Rethinking the Nursing Home:
Culture Change Makes Headway in California

Introduction

Interest in nursing home culture change has been increasing at the federal, state, and provider levels, spurred by advocates' efforts to promote person-centered care, industry initiatives to improve resident experiences, and new federal policy guidance and technical support. Recent additions to the literature show that nursing homes embracing culture change have experienced positive quality and business impacts.

Although California has not been in the forefront of culture change, there have been shifts in state officials' perspectives. The California Culture Change Coalition (CCCC) is making strides through:

- The California Culture Change Person-Directed Dining Pilot Project;

- The launch of a regular schedule of Regional Culture Change Forums; and

- The enactment of a civil monetary penalty (CMP) provision aimed at funding nursing home quality improvements.

Other positive developments include establishment of the Country Crest household model in Oroville and an array of non-traditional sites, including ten Eden Alternative sites, and a Green House® home effort in Southern California. See page 11 for profiles of culture change trailblazers.

California has unique challenges related to culture change, including higher-than-average construction costs and a volatile budgetary environment that may affect providers seeking long-term financing for construction and ongoing operations. Additionally, concerns linger about regulatory barriers to culture change.

What Is "Culture Change?"

The terms "culture change," person-centered care," and "person-directed care" are often used interchangeably when referring to nursing home care that focuses on relationships and people instead of regulations, policies, and procedures. Culture change often encompasses:

- Care practices
- Environment
- Workplace practice
- Leadership practice
- Family and community inclusion
- Regulation changes

For more information see CHCF's Fast Facts Resources for Nursing Home Professionals at www.chcf.org/topics/view.cfm?itemID=120346.

The State of Long-Term Supports

Nursing homes are an important building block of the nation's long-term supports (LTS) system, which addresses the needs of people with permanent disabilities and functional impairment. Long-term supports are defined as a set of coordinated medical, nursing, rehabilitation, personal care, and support services that are delivered in a variety of settings including the home, community-based residences, and institutions.

For nursing homes, the landscape is changing. Over the past decade, national Medicaid-financed nursing home spending has decreased by over 12 percent.[1] Utilization has decreased as well. Since 1993, there has been a 13-percent drop in use by the 85+ population.[2] Younger seniors

(75+) have been less inclined to use nursing homes as well. Approximately 7.4 percent of people 75+ resided in nursing homes in 2006, compared with 8.1 percent in 2000 and 10.2 percent in 1990.[3]

Seniors are increasingly opting to remain at home longer or are choosing more home-like alternatives including assisted living, continuing care retirement communities (CCRC), and rapidly expanding Medicaid-financed home and community-based services (HCBS).[4]

California has approximately 1,296 nursing facilities, the vast majority (1,244) in urban settings. Most are free-standing—only 160 are hospital-based nursing facilities.[5] California nursing home supply and utilization rates are below the national average. According to trade association information, the state has 123,920 certified nursing home beds—32 for every 1,000 people age 65+. This is lower than the national average of 46 beds for this age group.

For the 85+ population, the bed supply is equally low. California's ratio of 241 beds per 1,000 people age 85+ is the ninth lowest in the nation, and 30 percent below the national average of 345.

California's nursing home occupancy rate is equal to the national average (86 percent).[6] Total nursing home admission rates for the state decreased by approximately 4 percent between 2000 and 2005. Researchers point to community-based alternatives as the reason for the decrease. However, the decline was primarily in hospital-based nursing home admissions. Free-standing admissions actually increased by 10 percent.[7]

Despite these trends, nursing home care will likely remain part of the state's LTS continuum for a number of reasons. First, it is unclear that HCBS programs have the capacity to support people as acuity and cognitive impairments increase. It is questionable whether aging-in-place has been fully realized, since nursing home acuity

levels have trended upwards for many years. However, there is evidence that assisted living residents and nursing home residents are becoming more similar.[8] Second, even states like Washington with robust long-term supports efforts aimed at reducing nursing home usage through home and community-based services have been unable to completely eliminate the need for nursing home care.[9] Finally, in the coming decade LTS demand will reach unprecedented levels, driven by population aging and increasing disability prevalence among those under age 55.[10]

There will be an increasing number of older adults who will live longer and potentially need services for greater periods of time than past groups of elders. The expected increase in demand and decrease in mortality suggest that both home-based services and high-quality nursing home care will be equally important policy and program considerations. Such strategy development will be particularly important in California because of the state's large population and the high growth rate of its 65+ population.

Barriers to Improvement

The large majority of the nation's nursing home facilities are 30 to 40 years old, but providers face many challenges when attempting to make physical plant improvements, add or improve information technology, or modernize service approaches. These difficulties frustrate efforts to focus on consumer preferences through culture change approaches, offer staff development and careering programs, or measure quality. The U.S. Government Accountability Office (GAO) research on nursing home care, as well as recent media coverage in such publications as the *New York Times* and the *Wall Street Journal*, continue to raise serious questions about nursing home providers' capacity to deliver quality services.[11]

California, compared to the U.S. as a whole, has a higher rate of nursing home quality issues. Although there has been evidence of some recent improvements, research

has raised questions about the quality of nursing home performance data and related state action to address concerns.[12] Some California nursing home issues include:

- Residents spend more time in bed, compared to other states.[13]

- Residents experience more than twice the national rate of physical restraint.[14]

- There are problems with the state's survey and certification process, regional licensing and certification staffing, and related data systems.[15]

At the same time, California nursing home staffing and turnover rates are on par with national trends.

Financing and Payment Rates

Nursing home financing is extremely tight. Margins typically range from 3 to 5 percent, leaving little room for environmental modifications that are key to many culture change models. Low margins also breed an aversion to risk and change for many providers, limiting the implementation of new service delivery and organizational approaches, even when the budgetary impact is modest or negligible. To cover costs, nursing homes have increasingly moved toward service diversification or expanding higher-paying lines of business to cross-subsidize services with lower reimbursement levels, such as Medicaid-financed long-term placement.

For 2007, the national average projected daily Medicaid reimbursement shortfall was $13.10, an improvement over prior years when the Medicaid environment for the nursing home industry was less stable.[16] Between 2003 and 2007, many states increased Medicaid payments to nursing homes through rebasing, adjusting the rate methodology, or implementing or expanding Medicaid provider tax programs. Provider tax programs have allowed states to use such funds, and related federal matching dollars, to increase Medicaid nursing home payments. However, last year Congress enacted legislation that decreases the amount that states can assess in

provider taxes from 6 percent to 5.5 percent. California is second in the nation in its use of nursing home provider taxes to increase Medicaid payment levels.[17]

The majority of states have been in stable or good fiscal health over the last four years. However, beginning in fiscal year 2008, many states are projecting a return to budgetary shortfalls; federal analysts also predict a widening gap between state revenues and outlays.[18] Currently, 24 states, including California, are projecting shortfalls in FY 2008. Unlike the federal government, all states (except Vermont) have balanced budget requirements and must make adjustments accordingly. California faces a $14 billion deficit in 2008. In January 2008, the Governor proposed a 10-percent cut in Medi-Cal payment rates.

However, the state recently increased its nursing home payment rates, and the Medi-Cal State Plan requires that long-term care (LTC) rates be adjusted each year by approximately 2.35 percent. With the passage of AB 1629, this requirement now applies only to certain facilities: level A nursing facilities; hospital distinct-part level B nursing facilities; rural swing beds; hospital distinct-part sub-acute beds; pediatric sub-acute beds; and intermediate care facilities for the developmentally disabled (ICF-DD).[19] Since the rate increase, the average Medicaid per diem shortfall decreased from $7.83 in 2005 to $3.34 in 2007.[20] The 2007 shortfall placed California among only eight states with less than a $4 per day Medicaid shortfall. But, it is important to note that the Governor's budget calls for a 10-percent decrease in local assistance for all long-term care facility rates. It is unclear how the local assistance cuts and state-level Medi-Cal payment cuts for non-facility-based LTS will impact providers with robust lines of business that are subject to rate reductions (i.e., adult day health care, home health, multi-service senior programs (MSSP)). Additionally, the Governor has proposed administrative cuts that could impact state operations.

Culture Change Overview

Culture change has expanded in the past two decades, as state regulators, advocacy groups, and providers have introduced related concepts such as self-directed care and person-centered services into most elements of the LTS continuum. These approaches are frequently apparent in assisted living, in-home services, independent community living, and continuing care retirement communities (CCRC).

Culture change offers the promise of better quality care and quality of life for residents, as well as a more desirable workplace for direct care staff.

Generally, culture change models emphasize shifting from a program- or facility-based model of care to a consumer-driven model. This usually involves making changes to the physical plant to create a more home-like environment; restructuring staffing and management patterns to empower frontline workers; and creating a flexible and responsive service delivery system to meet the needs and preferences of individual residents. The staffing components are intended to improve worker satisfaction and reduce the serious quality impacts of high turnover rates.[21]

Five Key Areas

There are a number of definitions and models for culture change, but recent research points to five areas as key to culture change:

- **Establishing inclusive decision-making.** The traditional top-down approach is replaced with more inclusive and consensus-driven organizational decision-making;

- **Reinventing staff roles.** Direct care staff do their work more autonomously in self-directed work teams. They may take on multiple ("universal") roles across traditional departments, providing some nursing care, housekeeping services, meal preparation, personal care, and social activities;

- **De-Medicalizing the physical environment.** Residential environments are redesigned to eliminate or hide as many medical functions and tools as possible. Some models create "neighborhoods," "households," or "small homes" that break up facilities and eliminate the traditional warehouse feel;

- **Redesigning the organization.** As staff take on more roles and are more involved in organizational decision-making, organizations become less hierarchical and have fewer silos enclosing such functions as food services or laundry services; and

- **Creating new leadership practices.** Organizational leadership becomes more decentralized, moves to a coaching approach, emphasizes more staff involvement, and is multidisciplinary.[22]

Researchers propose categorizing nursing home culture change progress across these five areas into four stages (see Table 1 on the following page).

Six Models

California is still "behind the curve," according to interviews with four culture change experts in the state. A 2007 California Culture Change Coalition survey of both the for-profit and nonprofit trade association memberships resulted in only 25 responses with very little useful information.

However, models for change do exist. The following six descriptions are based on Web research and phone interviews. Because culture change is a unique process for each facility or organization, the models reveal different applications of the process stages shown in Table 1. Additionally, it is important to note that emphasizing consumer choice and home-like environments is not limited to these six models or any particular model.

The Eden Alternative. Developed by Dr. William Thomas, this model is based on guiding principles that incorporate four of the five of the key elements of culture

Table 1. Four Stages of Culture Change

STAGE	FEATURES
1 – Institutional Model	The traditional medical model is organized around a nursing unit without permanent staff assignment. Neither residents nor staff are empowered in this model. Staffing inconsistency limits relationship-building between staff and residents, and depresses job satisfaction.
2 – Transformational Model	Awareness of the key elements of culture change is pushed throughout the organization via workshops and educational sessions for various departments and types of staff. Permanent staff assignments to units may be made to start the development of communities within the facility. Low-cost physical changes may be introduced, including new furnishings, artwork, plants, carpeting, and higher-end finishes—such as crown molding.
3 – Neighborhood Model	Traditional units are divided into smaller areas. Resident-centered dining may be adopted, eliminating full kitchens. Neighborhood coordinators are sometimes introduced and unique names and physical attributes are developed for each neighborhood.
4 – Household Model	Self-contained living areas have up to 25 residents. Typically, each household has its own kitchen, living area, and dining area. Staff are self-directed teams who perform a variety of functions. Household management is a collaborative process that places resident preferences first, followed by staff and household capacities.

Source: Grant, L., Norton, L. (November 2003) A Stage Model of Culture Change In Nursing Home Facilities. Presented at the 56th Annual Scientific Meeting of the Gerontological Society of America.

change. It does not require—but encourages—nursing homes to make physical alterations to the facility. Staff training is based on restructuring the organizational service philosophy and values. There are some 270 registered Eden alternative homes, of which ten are in California: Delta Nursing and Rehabilitation in Visalia; Elder Homes in Fresno; Hacienda Rehabilitation and Healthcare Services in Hanford; Hanford Nursing and Rehabilitation Center also in Hanford; Horizon Health and Subacute Center in Fresno; Kings Nursing and Rehabilitation Center also in Hanford; Mercy Retirement and Care Center in Oakland; Oak Valley Care Center in Oakdale; Piners Quest Home in Napa; and Salem Lutheran Home in Oakland.[23] This model can span from Stage 2 to Stage 4 (Table 1), depending upon whether significant physical changes are made to the facility. The Eden Alternative often is considered a sister model of the Green House model discussed below.

Wellspring. This organizational model focuses on moving facilities from the traditional management and institutional service delivery configuration to an environment that is more person-centered and empowers staff. It uses a set of essential elements to achieve the Wellspring goals: (1) care decisions need to take place closest to the resident; (2) a substantial knowledge base is required by all staff to enable participation in decision-making; and (3) an empowered workforce increases resident and employee satisfaction and reduces staff turnover. Wellspring consists of a series of clinical and management training models; it is the only model that requires participating facilities to regularly submit performance data. The data are reported to the Wellspring Institute using the Wellspring Outcomes Reporting System. Some culture change experts question whether Wellspring is a culture change model or a quality improvement system. Based on the culture change progression model shown in Table 1, Wellspring efforts fall mainly into Stage 2. There are currently no Wellspring sites in California.[24]

Planetree. This model has been primarily implemented in the hospital environment, although its Web site points to expansion into the LTS marketplace. Planetree describes itself as a holistic approach that encourages healing in several dimensions including mental, emotional, spiritual, social, and physical. It requires changes in architecture and interior design to create

a home-like and barrier-free environment. Planetree implementers must adopt values that align with patient-centered service delivery and have ongoing staff training to ensure a shift in day-to-day activities. There are approximately 130 Planetree-branded sites, including four in California: Enola Medical Center in Chico; Loma Linda University Medical Center in Loma Linda; Sharp Coronado Hospital and Healthcare Center in Coronado; and South Coast Medical Center in Laguna Beach.[25] Enola offers home-care and hospice, Sharp offers skilled nursing, and South Coast offers home health and an array of prevention and wellness programs for seniors.[26] Planetree efforts mostly fall into Stage 3.

Household Model. Fostered by Action Pact, Inc., the household model emphasizes culture change staffing and organizational change elements. It typically involves renovation or construction to replace traditional double corridor designs with smaller units. The household model does not require a "universal" worker approach. There is at least one example of the household model in California: Country Crest, located in Oroville. The development of this household site, which began in 2002, was laborious; the Office of Statewide Healthcare Planning and Development approval took almost 18 months.[27] The household model appears to be at Stage 4.

Neighborhood Model. This approach shares many characteristics with the household model but typically involves less environmental change. Facilities attempt to create neighborhoods with unique, homelike atmospheres. Neighborhood model facilities must develop core service philosophies aligned with patient-centered services, and must implement staff training modules to ensure day-to-day implementation. Typically, facilities permanently assign staff, provide some cross-training, and may attempt to carve out neighborhood support services within existing departments. For example, the facility kitchen might have certain staff dedicated to a specific neighborhood. The neighborhood model appears to be at Stage 3.

The Green House® Home Model. Licensed as skilled nursing, the Green House environment goes beyond being "homelike" to what truly feels like "home" through fundamental changes to architecture, organizational structure, and philosophy of care. Key aspects of the model:

- Each facility is a self-contained residence, designed like a private home while meeting institutional construction standards. With a maximum of 10 to 12 elders per home, each resident has a private bedroom and bathroom. The common space in the house, referred to as the "hearth," includes a living area, a single dining table that accommodates all of the residents for meals, and an open kitchen.

- Specially trained workers (with core training as certified nursing assistants) staff each residence as a self-managed work team. They provide personal care, activities, meal preparation and service, light housekeeping, and laundry.

- Partnering with the direct care staff is a clinical support team of licensed nurses, therapists, medical directors, as well as social services, activities, and dietary specialists.

The Green House model includes architectural, organizational, staffing, and philosophical changes. Unlike most culture change approaches, this model is implemented all at one time, in a carefully crafted method designed to support initial success as well as long-term sustainability. California had no Green House facilities before December 2007, when Green House Replication Initiative began working with Mt. San Antonio Gardens in Pomona. Green House homes fall firmly into Stage 4 of the culture change progress model, and might be appropriate to a new stage defined by its practices and simultaneous implementation.

Table 2 provides a high-level comparison of the various culture change initiatives.

Table 2. Comparison of Culture Change Models

CHARACTERISTICS	EDEN ALTERNATIVE	WELLSPRING	PLANETREE	HOUSEHOLD MODEL	NEIGHBORHOOD MODEL	GREEN HOUSE HOME MODEL
Core values and philosophy	Yes	Yes	Yes	Yes	Yes	Yes
Requires staff changes	N/A (in values)	Yes – low	Yes – high	Yes – medium	Yes – medium	Yes – high
Requires physical changes*	Yes – low to medium	No	Yes – medium	Yes – medium	Yes – medium	Yes – high
May operate within existing physical plant	N/A	Yes	Yes	Maybe	Yes	No
Model is branded or requires registration	Yes	N/A	Yes	No	No	Yes

Notes: Level of effort within characteristic area is broken down by low, medium, and high where possible.

*Physical changes at a moderate level might entitle repainting and other cosmetic changes. Medium might entail creating neighborhood elements such as neighborhood kitchens and living rooms. The Green House model is "high" because it requires new construction.

Source: MDK Consulting, modified by NCB Capital Impact

Other than the Eden Alternative and Planetree, the major culture change models have not made significant inroads in California. Eden's foothold in the state is modest; there are ten Eden-certified facilities in a state of 1,200 nursing homes. However, many California nursing homes may be integrating elements of consumer choice and physical changes without using a formal model.

Culture Change Outcomes Research

Until recently, there has been very little peer-reviewed research that directly linked culture change models to outcomes.[28]

The majority of culture change research is funded by The Commonwealth Fund. In 2001, it underwrote an evaluation of the Wellspring model; researchers found improved staff retention and job satisfaction as well as reduced survey deficiencies in a sample of 11 Wisconsin-based Wellspring sites.[29] Importantly, this model produced low or no new costs for participating facilities. However, some culture change experts question whether fewer deficiencies correlates with improved quality outcomes for residents.

From August 2004 to October 2005, Quality Partners™ of Rhode Island conducted a pilot study, "Improving Nursing Home Culture" (INHC), in the northeastern U.S. to look at both clinical outcomes of person-directed care and impacts on workforce retention. Researchers found a decline in chronic pain rates for residents and a decline in the use of physical restraints. Outcomes in workforce retention were quite pronounced. Compared to estimated national nursing home turnover rates of 70 percent, participating INHC facilities experienced a 10-percent decline in turnover.[30] Other research on the impacts of empowering certified nursing assistants (CNA) produced similar results—improvements in resident care and better staff retention rates.[31]

Research comparing the Green House homes with traditional nursing home care showed that the Green House homes had: (1) high levels of satisfaction reported by residents, family, and staff; (2) reduced rates of decline in late-loss activities of daily living; (3) lower prevalence of depression; (4) fewer residents classified as bedfast; and (5) fewer residents having little or no activity.[32, 33]

In 2007, the Pioneer Network released preliminary research findings on early culture change adopters. The findings include fewer deficiencies than before culture change or early in culture change; better quality of care (measured in terms of deficiencies); and operating margins comparable to nonparticipating homes.[34]

The majority of research projects were conducted with nonprofit providers. However, in 2004, University of Pennsylvania researchers with the Hartford Center of Geriatric Nursing Excellence partnered with Beverly Enterprises, called National Golden Gate Senior Care, to compare three NGGSC nursing homes using the company's Resident Centered Care Model with three traditional nursing homes. The study found improved quality of life using evaluation design measures, and better job satisfaction.[35]

The Commonwealth Fund is underwriting further research, titled "Evaluation of Culture Change in For-Profit Nursing Homes: Business Innovation at Beverly Enterprises," at the University of Minnesota. Such research will be particularly important for California due to the state's high proportion of for-profit nursing home providers. Three points that have come out of the University of Minnesota research include:

- Homes that already are high performers should be selected for culture change programs;

- Extensive prep work is needed to help board members and shareholders understand the nature of culture change front-end investment, and that business units could lose money in the short term; and

- The regulatory and consumer focus is shifting from deficiencies to the quality of life a provider can offer, and this will directly impact a chain's potential market share.[36]

Few studies have been conducted on the business implications of culture change. However, in May 2008, researchers found that the "more nursing homes are engaged in practices associated with culture change, the more likely they are to report that culture change has made positive improvements in competition in their market, nursing home operations, staffing, and occupancy rates."[37]

Federal and State Support for Culture Change

Federal level efforts. The Omnibus Reconciliation Act of 1987 (OBRA-87) helped set the stage for culture change by creating more resident-focused standards for services. In recent years, the federal Centers for Medicare and Medicaid Services (CMS) has taken important steps to advance culture change principles. In 2005, the agency directed state quality improvement organizations (QIOs) to improve organizational culture. A year later, it released a facility self-assessment tool titled the "Artifacts of Culture Change Tool," to help nursing homes measure their progress. Also in 2006, CMS issued a detailed document to state survey agency directors explaining how the Green House and similar culture change models fit into the current federal survey requirements.[38] The CMS "2007 Action Plan for (Further Improvement of) Nursing Home Quality," stated that culture change principles "echo OBRA principles."

A February 2007 CMS letter indicated that culture change models, such as the Green House, "more fully implement the Nursing Home Reform provisions of… [OBRA-87]," including quality-of-life goals. CMS stated that no federal regulatory barriers exist for the model and similar culture change approaches.[39] Also, a series of CMS-sponsored educational conference calls on culture change was launched in September 2007.

In 2008, CMS convened a symposium on the implications of traditional nursing home physical environments and the Life Safety Code on culture change. One of the symposium aims was to identify strategies to meet needed Life Safety Code requirements while embracing culture change principles related to the physical environment.

On July 23, 2008, the United States Senate Special Committee on Aging convened a hearing on person-centered care. Goals of the hearing were to understand strategies for restructuring nursing home care, in

particular the Green House approach, and to explore ways to make it easier for other nursing homes to move toward these model programs.[40]

State level efforts. The states have taken a variety of approaches to support culture change. Several, including Arkansas and Oklahoma, have enacted legislation changing state level regulations and statutes to fully embrace the Green House model and other forms of culture change. Wyoming legislation establishes a Green House pilot project, and Massachusetts issued its first certificate of need in ten years for a Chelsea, MA, Green House project.[41]

Other states are using funds secured through OBRA-87 civil monetary penalties to improve nursing home quality and foster culture change. Examples include:

- **Arkansas** – Planning grants for Green House homes and Eden Alternative implementation;

- **Louisiana** – Culture change initiatives;

- **Maryland** – Wellspring projects;

- **New Jersey** – Eden Alternative grants; and

- **North Carolina** – Funding for Eden Alternative and Pioneer Network programs.[42]

In 2008, the Institute for the Future of Aging Services (IFAS) will release eight case studies assessing how the states of Georgia, North Carolina, Massachusetts, Kansas, Oregon, Michigan, and Vermont are fostering culture change. IFAS also will release a culture change tool kit tailored to state officials.[43]

California efforts. California recently enacted civil monetary penalty legislation—similar to federal legislation—targeting funds to nursing home improvements. State officials—particularly OSHPD and L&C—have expressed a strong interest in advancing culture change (see Table 3). For this issue brief, OSHPD and L&C provided important statements about their openness to nontraditional service delivery approaches focusing on consumer-driven care, direct care worker empowerment, and architectural features and design that reduce or eliminate medical model elements. Aside from the caveat that all innovations must comply with the statutory intent and regulatory requirements, both state agencies expressed keen interest in working with providers to explore culture change innovations.

Table 3. OSHPD and L&C Statements on Culture Change

California Department of Public Health Licensure and Certification	"The California Department of Public Health Licensing and Certification (L&C) Program supports culture change, as well as Olmstead-compliant smaller, more community-based and community-integrated settings, and patient-centered care.
	At the same time, L&C, as the enforcement agency for minimum safe standards, indicates that it must balance innovation with patient safety by ensuring that the intent of the regulations, patient safety and quality care, is not compromised.
	L&C officials also stated that where regulatory challenges emerge with innovations that do preserve the intent of the regulations, L&C has tools including regulatory flexibility to allow for the use of alternative methods, procedures, and techniques that meet the regulatory intent."
California Office of Statewide Health Planning and Development	"In general, the California Office of Statewide Health Planning and Development (OSHPD) is very supportive of innovative nursing home building design and philosophy of nursing home culture change. However, as the state agency responsible for enforcing the building code as it relates to health care facilities, OSHPD also must ensure that nursing homes comport with the California building code regulations.
	However, it is important to note that the building codes are written for conventional development and that, at times, OSHPD local and state officials may accommodate innovation and non-traditional concepts that still meet the building code through alternative compliance avenues."

California Challenges and Opportunities

To understand the culture change movement in California, researchers interviewed about 20 people who are involved in culture change within the state and nationally. The interviewees cited factors that make California a uniquely challenging environment and also identified several opportunities for culture change advancement. Some of their observations follow.

State agencies need to provide clear guidance for nursing home operators and local authorities. Despite positive indications from California OSHPD and L&C, providers remain concerned about implementing culture change innovations without official guidance. Interviewees recommended: (1) state transmittals to providers on aspects of culture change that can be easily implemented; and (2) integration of culture change models and principles, using the CMS tools, into OSHPD and L&C trainings for state and local staff.

Establishing strong centralized leadership is key to coordination across departments, leadership, and bureaucracy. With no clear champions within the system, moving culture change initiatives forward in the large California bureaucracy is daunting. Many states have acknowledged that if long-term care services are to be both functional and flexible, they must be housed in one department or there must be a process by which multiple departments work together.[44] California has a number of departments with some oversight of the long-term care system, including the Department of Health Care Services, Department of Public Health, Department on Aging, Department of Social Services, and Office of Statewide Health Planning and Development.

Interviewees defined strong leadership as the willingness to tackle tough issues, a strong commitment to home- and community-based services, and a willingness to work with private-sector champions seeking to implement new models. They cited Richard Ladd in Oregon, Charles Reed in Washington, and Herb Sanderson in Arkansas as great champions at the director/deputy director level who created significant change in their states and also throughout the country. Interviewees noted that culture change happens in states where there is a champion at the state level and champions in the public sector who come together to push change through both the legislative and regulatory processes. A first step could be an office or staff person within the state charged with integrating culture change principles into agency priorities and policies.

California's economy is in crisis and few legislators likely understand the value of culture change. California's severe financial crisis, marked by a $16 billion deficit, may detract from any type of innovation in the next year. However, policy alterations to advance culture change often are cost-neutral or very inexpensive; such policy changes often focus on creating additional flexibility for nursing home providers. Interviewees suggested briefings or educational events that highlight aspects of culture change that could help stabilize the nursing home marketplace (e.g., reduced costs related to staff turnover) and highlight the positive impacts on residents' health. Enhanced flexibility or culture change pilots could become part of a broader effort to save money.

A technical assistance strategy is needed to support California's culture change. California's complex nursing home business environment is characterized by unionized workers, exceptionally high costs for land and construction, and a high proportion of for-profit providers. Interviewees recommended a targeted culture change technical assistance strategy to help providers understand and analyze culture change approaches in the context of their unique local markets. It could facilitate connections with specialized technical assistance resources such as Action Pact and the Green House Replication Initiative.

Interviews with California Trailblazers

Below are interviews with three organizations that are in various stages of implementing culture change in California. Each has a slightly different starting point but all three have similar needs for technical assistance and clear guidance and support from the state.

Bay Area For-Profit

Q. What did it take for you to get culture change underway?

Our staff first heard about culture change through consultants at Lumetra, who talked about things that could be changed to make facilities more person-centered. We took part in a Lumetra project about four years ago. Staff was encouraged to work with residents to change one aspect of the facility to be less institutional. One staff person formed a group to work on our shower room, which was dismal. She offered the residents color choices, samples of fabric, and possible themes that they could look at and decide on. She took on all the extra work on her own time. It was very successful. Residents chose a tropical theme, with new paint, wallpaper, and shower curtains. All shower rooms were subsequently changed. We now have fireplaces in our lobby and fireside room. All the residents' rooms have been remodeled to be more cheerful and homelike. We replaced all our old beds, and now have all high/low beds that look like they could be in someone's home. All our dining tables now have tablecloths and flowers. One of the things that culture change encourages is consistent staffing, which we have done for the last five years. Also with Lumetra assistance, we are restraint free, which is wonderful for our residents.

Q. What will other California nursing home operators need to implement culture change?

At the time we made those changes, we had the encouragement of Lumetra and the support of other facilities in our group. Now, with the California Culture Change Coalition, there are resources and help.

Q. What does your culture change process look like and what culture change approach are you taking?

Our facility has been in operation for 35 years. So while we have made some changes, no large physical plant changes have been instituted. We have a secured 18-bed Alzheimer's unit that is self-contained, with its own separate dining area, patio, and activities. There is a higher staff ratio and the CNAs strive to provide care when the resident wants it. However, this is not the case on the other halls. Because we have consistent staffing

assignments, CNAs strive to provide care the way the resident wants it, although residents have no choice in meal times and many other activities. We could do far more in providing resident-directed care. We were planning on starting on restaurant dining in January, with the help of the California Coalition for Culture Change, but we were hit with our state and federal survey and that has been put on hold. We will still do it, but we don't have a firm date.

Q. What are your obstacles to change?

I know that many CNAs and licensed nurses would fully embrace change, and many go about small changes in their own way. One staff person in particular stresses this with other staff members and works really hard at making the changes she can for her hall and dining room. At this time there has been a slowdown. However, changes will be happening in the future, such as restaurant dining.

Q. What do you need to move forward with more culture change?

We need organizations such as the California Association of Health Facilities (CAHF) to put culture change on the forefront of their conferences. All administrators need to really get immersed in the concept. The more that it is put into the forefront of classes offered and meetings, the more widely it will be received. The California Culture Change Coalition puts on conferences that are excellent. Once you see the value of this for the residents and the facility, the more facilities will change.

Southern California-Based Nonprofit

Q. What did it take for you to get culture change underway?

Our residents and families play an important role in our organization and demanded the improvements in the structure of the current skilled nursing facility. While we have good quality services, the current facility is antiquated, with long hallways, semi-private rooms, and central showering facilities on each wing. We were looking for unique supports models that did not hinge on a traditional campus approach. We thought the Green House home model would be best for us. In particular, we liked its capacity to prevent institutional creep. The

NCB Capital Impact Green House Replication Initiative technical assistance, funded by the Robert Wood Johnson Foundation, has really provided the structure and support to move us forward. Additionally, two of our senior executives had parents in traditional settings—our personal experiences made it clear that a better way of delivering supports was needed.

Q. What will other California nursing home operators need to implement culture change?
Talk to committed family members of residents about what they want for their loved ones. Our families told us they wanted an environment that encourages more socialization. Also, we would really encourage providers to start a dialogue with OSHPD, as needed, and L&C early, and make them partners in whatever the culture change process is. Early engagement could head off confusion and delays later.

Q. What does your culture change process look like and what culture change approach are you taking?
We are using the Green House approach and are working closely with our architects, OSHPD, and L&C to develop a Green House home design. Those discussions have been quite positive. We have identified direct care workers who will be our Shabazim and are sending them to Green House trainings. We also are working hard to help all of our residents and families understand the model because it is so innovative. This education is important because we are really a resident-driven organization with several on our board of directors.

Q. What are your obstacles to change?
We have had to help frontline staff, residents, and families to understand and support culture change. Because the new approach is so different and exciting, we've had to work to keep our enthusiasm from pushing outside of our budget.

Q. What do you need to move forward with more culture change?
We need continued creativity and flexibility in policy and regulation [from the state] with commitment on paper to prevent a return to the old way of doing business. Basically, we're talking about institutional creep at the regulatory level rather than at the facility level.

"Because the new approach is so different and exciting, we've had to work to keep our enthusiasm from pushing outside of our budget."

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Q. What did it take for you to get culture change underway?
The residents deserve it! We have always been innovative, successful, and have a culture of change. Our effort really started with our management team.

Q. What will other California nursing home operators need to implement culture change?
They will need education, tools, direct examples, and site visits if necessary.

Q. What does your culture change process look like and what culture change approach are you taking?
My direct observation is that most organizations adopt the concepts, philosophies, and ideals of culture change and they figure out how to implement them in their facilities. For example, we have worked on our dining program for about five years now, blending a restaurant style with family dining. We have updated the dining area to include new tables, chairs, floor, wallpaper, and decorations. We've also eliminated the "feeding" tables or half-rounds that were so typical in nursing homes. We are in the process of expanding our menu to offer options at all three meals. This will be completed by the end of the year. Our ultimate goal is "anytime" dining.

Additionally, we have implemented resident choices for awakening, going to bed, and shower schedules. For the last three years, we have had consistent staffing assignments for CNAs, nurses, housekeeping, and dietary staff. Nursing staff is self-scheduling. Schedules are posted three months in advance and vacation requests accepted one year in advance. We have a new "planned time off" policy whereby employees can earn four extra days off per year with good attendance and minimal call-ins. They can also "cash out" their planned time off earnings within certain guidelines. We have a seniority bonus for all job classes; it begins at five years with $500, then goes to ten years ($1,000), 15 years ($1,500) and 20 years ($2,000).

Q. What are your obstacles to change?
The physical plant is not conducive to change, and there are regulatory restrictions from OSHPD and CDPH. I would say that for-profits sometimes have the perception that there is not a good business reason to implement culture change.

Q. What do you need to move forward with more culture change?
We do not need anything other than more time and regulatory relief.

Conclusion

The promise of culture change is that person-centered services, a more home-like environment, and more stable staffing that wraps around individual health and LTS needs will have real benefits for residents and providers. Early results point to the potential for a higher quality of life, improved outcomes, and reduced health care costs as a result of fewer acute care episodes and slower functional decline.

At the same time, the restructuring of jobs, organizational roles, and the physical environment improves job satisfaction for direct care workers and increases staff retention rates.

With momentum built by the California Culture Change Coalition and expanded interest among state agencies, particularly OSHPD, the state is likely to see more culture change initiatives in its nursing facilities. In the next two to three years, culture change approaches that require less up-front investment are the most likely to proliferate in the current fiscal environment. As the economy rebounds, other approaches that include higher-cost components such as changes to the physical plant also are likely to expand.

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