

CPI *Unrestrained* Transcription

Episode 67: Kim Warchol

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Terry: Hello, and welcome to *Unrestrained*, a CPI podcast series. My guest today is Kim Warchol. She is the founder of Dementia Care Specialists, a division of CPI, and the creator of the *Warchol Best-Abilities Care Model*SM. Hello, and welcome, Kim.

Kim: Thank you, Terry.

Terry: Thank you. Today, we're going to talk with Kim about her groundbreaking work creating the *Warchol Best-Abilities Care Model*SM. Building on the work of memory care and person-centered care pioneers like Claudia Allen and Dr. Thomas Kitwood, Kim developed a model of care for those living with Alzheimer's and dementia based on the fact that there are remaining abilities at every stage of the disease and that the most humane and effective care plans utilize and celebrate an individual's best ability to function.

In today's interview, we're going to talk with Kim about how the model was developed, why implementation of the model in memory care facilities is dramatically improving outcomes, talk about how facilities are using it today, and close with how you can bring the *Warchol Best-Abilities Care Model*SM to your memory care or the assisted-living facility right away. [00:01:56] All right, Kim, let's start our interview today with a story about how the *Warchol Best-Abilities Care Model*SM has helped a person living with Alzheimer's and dementia in a real-life scenario.

Kim: Sure. Well, you know, as I kind of go into that story, Terry, I'll just say that, you know, for a long time I've been working in health care, and it was always a dead-end street for me to be thinking about them from the perspective of rehabilitation which is what as an occupational therapist I was taught to do, and it's a lot of the medical approach that we take. And really, rehabilitation is a dead-end street because it's forcing us to think about what they've lost, what they can no longer do, and how do we try to restore that loss.

That's not possible when somebody has Alzheimer's and dementia. That approach does not work. But what does work is what's called habilitation, and that is focusing on those remaining strengths and abilities. [00:02:56] And then it's our job really as care providers to figure out, "How do I adapt the world around them so that they can use the abilities they have at this moment or in this phase of their disease?" So, I think that was a big

epiphany for me, that I had really been using the wrong approach for this very important group of people, people with dementia. And once I've figured that out that it was really a different way of caring, it was very exciting and empowering.

So, along the way, I got an opportunity to use this model, and when you asked for a story, a person by the name of, well, I'll use the name Mary just to use that as a placeholder, comes to mind. And Mary was a victim of the traditional health care system, which is considered the medical model where she had dementia due to Alzheimer's, [00:03:56] she had some other medical conditions, she was moved into an assisted-living community, and they felt that because she had dementia, there was no possible way to rehabilitate her. And she was beginning to lose the will to live, and she was just started on hospice care.

And her daughter called me. I was working at a memory care community in the area that was using my model, and her daughter called me and said, "My mom's living at this other community right now, but she's really not living; she's actually in the process of dying. Can you go and meet her because I don't wanna give up on her. I think there's still life in there."

So, I went out, met her mom, and her mom's name, we'll call her Mary, and I brought my director of nursing with me, and as soon as we met Mary, we did see that little spark in her eye that her daughter was talking about. [00:04:56] It still seemed like it was there. And we asked her daughter to tell us about Mary, you know, everything she could: who is Mary, what did she do for a living, what makes her happy and makes her smile. And her daughter told us she used to be a secretary, and that she'd love to go to the casinos or the boats and gamble.

So, we started introducing ourselves to Mary from that person-centered perspective. We got down at Mary's eye level, Mary was kind of slouched over in a chair just sitting in a corner, and she very much did look like a person who was on the threshold of dying, but we did see that spark in her eye when we started talking about the fact that she used to be a secretary and what that was like.

And this particular facility happened to have a little what they called life station around office supplies and office work. So, [00:05:56] we brought Mary over there and put her in front of the old standard typewriter. And I put her fingers on the keys, and I started depressing the keys, and suddenly, Mary, you know, sat up a little bit straighter, and her eyes opened and she looked interested in what we were engaging her in.

And while I was doing that, my nurse was looking at her medical chart and noticed that Mary had been on a lot of powerful drugs to control her "behaviors." Anyway, long story short, is we saw the same glimmer that her daughter felt was still there, and we thought we could tap into that and awaken her interest, her potential, and really awaken remaining life. So, the daughter entrusted us and we moved Mary to our community, and we wrapped this care model approach around Mary and our wonderful staff got to know

her. And [00:06:56] in a very short amount of time, in weeks, Mary was off of hospice care and doing really, really well. And I'll never forget when I brought her into the rehab gym, into the therapy gym, we wanted to try to get Mary to stand up and walk because she hadn't walked in a long time and she had been very unhealthy. So, my therapy counterparts said, "Well, how are we going to do that? You know, Mary hasn't stood up for a long time." And I said, "Well, we have a life station here, too, and that is the casino. So, let's put Mary in front of that slot machine, and let's make it make noise right in front of Mary and see if Mary wants to get up and pull that one-arm bandit."

So, sure enough, there Mary sat in front of it. We made it make all that noise, and Mary stood up for the first time, and her daughter stood there and almost cried because she had not seen her mom stand up in months. Mary stood up and [00:07:56] that was the beginning of our ability to really do good therapy with her. And we took away all those medications, and we had the ability to reach Mary through those very personal interests that were always important for her, that awakened her potential. And we had the knowledge to keep pushing for more. We understood how to get her to a higher level of function with this type of person-centered approach. And we never gave up on Mary, nor did her daughter, and Mary actually lived several years after that. She was walking, she was talking, she was engaging in meaningful activity. It was something I'll never forget.

Terry: So, that is sort of your first—when you revive somebody so dramatically from a path of death to back to enjoying life through their remaining abilities, it must have been a remarkable feeling to watch that happen before your eyes.

Kim: Yeah. It was, Terry, [00:08:56] and it was dramatic, too, and it was quickly dramatic, and I wonder how many people like Mary are out there just waiting to have their life reawakened with this type of approach.

Terry: So, that gets to my next question about how the *Warchol Best-Abilities Care Model*SM was developed. I read a CPI blog post you authored in which you wrote, "I got tired of writing 'patient not appropriate for occupational therapy because of their severe cognitive limitations.' That hurt my heart."

Now, with Mary, the story about Mary, now, this epiphany that you had, did you realize in that moment that you had a model that you could extrapolate to a whole community of people?

Kim: Yes. Actually, at that point in my journey, I was already using that model and that approach on a whole community of people.

Terry: I see.

Kim: But prior to that, it was sort of my own awakening that, you know, the whole reason I created this model [00:09:56] is that I had done it wrong for so long. You know, I had

focused on whenever somebody has a medical condition, I have to restore it or fix it, and quite frankly, that does not work when a person has a chronic progressive disease like dementia.

So, it was me hearing Claudia Allen for the first time. She was just a, you know, brilliant, passionate pioneer in the occupational therapy world, who started changing my frame of reference. When somebody has a disability like that, you just have to discover what they're capable of in this moment, in that phase of their disease process, and then make the most of those capabilities in that moment. And that's really what I learned a few years into my therapy career that I then started putting into this *Warchol Best-Abilities Care Model*SM system.

Terry: I see. So, there was a cumulative [00:10:56] experience as a clinician where you realized that because this was hurting your heart and you could see that the care that was prescribed for the patient was ultimately going to be ineffective, was that sort of the stimulus that made you rethink the paradigm?

Kim: Yeah, very much so. And I think another rethinking of the paradigm, it's not just, you know, shifting our focus from what a person can't do to what they can do, that's part of it. But the other part of the paradigm shift is moving out of that medical model to that social or person-centered model, and that's the other really key piece of all of this is anything we ever do with an individual in care should always first and foremost be built around who that person is. We should never prioritize their medical conditions at the expense of making sure we understand who that person has been, [00:11:56] who they still are, and what their goals are. And that was the other real, I think, shift, and that's a huge part of the *Warchol Best-Abilities Care Model*SM. I guess I never realized how important that was in the beginning, and I came to learn that through my years as clinician.

Terry: You've written, and I think we spoke of this, but I'd like to expand on it a little bit, that the objective of the *Warchol Best-Abilities Care Model*SM is to "improve the quality of life, level of functional independence, safety and health of those we serve." So, why is a paradigm shift in thought necessary to make people realize that people living with Alzheimer's and dementia don't have to suffer as Mary did, that they can actually thrive, and speak also if you would to the paradigm shift that the *Warchol Best-Abilities Care Model*SM replaces?

Kim: Okay. So, Terry, I'm going to take that if we can, I'll probably going to—it was a long question but . . .

Terry: I'm sorry.

Kim: But, no, that's okay. I'm going to start with the first [00:12:56] part and then maybe refresh me on that. Excuse me, I'm going to start with the second part and then refresh me on the first part.

Terry: Yeah.

Kim: So, what it really replaces is the medical model, so that's one thing is that every person in care is a diagnosis first and we need to do everything with medications, our medical treatment, that's the first priority. It's not the first priority. The *Warchol Best-Abilities Care Model*SM helps people to see first and foremost that this is a person, so this is a person-centered care approach that includes medical care, but we are never diminishing the person in care to a diagnosis or a task. So, I think that that's really key.

And then the other thing that you can say it sort of replaces is we use habilitation, and that replaces rehabilitation. [00:13:56] Habilitation is discovering what that person can still do, their remaining abilities, and their strengths, and compensating for what they can't do, capitalizing on the strengths, whereas rehabilitation is let me figure out what's broken, what they can no longer do, and restore the person or those deficits back to normal. That's not possible when somebody has dementia.

Terry: I see. And so, that would fit in very well with the objective as stated in the *Warchol Best-Abilities Care Model*SM, which is what that long question led with, which was your quote, "That the model is meant to improve the quality of life, the level of functional independence, safety and health of those we serve," and I think that really speaks to that person-centered habilitation that you just referred to.

Kim: Yes. So, exactly. So, those are the ultimate goals. And those goals matter a lot, not just to the person in care, you know, but also to the [00:14:56] communities that are serving them because there are all these, you know, these benchmarks, these quality benchmarks that our long-term care communities need to be reporting on in order to get reimbursement. And also, it matters a lot to families. You know, if they see their loved one has moved in to a senior living community and there's actually a reinvigorated life that's occurring as a result of that move instead of, you know, this person is moving in and sitting in a corner, sleeping in front of a TV, that's going to have a lot of value to that loved one who's made that decision to transition their family member to a senior living community.

But, you know, if we just think about it for a minute, like why person-centered care is so important especially when we apply person-centered care to people with dementia. You know, one thing everybody knows about the dementia medical condition [00:15:56] is that a strength is a person's long-term memory whereas their deficit or their weakness is short-term memory, what they did, you know, a minute ago, an hour ago, they might struggle on, but who they always have been, what they did for a living, and their past routines and preferences is their cognitive strength. Well, that marries perfectly, or that matches perfectly with person-centered care.

So, if we get to know who that person is, what they did for a living, what time they like to get up and go to bed, you know, how their daily routine went, what activities they really enjoyed, that's tapping into their strength, their long-term memory, and that's how we

awaken all of their potential, cognitive potential, physical potential, their attention, so we awaken that so that they do function better, they're more independent. [00:16:56] They do engage in meaningful activities at their best ability so they have quality of life. That's how that trickle effect happens.

Terry: I see. Well, Kim, you've kind of anticipated my next question which is about how the model works in practice. And there is what appears to be a critical part of implementation of a care plan based on the *Warchol Best-Abilities Care Model*SM begins with something called the life story questionnaire as developed by Dementia Care Specialists, which you founded. Why is this kind of patient assessment such a critical part of developing a treatment plan for an individual living with Alzheimer's and dementia? I think you just kind of gave us a little hint at that, but if you could expand on it, that would be great.

Kim: Sure. So, the life story questionnaire, the one that we've developed is pretty extensive. That includes more sections than a general or a generic one does, and we believe that's important. So, ours is actually 12 pages long. [00:17:56] But, you know, there is nobody that's going to debate us on the importance or the critical nature of person-centered care. It is truly at the core of quality care. So, that means we have to go that extra mile to really get this kind of extensive information about every person in care, not just, you know, high-level stuff.

So, we build our care plans in our model, in our *Warchol Best-Abilities Care Model*SM, the information that we're gathering about the resident helps to build an individualized care plan. It also helps us to make decisions that are considered group decisions or facility decisions like what should this activity calendar look like, making sure it's representing the interest of this resident group, what should be on my dining menu, what time should the meals occur, what should my staffing decisions [00:18:56] be, all of that is going to be built around the resident's routines, preferences, interest, and their level of care, or level of independence.

So, when you think about what our goals are, these are some of the questions that are embedded in our life story questionnaire, are you an introvert or an extrovert, are you comfortable in large groups? We're asking that question and then that gets put in to our software solution so that we understand who's going to come to that group activity that I have on the calendar, and who do I need more of a one-to-one program for. We're going to ask what are your favorite activities, and I wanna really expand on that term activity because activity can be a leisure activity or could be more of a normalization activity like helping to set the table, or helping to fold laundry. Those are valued activities as well.

So, we have a long list [00:19:56] of various types of activities that we want to learn about each and every resident, so that makes it into the decisions that we're making on our group activity calendar choices and our one-to-one program. We also ask what has typically made this individual happy, what has typically made them anxious or scared, there's a whole emotional profile, because we don't want to tap into anything that, in the

past, might have triggered, you know, an anxious response. You know, we all have them, like I'm claustrophobic. So, if you put me in a very small space, you might trigger my anxiety, and it might be bad for me and bad for my care partner.

So, let's really get to know that individual person's emotional profile so that we avoid it, you know, avoid the triggers when we are providing care. We're going to ask what kinds of foods and drinks the person [00:20:56] highly prefers or dislikes so that doesn't make it on our menus, or it doesn't make it into the cupboard in the neighborhood kitchen for our snack, and we're going to also make sure that we know their preferred wake-up and go-to-bed time because other than food, Terry, there's probably nothing much more personal to each and every one of us than our own circadian rhythms and making sure that we try to honor that.

Terry: I see.

Kim: We're not inviting them up at 5:00 in the morning if they like to sleep in.

Terry: You know, I have to say, in my own experience, my best friend's father passed of Alzheimer's in 2015, and he was staying at a fairly expensive and exclusive "memory care" facility—of course, I won't name it—but the process that they applied to him was almost exactly the opposite. They expected him to adhere to what their calendar was, what their schedule was. They didn't ask him basic things like whether [00:21:56] he preferred a bath or a shower; he strongly preferred a shower. So, I mean, these basic things were not happening there. And so, to hear you describe this process, it almost seems like certainly a revelation compared to what I've seen in my own life. How does a facility come to implement such a—from my own limited experience, such a radical shift and approach?

Kim: How do they come to that point?

Terry: Well, I mean, I'm trying to get after what I mean here just based on my own experience with seeing in practice the way a very expensive facility did exactly almost the opposite of what you described. So, maybe we can—well, I don't know if we'll keep this in, but I'm just kind of wondering in my own mind about how, say this facility, how you would introduce that and say, "Well, there's not going to be, you know, centralized bathing, or a standardized menu. We're going to personalize [00:22:56] all of this." How does a facility begin to change their paradigm?

Kim: Yeah. Good question, Terry. I guess I will answer it this way. First of all, it's so much easier to do what we've always been doing for the last 10 to 50 years, which is this very rigid, structured warehouse approach that doesn't evolve, it's not flexible, and it's just done conveniently for us as providers. So, to ask a community or a facility to really provide person-centered care is asking them to take this more fluid approach. They have to have that commitment to customization around all of that resident information.

And I think that there are some communities out there, that this is just truly in their heart and soul. [00:23:56] You know, they have leadership who, like you, like me, understand that not committing identity theft on every resident that moves in for our own convenience, you know . . . [laughter]

Terry: Nicely done.

Kim: Yeah, that they don't want to do that, that they know the quality of life truly is derived from remaining this individual, we've always been. So, they're just going to do it. But that's a small fraction, and you'll find some of those people in the Pioneer Network or you'll find some of those organizations in the Eden Registry because they are the trailblazers. But to get the mass, you know, quantity of senior living communities moving to this new paradigm is difficult, to be honest with you. And I think that maybe what's starting to move the needle a little to have more communities want [00:24:56] to do it this way is that it's more competitive now.

So, you know, anyone can say they provide person-centered individualized care, anybody can say they have specialized memory care, and they do. If you'd look at websites, it's sort of the same kind of language on every senior living community. But we have savvy shoppers, the middle-aged daughters, the typical shopper, they're feeling a lot of emotional guilt and stress about moving their mom from her beloved home in senior living. They don't want to just read about it on the website or in the brochure, they want to walk in and see life. And if they don't, they're going to keep on walking to the next community that isn't too far away, and vacancies exist in these communities and families have choice.

So, I think that some communities are feeling the pressure on the census side of it, and they realize that they have to do it different [00:25:56] to be able to attract and then maintain the resident.

Terry: So, the market reality is that because the baby boomers that are having to put their parents in places they'd rather not put them are becoming much more savvy about the kind of care that they're going to get.

Kim: Yes. And regulations also are starting to require person-centered care. So, our nursing homes are, you know, going through a huge transformation right now in the regulatory areas, and it's requiring person-centered care everywhere. So, that will also help to move the needle to some extent.

Terry: I see. Well, Kim, we talked about family members, what are some of the ways that the *Warchol Best-Abilities Care Model*SM helps family members of those living with Alzheimer's and dementia?

Kim: I guess it helps two ways, Terry, and one of the ways is what we were just talking about is that it's a very tough decision [00:26:56] for them to move their loved one from home into a long-term care community or senior living community. So, it helps them to feel really good about that decision when they see that their loved one has, you know, had life put back into them as a result of the move and they're actually doing better. I had one family member say to me, "I can be a daughter again and not worry about my mom after I moved her into a community using your model. I can come and visit with her. sometimes she doesn't even have time for me because she's busy playing her banjo for everybody in the social room."

Terry: [laughs] That's tremendous.

Kim: Yeah. So, I think it helps them in that way to feel as if something's been added to their loved one's life instead of taken away. But I think it also teaches them. I mean, ideally, we're going to be collaborating with the family member and helping to give them some inside knowledge [00:27:56] as to how to adjust their expectations, how to adjust their own approach and communication, so that when they're visiting with their loved one, it's a meaningful visit, and they can regain their valued relationship, and they don't have to think of this diagnosis of dementia or this move to senior living as sad and suffering. They can actually let go of the guilt because they see their loved one thriving.

Terry: You know, as a statement, "I can be a daughter again," I mean, that's dramatic. And it really speaks to how, you know, this person-centered care gives the family their identity back as well.

Kim: Very much so. Good way to say that.

Terry: Yeah. So, how does this *Warchol Best-Abilities Care Model*SM, how does it benefit the staff at these facilities?

Kim: If we think about staff, nurses, therapists, nursing aides, activities, everybody chooses to go to work with seniors and in these communities [00:28:56] because we wanted to make a difference. We want to do something with our 40 or 50 hours a week that we felt was having an impact. And it doesn't matter what professional level someone's at, that's in the heart and soul of almost everybody I meet who works in long-term care senior living.

Terry: That's encouraging.

Kim: Yes. And, you know, so I think that this helps them because it gives them knowledge and skills, how do I work with a person who may have dementia and I have to learn how I communicate differently, how I approach them and support them differently. So, it gives some really good knowledge and skills, but also what this memory care program does is it assures that the facility systems are set up so that that staff member can put their knowledge to work whether they're providing ADL care, or they're assisting in the dining

room, or they're working in activities, [00:29:56] or they're a nurse. They're going to say, "Hey, I've learned some really cool things, and my community or my employer is supporting me with this *Warchol Best-Abilities Care Model*SM system."

So, it's really a win, win, win. It makes sure that that staff person is successful when they're providing care, and that helps them to feel like they're making a difference, and that helps with their job satisfaction. It also helps them to be more successful, so they get less resident resistance, or less struggle, or agitation from the person in their care. And, you know, that's a good thing because that keeps everybody safe. Nobody wants to go to work and feel like they're at risk for being injured.

You know, I don't know if you know this, Terry, but one study that I read recently showed that 70%, I think it was 70%, or approximately 70% of nurses who worked in long-term care in Minnesota said they actually expect to be assaulted [00:30:56] by a person in care when they go to work every day in long-term care. I mean, that's staggering. So, this approach helps to improve safety, it helps improve job satisfaction, really is a win, win, win.

Terry: Right. So, Kim, say a facility commits to the *Warchol Best-Abilities Care Model*SM. How do you implement it? How do you begin to do that? How do you begin to turn that—you know, that whole org, I imagine, has to kind of shift its thinking. I mean, is it that dramatic, or why don't I let you tell the story?

Kim: Yeah. So, I think it always begins with us sitting down with the owners, the highest-level leaders, and saying, "Really, what are your goals? What are you trying to accomplish as your own personal mission, or your business objectives?" And we really want to hear that because it's important [00:31:56] that we set objectives and set our vision because we want to revisit that throughout the project. And, you know, everybody, every leadership team, or ownership team has different priorities. So, we'd really want to make sure that we're hearing that from them.

Then we begin the training process. So, we make sure that their workforce has dementia-capable care and dementia-capable care behavior training because that workforce needs to feel like when they go to work every day, they know how to provide care that capitalizes on the strength of each person in care, that is capitalizing on their wants and their needs. We need that workforce to be prepared.

Then we introduce the care system itself. So, these are the various assessments that we've developed. We have a very extensive package of person-centered care assessments, one of them is the Life Story Assessment, [00:32:56] another one is an interest survey and a dining survey. So, we're going to introduce that into their typical process and systems where maybe it didn't exist before. We're going to help them understand when those assessment should be done and who should do them on the team. We also have cognitive level assessments. So, remember, we want to learn, and now we know who these people

are, and what your resident group likes, and when they like to get up and go to bed, but now we need to understand how do we support them if they have dementia, so what stage of dementia are they at, and let's make sure we're providing staff adequate time because the more advance the dementia stage, the more time staff is going to need to provide that ADL care.

So, basically, we're bringing forth the cognitive or the dementia staging assessments, we're bringing forth the life story and the person-centered [00:33:56] assessments, and we're helping them to figure out how that valuable resident information gets fed through the entire care system. So, we actually help that information drive activity programming, ADL and staffing decisions, behavior programming, and then we end everything by giving them a quality assurance and a quality improvement program, and that's where we go all the way back up to the initial goals that the owners and the community leaders had.

So, once we get this new system, and these tools, and structure in place, and their staff trained, and we help them, you know, start leading these programs, we want to see those benchmarks that we said were important to us in the very beginning. We want to see them start changing. And if they're not changing or improving, then we need to figure out [00:34:56] where is the weakness and fix it. So, that whole process of us training the staff, bringing in the new system and training the staff to deliver the system, that can actually be 12 to 15 months of us highly engaged at the community itself.

Terry: And with the check and balance in the backend to make sure that you have, that a change has occurred and you have delivered what the plan was to deliver to the facility. It sounds like a facility would need to commit, you know, some significant resources to implement the *Warchol Best-Abilities Care Model*SM. What about facilities that might be on a bit of a tighter budget, can they still implement?

Kim: Yeah. Good question. So, we realized that not every community is going to need a full program. So, when I say the full program, Terry, what I'm saying is all of those assessments, and they may not also need activities program, [00:35:56] ADL program, and behavior program, you know, but they might not need all that. So, some communities say, "I've already got a program, or I have a lesser budget, so what can you do for me to help me improve what I have today?"

So, we've developed what are called workshops. So, instead of us going out for several months at your community and really guide and handhold through every step of this program process, we'll just bring your leaders together for short amounts of time to deliver these workshops. And each workshop is anywhere between one and a half and three days long. They still get some of these basic tools that we've been talking about today, but we're really just training the leaders in a short workshop how to use these tools, and then they are responsible for going back to their workplace, [00:36:56] and implementing it, and integrating it into their process and, excuse me, training their own staff. So, that's a less expensive way to still tap into some key aspects of this full program.

Terry: So, there's a flexibility. In other words, you can give somebody a road map of how to get there without having to make this significant commitment of resources to a 12- to 15-month program. I think that's encouraging for maybe smaller facilities that want to deliver person-centered care, but might need some expertise about how to get it done.

Kim: Yeah. And, you know, Terry, it's like part of the decision for a customer might be budget. You know, that is the facts, right? But another part of the decision is, you know, where are they today? Are they starting something brand new? Do they need a restart because the program they have today isn't really [00:37:56] getting good outcomes? In that case, they might want the full *Warchol Best-Abilities Care Model*SM and really need it.

Other customers say, "I've already got a program," a person-centered care program, or a memory care program, or both. "I already have it. I'm just needing a little bit of assistance or improvement in a specific area. I have a problem to solve. I have a gap to fill." In that case, the workshops could be a perfect choice.

Terry: I see. And can the model actually help drive down cost for a facility?

Kim: Yeah. You know, when I think about that, Terry, I would say yes it can. And I'll give you a couple of examples. We can drive down cost with things like less incontinence products, less supplements because people are eating better, because we've customized the menu more to their preferences. So, there can be some cost reductions due to improving independence or, you know, improving eating. But, really, I think the program [00:38:56] shows its value more in the fact that we're driving up the quality of care.

Terry: I see.

Kim: And when we have improved quality and recognizable value there, we can monetize that in a variety of ways. So, like we talked about a few minutes ago, you know, if we're trying to make sure that we have a full resident census and we know there's a lot of competition in the area, when a loved one is shopping for the community for their mom, or dad, or spouse, we want to make sure that we capture that prospect by showing how we differentiate, and how we bring life back to their loved ones, so that, you know, we don't have empty beds, we have full communities, and that's going to help with the return on investment in something like this.

Terry: That makes sense. And that leads into my closing question today. We read often about the impending, what's been termed the "silver tsunami," [00:39:56] and that is the incredible increase in the number of the population who will require memory care in the next several years as the baby boomers age out. Do you think there's a sense of urgency out there in the communities about this? And if not, how do we help our communities become more proactive and aware to prepare for the needs that are going to be there in such dramatic numbers?

Kim: I think there is some sense of urgency especially if you look at our nursing homes. They're feeling a sense of urgency and the importance of providing person-centered care and memory care because of two reasons. One, they're seeing a ton more people with memory care needs than they ever have. Again, that's just a fact. And the other thing is there's been a significant shift in the regulations, and the regulations are requiring person-centered care. And they're also requiring that staff are well-trained in dementia [00:40:56] and that training is very evident when they walk into the communities.

So, I think that the bar has been raised by the regulatory organizations, you know, by Medicare itself that is requiring nursing homes to act. Also, nursing homes are really being asked to use far less psychotropic drugs to control distress behaviors like agitation and anxiety. So, they have to find a way to use less drugs by providing better care, and a program like this is going to help get that kind of result.

When we look at assisted living as an example, I think the urgency comes from, yeah, we have a lot of people here with dementia, and we don't want to lose them. We want to keep them higher functioning. We want their families to choose us and to be really satisfied. So, we have to prove that we're providing person-centered care because that's the way we're going to keep that family satisfied, and that's the way we're going to keep their loved one happy. [00:41:56]

So, I think the sense of urgency is rising across the entire senior living long-term care spectrum. But I did want to just mention that the latest Alzheimer's facts and figures have been recently released from the Alzheimer's association. And no surprise here, we're still saying that there's a lot of people today age 65 and older who have dementia, 1 in 10 people age 65 and older have dementia. However, what we're seeing, and this is hot off the presses, is that 32% of people age 85 or older have dementia. That's 1 in 3. And what we know about senior living right now is people are moving in later. They're staying at home longer, they're moving in at older age, and that's why we're seeing so much more need for memory care in these communities.

So, that's what the statistics inform us, the longer we live, the [00:42:56] dramatically increasing rate of dementia, and people are staying at home longer, so when they're moving in senior living, most of them are going to have dementia and need a program like this.

Terry: Fascinating. Well, thank you so much, Kim. I enjoyed our interview. My guest today has been Kim Warchol. She is the founder of Dementia Care Specialists, a division of CPI, and the creator of the *Warchol Best-Abilities Care Model*SM. Thank you, Kim.

Kim: Thank you, Terry.

Terry: And thank you for listening.