

Person-Centered Care For Nursing Home Residents: The Culture-Change Movement

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ABSTRACT The “culture change” movement represents a fundamental shift in thinking about nursing homes. Facilities are viewed not as health care institutions, but as person-centered homes offering long-term care services. Culture-change principles and practices have been shaped by shared concerns among consumers, policy makers, and providers regarding the value and quality of care offered in traditional nursing homes. They have shown promise in improving quality of life as well as quality of care, while alleviating such problems as high staff turnover. Policy makers can encourage culture change and capitalize on its transformational power through regulation, reimbursement, public reporting, and other mechanisms.

Mary Jane Koren (mjk@cmwf.org) is assistant vice president, Frail Elders Program, at the Commonwealth Fund in New York City.

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. The movement encompasses almost three decades of consumer advocacy coupled with legal, legislative, and policy work aimed at improving both the quality of care and the quality of life in nursing homes.

Culture-Change Movement Begins

In the early 1980s, work by the National Citizens' Coalition for Nursing Home Reform, a consumer advocacy group concerned about substandard care in nursing homes, emphasized residents' rights and the importance of resident assessment. Its Consumer Statement of Principles for the Nursing Home Regulatory System,¹ released in 1983, was endorsed by more than sixty national organizations, presented to the U.S. Department of Health and Human Services, and distributed to all congressional offices.

Later, with support from the Robert Wood Johnson Foundation, the Health Care Financing Administration (HCFA, now the Centers for

Medicare and Medicaid Services, or CMS), and the American Association of Retired Persons (now AARP), the coalition conducted focus groups to learn how nursing home residents themselves defined *quality*. In 1985 it published *A Consumer Perspective on Quality Care: The Resident's Point of View*,² which became an important reference for the Institute of Medicine (IOM) committee on nursing home regulation. That same year, at a coalition symposium funded by HCFA, residents told federal officials that “quality of care” (which encompasses such considerations as the medical treatments a resident receives, and physical care routines including assistance with bathing, using the toilet, and eating) and “quality of life” (how one is treated—for instance, having one's privacy respected by others' knocking before entering a bathroom, or having one's dignity maintained by not being wheeled down a hallway scantily covered en route to the shower) are inseparably linked and, from the resident's perspective, equally important. This principle figured prominently in subsequent legislation and regulations.

In 1986 the Institute of Medicine published *Improving the Quality of Care in Nursing Homes*, which recommended changes in regulatory pol-

icies and procedures necessary to ensure that nursing home residents, a term that first appeared in this report, received satisfactory care. It also “emphasized the *home* part of the description more than the *nursing*”³ aspect of nursing home. A year after the IOM study was published, a sweeping set of nursing home reforms, known as the Nursing Home Reform Act, was incorporated into the Omnibus Budget Reconciliation Act (OBRA) of 1987. The newly enacted law required that each nursing home resident “be provided with services sufficient to attain and maintain his or her highest practicable physical, mental, and psychosocial well-being.” The law made nursing homes the only sector of the entire health care industry to have an explicit statutory requirement for providing what is now called “person-centered care.”

In mandating this individualized, person-centered care, these reforms helped spark the emergence of a grassroots movement. In the decade following the passage of OBRA 1987, several providers in Washington, Wisconsin, California, New York, and Minnesota began to break away from the prevailing nursing home model. They created smaller “households” out of large units, sought input from residents about routines and schedules, and tried to overcome the endemic boredom and learned helplessness that was common in nursing homes. In 1997 these leaders, along with consumer advocates, researchers, and regulators, met to articulate the common principles embodied in their separate models and to found an organization called the Pioneer Network. The network partners with the CMS to explore ways to overcome regulatory barriers to culture change⁴ and to provide information to congressional staff on the importance of supporting innovation in long-term care.

The Pioneer Network eventually took the lead in fostering the culture-change movement within nursing homes. Today the movement’s overarching goals are to individualize care for residents, making facilities more homelike and less “institutional.” It promotes person-centered care through reorientation of the facility’s culture—its values, attitudes, and norms—along with its supporting core systems (such as breaking down departmental hierarchies, creating flexible job descriptions, and giving front-line workers more control over work environments). It strives to honor residents’ individual rights, offering them quality of life and quality of care in equal measure. Culture change also recognizes the importance of all staff members’ contributions to the pursuit of excellence.

The culture-change movement espouses a set of principles,⁵ instead of offering a prescriptive set of practices or dictating conformance to a

model. These principles encompass not only resident care practices, such as elimination of physical restraints, but also organizational and human resource practices and design of the physical environment. At the facility level, culture change is often described as a journey, with facilities progressing through different stages of change.⁶ They typically move further or more quickly in one area than in another—such as the use of self-managed work teams and environmental modifications. As with continuous quality improvement, there is always room to do more, and to do it better.

Early in the culture-change movement, there was a lack of agreement as to precisely how all of these changes would manifest themselves in a nursing home transformed by culture change. A gathering of stakeholders⁷—including consumer advocates, CMS representatives, and large trade associations—reached consensus that the “ideal” facility⁸ would feature the following.

RESIDENT DIRECTION Care and all resident-related activities should be directed as much as possible by the resident. For example, residents would be offered choices and encouraged to make their own decisions about things personally affecting them, such as what to wear or when to go to bed.

HOMELIKE ATMOSPHERE Practices and structures should be designed to be less institutional and more homelike. Small “households” of ten to fifteen residents would be the organizational unit. Meals would be prepared on the units, and residents would have access to refrigerators for snacks. Such institutional features as overhead public address systems would be eliminated.

CLOSE RELATIONSHIPS Relationships between residents, family members, staff, and the community should be close. 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.

STAFF EMPOWERMENT Work should be organized to support and empower all staff to respond to residents’ needs and desires. For example, teamwork would be encouraged, and additional staff training provided to enhance efficiency and effectiveness.

COLLABORATIVE DECISION MAKING Management should enable collaborative and decentralized decision making. Flattening of the typical nursing home hierarchy and participatory management systems would be encouraged. Aides would be given decision-making authority. These strategies appear to have positive effects on staff turnover and performance.⁹

QUALITY-IMPROVEMENT PROCESSES Systematic

processes would be established for continuous quality improvements that would be comprehensive and measurement-based. Culture change would be recognized as far more than offering amenities or making superficial changes. Rather, it would be treated as an ongoing process affecting overall performance and leading to specific, measurable outcomes.

Awareness Of Culture Change Grows

Awareness of the culture-change movement grew slowly at first. As late as 2005, a Commonwealth Fund survey of health care opinion leaders showed that 73 percent of respondents were unfamiliar with culture change.¹⁰ But in 2008, when the survey was repeated, only about 34 percent reported unfamiliarity with the movement.¹¹ Providers in particular became very aware of culture change, in part because of the CMS's "Eighth Scope of Work" contract with the nation's quality improvement organizations. That contract specifically used the term "culture change" and required that quality improvement organizations work with nursing homes in each state "to collect information on resident and staff experience/satisfaction with care and staff turnover by engaging in activity that is likely to improve organizational culture."¹² These acts of recognition and promotion have given the movement considerable legitimacy and made it virtually impossible for providers to ignore.

STATE INITIATIVES State initiatives have also helped encourage the adoption of culture change. Efforts to "rebalance" the mix of long-term care services and supports offered in institutional and community settings, coupled with Medicaid coverage for assisted living, are giving consumers alternatives to nursing homes—thereby forcing traditional nursing homes to reassess what they must offer to stay competitive.

RESEARCH DEMONSTRATES RESULTS Research has now begun to demonstrate results—specifically, that the application of culture-change principles and practices can make life better for residents and improve working conditions for staff. Relatively simple interventions can produce measurable results—for example, keeping shower rooms warm can make bathing a more pleasurable experience for residents, reduce staff stress, and save time.^{13,14} Several management studies support the link between strategic human resource management and organizational performance,^{15,16} lending support for the organizational redesign called for by culture-change proponents. Similarly, research on facility design is providing evidence of the advantages of more homelike surroundings, such as single rooms, and the financial feasibility of these

designs over the long term.¹⁷

In addition, measures now exist to describe objectively what, if anything, has changed when a home claims to have adopted culture change. Tools such as the CMS's Artifacts of Culture Change enable providers to assess readiness for, implementation of, and sustainability of person-centered care. Defined measures, such as those for staff turnover and consistent assignment, can be used for practice improvement, incorporated into reimbursement methodologies,¹⁸ or made publicly available for consumers.

INITIATIVES EVALUATED Several culture-change initiatives have now been carefully evaluated. Wellspring¹⁹ uses ongoing learning collaboratives among groups of eight to ten facilities to share expertise among management and empower staff. Another, the Eden Alternative,²⁰ one of the earliest culture-change models, uses environmental and social enrichment to overcome boredom, feelings of helplessness, and loneliness among residents. Beverly Enterprises, the first publicly traded, for-profit nursing home chain to introduce deep system change, transformed a group of its facilities through its Resident-Centered Care Initiative.²¹

Lastly, Green Houses^{22,23} use free-standing small group homes, not large facilities, where residents are cared for by a consistent group of direct care staff with much expanded work responsibilities, such as activities, light housekeeping, and meal preparation, in addition to personal care. Studies of Green Houses, probably the most rigorous to date, found that residents' quality of life surpassed that of residents at control facilities, which were owned by the same operator as Green Houses but which were very typical large non-culture-change facilities, while clinical outcomes were equal or better. Green House staff were more satisfied, turnover rates dropped, and the homes did well on their annual federal inspections. With support from the Robert Wood Johnson Foundation, NCB Capital Impact, and Green House developer Bill Thomas, the model is spreading.²⁴ This is despite the fact that its model—a somewhat higher ratio of staff to residents and better pay for staff than is the norm in nursing homes—faces difficulties in states with low Medicaid reimbursement rates.²⁵

To be sure, the number of pertinent studies is still limited, many are only descriptive or represent single case studies, and it is sometimes necessary to extrapolate findings from research performed outside the long-term care field. A large information gap still exists on the costs of culture change and the strength of the "business case" for it. Researchers are working to provide answers to these and other questions, to enlarge the empirical base to support culture change.

Adoption Lags Behind Awareness

Despite widespread recognition of the movement, deep culture change is relatively rare. The Commonwealth Fund's 2007 National Survey of Nursing Homes²⁶ found that only 5 percent of nursing directors said that their facilities completely met the description of a nursing home transformed through culture change. Only 10 percent reported that they had initiated at least seven or more culture-change practices. All told, about one-third reported adoption of some culture-change practices, and another third said that they were planning to follow suit. But the rest of the respondents said that they were neither practicing nor planning to commence culture change.

Several aspects of the nursing home industry, including its workforce, regulation, and reimbursement, have conspired to limit the initiation of culture-change practices. Culture change requires dedicated leadership over a period of years, a stable workforce, the buy-in of nursing, and funds for environmental improvements. These features represent substantial investments in time, effort, and often money. The industry comes up short on a number of these parameters. Nationally, the annual turnover rate, for example, is more than 50 percent for licensed administrators.²⁷ For directors of nursing and nurse aides, annual turnover rates average about 40 percent and 65 percent, respectively.²⁸ The nursing profession is largely unprepared for the new roles expected of nurses,²⁹ and funds for capital improvements are in short supply. Incompatible state regulations³⁰—such as requiring that beds must project into the room, making it impossible for residents to arrange their furniture as they wish, or forbidding open kitchens, so residents are unable to fix a snack—can hamper innovation unless providers are able to obtain waivers from state agencies from existing regulations.

Despite federal requirements,³¹ moreover, most nursing homes remain far from the idealized visions of nursing home reformers. Quality continues to be criticized.^{32,33} Research suggests an association between poor outcomes for nursing home residents, such as decline in functional levels, and inadequate preparation for nurses,³⁴ minimal training for nurse aides,³⁵ and too few hours of nursing per resident per day relative to care needs.^{36,37} What's more, most nursing homes are "homes" in name only and retain a distinctly clinical orientation. Most are built to resemble hospitals, and most of the care is provided by aides and nurses, which skews priorities toward clinical care. The current regulatory process, which exerts enormous influence over nursing home behavior, further rein-

forces the clinical model. Nursing home surveyors frequently cite quality-of-care problems (such as weight loss and falls), instead of focusing on such areas as whether nursing home personnel honor residents' rights. A recent study³⁸ in Rhode Island found that almost 90 percent of providers thought that the surveyor's highest-priority area was detecting and eliminating deficiencies in the quality of care. In addition, various quality "report cards," including the one used by the CMS Nursing Home Compare program, tend to emphasize clinical data.

Many of the circumstances that direct attention toward physical care and organizational needs at the expense of residents' overall well-being can, at least in part, be addressed through such policy interventions as payment incentives tied to lower personnel turnover rates, credentialing of nurses practicing in nursing homes, code revisions, and tax credits or interest rate reductions to encourage upgrading of physical plants. Still other areas remain amenable to policy interventions.

DIRECT ENGAGEMENT Some states are actively fostering organizational and environmental change, workforce improvement, and resident-centered practices. They are encouraging state officials to participate in culture-change coalitions, workgroups, and taskforces.³⁹ Many states are using Civil Monetary Penalty funds, legislative funding, Medicaid dollars, or grants, or some combination, to help groups spearheading culture-change activities. A set of state culture-change case studies is in preparation, and a culture-change toolkit for policy makers is posted on the Web site of the American Association of Homes and Services for the Aging.⁴⁰

PAYMENT INCENTIVES States can incorporate culture-change criteria into payment models to provide incentives for the adoption of person-centered care. Or they can earmark rate adjustments to increase staffing levels.

FACILITY REPLACEMENT Many nursing home structures are becoming obsolete. Policy makers can revise construction codes to remove barriers to person-centered environments and further encourage design innovations by creating tax credits, targeted grants, or interest rate reductions to make capital costs more manageable.

REGULATORY APPROACHES Rhode Island's survey agency familiarized surveyors with culture change and tested a way to assess quality of life, residents' rights, and quality of care with equal rigor.⁴¹ It also piloted a process of collaboration with quality improvement organizations that bears further examination by state and federal regulators.

PUBLIC REPORTING AND RECOGNITION PROGRAMS Although few currently do it, states can gather

and report information on such important quality indicators as resident satisfaction, staffing levels, staff turnover rates, tenure of facility administrators, and use of per diem workers. Award programs for innovation, such as the Promoting Excellent Alternatives in Kansas (PEAK) program, also appear to motivate providers.

WORKFORCE ENHANCEMENTS The number-one challenge in long-term care today is securing a large enough and adequately trained workforce.⁴² Labor departments, local Workforce Investment Boards, and state departments of education can help policy makers improve entry-level training; lead job redesign, a critical necessity for culture change; revise licensing requirements to permit more flexible use of staff; and extend credentialing to nurses working in nursing homes.⁴³ States can likewise mandate increased training for nurse aides.

RESEARCH Although there is a growing body of evidence on the impact of culture change, many questions remain. Policy makers can facilitate access of researchers to data sets; participate in or conduct surveys; sponsor research; and use the results of research to change statutes,

regulations, and policies to promote person-centered nursing home care.

Conclusions

The outgrowth of many years of work on the part of consumers, policy makers, and providers, culture change has brought a diverse group of stakeholders together around the principle of person-centered care in nursing homes. Although awareness of the movement has grown, the difficulties of operationalizing and maintaining culture change remain daunting. Yet they are not insurmountable. With a policy environment conducive to innovation, and supportive of both initial and sustained adoption of new models, it is possible that—before the baby-boom generation needs long-term care—nursing homes will have become a better value proposition. The culture-change movement has shown that provision of high-quality nursing home care, individualized to meet each resident's needs in a setting that maximizes self-determination and well-being, can be a vision made real. ■

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