

# The Cultural Evolution

## *Part One: Testing New Strategies To Drive Performance*

Leslie A. Grant, PhD, and Edward McMahon, PhD

**W**hen it comes to improving performance, culture trumps strategy every time. Since culture provides the foundation for strategy, strategic goals are difficult to reach if an organization's culture is compromised.

Organizational researchers and scholars point out that organizational culture is a powerful driver of performance. Culture impacts the long-term success of companies in many different industries—whether it's Coca-Cola, Disney, General Electric, Intel,



Merck, or Toyota.

Is culture change (CC) a viable strategy to improve performance?

To answer this question, a research team from the University of Minnesota studied the Resident-Centered Care Initiative (RCCI) at Beverly Healthcare through a research grant from The Commonwealth Fund. Researchers determined the extent to which CC actually occurred and measured its effects on quality of life, staff satisfaction, and financial performance.

### Creating A Plan

**A**s early as the late 1980s, a grassroots effort known today as the culture change (CC) movement emerged in isolated pockets across the United States. Many of these early initiatives were driven by visionary leaders who shared a common goal—to transform the long term care industry by rethinking how services could be delivered to better serve the needs of an aging society through innovations in nursing facility design and operations.

Since then, the CC movement has continued to mature with new models of “person-centered” care being used on a wider scale.

“Home” is a unifying theme across these models that introduce new operational practices aimed at transforming the nursing facility environment as much as possible from an “institution” to a “home.”

#### **Culture Change Today**

CC practices are becoming more mainstream as more multifacility organizations begin to adopt best practices based on the experience of early CC adopters. Implementing CC successfully in large multifacility organizations is far more challenging

than in small independent companies. “It’s a challenge to sustain resident-centered care within a large national company like ours if leadership throughout the organization doesn’t buy into it,” says Larry Deans, executive vice president and chief administrative officer of Golden Living, Fort Smith, Ark.

Corporate culture must change, and systems must be realigned to support cultural transformation throughout all levels of the organization (corporate, regions, divisions, and individual facilities).

This three-part series highlights key lessons learned from Golden Living’s CC initiative that began in 2002 when the company, formerly known as Beverly Healthcare, piloted a program called the Resident-Centered Care Initiative (RCCI) starting with 10 nursing facilities in four states. In 2004, RCCI was expanded to 24 facilities in seven states. “Resident-centered care is gradually evolving to a whole new level,” says Andrea Ludington, senior vice president of clinical services for Golden Living. “We’re coming closer to making it a reality in all of our living centers.”

## Making Culture Change Work

LaVrene Norton leads Action Pact, the consulting firm that provided technical assistance to Beverly Healthcare's Resident-Centered Care Initiative (RCCI). She debunks a major myth about CC: "A big misconception for some [chief executive officers] is they tend to view culture change like another crash diet that gives instant results. Lot's of people think they are doing it.

They are trying hard to get rid of the unnecessary baggage from an outdated institutional model. Some are actually making real progress. But, others get stuck or even regress if there is a change of leadership so they can't sustain it over the long haul," Norton says.

Most CC experts believe that progress requires a long-term investment of human and capital resources

that can take three or more years to achieve. According to the "Four Stages of Culture Change," organizations undergoing CC go through four distinct stages reflecting CC advancement (see sidebar, below left).

So how far did Beverly Healthcare get on its CC journey? The table on page 38 shows how RCCI and non-RCCI facilities compared on CC practices at baseline (0 months), six months, and 12 months after RCCI implementation.

RCCI facilities made progress in five areas associated with movement from an Institutional Stage 1 to a

*Some CEOs tend to view culture change like another crash diet that gives instant results.*

Transformational Stage 2. Few of these facilities implemented Stage 3 (Neighborhood) practices such as decentralized dining in neighborhoods.

## How Beverly Fared

The cost of physical renovations to support Stage 3 CC practices turned out to be more expensive than what was originally budgeted. So, major renovations to redesign nurses' stations, remodel dining rooms, create new living rooms, and upgrade existing bathing areas into "spas" were delayed.

Compared to baseline scores, RCCI facilities successfully implemented five CC practices, which are evident at six- and 12-month follow-up. Non-RCCI facilities showed little or no improvement over time, while RCCI facilities improved by having more:

■ *Permanent staff assignment:* Nursing staff who are assigned permanently to units and residents.

■ *Culture change awareness:* Staff who are more aware of RCCI and other CC practices.

## Four Stages Of Culture Change

■ **Stage 1**—Institutional stage is a traditional medical model organized around a series of nurses' stations. Nursing staff are not permanently assigned to residents or permanently assigned to nursing units. Staff input into operational decisions and resident input into their daily activities and choices are limited. The organizational power structure is "top-down," or hierarchical, going from administrator to department heads to supervisors to direct care staff. Organizational policies and procedures are designed to support the efficiency of the nursing unit.

■ **Stage 2**—Transformational stage is the initial phase of CC when awareness and knowledge of CC spread among direct-care staff, supervisors, managers, and the leadership team. An important characteristic of facilities at this stage is permanent staff assignment to the same nursing unit or the same group of residents. Often, "symbolic" or minimalist (low-cost) changes are introduced into the physical environment to make the setting less institutional

(through new furnishings, interior finishes, artwork, animals, and plants).

■ **Stage 3**—Neighborhood stage breaks up traditional nursing units into smaller functional areas and offers decentralized dining. Due to the high cost of kitchen renovations, facilities may use steam tables to transport meals to the neighborhood, and thereby avoid tray line service. Neighborhoods may be renamed (Spruce Lane, Willow House) to replace institutional names that were previously used to refer to nurses' stations (One South, Two West).

■ **Stage 4**—Household stage is represented by self-contained living areas typically with 25 or fewer residents. Households usually have their own fully functional kitchens. A shared living room and dining room may be provided for residents who are part of the household. Self-directed work teams provide greater control over decisions about daily operations. Residents are afforded greater autonomy and choice in their daily schedules and activities as operational decisions become decentralized to individual households. Staff roles within households may become less differentiated through the introduction of "blended roles" or a "cross-trained" workforce.

Source: Leslie A. Grant, PhD, and LaVrene Norton, MSW

### For More Information

■ To learn more about the stage of CC at your facility, go to [www.myinnerview.com/ccstaging-tool.php](http://www.myinnerview.com/ccstaging-tool.php) and complete a free staging assessment using the Culture Change Staging Tool.

■ *Informal leadership behavior:* Non-supervisory staff and non-management staff who routinely help fellow staff do their jobs better.

■ *Resident-directed behavior:* Staff who respond more affirmatively to special requests from residents.

■ *Leadership team behavior:* Leadership team members who regularly engage in tasks outside of their traditional departmental roles.

### Culture Change Creates Value

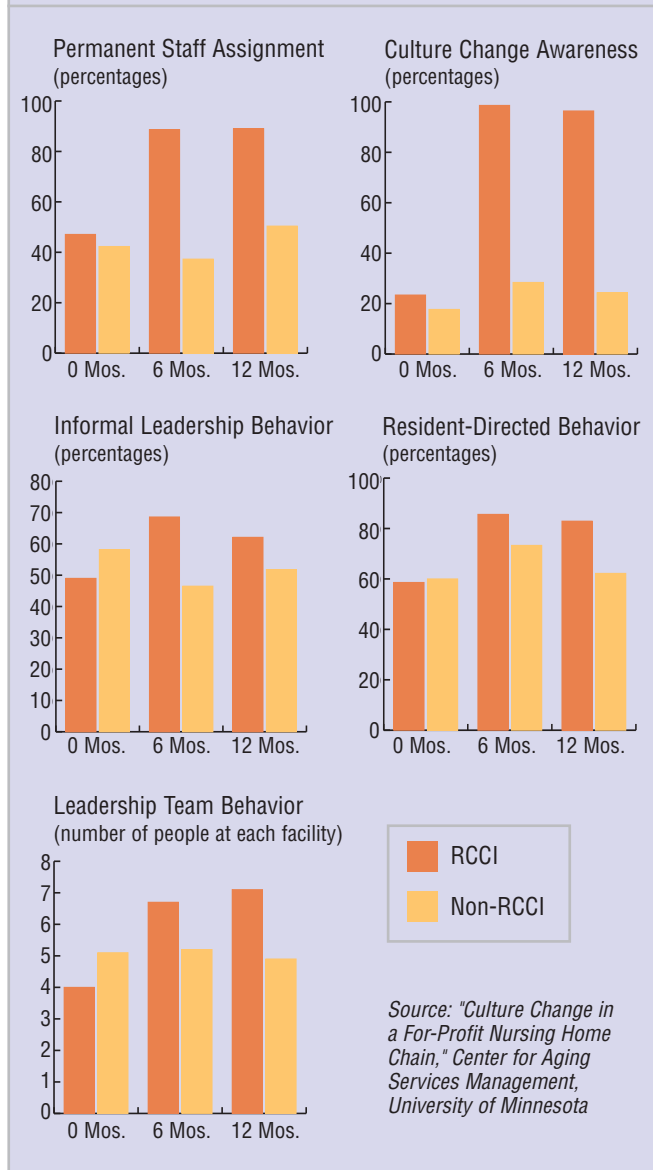
Evaluation of RCCI was complicated by two factors. First, a decision was made in 2004 to target RCCI in those facilities where the likelihood of success was the greatest. RCCI facilities were chosen based on key performance metrics tracked by Beverly Healthcare's internal "scorecard."

Facilities selected for RCCI tended to be the best performers overall, so it was not always possible to attribute differences in performance between RCCI and non-RCCI facilities to CC.

Among researchers, this effect is called a "selection bias." The evaluation of RCCI could not be designed as a randomized intervention similar to many clinical trials.

Second, Beverly Healthcare was sold to new owners in 2005. This unanticipated event introduced a "historical effect." It can't be known how RCCI might have played out without the change in corporate ownership. The details of the sale were being negotiated at the same time that RCCI was expanding. Once the pending sale became public knowledge, it was impossible to separate the effects

## Progress On Five CC Practices



of the sale from the effects of RCCI.

For example, the pending sale undermined staff morale as rumors about job security began to circulate. The sale created unintentional impediments to CC progress by undermining the trust that some frontline staff had in corporate managers. Since this "historical effect" impacted staff in both RCCI and non-RCCI facilities, this research suggests that CC actually mitigated these negative effects among RCCI facility staff.

Did CC make a difference in terms of performance? Based on this research, the answer is "yes." RCCI had little effect on financial performance. RCCI did not increase operating expenses per patient day. Both RCCI and non-RCCI homes (which were matched by geographic region) had comparable increases in operating expenses between 2003 and 2005 (about \$30.01 and \$33.31 per patient day, respectively). RCCI facilities saw smaller increases and maintained lower operating expenses per patient day than the non-RCCI homes.

### Positives For Staff, Residents

The RCCI homes created greater value for residents by enhancing their quality of life and for staff by improving their job satisfaction while maintaining comparable operating costs.

Residents in RCCI facilities were afforded more choice in decision making about their daily lives and were treated with greater dignity by staff. RCCI enhanced quality of life by improving resident:

■ *Choice and autonomy:*

Allowing residents to decide when to go to bed, when to get up, what and when to eat, how often to shower or bathe, when to spend time pursuing activities of their choosing, and making other choices in their lives.

■ *Dignity:* Treating residents politely, showing residents respect, handling residents gently when giving care, listening to residents, and respecting residents in other ways.

Staff working in RCCI facilities had higher satisfaction with:

■ *Training:* Providing better orientation and in-service programs and better training to deal with difficult residents and family members.

■ *Management:* Having managers who listen and care about employees.

■ *Work environment:* Providing adequate equipment and supplies, making a difference in people's lives, communicating between shifts, working together with co-workers and getting help dealing with job stress and other aspects of the work environment.

■ *Overall job satisfaction:* Including recommendation as a place to work, recommendation as a place for care, and other factors underlying overall job satisfaction.

Unfortunately, these differences in levels of staff satisfaction could not be attributed entirely to RCCI due to the "selection bias" problem. RCCI facilities had more satisfied staff at baseline and at six- and 12-month follow-up.

RCCI advanced nursing facilities from an institutional stage to a transformational stage without major capital investments.

Major physical renovations necessary to implement neighborhood or household models posed financial barriers to CC. Organizations contemplating CC must carefully consider the capital costs and investments in human resources necessary to implement CC successfully.

This research shows that CC is an effective strategy to improve resident quality of life and create better work environments for staff. ■

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management. EDWARD MCMAHON, PHD, is national director of Alzheimer's care and quality of life at Golden Living, Fort Smith, Ark. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to the fund or its directors, officers, or staff.

## Coming Up

Part Two of this series will appear in the next issue of *Provider*. It will develop the business case for CC by exploring the short-term and long-term gains associated with CC. Part Three will appear in a future issue. It will explore the costs and benefits of different CC models and identify unique challenges to CC within large multifacility organizations and suggest effective implementation strategies.

# The Cultural Evolution

## *Part Two: Culture Change Or Perish: The Business Case*

Leslie A. Grant, PhD, and Edward McMahon, PhD

**T**his is the second installment of a three-part series about Golden Living's continuing crusade to instill the values of culture change (CC), or person-centered care, throughout all of its nursing facilities, which are now called Living Centers. Part One last month reviewed a program called the Resident Centered Care Initiative (RCCI), which was evaluated by a research team from the University of Minnesota.



What started out as RCCI in 2002 under the auspices of the former corporation known as Beverly Healthcare continues to mature at Golden Living, Fort Smith, Ark.

"Those early efforts mark a major milestone for the culture change movement," says Larry Deans, executive vice president and chief administrative officer at Golden Living. "It's the first time ever that a big company like ours tried a resident-centered care approach." Prior to RCCI, most CC

models had been tested by nonprofit organizations on a more limited basis, Deans says.

Why would a large publicly traded company (like Beverly Healthcare) adopt a corporate strategy to implement CC? Investing in RCCI was

undoubtedly a gamble. It required \$7.5 million in capital costs and \$2.0 million in implementation costs. How could corporate leaders justify these expenditures to the board of directors and shareholders at a time when the business case for CC was still ill-

### Leadership Drives Successful Culture Change, Organizational Excellence

**I**s the way a company does business today the best road map to its future? After all, isn't this how the company has always done it? If not, how are leaders going to move the organization from where it is today to where it ought to be tomorrow?

The answers to these questions reflect the company's leadership strengths. Like it or not, leadership competencies affect organizational culture and performance. Some leadership competencies are so tightly coupled with organizational culture that these attributes are inseparable from the company's culture.

Research about Golden Living's RCCI underscores just how profoundly leadership affects organiza-

tional culture and successful organizational transformation. Researchers from the University of Minnesota found that culture change (CC) failed to take hold in nursing facilities where leadership competencies were weak or where there was turnover in key facility leadership.

Five leadership competencies—focused visionary, strategic management, caring leadership, communication, and supporting change—accounted for three-quarters of the differences seen in culture across Golden Living's nursing facilities. Research done by My InnerView on an independent sample of nursing facilities found that these same five competencies predict clinical, workforce, and financial performance.

defined? “We didn’t have the numbers, so it took a leap of faith,” says Andrea Clark, senior vice president of clinical services for Golden Living. “We just knew in our hearts and minds that this was the right thing to do. If we ever thought it wouldn’t produce clinical,

quality-of-life, and financial results, we would not have gone down this path. In order to maintain the support of corporate leaders and board members, we had to prove its value,” she says.

Not-for-profit organizations (and privately held firms like Golden

Living) may be in a stronger position to implement CC successfully compared to publicly traded entities driven by quarterly financial results. The former can more easily justify the long-term investments in capital and human resources needed to reach more advanced stages of CC development. It is common wisdom that it takes three or more years for an organization to develop from an institutional to a neighborhood or household model. (See *Part One of this series for a description of these models*).

“Before the sale of the company to Fillmore Capital Partners, we couldn’t

*‘We just knew in our hearts and minds that this was the right thing to do.’*

take a long-range view of things,” says Deans. “We were always under the scrutiny of Wall Street to maximize returns. Golden Living is making an infusion of new capital to improve our facilities, staff, and operations. Initiatives are starting that will deepen culture change across our Living Centers.” Regardless of corporate ownership, providers can lose or gain market share depending on how competitive their services are. Does CC yield any competitive advantage over an institutional model?

### **Making The Business Case**

The business case for CC can be based on diverse criteria, including short-term financial objectives (growth in profitability from boosts in revenue and/or reductions in cost), long-term financial goals (gains in market share), or nonmonetary benefits (improvements in resident satisfaction and quality of life, or improvements in employee satisfaction and quality of the workplace). Beyond more immediate finan-

## What’s Deep Systems Transformation?

**T**he Culture Change Staging Model (developed by Leslie A. Grant, PhD, and LaVrene Norton, MSW) views CC as deep systems transformation. Five core organizational systems and/or processes are transformed through different CC models:

1.) *Decision making.* Methods used to reach decisions become more consensus oriented. Decisions are made based on group process using techniques such as learning circles. Greater decisional control is given to frontline workers and family members, and ultimately, decision making becomes resident-directed.

2.) *Staff roles.* Staff assignment to residents becomes more permanent and consistent over time. Staff roles change from those found in traditional departments (nursing, housekeeping, food services, activities, or social services) to roles that are multifunctional. Staff are cross-trained, or work in blended roles. Ultimately, staff become empowered and work more autonomously in self-directed work teams that are multidisciplinary.

3.) *Physical environment.* The nursing facility environment is changed as much as possible from an “institution” to a “home.” Functional areas where residents live and staff work become smaller and more residential. Nursing units are broken into smaller

functional areas such as “neighborhoods” or “households.” These areas are often given new distinct names that have special meaning to the residents who live there. Services such as activities, dining, personal care, and nursing are no longer centralized at the facility or unit levels but decentralized into neighborhoods or households.

4.) *Organizational design.* Organizational functions become less compartmentalized in traditional departments (such as nursing, housekeeping, food service, activities, business office, or social services). The leadership team begins to work outside of traditional departmental roles. Roles within traditional departmental “silos” begin to disappear.

This redesign makes the organization flatter and less hierarchical. A flatter organizational structure allows for more direct communication between the frontline worker and the leadership team.

5.) *Shared leadership practices.* The composition of leadership teams changes as shared leadership practices disperse leadership functions throughout the organization. Leadership becomes shared by formal and informal leaders. Leadership competencies improve across a broad range of staff positions—not limited to staff in formal leadership positions.

*‘Ultimately, staff become empowered and work more autonomously.’*

cial gains, there may be other reasons why CC could bolster the long-term viability of a company.

There is a growing body of empirical evidence showing that results in workforce performance, customer satisfaction, employee satisfaction, clinical outcomes, and financial performance are interrelated. My InnerView researchers have studied high-performing nursing facilities. They find three common elements in these facilities:

- A culture of excellence
- Workforce commitment
- Leadership strengths

The researchers point out that an organization performs at the highest level that is supported by the weakest leg of this triad. If any leg is compromised, performance suffers.

“We now have data showing how companies consistently outperform their peers,” says Neil Gulsvig, president and chief executive officer of My

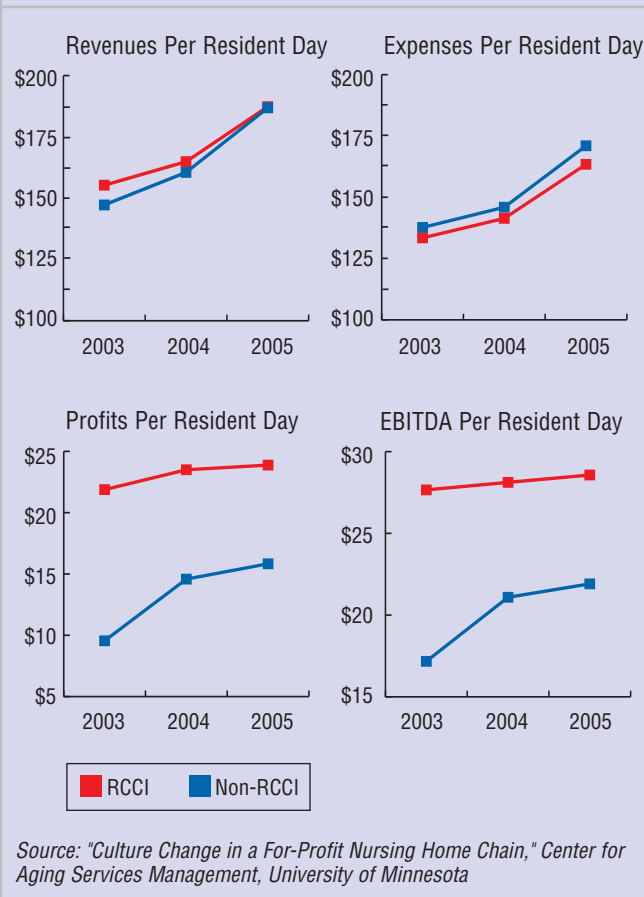
InnerView, Wausau, Wis. “These are the industry leaders or top performers who set benchmarks for the best-in-class. They consistently do better than their peers on metrics we’ve been tracking.”

### Workforce Commitment Key

Organizational systems driving performance in one area such as human resources affect performance in other areas such as clinical outcomes and financial performance. My InnerView researchers found that workforce commitment—as evidenced in low turnover, high retention, and low absenteeism among direct care staff—is critical to clinical outcomes (such as falls, use of antipsychotic medications, and physical restraints).

**Figure 1**

## CC Impact On Bottom Line



*Like other CC strategies, RCCI was designed as a series of incremental changes spanning years.*

Workforce commitment also predicted financial performance (as seen in higher occupancy rates). The core organizational systems driving performance are interdependent. This is why high-performing organizations have cultures and leadership strengths that drive organizational excellence (see sidebar, page 31).

Scientific inquiry about CC in nursing facilities has progressed slowly because researchers disagree on what actually constitutes CC. At the same time, practitioners are trying out many different new strategies for CC. A useful way to think about CC is to view it as deep systems transformation. CC implements operational practices and organizational strategies that profoundly alter the core processes that drive the most valued outputs.

Outputs are reflected in key performance parameters that are the focus of the company’s strategic plan: quality of life, customer satisfaction, financial ratios, clinical outcomes, employee satisfaction, occupancy, workforce commitment, regulatory compliance, or whatever the organization values most.

The Culture Change Staging Model identifies systems and processes that are typically transformed by CC innovations. While these don’t represent the entire universe of systems impacted by CC, the model highlights five critical areas that CC strategies, including RCCI, are trying to change (see sidebar, page 32).

### Bottom Line Results

RCCI and non-RCCI facilities were matched by geographic region. Researchers from the University of Minnesota collected data comparing these facilities on revenue, expenses, profits, earnings, payer mix, and occupancy. Annualized data are shown in Figures 1 and 2 comparing the four quarters of 2003 (the year before RCCI started), 2004 (the year when RCCI started), and 2005 (the year after RCCI started). The fact that RCCI

was implemented incrementally raises questions about what the appropriate time frame should be for making these before and after comparisons in financial performance.

Like most other CC strategies, RCCI was designed as a series of incremental changes spanning years. So, this evaluation is complicated by the time lag that occurs between when RCCI actually started and when financial gains may be realized.

From the beginning, RCCI facilities were more profitable. They had greater revenue, better earnings, higher occupancy rates, and a more favorable payer mix than non-RCCI facilities.

Corporate managers made the strategic decision to invest corporate resources in better-performing facilities. The rationale for this decision was that better performers are more likely to implement CC successfully. This decision

made it more difficult to show a return on investment given that RCCI facilities were better performers from the start.

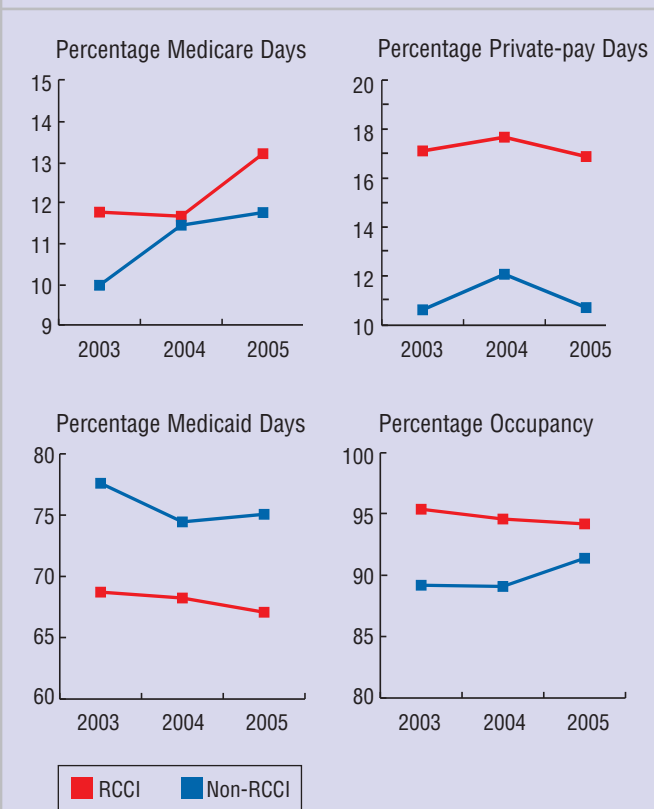
Both profits and earnings per resident day (EBITDA) showed greater differences between the RCCI and non-RCCI facilities in 2003 before RCCI began. However, these differences in profitability and earnings are due to selection bias. RCCI had little effect on payer mix and occupancy, so it had little impact on the bottom line during 2004 and 2005.

### Looking At Expenditures

RCCI did not lead to higher operating expenditures. In fact, RCCI facilities had slightly lower operating expenses per resident day than non-RCCI facili-

Figure 2

## CC Impact On Payer Mix And Occupancy



Source: "Culture Change in a For-Profit Nursing Home Chain," Center for Aging Services Management, University of Minnesota

ties. Non-RCCI facilities saw slightly greater increases in operating expenses between 2003 and 2005. RCCI facilities also created more value by enhancing the quality of life for residents and by improving satisfaction among staff. These gains were achieved without increasing operating costs. The busi-

### Coming Up

Part Three of this series will appear in the next issue of *Provider*. It identifies unique challenges to CC within large multifacility organizations and suggests effective implementation strategies. It will explore the costs and benefits of different CC models.

ness case for CC might ultimately be found in the long-term competitive advantage that CC offers in the marketplace. This evaluation did not find immediate cost savings or boosts in revenue and profits. Long-term improvements in performance make a more compelling justification for CC than short-term financial gains.

Because physical renovations are the most expensive component of RCCI, the financial returns on capital improvements are especially difficult to justify, and especially so within companies focused on quarterly returns. Excluding capital costs (roughly \$750,000 per facility), the costs of CC implementation averaged about \$78,413 per facility. Given the lack of short-term financial returns, a reasonable approach would be to amortize the capital costs.

Expenditures for CC are justifiable as part of a long-range strategy to

re-brand a company or reposition the skilled nursing facility within an evolving continuum of long term care services. ■

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# The Cultural Evolution

## Part Three: Strategic Investments In Person-Centered Care

Leslie A. Grant, PhD, and Edward McMahon, PhD

**T**his article about Golden Living's culture change (CC) program, called the Resident-Centered Care Initiative (RCCI), explores challenges to CC within large multifacility organizations and identifies strategies to overcome these barriers.

Earlier articles about RCCI appeared in the January and February 2008 issues of *Provider*. Research found RCCI to be an effective strategy for improving resident quality of life and employee satisfaction. RCCI improved resident choice and dignity, and it enhanced employee satisfaction with training, management, and the work environment. It also improved overall job satisfaction among staff.

Although RCCI had little effect on financial performance over the short term, it has provided benefits to residents and staff without increasing operating costs.

### What Is The Motivation?

Why should nursing home providers pursue a CC strategy in an era of diminished resources? Among some stakeholders, there is a belief that structural shifts are no longer sufficient for nursing facilities to remain competitive in an increasingly challenging market characterized by demographic

shifts and an environment fraught with economic and regulatory constraints.

According to some CC proponents, transformational change is needed to improve organizational performance and reposition nursing facilities within an evolving continuum of services.

*'An institutional model with only the physical renovations is like a caterpillar with wings.'*



One of the early lessons learned by senior managers at Golden Living, Fort Smith, Ark., is that CC is not a short-term strategy that can be implemented half-heartedly. Transformational change requires a focused long-term commitment of organizational resources.

"Everyone has to be realistic about what it takes to make person-centered care a reality," says Larry Deans, exec-

utive vice president and chief administrative officer at Golden Living.

"We're still making [person-centered care] better in our LivingCenters. I am proud we were willing to try different approaches until we learned how to make it workable and cost-effective."

RCCI was started in 2002, and it continues to evolve. As RCCI matured, CC practices were mainstreamed throughout the corporation. Golden Living had to develop more cost-effective strategies to make this effort sustainable. During this process, strategies evolved to spread person-centered care throughout the corporation.

### Piloting RCCI (2002-2003)

To initiate RCCI, Golden Living sought additional technical assistance from Action Pact, an external consultant. In 2002, Golden Living and Action Pact tested CC in 10 facilities in Indiana, Pennsylvania, Wisconsin and Minnesota. Six pilot facilities implemented CC successfully. Four were not as successful. Company leaders learned key lessons from the pilot:

- *Facilities with below-average state survey results are not the best candidates for CC.* Facilities that successfully implemented CC had better compliance histories than unsuccessful ones.

- *Instability in facility leadership*

*undermines CC progress.* Successful CC facilities had less turnover among administrators and directors of nursing than unsuccessful ones. Without stability and continuity in leadership, CC did not take root.

■ *CC requires strong, effective leadership.* Successful CC facilities had more competent leadership than unsuccessful ones at pre-test (even before RCCI started).

### **Expanding RCCI (2004-2005)**

During the expansion phase, 18 more facilities in seven states joined RCCI. The implementation strategy was redesigned to increase the likelihood of success. A streamlined process reduced the amount of assistance needed from Action Pact. It also created greater ownership of RCCI among Golden Living's caregivers. These changes are described below.

■ *New application process.* Facilities were selected on the basis of current and past performance. Only facilities with strong leadership, good regulatory compliance histories, and superior track records could participate in the expanded RCCI program. Because individual facilities had to formally apply to the corporate office to participate, facility leadership's interest in making RCCI work for them was already high.

■ *Cost of renovation.* Another consideration in facility selection was feasibility of CC renovations. Architectural and interior design studies found that amounts initially budgeted for renovations were insufficient. Renovations necessary to convert traditional nursing units from an institutional to a neighborhood or household model could be cost-prohibitive.

■ *Train-the-trainer model.* Rather than relying exclusively on external consultants for staff development, a "change-agent" training model was developed. This new strategy trained staff to become internal CC consultants responsible for implementing CC within each of their regions. A series of

workshops educated the "CC agents" using standardized training modules provided by Action Pact. The agents then used these modules to train leadership teams and frontline staff.

■ *Realignment of management systems.* Multifacility providers such as Golden Living represent complex organizations with hierarchical structures. Organizational changes were necessary to support CC throughout the corporation. Organizational policies and procedures had to be changed to align operational systems throughout the entire chain of command—from the

*'The conversion of traditional units to household models could be cost-prohibitive.'*

corporate office to regional offices, to district offices to individual CC facilities.

Corporate policies were revised to allow greater autonomy in decision making by individual facilities, particularly regarding such issues as reassignment of facility staff, raw food purchases, and outsourced services (such as housekeeping).

■ *Leadership buy-in.* In a company-wide integrated approach, CC training was provided to leaders at all levels of the organization—corporate, regional, district, and facility. The new implementation plan began with a two-day regional retreat attended by regional vice presidents, district managers, and facility leaders. It reinforced the importance of RCCI throughout the chain of command. Retreats took place before training was provided to frontline facility staff.

■ *Corporate champion and steering committee for RCCI.* Because a corporate CC champion was needed to lead RCCI, the senior vice president of operations was assigned that responsi-

bility. Given that RCCI affected many different departments, a corporate steering committee also was established to provide oversight.

■ *Financial incentives.* As key CC milestones were reached, facilities—or units within them—were recognized for their achievements and rewarded financially. Major capital improvements were tied to a facility's demonstration of tangible CC progress.

### **Designing More Cost-Effective Strategies (2006-2008)**

Renovations to the physical plant were by far the single most expensive component of RCCI during the expansion phase. A critical lesson learned is that substantial CC progress can be made without large capital outlays for physical renovations.

Capital improvements cannot be the only strategy pursued because transformational change is rooted in interdependent organizational systems. Deep systems transformation by definition involves multiple organizational systems not limited to the physical environment (as described in Part Two of this series).

The physical environment helps catalyze or speed up the CC process by enabling new operational practices such as dining in neighborhoods or households.

However, according to Action Pact's Executive Leader LaVrene Norton, "Changes to the physical environment—in and of themselves—don't reflect real CC progress. An institutional model with only the physical renovations is like a caterpillar with wings. Physical renovations alone don't reflect transformational change. A caterpillar with wings is not yet a butterfly."

Can transformational change occur without huge capital outlays? The answer is "yes." Experts identify six core elements that define CC. As shown in Table 1 on page 56, most CC practices are not related to physical renovations.

### **Speeding Up The Process**

More cost-effective strategies for CC implementation emerging at Golden Living reflect the staff's renewed efforts to make CC practices universal in all LivingCenters. The prior strategy was to diffuse CC incrementally within small groups of facilities. Large-scale efforts are currently under way to spread CC practices more quickly throughout the entire organization.

For example, companywide policy now supports consistent staff assignment—first by assigning the same nurse assistant to the same unit, and, ultimately, by assigning the same nurse assistant to the same resident. A new meal program called Dining Your Way provides greater meal options and flexibility, including between-meal snacks.

New buildings being opened are configured as “neighborhoods.” Orientation materials for new residents and families explain how the principles

of resident-centered care are being implemented in all LivingCenters.

New programs, such as Life's Simple Pleasures, allow residents greater opportunities for daily enjoyment. Golden Living's quality and performance scorecard includes a new metric to determine if every resident has at least one daily pleasure in his or her care plan.

Life's Simple Pleasures are designed to identify a personal pleasure important to each resident that could be delivered on a regular basis at least five times per week.

On admission each resident is asked what daily pleasures they now enjoy (or have in the past) that staff can provide. It could be something as simple as a hot cup of coffee upon rising in the morning or a late afternoon walk outside. Sometimes it is a favorite television show or a daily bath at a certain time. Whatever it is, staff make

arrangements to offer the identified pleasure.

### **Starting At The Top**

Responsibility for the program rests with the executive director (administrator at each facility). Implementing Life's Simple Pleasures had to be an interdisciplinary effort because it affected operations across multiple departments.

For long-stay residents who had psychologically adjusted to institutional regimens, there was the additional challenge of overcoming the effects of learned helplessness. When asked about daily pleasures, many residents living in the facility gave statements such as: “I get everything I need here already,” or “you choose for me, I don't know what to say.” So, it took some coaxing by staff and involvement from families to identify a pleasure for each resident.

## Implementation Strategies For Culture Change

A panel of CC experts identified six core constructs that underlie most CC models, including RCCI. Practices associated with each are shown in the table below.

Table 1

Core Construct	Practices
<b>Resident-directed care and activities</b>	<ul style="list-style-type: none"> <li>■ Expanding choices at meals</li> <li>■ Providing options for bathing</li> <li>■ Assisting residents in determining their own schedules, activities, and care plans</li> <li>■ Communicating the vision, principles, and values of person-centered care to all staff</li> </ul>
<b>Home environment</b>	<ul style="list-style-type: none"> <li>■ Designing resident rooms for privacy, personalization, and individual needs or preferences</li> <li>■ Introducing plants, pets, children, or familiar artifacts from the resident's past</li> <li>■ Changing the environment as much as possible from institution to home</li> <li>■ Implementing neighborhood or household designs</li> </ul>
<b>Relationships with staff, family, resident, and community</b>	<ul style="list-style-type: none"> <li>■ Committing to consistent staff assignment</li> <li>■ Promoting a sense of community</li> <li>■ Involving family members in decision making</li> <li>■ Providing intergenerational activities</li> <li>■ Honoring death and dying with dignity</li> </ul>
<b>Staff empowerment</b>	<ul style="list-style-type: none"> <li>■ Involving multidisciplinary staff in care planning and care conferences</li> <li>■ Enabling staff to self-schedule</li> <li>■ Implementing cross-training across departments and staff roles</li> <li>■ Promoting staff development and autonomous decision making in multidisciplinary teams</li> <li>■ Developing self-directed work teams</li> </ul>
<b>Collaborative management or shared leadership</b>	<ul style="list-style-type: none"> <li>■ Encouraging multidisciplinary teamwork and problem solving</li> <li>■ Decentralizing decision making about hiring and promotion</li> <li>■ Implementing practices to improve staff satisfaction through enhanced work environments</li> <li>■ Improving core leadership competencies and expanding participation on the leadership team</li> <li>■ Promoting open communication through consensus-oriented group decision-making processes</li> </ul>
<b>Measurement-based quality improvement processes</b>	<ul style="list-style-type: none"> <li>■ Adopting the principles of evidence-based management</li> <li>■ Monitoring and benchmarking organizational performance on key metrics (e.g., clinical, workforce, customer satisfaction, quality-of-life, and other outcomes)</li> </ul>

Source: Adapted from "Measuring Culture Change," Englewood, Colo.: Colorado Foundation for Medical Care. Publication No.: PM-411-114 CO 2006

According to Deans, "What gets measured on our scorecard gets done." Items on the scorecard are included in annual incentive plans for the leadership team at each LivingCenter. So, corporate leadership decided to use the scorecard to document if daily pleasures are being delivered.

True to existing culture, what got measured got done. Within six months, nearly all of Golden Living's residents had a simple pleasure identified in their care plan, and they were delivered on a regular basis.

An important lesson learned is how to leverage the existing culture of the organization to drive CC rather than trying to reinvent the culture anew. Employing tactics from the existing culture can be helpful in overcoming barriers to change. Life's Simple Pleasures is now a part of the CC effort, and it happened quickly and without major new expenditures.

In summary, a sustainable CC strategy must be grounded in contextual factors. CC practices must be cost-effective and aligned with strategic organizational goals. In complex multifacility organizations, CC must occur simultaneously at all levels of the company. The ultimate beneficiaries are the residents and employees, who are happier to live and work in a family-style, neighborhood environment rather than in an institutional one. ■

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