GRANTMAKERS IN HEALTH

Embracing Risk, Understanding "Failure," Salvaging Treasure from the Wreckage

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The following remarks are excerpted from Mary Jane Koren's acceptance speech upon receiving the Terrance Keenan Leadership Award in Health Philanthropy on March 11, 2010.

I'm a geriatrician, and I've also been a health services researcher and a policymaker in the field of long-term care quality – basically, I've spent a lifetime in preparation for my job at The Commonwealth Fund. I must begin, however, by recognizing the role that Karen Davis and The Commonwealth Fund's board have played in the development of my program. They were very specific about what the focus of the Frail Elders Program should be and explicit about the goal. They said, in effect, nursing homes have tremendous quality problems, they care for an extremely vulnerable population, and yet, there's a "funding vacuum" – not many other foundations are working on this. The board said, "The program's focus is nursing homes and the goal is to improve nursing home quality." Having this degree of clarity is fundamental to strategic grantmaking. Karen and the board were critically important because they bought into my vision of what nursing homes could become; they gave me considerable latitude to do the job and backed the long shots I recommended.

First and foremost, I'll start with aging: the number of old people in this country is about to take off. This fact will have profound consequences for society as a whole, as well as for the organization, financing, and service delivery of the entire health care system. This means that no matter what aspect of health care your foundation focuses on – be it safety net programs, workforce, or payment policy – it will be influenced by the graying of America. Aging is everybody's issue.

Next a few words about nursing homes. I can hear you thinking, "Nursing homes are so not my problem!" Think again. Something like one in three people over the age of 65 will spend some time before they die in a nursing home. That could easily be your parents. It could be you. There are over 15,000 nursing homes in the United States, and more than 60 percent of nursing home care is paid for by public dollars – mostly Medicaid. Also of note is that roughly two-thirds of the industry is for-profit and a significant number of facilities are owned by large corporate chains or private equity investors. Given the proportion of Medicaid dollars that go to pay for nursing home care, nursing homes have a huge impact on all sorts of other health services in a state. While states are trying to rebalance the types of supports and services available for people with long-term care needs, residential care will always have to be one of the options because the need for nursing home care is driven as much by psychosocial factors as it is by functional deficits or complex chronic conditions. Translation: Nursing homes aren't going away. They can't. Therefore, we have both the moral and ethical responsibility to improve care for vulnerable older adults living in nursing homes, as well as the fiduciary responsibility to ensure that the money we're spending, much of which are taxpayer dollars, is money well spent.

Now, nursing homes have traditionally functioned as health care facilities where people live, although in truth,

ABOUT THE TERRANCE KEENAN LEADERSHIP AWARD IN HEALTH PHILANTHROPY

The Terrance Keenan Leadership Award honors outstanding individuals in the field of health philanthropy whose work is distinguished by leadership, innovation, and achievement. Grantmakers In Health established this annual award in 1993 in honor of Terrance Keenan who, by example and instruction during his more than 40 years of service and contributions to health philanthropy, charged grantmakers with exercising the freedom to invest in leadership and develop new institutions and systems to confront major needs. He encouraged those in the field to embrace both the freedom to fail and the freedom to persist. He also challenged grantmakers to make "their self concept as public trusts…the overriding article of their faith and the guiding force of their behavior." The Terrance Keenan Leadership Award is intended to stimulate others to strive toward this same standard of excellence and acknowledge those whose work embodies his spirit.

physicians are not particularly engaged, nurses are few, and most of the care is actually provided by paraprofessional staff with only the federally mandated 75 hours of training. Compare this with the training a guide at Disney World receives before meeting the public or a beautician in Maryland is required to have before cutting a client's hair. How can we be surprised that there are quality problems? The traditional nursing home model puts institutional priorities first and underplays concerns about quality of life and resident well-being. Over several decades, however, and supported by the groundbreaking piece of legislation OBRA-87 (mandating individualized care), consumers, providers, researchers, and policymakers have been trying to break away from the traditional model to become truly "person-centered" to make nursing homes good places to live, work, and visit. This transformation, called "culture change," has been spearheaded by a loose-knit confederation called the Pioneer Network.

With that preamble and in keeping with this year's conference theme of "taking risks," let me share with you three observations I've made over the years that I've found to be helpful when assessing and managing a project's risk.

THREE POINTS FROM THREE PROJECTS

The first point has to do with innovation. Back in 1989, while serving as the director of nursing home survey and certification in New York, I also managed a $2 million/year grant program established by the legislature to stimulate innovation in nursing homes. One day as I was driving around, I made an unannounced stop at a typical small, 80-bed rural facility. When I went in I was impressed with how orderly and quiet it was. Suddenly the medical director appeared and said, "I've got a great idea for a project. You're going to love it. But I won't tell you about it. You'll see the proposal."

When the next round of proposals came in, sure enough, there was one from Chase Memorial. Its goal was to overcome the boredom, loneliness, and helplessness that plague nursing home residents. It proposed giving every resident a parakeet; putting several cats on each floor; and getting a couple of dogs to help out in physical therapy and occupational therapy, visit the bed-bound, and generally keep things lively. They were also going to put in a large organic vegetable garden, which would supply fresh produce for the home and have small groups of children from the nearby nursery school dropping in to visit with residents.

Of course we had a review panel made up of academics and provider representatives because, after all, we're spending money from a legislative appropriation. Every one of our reviewers dismissed the project out of hand as totally crazy. And the surveyors hated it, foreseeing epidemic psittacosis, hives, cat-scratch fever, FLEAS!!! And (and this was the clincher) it violated the regulations that said that you could only have one pet to a nursing home. Case closed as far as they were concerned.

But the proposal "spoke to me" – the medical director was right. He had put his finger squarely on a problem that was hidden in plain sight. We were upholding a model that robbed nursing home residents of their sense of purpose and their lives of meaning. To make a long story short, we put together a "fears and worries checklist," figured out every terrible thing that could go wrong, and worked with the facility to develop a plan to either avert or deal with the issue. And since I was the bureau director, I gave them a waiver from the applicable regulation to allow multiple pets in the facility. About nine months later I went back. There was a hum of conversation in the dining room; no one was parked by the nurse's station; and according to the medical director, psychoactive medication use had dropped to near zero and the administrator no longer had to order dietary supplements. The place had come alive. The Eden Alternative, a culture change model that is still going strong, had been born.

This story leads me to my first point: **Innovation doesn't look like anything you've ever seen.** Now, I will bet that a good many of us here have guidelines that say we're looking for innovative ideas to do X, Y, or Z. Yet, how many of us have the courage to fund an idea that falls completely outside the box, that breaks the rules, and – hold your breath – for which there is not a shred of evidence? Certainly, it's easy to value something after it works, but the next time you get a proposal that makes you ask "You want to do what?!", remember the Eden Alternative.

My second point has to do with **being willing to try something again, even though "it's never worked."** In 2006 a group of some 20-odd nursing home stakeholder organizations began to plan for a nursing home quality campaign called Advancing Excellence. Funding came from contributions made by each of the stakeholder organizations. After a frenzy of preparation, we were ready to launch the campaign. At the kickoff event we had actual nursing home residents; representatives from the steering committee organizations; Mark McClellan, then administrator at the Centers for Medicare and Medicaid Services (CMS); and various politicians – governors, Hill staff. Most notably, Senator Charles Grassley, a longtime critic of nursing home quality, had agreed to speak and so, we're all there ready to receive his blessing. He gets up, looks around the auditorium and says, "Well, I wish you luck, but in my experience, voluntary campaigns like this never work," and sat down. It was like he'd just sucked all the oxygen out of the room.

We resolved to go ahead anyway, not only to improve nursing home quality, but to prove him wrong. Fast forward to the fall of 2009. In those three years, Advancing Excellence established state nursing home quality coalitions or networks in 48 out of 50 states; recruited almost 7,500

nursing homes; and had two states with 100 percent participation. Even more impressive, the data showed that participating nursing homes were improving more and faster than those not in the campaign – there was an actual "campaign effect." It was working. We had the data to show we were making a difference.

This brings up the question of, when faced with an idea or program that hasn't been successful before, do you fund it? I would argue that there are any number of reasons that projects don't realize their potential, or fail outright, that may have little or nothing to do with how sound the underlying idea or model is.

For example, good ideas may fail because:

- **Badly done** – An inept team or lack of good leadership. Who is doing it is as important as what is being done, so trying it again "under new management" may be a great idea.
- **Insufficient dose** – Not enough of the intervention or not long enough for it to work. We see this in medicine all the time. Right antibiotic but too low a dose or the patient doesn't stay on it long enough. How often do we get in a proposal, arbitrarily cut the budget, and then wonder why the results don't knock our socks off? I say to a grantee, "You need more money to do this project right" at least as many times as I tell them they've asked for too much.
- **Model sounds simple but in the long-term, it doesn't "stick"** – Why? Because, operationally, it's a nightmare. Take for example the Hospital Elder Life Program at Yale. Here was a simple idea: use volunteers to deliver a proven intervention to reduce delirium in hospitalized older patients. But the difficulty of operationalizing this was monumental; you had to convince the volunteer department that this was a good thing, ditto nursing, and so forth. Then recruit, train, schedule, and monitor the volunteers. Keeping the whole thing going required a tremendous expenditure of energy, making it hard to sustain and even harder to spread.
- **Square peg in a round hole (nothing wrong with the model but it wasn't designed to do what folks tried to make it do)** – Nursing home regulation process, for example. It is designed to hold nursing homes accountable and to ensure a minimum level of performance. It is not designed as a quality improvement process, nor is it able to show fine gradations of quality above the minimum threshold. But all the criticism leveled at the regulatory process is because people want it to do something for which it wasn't intended.
- **Good fit but needs to be strengthened** – We funded a project with the Rhode Island Department of Health to use the survey process to focus nursing homes' attention on quality of life and residents' rights. Now to appreciate this project you need to know that nursing homes will pay attention to two things almost to the exclusion of anything else: one is money; the other is the survey, or as we used to say when I directed the survey process in New York, "Nursing homes do what you inspect, not what you expect." But it became clear that the surveyors themselves didn't really "get it"; they weren't "seeing" it even when it was in front of them. If our idea was going to work, the surveyors themselves had to experience an epiphany. We worked with some inspired consultants and knew we had won when a longtime surveyor told us, "It used to be when I went into a nursing home at seven in the morning and saw all the residents up, washed, dressed, in their wheelchairs and lined up outside the dining room waiting for breakfast, I was impressed by how organized and efficient they were." "Now," she said, "I realize that what I was seeing were people deprived of the right to make a choice about when to get up and when to have breakfast. That nursing home had taken away their choice." Had we not taken the time with the surveyors, it wouldn't have worked.
- **The stars aren't aligned** – Timing and context are everything. Senator Grassley had a point. Voluntary campaigns may, in the past, have been largely "feel good" exercises. However, in this instance, circumstances were propitious: CMS was leading the charge, the Quality Improvement Organizations' *Eighth Statement of Work Quality* tasked them to develop state quality coalitions, consumer advocates were willing to come to the table, the stage was set for success. Five years earlier it might not have worked, or if we'd waited until this year it might have been a nonstarter. The window of opportunity was open, and we went through it like a shot.

So, the next time a proposal comes in over the transom that is asking for funding to do something that you *know* won't work "because it never has," think about the Nursing Home Quality Campaign. Don't take past failures, yours or someone else's, at face value. Trying something again, especially if you can figure out why it didn't work, makes good sense.

My third point has to do with the need, on occasion, to **snatch victory from the jaws of defeat**. Think about it. The projects we're funding are very complex. This is not sending a rat through a maze. My grantees are defying the laws of physics by trying to bring structure to a system in Brownian motion. I know that. Things happen. What the grantee promised to do, may become impossible.

A project we did with Mary Naylor springs to mind. Mary wanted to take her Transitions of Care Model to scale in the real world setting of a large managed care organiza-

tion, Aetna. Her evidence-based model includes predischarge in-hospital assessment and discharge plan development followed by in-home visits to evaluate the patient's condition and intervene if problems arise. It is a model that improves outcomes for patients and saves money for payers. Aetna was hot to do it, all the preliminary work was done, and we were about to "go live" when some legal beagle sat up and realized that Aetna's nurse couldn't perform the tasks called for in the model because Aetna didn't have a home care license. Consternation!

The first thing Mary did was call me and tell me what was happening – the project had run headlong into a brick wall. We spent hours over the next few weeks brainstorming, as one potential solution after another went down in flames. Finally, it was arranged that another home health agency would do the visits. This sounds simple, doesn't it? "Oh, just have another home care agency do it." May I remind you that anytime corporate lawyers are involved, nothing is simple. Even so, we were lucky. We had a real champion within Aetna, and we had a principal investigator who was willing to be flexible in terms of insistence on fidelity to her model.

But it illustrates that a big part of grantmaking is being able to be creative and think on your feet when things go wrong. But before that can happen, grantees have to trust you so they feel "safe" leveling with you when things start to go off the rails. I always tell them, "Remember, I don't want the money back." Once I say that then everybody relaxes so that together we can figure out how to end up with something useful, even if it's not what we thought we'd have when we started. This approach is based on The Commonwealth Fund's strong sense of partnership with our grantees. We invest ourselves in their work, and we take pride in their success not solely because of the money we've given, but rather because we believe in what they're trying to do.

Taking a chance on innovation, being willing to revisit old ideas, and finding treasure among the wreckage are important, but let's face it. While they may result in some wonderful projects, they are not a sufficient recipe for a successful *program*. Having a focus and a goal are not enough, you need to also have a strategy, so each grant either prepares the way for change or, itself, moves us incrementally closer to the goal. For example, we have promoted the idea of person-centered care in nursing homes through our support of the culture change movement, yet progress was haphazard until a small grant supported the development of a *definition* by the key stakeholders on what "a culture-changed nursing home" would look like. Another small grant supported the very first efforts to identify measures of culture change. Did those projects, in and of themselves, create change? No, but they set the stage for the next step in the advancement of the field. Without them, things were stuck.

The way I like to think about it is that I'm painting a picture, one dot of color at a time. It is a process of accretion. At first it doesn't look like much, but over time, the picture emerges.

Therefore, I will close with a few recommendations, things I have found were helpful in creating a program likely to have an impact:

- **Stay focused** – Choose an area, define your goal but within that be creative – there are many paths to enlightenment.
- **Be strategic** – Get to know the field in which you're working. Find out what makes it tick and then use that knowledge to chip away at the problem, bit by bit.
- **Take chances** – Certainly with new ideas but also with untried grantees, since one of the most effective things we can do is invest in people. The Eden Alternative has made a lasting impact, but as important as the model is, the opportunity we gave to Dr. Bill Thomas to spread his wings to become one of the really original thinkers in the field of nursing home care is just as important.
- **Tell people what your grantees are doing** – Dissemination and spread are as much your responsibility as they are the grantees. We, as grantmakers, have to be connectors, linking our work with that of others to leverage the funds we spend.
- **Persevere** – It is incredibly hard to resist the siren song of the new and nifty, especially when working on something that's the antithesis of trendy. But there is a need and there are no simple solutions to complex problems; changing an industry requires a long-term investment.

ABOUT MARY JANE KOREN

Mary Jane Koren is assistant vice president of the Quality of Care for Frail Elders Program at The Commonwealth Fund and manages The Commonwealth Fund/Harvard University Minority Fellowship Program in Health Policy. She has committed nearly 30 years of work to improving the quality of institutional long-term care, a focus area that faces considerable challenges and is often overlooked by the broader field of health philanthropy. Dr. Koren's expertise as a clinician and geriatrician and her influence as a grantmaker have cultivated high-impact and sustained initiatives, including the national campaign Advancing Excellence in America's Nursing Homes.