autonomy.

Research Methods

The research methods used to examine the two models of long-term care were primarily participant and non-participant observation as well as informal interviews at Hogar Hermanitas de los Pobres in Viña del Mar Chile for an average of five hours per day for ten days over a three-week period in May 2017. The same methods were employed on two visits to the Green Houses at Ave Maria, a long-term care community in Memphis, Tennessee, on November 13th, 2017 and February 5th, 2018 for a total of around seven hours. In order to explore and analyze these two models of long-term care within the framework of the long-term care culture change movement I have drawn on social scientific and gerontological literature.

Populating Aging

As was briefly mentioned before, we live in a rapidly aging world. It is important to understand global population aging trends and then more specifically for this project, the population aging trends of the United States and Chile.

According to the US. Census report, *An Aging World*, "Among the 7.3 billion people worldwide in 2015, an estimated 8.5 percent, or 617.1 million, are aged 65 and older. The number of older people is projected to increase more than 60 percent in

just 15 years—in 2030, there will be about 1 billion older people globally, equivalent to 12.0 percent of the total population” (Wan He, et. al., 3). Thus population aging is not an isolated issue simply for the United States or Chile but one that affects the entire globe. One striking global statistic is that “The global number of centenarians worldwide—those aged one hundred years and older –is expected to more than double by 2030, with projections of nearly 3.4 million by 2050” (Bloom, et. al., 80). We now find ourselves in an unprecedented moment in history when it comes to population aging and this brings up the issue of how countries intend to support these rapidly changing demographics. The US Census notes that, “For the first time in human history, people aged 65 and over will outnumber children under age 5. This crossing is just around the corner, before 2020” (Wan He, et. al., 3). This is due to a myriad of factors such as lower fertility and increased life expectancy (Wan He, et. al, 3). Also, the baby boomer generation is now entering retirement, which is a large contributing factor to the surge in the aging population especially in the United States and Europe.

Nearly every country is rapidly aging, however significant variations do exist on the regional and countrywide level often correlating to income level. Both the United States and Chile are considered more-developed countries, which tend to trend more towards lower fertility and increased longevity, versus less-developed countries that may in some cases exhibit opposite or more widely varied trends (Bloom, et. al, 81). Now I will focus in more specifically on the aging population trends of the United States and Chile.

In a recent, 2017 data release, the U.S. Census Bureau reports, “new detailed estimates show the nation’s median age — the age where half of the population is younger and the other half older — rose from 35.3 years on April 1, 2000, to 37.9 years on July 1, 2016” (US Census Bureau, 2017). This is in large part due to the baby boomer generation that began to reach the age of 65 in 2011 and will continue to do so for years to come (US Census Bureau, 2017). Moses notes referencing the US census data that, “those aged eighty-five and older are the fastest growing segment of the elderly population” in America (15). This is of particular interest for considering long-term care because as Rodriquez writes in his book on nursing homes and the structure of care work, “individuals over age eighty-five, are the most likely to require continuous care in institutional settings and currently make up more than half of the nursing home population” (7). Thus the need for care for the aging population is imperative but often an unpopular one within public policy.

The same is true for Chile. Gitlin and Fuentes note that aging has only recently become a public policy concern in Chile in the last 18 years or so (303). Relatively similar to the United States, Chile has a median age of 32.1 (Gitlin and Fuentes, 299). However, the United States is the 48th oldest country (in terms of aged population) as of 2015 with the older population making up 14.9 percent of the population and is projected to be 85th in 2050 with a percentage of 22.1 percent. The older population of Chile is projected to make up 23.2 percent of the population as of 2050 and will surpass the United States with their very rapidly growing aging population (Wan He, et. al., 9). As of 2017 data, Chile’s older population makes up an estimated 10.81 percent of the population (The World Factbook).

Thus, in addition to being where I personally studied, Chile provides an interesting case because it is a rapidly economically developing country as well as a rapidly aging country. Chile is projected to be the most aged country in Latin America in the next two decades (Matus-Lopez and Petraza, 900.e7). However long-term care policy has not really existed in Chile until recent years, and new programs have only recently been established as it faces a large demographic shift with its aging population as well as cultural and societal changes in that the norm is no longer for families to care for their elderly relatives, as more women have entered the workforce.

Long Term Care in America

The Centers for Disease Control and Prevention (CDC) defines long-term care as including “ a broad range of health, personal care, and supportive services that meet the needs of frail older people and other adults whose capacity for self-care is limited because of a chronic illness; injury; physical, cognitive, or mental disability; or other health-related conditions” (Harris- Kojetin, et.al.). The forms of long-term care vary: “Individuals may receive long-term care services in a variety of settings: in the home from a home health agency or from family and friends, in the community from an adult day services center, in residential settings from assisted living communities, or in institutions from nursing homes, for example” (Harris- Kojetin, et.al.). These services are paid for in three main ways:

Medicare, the federal program for the elderly and disabled, covers many of the costs of acute medical care but only tangentially covers some long-term

care services. Medicaid, the federal/state Health program, covers long-term care but only for people who are poor or who become poor paying for long-term care or medical care. Who gets what kind of services under Medicaid varies from state to state. (Feder, et al.).

Third, there is private pay or personal savings or individuals who have purchased long-term care insurance. The problem is that the system is not sustainable for the projected aging population growth as was made evident in the above population aging section. Furthermore, even if the current system could provide for the needs of the growing aged population, it is imperative to look at how it will do this. The current system does not place enough value on providing care in a way that respects, preserves, and maintains, the autonomy and dignity of the individual.

Long Term Care in Chile

Let us look at a broad overview of the Chilean Health Care System and its forms of Long-Term Care. Chile has what Matus-Lopez and Petraza describe as a “health social security system” (900.e8). They write:

The National Health Fund (FONASA, for its acronym in Spanish) is public and low-income biased, and the Health Social Security Institutions (ISAPRES) are private and high-income biased. Both are financed through obligatory contributions of 7% of the salary, plus out-of-pocket expenses, and, in the case of the public system, is financed with general taxes. (Matus-Lopez and Petraz, 900.e8).

The majority of the population is covered by FONASA with only the middle-high income earners typically being able to afford ISAPREs. Furthermore, for the poorest sector of the population, who cannot adequately contribute to their pension fund a “Pensión Basica Solidario” or “Basic Pension” is provided by the public system (Wan He, et. al., 124). 86.1 percent of the population over 60 is covered by the public system, FONASA (Matus-Lopez and Petraza, 900.e8). This basic pension is what all of the residents at the hogar Hermanitas de los Pobres receive as the Little Sisters care for the neediest elderly.

Defining Autonomy within Long Term Care

Lewis Vaughn in his classic bioethics textbook defines “autonomy” as, “ a person’s rational capacity for self-governance or self-determination” (807). However it seems that due to the dependence of frail elderly, autonomy is often devalued in the traditional nursing home setting. Polivka writes,

In my experience, respect for the need and desire of frail elderly people to remain as autonomous as their impairments allow by providing supportive, nurturing environments and services has been, more often than not, compromised by the needs of policy makers and providers to achieve short-term bureaucratic or fiscal goals and the implicit notion that autonomy may well not be an appropriate or achievable goal for the dependent elderly. (Polivka, 23).

Thus Polivka discusses how the definition of autonomy only need be reimagined in the realm of long-term care where dependency and autonomy are considered

together. He writes, “autonomy is also the power of an individual, however dependent, to interact and communicate freely with others, to give and receive affection, and to initiate actions that are consistent with the person’s sense of self.” (Polivka, 24). Within this definition, the value of autonomy is preserved even for the frail elderly or those with cognitive decline of some type. Forming his ethic of long-term care, he draws from the ethic that has been well established among the disabled community resulting in well-organized advocacy. Central to this advocacy moment is “the normalization principle, which holds that while developmentally disabled individuals may be different from others, these differences should not be viewed negatively. Society, the principle maintains, must be prepared to support and nurture them” (Polivka, 23). Advocates in the disabled community use a rhetoric of “different not disabled” and discuss how “people are impaired but the environment is disabling” (qtd in Polivka, 23).

This ethic applies nicely to long-term care as well and needs to be used to combat the disabling environment that Brenda Bergman Evans describes as “learned helplessness.” She writes, “The need to control the environment is of fundamental importance to human beings. Yet when one enters a nursing home, choice often becomes a thing of the past. Such basic choices as when to eat, what to wear, or when to go to bed are often in the hands of someone else. The result is often a sense of helplessness” (Brenda Bergman-Evans, 29). When talking with one of my friends in the nursing home I visit, she mentioned that she is now too scared to walk, even though she knows that she is capable, but she kept saying, “they scared me into not walking anymore, I know its all in my head but they scared me,”

acknowledging that it was her environment that made her decide to stop walking and only use her wheelchair because of the staff's concerns that she might fall. This illustrates that sense of helplessness that is all too common in traditional nursing homes.

Bergman- Evans further emphasizes this drawing on other research, writing:

Elderly residents in long-term care facilities are often more vulnerable to learned helplessness as a result of the dependent role that is typically expected and assumed on admission (LeSage, Slimmer, Lopez, & Ellor, 1989). The older adult's passive, dependent behaviors result from an inability to control present life events. Consequently, future life events are also assumed to be beyond control (Barder, Slimmer, & LeSage, 1994). (qtd. in Bergman-Evans, 29).

In establishing his "ethic of long-term care" Polivka calls for the need for "moral imagination," in order to reshape culture to in turn reshape policy surrounding long-term care. In fact, around 1997 a movement known as the "culture change movement" was born and aims to focus on more person-centered care and empowering the staff that are in direct contact with the elders within nursing homes.

The Culture Change Movement

Rahman and Schnelle write, "culture-change proponents aim to create caring communities where both empowered frontline staff and residents can flourish, and where residents experience enhanced quality of life" (2008). In her article in

Health Affairs, Mary Jane Koren provides an outline of the culture change movement that will provide a framework for this paper. Koren is an M.D. M.P.H who served as Vice President for Long Term Care Quality Improvement at the Commonwealth Fund and now serves as a Program Consultant at the John A. Hartford Foundation, and has held various other leadership and advocacy positions for long term care.

The Culture Change movement is “a broad based effort to transform nursing homes from impersonal health care institutions into true person-centered homes offering long-term care services” (Koren, 1). As the culture change movement has gained more traction, a more clear consensus from the Centers for Medicare and Medicaid (CMS), consumer advocates, and large trade associations has emerged as to what the “ideal” facility would include: resident direction, homelike atmosphere, close relationships, staff empowerment, collaborative decision making, and quality improvement processes. Koren defines resident direction as “care and all resident-related activities should be directed as much as possible by the resident.” Her article explains that such self-direction would include basic tasks like choosing one’s clothes and deciding what time to go to bed. The homelike atmosphere implies that “practices and structure should be designed to be less institutional and more homelike.” This principle calls for households where only ten to fifteen residents live and includes the elimination of elements such as an overhead public address system. As regards relationships between residents, family members, staff, and the community, there should be genuine closeness between persons. Koren writes: “For example, the same nurse aides would always care for a resident (a practice known as ‘consistent assignment’), because this appears to increase mutual familiarity and

caring.” The principle of staff empowerment means that residences “should be organized to support and empower all staff to respond to residents’ needs and desires. For example, team- work would be encouraged, and additional staff training provided to enhance efficiency and effectiveness.” Culture change also demands “collaborative and decentralized decision making.” This entails overcoming the strict hierarchy of traditional nursing homes, incorporating “participatory management systems,” giving aides real authority in decision-making. Koren notes that “quality improvement processes” refer to “systematic processes” that would create “continuous quality improvements that would be comprehensive and measurement-based” (Koren, 2-3).

In his book *Labors of Love: Nursing Homes and the Structures of Care Work*, Jason Rodriguez echoes these same six tenets of the culture change movement and writes, “the overarching goal is the transformation of the nursing home from operating based on an institutional-bureaucratic logic, what I have referred to as a logic of cost, to a logic of care, that puts the individuals living in nursing homes at the center of all practices and priorities—to make a home out of an institution” (160).

Now I will examine two models of elder care through the lens of the culture change movement to explore what can be learned from each of these models in order to allow elders to grow in dignity and autonomy. The first is the Green House Project, and the second is the Chilean home that I worked in, Hogar Hermanitas de los Pobres, Viña del Mar.

Chapter Two: The Green House Project

General Background and History of the Green House Project

To Understand the Green House Project model of elder care it is first useful to look at a brief history of its beginnings. The Green House Project began in 2001 with Dr. Bill Thomas, who is a well-known geriatrician and activist in the long-term care field. He established the Eden Alternative in 1991 in an effort to bring about a “culture change” in long-term care, by “combating what Thomas considered the three main problems in institutional nursing homes: “boredom, helplessness, and loneliness” (Moses, 60). However, the Eden Alternative focused more on reforming existing nursing homes, and the results were not as effective as hoped in creating change in the lives of the elders, and promoting autonomy and growth in the latter stages of life. Thus Bill Thomas saw a need to totally re-imagine the nursing home and create something new in long-term care and the Green House Project was born. Thomas said regarding the Green House, “I believe that America can outgrow the mistake it’s been making for the past 40 years, which is institutionalizing older people. But in order to be a real abolitionist, I really had to bring to the table an alternative—something that was not a nursing home—to help people who can’t live at home” (“Green House Projects”). The Green House Project model turns the traditional nursing home or “skilled nursing facility” (SNF) model upside down. The vision of the Green House Project is as follows, “we envision homes in every

community where elders and others enjoy excellent quality of care; where they, their families, and the staff engage in meaningful relationships based on equality, empowerment, and mutual respect; where people want to live and work; and where all are protected, sustained, and nurtured without regard to the ability to pay” (*Guide Book*, 4). The mission of the Green House Project is, “we partner with organizations, advocates, and communities to lead the transformation of institutional long-term care by creating viable homes that spread ‘The Green House’ vision – demonstrating more powerful, meaningful, and satisfying lives, work, and relationships” (*Guide Book*, 5).

The Green House Project is a “technical assistance program” and thus functions as a sort of brand in that they partner with other non-profit or for-profit long-term care organizations in order to re-imagine long-term care (*Guide Book*, 1). Thus each Green House can look different and are run by different organizations although they will have to have the same core features to get the Green House certification. This is the case with the Green Houses in Memphis, TN that I visited at Ave Maria, a long-term care community that began in the 1960s (“About Us”).

Implicit within both the Green House Project’s vision and mission are elements of long-term care culture change. Now let us look at how the Green House Project works to achieve this mission and vision in the actual administrative and physical makeup of the home, and the community that these key features helps to create.

Physical Structure

The “transformation of institutional long-term care” that is referred to can be first seen very evidently in the physical structure of the homes. No matter where a Green House is located, it must be completely independent of other homes or buildings and house no more than 10 elders with a “financial hardship” exception for a maximum of 12 elders. Each Green House must include:

A hearth area providing a living area, dining area, and open kitchen, a single dining table that seats all elders, the Shahbazim, and two guests, private bedrooms providing a full bathroom, locked medicine cabinet, and ample natural light, ceiling lifts, fenced outdoor space with walking paths, visual sight lines from the kitchen to the majority of the hearth area, bedrooms, and outdoor space, and significant window areas in all common areas of The Green House home (*Guide Book*, 16).

The goal of creating such a physical space is truly to create a “home” rather than simply a “home-like” space (*Guide Book*, 6). Thus, each Green House looks different depending on where it is located and the surrounding buildings. For example, some Green Houses are constructed within the floor of an apartment building in more urban areas. The Green Houses in Memphis, TN that I had the opportunity to visit look from the outside like individual family homes, and upon entry have the same feel with everything being centered around the open kitchen and central hearth area, and the absence of medical equipment or medicine carts.

The emphasis on the physical structure is extremely important. Thus in order

for a partner organization to receive the Green House certification, “The Green House team must review and approve architectural designs at schematic design, design development, and construction documentation phases” (*Guide Book*, 16). This structure marks a very stark contrast to a typical nursing home in the United States that on average contains 120 beds (*Guide Book*, 30).

Other physical components worth noting include the incorporation of a doorbell that all visitors ring to gain entry, and there are also no public address systems as you would not find this in most homes. The Green House Project model takes the “homelike atmosphere” principle of culture change a step further in truly aiming to “create a ‘home’” rather than simply a ‘home-like’ space. Furthermore, this open floor plan provides a conducive setting for resident direction, closer relationships, and collaborative decision-making, as there is more interaction among direct care workers and residents due to the open shared space. One study reported GH homes having 4.2 hours direct care worker time per resident per day in comparison to 2.2 hours in traditional nursing homes (Zimmerman et. al, 479).

Administrative Structure

Not only does the Green House Project re-imagine the physical structure of long-term care but also the administrative structure. It seeks to “flatten the hierarchy of the traditional organization” (*Guide Book*, 9) “Each house functions independently with consistent and dedicated Shahbazim staffing. These self-managed teams of Shahbazim report to the guide, a position typically assumed by the nursing home administrator” (*Guide Book*, 9). The shahbahzim are certified nursing assistants who

receive extra training in “CPR, culinary skills, household operations, including basic maintenance and emergency response, and the Green House Curriculum” which includes elements like the Green House Philosophy, problem solving and communication skills, and more (*Guide Book*, 10).

There are typically 2 shahbaz in each house for the day and evening shifts and there is one nurse that provides for the medical needs of the elders in two Green Houses. The shahbazim staff is ideally very consistent, thus fostering community within the homes, which will be discussed in greater depth later. In addition to the core shahbazim staffing, there is a clinical support team of other health professionals, such as physical therapists, occupational therapists, etc. The shahbaz provide the direct care to the elders, that on average is about 4 hours of care per elder per day (*Guide Book*, 9). This is more than the average direct care given to elders in traditional nursing homes (Afendulis, 457).

This model empowers those care givers that are in most direct contact with the elders, as they do not feel like they are constantly being watched over, and they are truly the core team that run the homes alongside the elders. Yet there still exists accountability because they are part of a team that rotates the responsibility every several months in being the “coordinator” of each different area of how the home functions, such as “team coordinator”, “food coordinator”, “house-keeping coordinator”, “scheduling coordinator”, and “care coordinator” (*Guide Book*, 11).

This organizational structure aims to allow the core care workers; the shahbaz—to first consult each other with any potential issues, communicate with the clinical support team about the needs of the elders, and then if need be have the

guide to turn to should it be necessary. The emphasis is on collaboration and teamwork, even and especially between the different team members, without regard for level of professional training. Zimmerman and colleagues reported “interaction between medical care and direct care staff, other care staff, and families, was more common in GH homes that had fewer hospitalizations” (483). This could indicate the effectiveness of the Green House model in fostering communication and collaborative decision making which may play a role in positive outcomes such as fewer hospitalizations. The Green House model recognizes that everyone has an important role to play in the care of the elders as well as to give the shahbaz and other professionals dignity in their own work. Here the culture change principles of staff empowerment and collaborative decision making are most evident as the shahbaz are encouraged to work together and be the front lines of problem solving within the homes, and also are given greater responsibility and autonomy than typical CNA’s in traditional nursing homes. I saw firsthand the teamwork that exists between shahbaz and lack of hierarchical administrative structure, as one shahbaz kindly reminded the other that she had forgotten to do her reporting the previous day.

Community

I think implicit in both of these core components that guide the Green House project are the underlying tones of the importance of community, which can also be stated in the philosophy of the Green House Project:

Creating small homes where intentional communities are developed and high levels of care are offered, recognizing and valuing individuality of elders and staff, honoring autonomy and choice, supporting elders' dignity, offering opportunities for reciprocal relationship between elders and staff, fostering spiritual well being, and promoting maximum functional well-being (*Guide Book, 7*).

The physical structure and administrative structure help to make these philosophies a reality by fostering communication between elder and shahbazim and other professionals by the team workforce structure, as well as the universal nature of the shahbazim.

Aspects such as the community table and communal living spaces are of key importance and the overall shared and open access living spaces that promote participation for each elder as well as the staff. The elders spend a lot of their days in the central hearth area and the open floor plan contributes to promoting community throughout each home. Another key aspect of Green Houses that serve to promote community is the practices surrounding food and the table. Each Green House has a community table and elders and family members contribute recipes and suggestions for the house menus. Elders also have full access to the kitchen, and everyone, including staff, eat around the one large dining table with room for guests as well.

During my visit to Ave Maria, I also sat at the table for lunch and got to participate and see how the shahbazim interact with one another and the elders. Meal times function much like one would expect them to within a family. The

shahbazim are laughing with one another and with the elders, trying to engage them as much as possible. Furthermore, Green Houses include spaces for family members to stay the night and on each of my visits to the Green House in Memphis, there were visitors. I have been visiting a traditional nursing home in Oxford, MS for 3 years and can count on one hand how many times the residents that I visit have had family members or visitors, other than the group with whom I visit. This speaks to how the environment could be the source for greater family participation and fostering close relationships not only among the elders, or elders and staff, but also between family and friends of the elders.

The fact that the shahbazim are universal workers and are given more responsibility in their role as the direct care givers, gives them more license and freedom to interact with the residents without fear that they will be reprimanded for not doing their particular duty. They also seem to receive empowerment by being deferred to for any questions regarding the elderly. For example, on my observational visit to the Green House in Memphis, I saw one of the administrators come in and ask the shahbazim different questions about who had been to core training and how things were going in the house, etc. She did not seem to be doing this in an evaluative tone; rather she simply wanted to know how that shahbaz was doing. On my first visit, I got to talk briefly with one of the shahbaz who had been working at the Green House for ten years, and spoke of how she loves it because it is really, “bringing back the family” (Yolanda, Personal Communication, 2017). This speaks to the vision of the Green House project to create an empowering environment for both elders and staff. Bowers and Nolet note that the Green House

model is “based on a belief that living in a family-like environment will result in both improved quality of life and improved clinical outcomes for residents” (111). Additionally, it expresses the desire to keep consistent staff within each Green House, if most shahbaz feel like they are truly a part of this “family-like environment.” All of these aspects of community demonstrate the culture change principles of close relationships, staff empowerment, homelike atmosphere, and resident direction.

Conclusion

As the Green House Project was developed completely out of the American culture change movement for long-term care, the six basic tenets can be seen throughout. The simple change in rhetoric within the Green House model is one way in which it accomplishes “resident direction,” by the use of the term “elder” rather than patient, resident or client. “In this way, the Green House vision insists on a holistic view of older people as full persons, refusing to reduce their identity to a medical or social-service status” (Moses, 67). The overall physical structure contributes to resident direction with a central living and dining area and open floor plan, allowing the residents an opportunity to participate in the activities of the home.

In her article about culture change, Meg Laporte writes on the Green House Project model and founder Dr. Bill Thomas. She quotes Thomas saying, “this isn’t ‘some kind of silly-turn-off-all-lights-and-walk-away idea.’ No, he says, ‘that’s not what I want- I want us to deliberately plan to outgrow the nursing homes. Let’s go

beyond something that was handed to us half a century ago; let's embrace and develop and implement new models of care.” (Laporte, 23).

It is also important to understand how the Green Houses are financed to evaluate if it is something that would be available to all types of people from different socioeconomic backgrounds as well as its financial feasibility in the long run. It is in the vision of the Green House Project to provide care for anyone “without regard to the ability to pay” this is true in that many Green Houses do have elders on Medicaid within the Green Houses, but there typically has to be a balance of Medicaid, with private long-term care insurance or simply private pay so as to run the Green Houses in a economically sound manner, seeing that Medicaid reimbursements are typically low. (Gatusso, 2017).

In regard to quality of life for elders living in Green House homes, there is a growing body of research to provide evidence for the improved quality of life that elders experience within Green House homes. Kane and colleagues studied eleven quality-of- life measures and self-reported responses of elders in Green Houses as compared to two other long-term care facilities, with the results indicating favorable responses for the Green House elders as compared to both other facilities. Furthermore, “Green House elders did not report lower quality of life on any of the 11 measures” than residents from the other two facilities (Kane et al, 836). Not only does research indicate better quality of life within Green House homes but also better quality of care. Zimmerman and colleagues report decreases in hospital readmissions, avoidable hospitalizations, bedfast elders, catheterized elders, and “low-risk residents with pressure ulcers” within Green House homes (483). Thus

research is showing that this “new model” of long-term care consisting of deep culture change is showing results. Now we will turn to another model of elder care to glean how it implements elements of culture change and what can be learned from the model of Hogar Hermanitas de los Pobres in Viña del Mar, Chile.

Chapter Three: Hogar Hermanitas de los Pobres Viña del Mar, Chile. (The Little Sisters of the Poor Home for the Aged, Viña del Mar, Chile)

General Background on the Little Sisters of the Poor

In order to understand the vision, mission, and objectives of the Little Sisters of the Poor, first it is important to know a little bit about the history of the congregation. Central to the history of the congregation is the history of its founder Jeanne Jugan. “The Little Sisters of the Poor are an international congregation of Roman Catholic women religious founded in 1839 by Saint Jeanne Jugan. Together with a diverse network of collaborators, we serve the elderly poor in over 30 countries around the world” (Mission Statement).

Jeanne Jugan was born in France in 1792. She had a hard start in life as she was born into a family with limited resources. When Jeanne Jugan was four years old her father was lost at sea and thus her mother worked various odd jobs to provide for her family. Jeanne starting working as a shepherdess and later would work as a kitchen maid for a prominent family. However, Jeanne Jugan felt that God had a specific plan for her life. After declining a marriage proposal twice, she told her mother that “God wants me for himself. He is keeping me for a work which is not yet founded” (“Her Story”, 2017). After this, for many years Jeanne Jugan lived a simple life working with the poor in a hospital.

In 1839, Jeanne found an elderly woman in the street with no one to care for her. She decided to take this woman into her own home and cared for her until the end of the woman's life. This was the beginning of her dedication to caring for the elderly in situations of poverty. Jeanne realized that there were many more elderly persons that needed help and she took in more and more. At the same time, other young women were joining Jeanne Jugan in her work. Jeanne and this group of women were also focused on deepening their Catholic faith. Gradually this group was transformed into a religious community. "The Congregation received diocesan approval on May 29, 1852. It was recognized as a Pontifical Institute by Pope Pius XI on July 9, 1854. Pope Leo XIII approved the Constitution of the Little Sisters of the Poor on March 1, 1879. By then there were 2,400 Little Sisters in nine countries" (Little Sisters of the Poor, 2017). Today the Little Sisters of the Poor have houses in more than thirty countries around the world.

The vision of the Little Sisters of the Poor is as follows: "Our vision is to contribute to the Culture of Life by nurturing communities where each person is valued, the solidarity of the human family and the wisdom of age are celebrated, and the compassionate love of Christ is shared with all ("Mission Statement", 2017). The mission of the Little Sisters of the Poor is, "to offer the neediest elderly of every race and religion a home where they will be welcomed as Christ, cared for as family and accompanied with dignity until God calls them to himself" ("Mission Statement", 2017).

Furthermore, the Little Sisters state their values as the following: "*reverence, family spirit, humble service, compassion, and stewardship*" ("Mission Statement",

2017). Here we can see the value of community also at play with the Little Sisters, which was also a key component of the Green House philosophy. There are many similarities that align nicely with the principles of the culture change movement and parallels that can be drawn between the homes run by the Little Sisters and Green House Project homes.

First, in their first listed value of “reverence” they describe the care they offer as “holistic and person-centered” which is the exact language used for the aim of culture change and in the Green House Project rhetoric. The value of “family spirit” is a key component to the little sister’s way of life and is very evident in the atmosphere of the house as will be discussed later. It is easily paralleled with creating a “homelike atmosphere” and “close relationships” as the culture change movement defines them. The value of “humble service” could be argued to be the Little Sisters version of “staff empowerment and close relationships” and resident direction. Compassion is something that is clearly valued in the Green House project as well and the culture change movement at large, as the aim is to improve the quality of life and thus happiness of the elders. The Little Sisters’ value of stewardship is starkly unique in how the sisters provide for their own needs, those of the elders, and those of the home. An intense faith in Divine Providence is really what sustains the sisters, residents and homes. A Wall Street Journal article on one of the Little Sisters homes for the aged in Pittsburgh quotes a CEO on the home’s advisory board saying, “They’re unshakeable in their belief that they’re doing God’s will and because they’re willing to do it, they will never be let down,” says Mr. Will.

‘It’s hard for us in the everyday world, fighting financial battles, to understand’”
(Ansberry, 2005).

Each home of the Little Sisters is independently run and does not receive any help from their local diocese or any continuing financial support from the Vatican. Homes run by the Little Sisters in the United States and around the world operate off of donation for which the nuns beg. The article on the Pittsburgh run Little Sisters home describes the following: “the nuns beg for food, for clothes, for money and for special wheelchairs. Donations account for about 60% of their annual \$5 million budget. The rest comes from Medicaid, Medicare, Social Security and other sources” (Ansberry, 2005). This is similar to how the Chilean house (hogar) in which I worked functioned, with little outside support but the sisters begging for donations from local groceries, markets, farms, and stores for their needs. The hogar, also receives eighty percent of the social security from each resident. However it is important to note that all of the elders in the home earn only the most basic pension.

Chilean Home for the Aged, Little Sisters of the Poor

The Little Sisters of the Poor is an international congregation, thus they have homes with the same mission of caring for the “neediest elderly”, but each of the homes is independent in the way that each home is responsible for its own maintenance, organization, and funding. In the case of the home in Viña del Mar, Chile, the majority of the resources come from donations. This is one of the ways in which the Little Sisters are living like Jeanne Jugan did because just as Jeanne did,

the sisters carry out many “collects” of different forms with the purpose of collecting sufficient resources for the successful administration of the home. For example, many businesses, and farms surround the home, and there are many farms outside the city of Viña del Mar, all of which make donations of fruits, vegetables and other goods to the home. In this way, almost all of the food that is prepared and served in the home is a product of the donations. The sisters only have to buy the meat. Also, the Little Sisters make collections in the local supermarkets, where they distribute fliers with the description of their work and their needs, and thus the people at the supermarket can buy different items that the hogar needs, choosing what they want to purchase from the flier.

Additionally, the Little Sisters live in the homes in the same conditions as the elders for whom they care. This is a very important aspect and one of the distinct hallmarks of the Hogar Hermanitas de los Pobres. It makes sense that the Little Sisters take so much care and effort in the maintenance of the home, because it is their home too. This is an excellent example of how community or “close relationships” in culture change terms is manifested within the hogar. This fact also contributes to the sense of the home really being a home, not just an institution for forgotten people or those with little resources. This is reminiscent of what Moses writes about the Green House: “As one architectural designer explained, during the design process for a Green House development, the planning team kept asking, ‘Would you do that in your home?’ (Walace, 2006)” (qtd in Moses, 65). Although, the staff of the Green Houses do not actually live in them, the same idea of creating a

normal home that anyone would want to live in is present within the home of the Little Sisters, because it is indeed their home as well.

The requirements of an elder to enter into the Hogar are as follows: must be a self-sufficient person at the time of entry, must be at least 65 years old, can not be responsible for the care of a minor, must be in a situation of limited resources, must depend on a basic pension, must contribute eighty percent of pension, and other support that elder receives for the elder's maintenance, must not have infectious diseases or other illnesses, such as: Alzheimer's, Parkinson's, Schizophrenia. (The institution is not equipped to attend to persons in these cases). The process of application for the residents also requires a waiting period before the applicant can enter the hogar. Also worth noting is that although no one can enter the hogar with any serious illness or neurodegenerative disease, after an elder enters the hogar, the Little Sisters and the worker will care and attend to those elders until the end of life.

These requirements represent an important difference between the Green House Project and the Little Sisters home in Chile because Green Houses will admit people with those diseases or illnesses, such as Alzheimer's.

Physical and Administrative Structure of the Hogar

The Hogar in Viña was found to be very well organized, under the charge of Mother Albina and eleven other Little Sisters of the Poor, who function as the heads of the hogar and are in charge of everything, from administrative duties, to the actual care of the elders. In this way the Little Sisters function like universal workers similar to the Shahbaz in the Green House homes.

There are around 35 staff members in the hogar that are often called “nocheras” and would be the same as certified nursing assistants (CNAs) or Shahbazim in the Green House Project model. Some of these staff members are the cooks for the hogar or take care of the laundry. The “nocheras” are the ones that provide the direct care to the elders and function as universal care workers as the Shahbaz do in that they do the meal prep, cleaning, laundry, etc. in the hogar as well as the more traditional responsibilities of nurse assistants, such as bathing, changing, and administering medications to the elders. There were 79 elders in the hogar when I was there—affectionately called “abuelitos” or “abuelitas” which directly translates to grandfathers and grandmothers, but is an endearing term for an elder in Chile. There are only two full time professionals at the hogar: the social worker and the physical therapist. The other professionals that work in the hogar, such as the nurse and the doctor, are volunteers or part time.

The hogar is divided into five sections: the women’s infirmary, the men’s infirmary, the women’s wing, the men’s wing, and there are also three married couple that have their own room and private bathroom. In both of the infirmaries, each of the elders have their own room with their own bathrooms. The two wings are for men and women that are self- sufficient and everyone has their own bedroom and sing with shared hallways bathrooms. The infirmaries are for the elders that need more attention due to a physical or neurodegenerative illness, and thus provide the care that is typically seen in a traditional nursing home in the United States and the care that is possible within Green Houses. Normally, there are two or three nocheras in each of the sections and a sister in charge of each section.

The same nocheras work in their particular section along with the sisters which helps to create those close relationships that is a principle of culture change. The nocheras know each of the residents personally and could tell me about their life, revealing that they treated each elder as a whole person rather than simply a recipient of their care. In a US-based Little Sisters of the Poor home in Pittsburgh it was also reported that:

There is little staff turnover among the lay workers here. The average length of service is 12 1/2 years. By contrast, between a third and a fourth of the nation's long-term-care workers have less than a year's experience.

Residents here live an average six to seven years, compared with the nationwide average for nursing homes of two to three years. (Ansberry, 2005).

Although just one example, I think this speaks to the effectiveness with which the sisters run their homes creating an environment that is enjoyable for elders to live and for staff to work. This type of consistent staffing and low turnover is also crucial for having close relationship between elders and staff. A resident of that Pittsburgh home also said, "If I had my own home, I wouldn't be any happier," says Cecilia Hugo, who has lived with the sisters for 17 years" (Ansberry, 2005).

I had similar experiences and conversations during my time working in the Chilean home. During my time spent in the infirmary, the nocheras were so caring towards the elders. This contributed to creating the environment of "home", and not just an institution. This sentiment seemed to be shared by the residents as well. One woman told me, "It is very good here, everything is calm and everyone helps one

another, we are like a family.” I often observed the elders helping one another, in the form of a comforting touch if someone was upset, or bringing another elder a blanket because they seemed cold.

My research in Chile never revealed any specific measures to empower staff and it is very clear that the Little Sisters are the ones in charge, and the ultimate decision makers, which is most probably related to the tradition of hierarchy in monastic life. However, they are working right along side the nocheras in the dining rooms, and infirmaries and in the maintenance of the home. The sisters have a hand in everything, which is expressed in their value of “humble service” or their ability to find meaning and have an “appreciation” for the smallest and most humble works within the hogar. This sets the tone for the nocheras to also find dignity and meaning in their work. In writing on when staff empowerment was most effective in a Green House Study on sustaining culture change principles, Bowers, Nolet and Jacobsen reported, “Guides and other leadership staff were pivotal in supporting Shabazim to develop these skills when shortcomings were evident. Role modeling, practicing, and careful coaching were used to support development of skills” (407). This is exactly what the Little Sisters do by nature of their values.

The hogar is very extensive, with an infrastructure of three floors all centralized around an open pavilion. Aside from the residential areas of the hogar you can find: a theater, a chapel, a small store, a laundry room, the kitchen, a large dining room, rooms for doctors visits, nurses office, and a dental office. There is also the physical therapists office, and small physical therapy gym, artisanal workshops where elders can sew and make other things, various dorms and rooms for visitors,

a library, a beauty parlor, various patios, gardens and land surrounding the hogar. The sisters also have a wing of their own where only they may enter, and a small private wing for a priest that lives in the hogar as well. The expansiveness of the hogar provides opportunities for activities such as the fostering of community and close relationships between elders and staff as I saw in the practices for the play that they were putting on in their theater. The chapel also was a place of community where the sisters and many residents would say the rosary or the liturgy of the hours each day.

Other noteworthy elements of the hogar are the lack of medicine carts out anywhere. Even within the infirmaries, where the elders are more dependent and are given their medicine each day—all medicine is kept in cabinets within the kitchen of that section. The hogar in general does not feel like a hospital as many traditional nursing homes do in the United States because there is a lot of natural wood on the interior and plants.

Conclusion

There is something that can be learned from the way that the Little Sisters, although the defacto heads of the house with the ultimate authority being their Mother Superior, work in every area of the hogar right alongside the nocheras and lay workers. They model a means in which to find appreciation and dignity in the small mundane tasks and this modeling in itself serves to empower staff. I certainly experienced this when I would get tired sweeping half of the main dining room; when Sister Rosario had finished her side in half the time and was on to do a handful

of other tasks. The Wall Street Journal article on the Pittsburg Little Sister home notes that, “the Little Sisters and their begging tradition are an anomaly. They provide high-quality care—individual rooms and lots of individual attention—on a tight budget” (Ansberry, 2005). Although a rather unorthodox model of elder care, and not necessarily an entirely replicable one given the nature of religious life, there are elements of the Little Sister’ model that fulfill the central tenants of the culture change movement and can be looked to as an example.

Chapter Four: Conclusion

A look at global population aging trends quickly reveals that the world is aging rapidly and consequently necessitates a critical look at how the aging population will be supported in a way that allows elders to grow in dignity and autonomy. The primary principles of the culture change movement serve to accomplish this goal by focusing on person-centered care through: resident direction, homelike atmosphere, close relationships, staff empowerment, collaborative decision making, and quality improvement processes. The Green House Project model grew specifically out of the US culture change movement and thus the culture change tenets are rather obvious in their philosophy, mission, and execution. For example, the complete reimagining of the physical structure of the home from which each other culture change tenet flows. Green House homes are built as actual homes for a maximum of twelve elders, with an open floor plan and with each elder having their own room, this provides elders with a level of independence and autonomy that they deserve while also attempting to foster effective communication between elders and staff leading to close relationships. Furthermore, the physical structure ideally contributes to the teamwork or “collaborative decision making” of the direct care workers along with the elders. Additionally, the flattening of the hierarchical nature of the staff of the Green House home aims to empower the direct care staff. Each element of the culture change

movement strives to help the other principles function more effectively as well. I think a broad underlying principle within all of them, and especially if they work together as envisioned, is a strong sense of community within each Green House.

This strong sense of community and home is also very evident within the Little Sisters of the Poor home in Chile and presumably other homes run by the Little Sisters according to the limited accounts available. So many of the values held by this religious congregation map very nicely onto the principles of the culture change movement such as the impact that the Sister's dedication to "humble service" has on empowering the direct care staff because the sisters work right along side of them even though they are the "bosses." This could be a contributing factor to the very consistent staff that the Little Sisters' home has, which also contributes to the closeness in personal relationships and feeling of home rather than institution. There is also the unique fact that the Little Sisters do in fact live in the homes in which they work and care for the elderly, which is a huge factor in the sense of community that can be experienced within a Little Sisters home. A US Little Sister of the Poor was quoted saying, "Would you like to go to heaven and stand before St. Peter and say I lived in a wonderful and beautiful home but when it came to putting together a home for the poor, I gave them a cheaper version?" (Ansberry, 2005). This is a great representation of the Little Sisters' vision and mission to provide quality care to the poor even on a very low budget, and the almost unbelievable thing is that they actually accomplish this. However this is not to say that their financial model is to necessarily be replicated.

Both the Little Sisters of the Poor and Green Houses accept people without the ability to pay. Thus it becomes necessary to consider the financial viability of each model. We have seen how the Green House model is a direct product of the culture change movement in long-term care and radically tries to exemplify each principle of culture change. However, it is important to consider the financial feasibility of this model in the long term and its effectiveness. First, the up-front cost of a Green House versus a traditional nursing home is higher in large part due to “increased square foot requirements”. (Jenkins, et.al, 20). However after the initial costs to build the Green House, research is showing that the operating costs are the same as a traditional nursing home. In fact, Jenkins and colleagues report that “implementing the Green House direct service staffing model, especially the shift of expensive supervisory time into direct care, will result in staff and cost neutral operations or, perhaps, modest savings” (19). Moreover, it seems that elder, family, and employee satisfaction are higher within the Green House as reported in a longitudinal study on resident outcomes from 2007 by Kane and colleagues (837). Jenkins and colleagues conclude that, “it is possible to provide a high-quality of life and care through The Green House model at a net profitability and return on investment comparable to large, traditionally structured nursing facilities” (21). Thus we see that a deep culture change model can work to both achieve its goals of quality of care for elders as well as remaining financially viable.

Not only is it important to consider financial feasibility and sustainability but also the sustainability of culture change within these models. For example, with the Green House Project, and my observations at Ave Maria, an issue can be the ease of

falling into old more traditional practices, as Bowers, Nolet, and Jacobson note, that there is not a means by which “sustainability of the culture change” aspects in Green Houses are being accounted for and there has been wide variation in the sustainability of the culture change tenets within different Green Houses (400).

I saw this within a conversation with a shahbaz who didn’t find her work much different than in other nursing homes but thought that the quality of life of the elders was better in the Green House (Personal Communication, 2018). This could be a signal that more emphasis could be placed on continued efforts to empower the direct care workers, or as several researches concluded, the need for better or further “coaching” in problem solving skills by the Guide (Bowers, et. al., 407). Bowers and Nolet note in a study specifically analyzing direct care worker empowerment that there was “a high level of consistency in feelings of empowerment among Shahbazim working with the same nurse, i.e., Shab hazim tended to connect their sense of empowerment to their interactions with the nurses they worked with” (114). This could also serve as a possible explanation for the shahbaz’ response in not seeing a significant difference from her work in a Green House versus that of a traditional nursing home. It also provides support for the advantage in consistent staffing among the entire care team.

This feeling of home that can be found in both of these quite distinct institutions is interesting when considering their beginnings. The Green House Project has emerged in the last 15 years out of a need to totally reimagine the institutionalized nursing home in the United States. The homes of the Little Sisters of the Poor, on the other hand, are structurally different and distinct around the world. They

usually don't incorporate a total reimagining of the physical structure, but are run by the Little Sisters who live each day trying to care for the elderly in the way that their founder did. Jeanne Jugan did indeed start by simply taking in elders to care for them in her home. Unfortunately, the little sisters are currently destined to disappear as an order because of the lack of vocations to religious life. However, there are still elements of the way that the Little Sisters provide care to the poor elderly that could be duplicated to try and provide quality care to the elderly that allows them to maintain their autonomy and dignity within their circumstances. If larger institutions earnestly tried to incorporate aspects of culture change and instill and embody similar values to those of the Little Sisters of the Poor, especially in terms of staff empowerment and close relationships then they too could improve the environment and quality of life within their facilities. This could be done in a similar way to how the Green House Project has particular extra training for learning the "Green House philosophy" and how to implement it. On the other hand there are elements of the Little Sisters of the Poor's model of elder care that simply should not be adopted because they would not be sustainable in a normal business model, such as their financial model of reliance on donations and divine providence. A comparison to Ave Maria can be made though in that although not quite as radical as the Chilean Little Sister's home, they also use donations to augment the revenue they get from resident reimbursements. Furthermore, as a non-profit, they do not have to produce a profit for investors.

This is important as Rodriguez writes on the issue of for-profit nursing homes that often must operate with a seemingly sole focus on cost-efficiency and

profitability (2). This causes a hindrance to for-profit nursing homes adopting deep culture change with models such as Green House because of the structure of the Medicaid reimbursement system among others, thus Rodriguez argues that for more wide-spread culture change principles to be adopted, structural changes in the regulatory and reimbursement systems of long term care also need to occur (168). Evidence of this can be seen in the case of the first for-profit Green Houses that were built in Arkansas, a state that also passed legislature that “allow dollars collected under civil monetary penalties to be used for specialized reimbursements for nursing homes that implement a Green House project or an Eden Alternative program” (Grabowski, S73). This type of innovative policy is a possible solution to promoting deep culture change such as the Green House Project model in both the non-profit and for-profit fields.

Limitations and Future Directions

There is a lack of qualitative and quantitative research on the Little Sisters of the Poor and their model for long-term care delivery. Thus it is difficult to draw definitive conclusions or comparisons between their model and more traditional nursing homes. I also did not spend near equal amount of time at the Green House in Memphis as I did with the Little Sisters in Chile, thus this project exhibits heavy observational data for the Little Sisters and much more data from secondary sources and gerontological literature on the Green House project. With that being said, it would be extremely beneficial going forward to see more qualitative and quantitative research on the Little Sisters of the Poor to then be able to gage how

their positive aspects of elder care could potentially be implemented in a non-religious order run elder care setting. With the Green House Project literature, although there have and continue to be more qualitative and quantitative studies on its effectiveness and impact on overall quality of care and life together, the model is still fairly new and thus results are still considered somewhat inconclusive.

Furthermore, I would be interested in further study of the sustainability of the aspects of culture change within the Green House project as it seems that it is easy, especially within the administrative structure, to fall back into more of a hierarchy and less staff empowerment in particular.

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