

CONVERSATIONS



HOW STRATEGIC DESIGN CHOICES

Can Address the Impact of Aging While Meeting the Needs of All
Generations

An Interview on the Impact of Aging with Maggie Calkins, PhD

INSIDE YOU WILL LEARN ABOUT:

Why the needs of older people are often overlooked.

How universal design can support people as they age.

How universal design also benefits people of varying abilities and generations.

The need for designers to think about functionality in new and existing spaces.

The Impact of Aging toolbox is made available through a partnership with

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Maggie Calkins, PhD

Margaret Calkins, PhD, is the President of IDEAS Consulting, Inc., Board Chair of the IDEAS Institute of Environmental Design, and Elliott Professor for Healthcare Design in the College of Architecture and Environmental Design at Kent State University. Her focus is on exploring the therapeutic potential of the environment, particularly for frail or impaired older adults. She wrote the first comprehensive design guide for special care units, *Design for Dementia: Planning Environments for the Elderly and the Confused*. She also recently developed a four-volume book set, *Creating Successful Dementia Care Settings*, and co-authored *Environment & Communication Assessment Toolkit for Dementia Care*.

How Strategic Design Choices Can Address the Impact of Aging While Meeting the Needs of All Generations

How did you become interested in the concept of supporting the needs of older adults through the design and function of physical space in healthcare and residential settings?

I earned my undergraduate degree in psychology in the 1980s, and I wanted to continue on in environmental psychology. My oldest brother, who is an architect, convinced me that in order to help architects design better buildings, I needed to understand the design process. This prompted me to earn my master's degree in architecture at the University of Wisconsin–Milwaukee. While in graduate school, my class did a project to provide some design options to a local nursing home that had been given \$40,000 by the county. We put together three sets of recommendations on what to do with the money. One of them included an ambitious plan that showed how, with a considerably bigger investment, the facility could open up a new room in the middle of the unit to create a new nursing station and two separate activity rooms just for the residents who were living with dementia. We presented the options to the county board, and they actually liked the ambitious plan so much that they ended up approving \$400,000 (instead of \$40,000) to turn it into a reality.

This project really sparked my interest in deepening our understanding of what makes healthcare facilities and senior residential settings function effectively for quality of life and the patient/resident experience. I also learned that older people are a group of individuals who are challenged in so many different ways, and I saw where the design of the built environment could have such an impact—either positive or negative—on their ability to function and their quality of life. Therefore, I applied for and received an American Institute of Architects/American Hospital Association (AIA/AHA) graduate fellowship in health facilities design for my third year of school, and I focused on creating a design guide for people with dementia called *Design for Dementia*. This was the first book published in this area, and since then, many other resources have continued to build on the information it contains.



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We know that elders have a higher proportion of inpatient stays than younger people, and use a large share of outpatient services—and still, this population often seems to be overlooked. What’s your perspective on this oversight?

I think one of the issues is that much of the medical profession views death as a failure. With older adults, the reality is that you get to the end of your life and you die. When medicine was making such huge strides back in the '60s, '70s, '80s, and '90s, the focus was on treatment and cures that save lives. While older adults benefit from a lot of those treatments and can live longer, there are many times when an older person has chronic conditions that don't respond to a critical intervention and, instead, requires chronic care management. This makes older people and their conditions much less exciting to the medical field.

In addition, funding and insurance are different for people in a nursing home than in an acute care hospital. By putting it into a separate class, it's easier to separate care for older people. Further, medicine has become so specialized, with doctors looking at only one area (such as a specific part of the heart or knee), that they aren't looking at the entire person.

What do you recommend to overcome these issues and create an environment that supports older people’s needs?

Designers can look to universal design, which is an approach to creating environments that can be used easily by people with a broad range of abilities or disabilities. For instance, most houses have a few steps to get in the front door. Steps can be hard to navigate—not only for an older person, but also for someone who is in a wheelchair, who has a broken leg or sprained ankle, or who has a child in a stroller. Designing a front door without steps does not make it more difficult for anyone—but it *does* make it easier for a lot of different situations.

The same principle can apply in hospital design. Think of how you can design the space to be more accessible for people of all ages who have physical challenges and mobility aids.

What are some of the challenges right now in creating more supportive designs?



One problem is that hospitals are only required to have between 5% and 10% of bathrooms meet the Americans with Disabilities Act (ADA) accessibility codes. If the accessibility codes are designed for people with some impairment to make spaces accessible for them, and you understand that in a hospital most people have some impairment, why require only 10% of the bathrooms in the hospital to be handicapped-accessible?

Further, the way the accessibility codes are written, they are supposed to enable people to be as independent as possible without any assistance. Yet the codes don't apply to everyone's needs appropriately. I am now working with a colleague to try to get new codes passed that will allow the center line of the toilet to be 24 inches (the current code is 18 inches) from the wall, with fold-down grab bars to allow space for two caregivers to assist as needed. If you don't need grab bars, you can flip them up out of the way. This gives you the greatest flexibility to meet the needs of all different populations.

How does the increased focus on patient-centered care play into the equation of treating older people in the healthcare space?

Patient-centered care (also called person-centered care) takes a more holistic perspective of people. It goes beyond specific outcomes to also consider communication, the quality of interactions with staff, and how supportive the environment is. For instance, depending on the reason for an inpatient stay, the family may want to stay with the patient. Does the space easily accommodate someone spending time in the room, other than having them in an uncomfortable chair?

The principles of patient- or person-centered care are also increasingly being codified in measurements of the patient experience, such as the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS). I think it was an amazing step forward for the Centers for Medicare and Medicaid Services (CMS) to say, "We are going to base hospital reimbursements on the HCAHPS scores." When CMS started saying, "This is really important, and we are going to base your reimbursement on it," hospitals began to pay attention. That was a critical step in making the patient experience more holistic in the eyes of healthcare providers and making it as much of a focus as the quality of treatment in medical care.



Because communication is so important to all aspects of healthcare, I would encourage designers to do research to see what it will take for the environment to support effective communication.

What are some of the challenges that need to be overcome? And where can designers access resources to help them with such a tall order?

People today don't want to get old. Aging isn't valued in this country. Therefore, it takes a strong organization to come out and say that 75% of emergency department (ED) visits are by people who are 60 years or older—so we are going to create a senior-friendly ED, or split our existing ED into two areas: one for younger people, and one that is senior-focused.

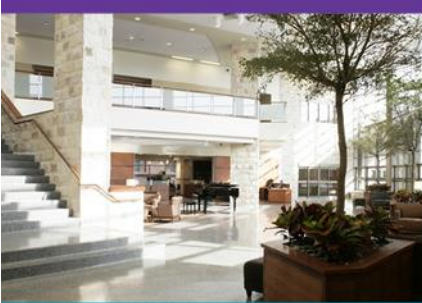
Keep in mind that features that support older adults in the healthcare setting are probably also good for people of all ages. In fact, there are very few things I would include in a senior environment that I wouldn't include in an ED for all people. Less noise, less stimuli, separate bays with doors—all of these things would be good for everyone, but it takes a strong commitment to the community to be willing to come out and say, "We are doing this to be elder-friendly."

For designers and healthcare organizations that want to learn more creative, supportive designs, there are lots of organizations with good resources on improving the patient experience, such as the Institute for Patient- and Family-Centered Care, The Beryl Institute, The Center for Health Design, and Planetree, Inc.

What would you like to say to designers to help them create the strongest and most functional designs?

There are actually two important points to keep in mind. First, I think one of the top priorities should be to think about how the environment impacts effective communication. That has to do with noise transmission between spaces and the absorption of noise—not just the decibel, but the megahertz (the frequency at which building products either absorb or bounce back noises). Because communication is so important to all aspects of healthcare, I would encourage designers to do research to see what it will take for the environment to support effective communication.

Second, designers should work with the assumption that every room is going to serve people who have physical disabilities, whether they use a walker or a cane, are in a wheelchair, and/or have an IV pole. And they should also assume that



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the facility is going to serve people of all sizes. That's why some hospitals are making bariatric wheelchairs the norm, since they can fit everyone. This meets the universal design principles. From a design standpoint, having larger wheelchairs requires allocating more space for them to fit through doorways and around corners. While I know that every square foot is expensive, designers really need to think not just about designing to ADA but, rather, on how to be much more realistic about how people are able to navigate through the spaces you create.