ABSTRACT

THE CULTURE CHANGE MOVEMENT IN OHIO’S NURSING HOMES

By Anne E. Johnston

Nursing home culture change is a national movement with the specific goal of transforming the industry of long-term care from an institutional system into home-like, person-centered care environments. Several models of care have emerged since the mid-to late- 1990s to provide support and “best practice” concepts for the idea of culture change. This study seeks to identify characteristics of Ohio nursing homes that indicate strong culture change behaviors and activities, and examines possible barriers that facilities experience in their attempts at transforming their culture. The data collected from nursing homes throughout Ohio provides a snapshot of culture change activities, and indicate limited progress in Ohio’s facilities overall, but a significant difference between homes based on their size and type of ownership.
THE CULTURE CHANGE MOVEMENT IN OHIO’S NURSING HOMES

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by
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Chapter 1

Background and Review of Literature

Introduction

When the average American thinks about nursing homes, what is likely to come to mind is an image of a frail-looking individual sitting slumped and asleep in a wheelchair, alone, in a long double corridor. Today’s nursing homes are filled with sick people who are frail; many of them experience physical challenges or have a limited cognitive capacity, making interaction and communication difficult (Fahey, 2003). It is expensive to reside in a nursing home. Adding insult to injury is restricted autonomy and choice experienced by residents. This negative picture is a common view held by the general public and the news media.

Although nursing home industry representatives recognize that the needs and expectations of older adults have changed over the decades, the ways in which nursing homes provide services generally have not. They continue to operate under an outdated medical model, and quality of care and quality of life continue to be problematic despite efforts to reform the system. Fahey maintains, “Substantial change in facilities can occur only in the context of a change in long-term care public policy and the public’s commitment to this change” (2003 p. 36).

The focus of this paper is on the concept of nursing home culture change in Ohio. Culture change is the transformation of nursing homes from a medical need model to a more "consumer-centered" model, which includes a more home-like environment, flexibility in sleep and dining schedules, and autonomy in personal choices for residents. In addition, a less bureaucratic organizational approach is often part of the transformation. The study will examine the progress toward culture change that nursing homes in Ohio are experiencing and will also consider reported barriers and challenges faced in implementing culture change efforts.

History of America’s Nursing Homes

In order to understand more about nursing home culture change it is important to examine the history of nursing homes, including the policies that have gotten us where we
are today. Such history will provide a context in which to understand and appreciate culture
transformation in nursing homes.

Nursing homes have their roots in two settings, the almshouse and the hospital. The
first nursing homes in the United States were modeled after the Almshouses of England,
which date back as far as the 11th century. These institutions were a last resort for the most
impoverished members of society. Initially, the almshouse served individuals of all ages, but
over time they came to serve primarily older people. Because many of the older residents of
the almshouses of the early 20th century had illnesses, a number of these facilities became
hospitals. World War II and the subsequent baby boom gave rise to the need for more
hospital beds, forcing the older patient with chronic care needs out of the hospital setting
(Payne, 2006). The United States government supported the growth in hospitals, which
increased the need for nursing homes. Nursing homes built during this time and through the
end of the century have largely been modeled after hospitals – both in physical structure and
organizational framework; and as Koncelik wrote, “between the 1950s and mid-70s a
massive building effort took place, with no clear concept of what to build” (1976). Until the
1990s very few recognized that such a model would not adequately serve the older
population with chronic illnesses who need round-the-clock care or monitoring.

Discussion of nursing home reform in the 1960s and 1970s led Vladeck to suggest a
rethinking of the role of physicians in nursing home care practices and indicated that by
improving medical services within the nursing home without further “medicalizing” the
institution, the quality of life of residents living in the nursing homes could be greatly
improved (1980). Facilities built in the 1970s and 1980s continued to be designed like
hospitals with as many as 400 beds. The purpose of this design was to enable staff to
accomplish tasks as efficiently as possible (Norton, in Akin, 2005, Massachusetts Extended
Care Federation). However, an efficient design did not necessarily provide job satisfaction,
quality care or a good quality of life for residents.

In 1987 the federal legislation known as OBRA was passed. The Omnibus Budget
Reconciliation Act (OBRA) included the Nursing Home Reform Act (NHRA), which
stemmed from growing public concern with the poor quality of care in nursing homes.
Among the numerous changes that OBRA brought to nursing homes was an emphasis on
resident quality of life as well as the quality of care (www.ltcombudsman.org). The NHRA
was a step in the right direction and did improve quality in some areas, but the industry as a whole continues to face a number of challenges when it comes to providing quality care and promoting a good quality of life. Hofland wrote that “…I think we’ve helped to improve the quality of life for people in long-term care. It’s important for them to have whatever degree of control is possible” (1990). Although the NHRA was an important step, it would not guarantee good quality of care and life for residents, nor would it improve residents’ autonomy and control related to their everyday life in a nursing home.

Calkins, an internationally recognized leader in the field of environments for elderly, fervently stated that it doesn’t matter what you call it – “culture change, or re-structuring, or re-engineering, or resident-directed care, or resident-centered care, this movement is all about changing the way nursing homes operate” (2002 p. 45-46). Concerned that many facilities are merely paying lip-service to culture change concepts by changing their marketing language or adding a set of fire doors in a hallway in order to call the separated areas “neighborhoods” or “households”, she points out that restructuring a nursing home “includes significant re-thinking of staffing roles and relationships” and stresses the need to “move out of the 1950s hospital-based model, just as hospitals have reinvented themselves over the past decade” (p. 46-47). Giving residents more power and control in directing the care they receive, and educating staff about focusing on individuals’ strengths as well as making consistent staff assignments is a recommended first step in the direction of culture change.

In the same vein, Rabig et al. (2006) found in their study on the outcomes of the Green House concept in Tupelo, Mississippi that realignment of power and energy promote meaningful life for nursing home residents; improving and influencing their quality of life.

Quality of Life and the Modern Nursing Home

Many believe that autonomy is a key component to having a good quality of life, and would argue that it is the centerpiece of culture change. Chappell includes autonomy and self-determination as necessary issues in resident quality of life (2001). Yet until the last decade or so, it was not common practice for residents to be asked what care they believed they should receive. The culture change movement and facilities’ commitment to improving the quality of care they provide has changed this to some degree; changing the resident’s role from that of passive, submissive care-recipient to active, engaged members of a community.
Autonomy must be authentic in order to be effective in one’s life. Collopy describes autonomy as authentic “when it reflects the identity, decisional history, and moral norms of an individual” (1990 p. 10). Ensuring such autonomy puts onus on the caregivers to focus on the individual’s personal history and character. This is challenging when faced with a resident who has cognitive impairment. Legislation exists to keep residents safe, but where is the line drawn between keeping one safe from harm, and letting them make a decision for themselves that could potentially cause them harm? Herein lays the complexity of personal autonomy. Kane said it best when discussing the problems with long term care: “Embedded in most of our rules and regulations is the idea that LTC (long term care) should aspire to the best possible quality of life as is consistent with health and safety. But ordinary people may prefer the best health and safety outcomes possible that are consistent with a meaningful quality of life” (Kane, 2001, p. 296).

Hofland identified three aspects of personal autonomy (Hofland, 1990). The first is physical, which relates to freedom of mobility in an environment with as few barriers to that movement as possible. Next is psychological autonomy, which is what most people think of when they hear the word and it is about choice and control. The last dimension to autonomy that Hofland talks about is the spiritual. It is “an expanded concept of self and relates to a continuity in the sense of identity for a person over time” (p. 91). For organizations participating in the culture change movement, these three aspects of autonomy, or consumer empowerment, are the ultimate goals and lie at the heart of culture change.

Lidz and Arnold wrote “One way to increase the importance of autonomy in a nursing home is to separate its medical care function from its residential function” (1990 p. 67). This is not an unreasonable or impossible suggestion. Rather, it seems like common sense. The difficulty lies with providers overcoming their fears of error and stepping up to “exercise creativity or common sense in daily work” (Kane, 2001 p. 295).

Background on Culture Change

In the 1970s, Vladeck talked at length about reform, rethinking roles, and improving the quality of life for nursing home residents. Essentially, he was talking about what we call culture change today. Also in the 1970s, Koncelik wrote about the design of nursing homes and concluded that “…there should be a tremendous effort to change and refurbish existing
structures, as well as to build new environments with a greater consciousness of the needs of the older people who will reside or are residing in the nursing home” (1980). He recognized more than 30 years ago an atmosphere of oppression in the nursing home and articulated the need to make the residential nature of the establishment “emerge and predominate.”

Unfortunately, almost 25 years after “Unloving Care” was published, Vladeck recognized that although substantial changes have been made in the nursing home industry, “some of the chronic malaise that characterizes the dominant culture in many nursing homes appears to be remarkably persistent” (2003 p. 1).

This is what the current culture change movement in America’s nursing homes is all about. These issues, resident autonomy and quality of life, make culture change an important topic for all the stakeholders effected by and involved in the nursing home environment – residents, families of residents, administrators, direct care workers, other providers, and policy makers. Culture change in long-term care is an initiative that is being embraced by many health care and nursing home providers across the country. Culture change strives to give individualized care and meaningful interactions to residents. It is a departure from the traditional medical model of care in which the dominant value is health and safety, rather than overall quality of life. The Ohio Person Centered Care Coalition (OPC3), states “Culture change in nursing homes refers to a shift from that cold, sterile, hospital-like environment, to an environment that is more centered on the individual needs and unique preferences of the people who live and work there.

Culture change is viewed in nursing homes as the movement from a ‘traditional’ model of care, characterized as hospital-like in nature, to a new model that emphasizes person-centered care and ‘home’” (www.centeredcare.org, 2007). It is more than changing the wallpaper, installing new furniture, and adding decorations that will make the institution feel more home-like. Such small, seemingly insignificant physical changes do add up, however, and collectively make a significant contribution to a facility’s culture change process, and are often the first of the changes to be made as they are the least costly for a home to make. Nevertheless, these are just one aspect of transforming the nursing home into a nurturing home setting, and often the first visible step that many nursing homes take in the process of transforming their organization into a residential home for older persons with chronic illnesses. The next steps involve educating and training all staff about what culture
change is and why it is important to implement resident and staff programs that align the facility with a mission to provide quality care. This step can take several months to a few years before a facility is ready to implement a new program.

The ball is rolling toward a better environment for nursing home residents, but has been slow in gaining momentum. Seventeen years ago, Hofland stated that “in 30 years, we will be shocked when we look back at how we treated elders in long-term care in 1990, just as we are shocked now at the way in which women, African Americans, and mentally retarded people were once treated, supposedly to protect them” (Hofland, 1990, pg. 91). We are more than halfway to the point of Hofland’s prediction. Will the culture change movement in the nursing home industry have gained enough ground in the next 13 years to shock concerned members of society? Let’s hope that Dr. Hofland was not wrong in his prediction.

Since that 30-year forecast was made, people across the country have banded together to form small groups that strive to make nursing home reform a reality. The following are a few projects and initiatives that are nationally recognized as supporters, models, and/or promoters of long term care culture change: 1) **Action Pact** is based in Milwaukee, Wisconsin and is “a company of trainers, consultants and educators who assist nursing homes and other elder care organizations in becoming resident-directed.” They seek to help organizations make a home out of their nursing home by restructuring the organization from a top-down hierarchy to a collaboration of self-governing teams. ([www.culturechangenow.com](http://www.culturechangenow.com) 2) The **Eden Alternative** was developed by Dr. William H. Thomas to improve the quality of life for elders living in nursing homes; to rid them of the plagues of loneliness, hopelessness, and boredom by incorporating companion animals and providing the opportunity to give meaningful care to another living creature. ([www.edenalt.com](http://www.edenalt.com) 3) The **Green House® Project** was born out of the Eden Alternative and is perhaps the most recent development in the long-term-care culture change movement. “Green Houses are homes for 6 to 10 elders who require skilled nursing care and want to live a rich life. They are a radical departure from traditional skilled nursing homes and assisted living facilities, altering size, design, and organization to create a warm community, yet they are skilled nursing facilities. Their innovative architecture and services offer privacy, autonomy, support, enjoyment and a place to call home” ([www.ncbcapitalimpact.org](http://www.ncbcapitalimpact.org)). 4)
Having an informal start in 1992 through the state of New York’s Ombudsman program and then meeting regularly by 1997, the Pioneer Network makes its home in Rochester, New York. It is their mission to “advocate and facilitate deep system change and transformation in our culture of aging.” This movement is about promoting an environment where elders and those who care for them are “able to express choice in meaningful ways” and in 2004 developed and published a handbook to help nursing home providers with their culture change journey entitled Getting Started: A Pioneering Approach to Culture Change in Long-Term Care Organizations (www.pioneernetwork.net). 5) The Society for the Advancement of Gerontological Environments (SAGE), this grassroots organization was “originally created from a 3 year project on aging, design, and regulations, which culminated with a congressional symposium in Washington DC in March of 1993. Based upon a common desire for change, the SAGE organization has evolved from a few volunteers into a multi-state organization with hundreds of members.” (www.sagefederation.org). 6) The Wellspring Model, based in Seymour, Wisconsin, came together in 1994 as a proactive response to managed care. The organization believes the key to an improved resident experience and success is collaboration and cooperation among facilities, keeping care decisions as close to the resident as possible, staff empowerment, database decision-making and accountability between partner organizations for improved resident outcomes. The core charter group consisted of 11 independent not-for-profit organizations located throughout eastern Wisconsin. (www.wellspringis.org). 7) The Ohio Person Centered Care Coalition began in June of 2005 when 5 representatives from the state attended the St. Louis Accord (sponsored in part by the Pioneer Network) “where they learned more about culture change and developed an action plan to move culture change throughout Ohio.” In September of that same year, those same 5 representatives plus another group of stakeholders “met to discuss their common goal of promoting the ideals of person-centered care to long-term care providers in Ohio. The result of that meeting was the creation of the Ohio Person-Centered Care Coalition (OPC3). The coalition does not subscribe to a specific model of person-centered care, but seeks to promote the ideals of the culture change movement throughout the state of Ohio” (www.centeredcare.org).

Wellspring, Action Pact, and OPC3 are all examples of state culture change organizations. Many states or regions have at least one of these initiatives or organizations
and they share one main concern; quality of life and care in nursing homes and other long-term care settings.

Exploring Culture Change

Aldrich discusses at length the evolution of organizations, stating that “organizations are shaped by the contexts in which they are established” (pg. 6) and lays out their transformation as a major change that occurs along three possible dimensions (Aldrich, 2000). These dimensions are goals, boundaries, and activity systems; and transformation in each dimension can overlap into another as they are often interdependent. He clearly states that “a transformation is a change, but not all changes are transformations” (pg. 163). In a nursing home, a change could be something like redecorating, yet this alone is not transformational. Transformation requires a “qualitative break with routines and a shift to new kinds of competencies that challenge existing organizational knowledge” (pg. 165). This describes what is taking place in the nursing home industry today. Aldrich suggests that an evolutionary view “gives greater weight to widespread transformations than to changes occurring within isolated organizations, no matter how large or important they might seem” (pg. 221).

Leslie Grant of the University of Minnesota, along with LaVrene Norton, Executive Leader of Action Pact, developed a four-stage conceptual model of the culture change process (2003). They approached the assessment of the degree of culture change from an organizational development perspective, and explain that “nursing facilities undergoing culture change progress through distinct stages of organizational change and development. Just as personality changes occur in individuals at different life stages, core systems change within organizations at different stages of CC” (culture change) (pg. 2).

The first stage is the Institutional model that represents a traditional medical model. This is the kind of nursing facility that was alluded to in the opening paragraph of this paper; and little, if any, culture change activities are present. The organizational power structure is a top-down hierarchy. The second stage is called the Transformational model and indicates an initial awareness of culture change that spreads from leadership to direct-care workers. Permanent staff assignments are usually found in this stage. Stage three is the Neighborhood model. In this stage, the nursing unit is broken up into smaller functional areas, given unique
names, and usually establishes dining areas for the residents of that specific “neighborhood” only, minus the kitchen. The fourth and final stage of Dr. Grant’s four-stage model is called the Household model. Here, units are called households because they are self-contained living areas with less than 25 residents. They have full kitchens, their own living and dining rooms, and the staff is part of self-managed teams, thus eliminating traditional departments and the hierarchical structure.

In their article on organizational culture change, Wilkins and Dyer, Jr. discuss how it is important to consider the nature of the culture that is to be changed (1998). Symbolic interactionists view organizational culture as “socially acquired and shared knowledge that is embodied in specific and general organizational frames of reference” (1998 p. 523). One of the key aspects of symbolic interaction theory purports that our social structures are worked out through the social interactions with others. This aspect and definition of culture assists us in understanding the broad picture of nursing homes as organizations and why the nursing home culture change initiatives have taken so long to take hold across the industry. A shared culture between providers, customers and regulators is what has been handed down since the rise of “modern” nursing homes of the mid-1900s and has been accepted as the “norm.” In order to achieve a true, genuine, and lasting change in any culture it is the collective beliefs and practices of the people who make up the culture that must be altered.

Wilkins and Dyer, Jr. identify three factors that determine why some cultures are more resistant to change than others: 1) the availability of alternative cultural frames, 2) the level of members’ commitment to the current frame, and 3) the fluidity of the current frame. The first factor suggests that if another way of operating is not realized by employees or organizations, they are not likely going to consider changing their general organizational frame. That is, a nursing home has a general frame of reference in relation to other nursing homes. They all share a general organizational culture. For example, if all nursing homes follow a medical model in the way they conduct business than this is their general frame of reference. Without knowledge of another model under which to operate, a nursing home will not be likely to change their frame of reference just for the sake of being different.

The level of members’ commitment to the current frame is another indicator of the likelihood to change. A positive or strong commitment to the current frame makes change difficult and perhaps unthinkable. In the nursing home industry, where there have been
decades of survivorship by way of implementing minor changes and policies in the wake of difficult challenges or crises, there is generally a heightened sense of commitment to the current frame.

The last factor influencing change is fluidity of the current frame. This is best explained by Lundberg (1985) who classified organizations as either change-oriented or stability-oriented. Nursing homes tend to be stability-oriented and rather complex organizations due to the fact that the government, through the Medicaid and Medicare bureaucracy, is considered to be both a customer and regulator of such organizations. Because of this complexity, nursing homes tend to be less fluid. It is when change strategies are incorporated and adaptation is encouraged that a frame has fluidity. There are a growing number of nursing home companies or organizations across the nation striving for fluidity via change strategies. These strategies are centered on the nursing home culture and its organizational structure.

Nursing home organizations must recognize that what may make another nursing home organization successful at achieving cultural transformation will not necessarily be the recipe for their own success. The location, size, and developmental stage of the change process all matter, and each organization is unique in these ways. Gibson and Barsade caution organizations to stray from thinking there is a perfect culture and from emulating a specific successful organization’s process toward improvement. They state that while it can be helpful to use those successful organizations as benchmarks, an emergent successful culture “will be one that “fits” –fits the organization’s environmental factors, fits its long-term strategy, and fits its people” (2003, pg. 19). For nursing homes moving toward the culture change process, they will do well to examine each existing model (like those mentioned above) to determine which, if any, is a good fit for them.

There are different groups of people in organizations that make up the culture, and nursing homes are no exception. The residents, their families, direct caregivers, administration, vendors, regulators, and corporate structure are all part of the nursing home culture. The exchange among them is another component that will determine their success at culture change. Everyone needs to feel like they are contributing something to their world, and often, workers in nursing homes do more for the resident than is necessary, leaving the resident feeling helpless from the imbalance of the relationship. Dr. William H. Thomas
wrote about helplessness as one of three plagues in modern nursing homes (1996). Helplessness, along with boredom and loneliness, withers the spirit of the resident. The resident wants to contribute to the relationship in whatever capacity they can; being a giver as well as a taker. A college student in Kansas wrote about an encounter with a resident while volunteering at his nursing home, “…he was happy when he could do the little things and could make peoples’ day better” (Roth, 2005 p. 242). When residents can contribute as much as they are able and desire, and when a true and deep culture change is at work, the resident becomes involved in the events of daily life, engaging both mentally and physically to the highest degree possible; and in turn, the housekeeper, nurse’s aide, and all others involved in the care giving role gain satisfaction from seeing the resident engaged and active and the exchange is more in balance.

Research questions

Although culture change is still a relatively new concept, a solid literature has now developed in the area. Recent research on the Green House® model has indicated sweeping and comprehensive changes, “so much so that some proponents perceive it as the deinstitutionalization of a nursing home” (Kane et al. 2007, p. 838). Residents can be found in kitchens when meals are cooked despite concern of some staff regarding the risks of infections, residents may be found in their own rooms or on the Green House® patio – out of the line of sight of staff, general therapy tasks and activities are carried out mainly by frontline CNA-level staff rather than by aides in the specialized departments of traditional nursing homes, reducing the direct supervisory control of charge nurses.

The Green House® research also indicates outcomes of higher resident quality of life and increased resident satisfaction than residents in either of the two comparison settings which were conventional nursing homes, as well as having better emotional well-being than residents at the comparison sites. This says a great deal about the importance of smaller-scale facilities and flattening organizational hierarchies in order to increase not only resident satisfaction and quality of life, but staff satisfaction and improvement in the quality of care provided.

Stone et al. evaluated the Wellspring model of nursing home quality improvement using qualitative and quantitative methods and found that the model “successfully and
intentionally meshes clinical and culture change together to meet its goals” (2002, p. 17). The model demonstrates that there is lower staff turnover, better performance on the federal survey, more staff vigilance in assessing patient problems, and better quality of life for residents, with no additional costs to the facility. A critical finding of the evaluation was that, to be successful, an intervention of this magnitude requires careful alignment of Wellspring's philosophy and structure with the administrative, operational, and management structures of the participant facilities. This is another example of not just a culture change model, but a process of deep organizational change.

The remainder of this study will examine the state of Ohio’s nursing home culture change movement. The main question examined in this study is: “Which organizations in Ohio have begun the process of culture transformation and what do those organizations look like?” Is it small, single-owned homes, or are large regional and/or national chain homes getting involved as well? Also, what are providers reporting as barriers and challenges to proceeding with transforming the culture of their nursing home environment; and what prevents them from doing more than making superficial changes to their culture?

Does there seem to be greater interest in changing organizational structure in not-for-profit or for-profit homes? Some long-term care organizations in Ohio are openly participating in this movement by affiliating themselves with regional or national projects like those mentioned above, while others are going about improving the culture of their nursing home by taking small measures to improve. There is also the home or organization that operates as it did 15 or 20 years ago with no plans to participate in the culture change movement.

This study will describe Ohio nursing homes on culture change activities.
Chapter 2
Methodology

Introduction

The 2005 survey of Long-Term Care Facilities was sent to 972 licensed and certified nursing homes in the state of Ohio. It was developed at the Scripps Gerontology Center, Miami University with support from the Ohio Department of Aging. The purpose of the survey was to gather information about nursing homes in order to identify trends in the industry for policy-making and planning purposes.

The surveys were mailed to each nursing home in the spring of 2006. Accompanying the survey was a cover letter, a Frequently Asked Questions sheet, instructions on how to fill out the survey, and a pre-addressed return envelope. Follow-up letters were sent and phone calls were made in order to increase the response rate. Nursing homes are required by law to complete the survey.

At the initial deadline date, 224 (23%) of nursing homes responded and after the first follow-up the response rate nearly tripled to 661 (68%). A final tally of 852 (87.7%) nursing homes returned their surveys with enough of it completed to be considered useable for data analysis. Any survey where the section regarding culture change was completely blank was removed from this study, resulting in 8 surveys being eliminated out of 852 (1%).

Certain facility characteristics were examined such as number of beds, ownership as either not-for-profit or proprietary, and geographic location (described as either urban or rural). Facility type was also examined and those that were part of a hospital (47) were dropped from the analysis. Facility characteristics are shown in Table 2.1.
### TABLE 2.1
Ohio’s Nursing Facility Characteristics, 2005

<table>
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<td>Average Number of Beds</td>
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<td><strong>Facility Size (percent)</strong></td>
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<td>74.1</td>
<td>47.4</td>
<td>81.0</td>
</tr>
<tr>
<td>Rural</td>
<td>25.5</td>
<td>52.6</td>
<td>19.0</td>
</tr>
<tr>
<td><strong>Ownership (percent)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For Profit</td>
<td>77.5</td>
<td>--</td>
<td>32.0</td>
</tr>
<tr>
<td>Not-For-Profit</td>
<td>20.5</td>
<td>--</td>
<td>68.0</td>
</tr>
<tr>
<td>Government</td>
<td>2.0</td>
<td>100.0</td>
<td>--</td>
</tr>
<tr>
<td><strong>Facility Chain (percent)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>yes</td>
<td>55.5</td>
<td>0.0</td>
<td>19.5</td>
</tr>
<tr>
<td>no</td>
<td>44.5</td>
<td>100.0</td>
<td>80.4</td>
</tr>
</tbody>
</table>
More than three quarters of all nursing homes in the state are under private ownership, and nearly three in four homes are in urban counties. More than half of the facilities in the state are part of multi-facility chains. The average number of beds in Ohio facilities is 98.

Facility size, location of a facility, and type of ownership can each have an impact on the culture change process. The literature does not clearly state how such characteristics might impact culture change. For example, does size matter when it comes to quality care and quality of life? Magito-McLaughlin, Spinosa and Marsalis suggest that it does (2002). Many traditional facilities are large, serving more than 100 residents. Conflicting priorities can be a barrier to planning and providing individualized plans, when, on the one hand person-centered plans are developed by the resident and their circle of support; while on the other hand the large, traditional service models “are often built around regulatory compliance issues and the establishment of broad, systemic treatments that impose rigorous standards of care to meet licensure requirements” (pg. 128–129). They continue with suggesting a service model that supports person-centered care and includes providing a smaller residential environment, offering one-to-one support during peak periods of the day, and consistent teams of staff throughout every day and shift.

Exploring Culture Change

The culture change assessment was designed by Scripps Gerontology Center in collaboration with an assessment sub-committee of the Ohio Person-Centered Care Coalition. The stages of transformation suggested by Grant, along with some defining characteristics of facilities at each stage provided the conceptual underpinnings. Cognitive interviews with ten nursing home administrators were used to refine the instrument prior to statewide distribution.

Questions on the survey pertaining to culture change reflect a facility’s organization, structure, and practices in the culture change process; and a brief description of the individual item categories are below.

Staff Roles. The roles of all staff, how they are scheduled, and who schedules them, are all components of this item.
Decision-making by staff that affects the way the facility is run on a day-to-day basis is another item in this category. It is designed to shed light on who makes decisions regarding staffing, scheduling, and other staff activities.

Organizational design, asks respondents to describe their facility’s organizational structure. Options range from “our organization is a traditional hierarchy”, to assigning department heads to a particular unit or group of residents, to not having department heads at all, to a neighborhood coordinator and self-directed work teams.

Resident Decision-Making. Questions assess how decisions are made that directly affect the daily activities of each resident. For example, can residents decide when to go to bed, when to wake up, when to bathe, when to eat, what to eat, and what kinds of activities are offered.

Staff Development. Questions about staff development including cross-training of staff, conflict management, teamwork, leadership, and support group facilitation were examined in this item

Community Integration items reflect the different kinds of activities that occur both inside and outside the facility that involve children, schools, churches, and the degree to which the facility assists residents in making arrangements for activities away from the facility.

Culture Change Activities. This item asks “What culture change activities describe your facility?” and is related to education of all levels of staff on culture change and the organization’s values and mission statement.

Charts. This item examines where resident charts are maintained. Keeping resident charts at a centralized nurse’s station is an indicator of a traditional model nursing home. Other possibilities for the location of resident charts are in a nursing office, in a charting room, or in a residential desk or kitchen in a household or cluster. The location of resident charts in a residential desk suggests the presence of a Neighborhood or Household model (Norton) of care as opposed to the traditional model.

The last area gives respondents the opportunity to describe their physical environment. Aspects of the nursing home environment that would indicate movement toward a true culture change are: organizing the facility into clusters or neighborhoods, and providing residents free access to a kitchen with a cook top, sink, and refrigerator. The other
entries that a respondent could check are less indicative of culture change, such as caring for live plants and animals that live in the facility.

**Scoring**

A scoring system was designed to assess the degree to which a nursing home is participating in culture change. Table 2.2 displays the item categories, and the range of possible points that could be scored on each. After removing those facilities that were part of a hospital and those who did not answer any of the items on culture change, 805 facilities remained for use in the data analysis.

The points assigned to the items on the 2005 Ohio Long-Term Care Survey were arrived at by examining the “Artifacts of Culture Change” tool line items (described below) and the points assigned to them in combination with the knowledge and experience of this author and Dr. Jane Straker of the Scripps Gerontology Center at Miami University. These two individuals assigned points to each item, and then compared one another’s points in order to finalize them before moving to the analysis. If there was disagreement on the points assigned to an item, the two individuals discussed the grounds for why each person gave that item specific points and then came to an agreement for a final amount of points for the item.

The “Artifacts of Culture Change” was co-developed in 2001 by Karen Schoeneman at the Centers for Medicare & Medicaid and Carmen Bowman of Edu-Catering to collect information on the concrete changes nursing homes have made in their policies, practices and schedules (http://www.culturechangenow.com/pdf/artifacts.pdf). It also examines resident autonomy and the physical environment of homes and results in individual homes being able to compare themselves to other homes that indicate they are participating in culture changing activities. Each item in the survey has points assigned to it, and it captures changes that have already occurred in facilities so they can gage the degree of culture change they have already achieved and how much more work may be required to take them to the point of culture change they desire. It exists as a paper questionnaire for facilities to fill out and compare their scores to what a perfect score would be. The points assigned by this author and Dr. Straker for the 2005 Ohio Long-Term Care Survey follow this same logic. The purpose of assigning points is to describe whether a facility possesses a certain culture changing entity, is making progress toward it, or does not possess it at all. Schoenemen points out that the
Artifacts of Culture Change tool “is not intended to replace any available tools, only to add to them an instrument to collect actual policy and building changes that many culture change innovators are making” (pg. 6).

Table 2.2 lists the survey item categories and the possible number of points a facility could obtain according to the boxes checked.

<table>
<thead>
<tr>
<th>SURVEY ITEM CATEGORIES</th>
<th>POSSIBLE SCORE RANGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Staff Roles</td>
<td>0-6</td>
</tr>
<tr>
<td>Decision Making</td>
<td>0-13</td>
</tr>
<tr>
<td>Organizational Design</td>
<td>0-11</td>
</tr>
<tr>
<td>Resident Decisions</td>
<td>0-9</td>
</tr>
<tr>
<td>Staff Development</td>
<td>1-10</td>
</tr>
<tr>
<td>Community Integration</td>
<td>1-23</td>
</tr>
<tr>
<td>Culture Change Activities</td>
<td>0-15</td>
</tr>
<tr>
<td>Resident Chart Location</td>
<td>0-3</td>
</tr>
<tr>
<td>Physical Environment</td>
<td>0-5</td>
</tr>
</tbody>
</table>

**Analysis**

In order to give facilities an overall score, the Statistical Package for the Social Sciences (SPSS) was used. It was possible for facilities to score as few as 2 points, and the maximum overall score could be as high as 110.

The primary analysis includes a comparison of means, using T-tests to compare culture change scores by the facility characteristic variables discussed earlier. Chi Square statistics will also be used to examine categorical data such as culture change categories by variables such as location and ownership. A multiple regression model was also estimated. The total culture change score was the dependent variable and the previously identified independent variables of facility size (continuous), profit status, (for or nor for profit) location (urban/rural) and part of a chain (yes/no) were used.
Limitations

Although measures were taken to standardize nursing home culture change through the points scale, it should be noted that the points system used in this study is exploratory in nature. While a rating system has been developed, the scoring as now developed is not considered to be an interval-level measure. For example, a score of 100 does not mean that a facility is twice as far along in culture change than a facility that scored 50 points.

It is not clear that culture change can be fully assessed through quantitative study and in-depth interviews with those who are and are not participating in the movement would provide more information about how culture change innovations operate in a nursing home. In addition, this study is limited to one state and while the response rate was high, there were some missing facilities. Another limitation is that data are from 2005 and facilities were asked to report where they were in the culture changing process at that point in time.
Chapter 3

Results

In this chapter, the results of the survey will be presented. We begin by looking at the total culture change score of all facilities. The independent variables in the analysis include facility size, type of ownership (described as for-profit or not-for-profit), geographic location (rural or urban), and part of a multi-facility chain (or not).

Figure 3.1 shows the observed range of scores that facilities received according to their answers on the survey. The highest point or peak on the graph is for the 35 facilities that scored 37 points. The graph is skewed, demonstrating relatively low culture change scores among Ohio nursing homes, as a majority of the facilities are clustered around the upper 30s and lower 40s for points obtained. The average score was 40.3 out of a possible 109 points. Eighty-seven percent of the 805 facilities, or about 700 of them, achieved an overall score of 55 (half of the total possible) or below. One can see here that the highest score achieved by any facility was a 92, and the lowest score was 9. Although the majority of facilities appear to not be far along in the culture change process, there are some facilities that are making significant progress based on their scores.
Figure 3.1
Observed Range of Possible Points
And Number of Facilities
Table 3.1 shows the average overall culture change scores by the four facility characteristic variables previously discussed. In examining scores by the major independent variables on balance, larger facilities tended to have higher culture change scores, as did not-for-profit-owned facilities. However, in no cases are these differences substantively large. The largest facilities, those with 150 beds or more, recorded an average score of just fewer than 43, compared to a mean score of 39 for facilities with 50 beds or less. These differences are statistically significant. Not-for-profit facilities also scored significantly higher on the culture change measure than for-profit nursing homes (43 vs. 40). There were no statistically significant differences for the variables that examined urban/rural location or whether the facility was part of a chain.

<table>
<thead>
<tr>
<th>FACILITY CHARACTERISTICS</th>
<th>Overall Score (0-109)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Score</td>
<td>40.33</td>
</tr>
<tr>
<td>Ownership by: *</td>
<td></td>
</tr>
<tr>
<td>For-Profit</td>
<td>39.57</td>
</tr>
<tr>
<td>Not-for-Profit</td>
<td>43.47</td>
</tr>
<tr>
<td>Size: *</td>
<td></td>
</tr>
<tr>
<td>0-49 beds</td>
<td>38.75</td>
</tr>
<tr>
<td>50-99 beds</td>
<td>39.00</td>
</tr>
<tr>
<td>100-149 beds</td>
<td>40.93</td>
</tr>
<tr>
<td>150+ beds</td>
<td>42.80</td>
</tr>
<tr>
<td>Geographic Location:</td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>40.5</td>
</tr>
<tr>
<td>Rural</td>
<td>39.9</td>
</tr>
<tr>
<td>Part of a Chain</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>39.94</td>
</tr>
<tr>
<td>No</td>
<td>40.89</td>
</tr>
</tbody>
</table>

* = P ≤ .05
The following table (3.2) shows the average culture change scores for a series of item categories that describe nursing homes in Ohio. These categories deal with decision-making, staff roles, staff development, and the organizational design of the facility, as well as community integration, resident decision-making opportunities, culture change activities, the physical environment and the location of resident charts in the facility.

The numbers in parentheses under each item category heading indicates the range of possible points a facility could achieve in that area. Below that is the average score across all facilities (805) in the study, and then average scores by each of the four characteristics described above are given per item category.

In looking at individual dimensions of culture change by the four independent variables, data show patterns similar to the overall score findings. For example, on average, not-for-profit facilities score significantly higher than for-profit facilities across the range of culture change items. These differences are small and are not consistent for all measures. For the variables examining facility size, geographic location, and whether the facility is part of a chain, there are minimal differences across item categories and no patterns are identified.

However, an interesting observation can be pointed to the “Part of a Chain” characteristic. Two category items, Organizational Design and Physical Environment, within this characteristic show statistical significance and the higher score goes to the non-chain facilities in both. These two category items indicate facility activities and behaviors that are in line with what Stone et al. (2002) referred to as administrative, operational, and management structure changes. This observation might indicate that due to the nature of facilities that are part of a chain, they experience greater challenges in making such changes than their non-chain counterparts, therefore leading to more superficial changes that do not lend to deep process change.
### Table 3.2
Survey Category Item Scores by Nursing Home Characteristics

<table>
<thead>
<tr>
<th>CHARACTERISTICS</th>
<th>Resident Decisions (0-9)</th>
<th>Staff Development (0-10)</th>
<th>Decision Making (0-13)</th>
<th>Staff Roles (0-6)</th>
<th>Organizational Design (0-11)</th>
<th>Community Integration (1-23)</th>
<th>Culture Change Activities (0-15)</th>
<th>Charts (0-3)</th>
<th>Physical Environment (0-5)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average score</td>
<td>6.3</td>
<td>5.8</td>
<td>7.0</td>
<td>2.5</td>
<td>0.5</td>
<td>12.3</td>
<td>4.0</td>
<td>0.2</td>
<td>1.5</td>
</tr>
<tr>
<td>Ownership by:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>For-Profit</td>
<td>6.4 *</td>
<td>5.9</td>
<td>7.0 *</td>
<td>2.4 *</td>
<td>.46 *</td>
<td>12.2</td>
<td>3.6 *</td>
<td>.18</td>
<td>1.4 *</td>
</tr>
<tr>
<td>Not-for-Profit</td>
<td>6.0</td>
<td>5.4</td>
<td>6.7</td>
<td>2.9</td>
<td>.70</td>
<td>12.9</td>
<td>5.6</td>
<td>.27</td>
<td>1.9</td>
</tr>
<tr>
<td>Size: 0-49 beds</td>
<td>6.8</td>
<td>5.0 *</td>
<td>6.4</td>
<td>2.5</td>
<td>.49</td>
<td>12.8</td>
<td>3.2</td>
<td>.16</td>
<td>1.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>50-99 beds</td>
<td></td>
<td>6.1</td>
<td>5.7</td>
<td>6.7</td>
<td>2.3</td>
<td>.39</td>
<td>12.5</td>
<td>3.8</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>100-149 beds</td>
<td></td>
<td>6.4</td>
<td>5.9</td>
<td>7.3</td>
<td>2.5</td>
<td>.55</td>
<td>12.2</td>
<td>4.2</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>150+ beds</td>
<td></td>
<td>6.4</td>
<td>6.3</td>
<td>7.1</td>
<td>2.8</td>
<td>.65</td>
<td>12.1</td>
<td>4.4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Geographic Location:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urban</td>
<td>6.3</td>
<td>5.8</td>
<td>7.0</td>
<td>2.6 *</td>
<td>.48</td>
<td>12.3</td>
<td>4.0</td>
<td>.22</td>
<td>1.5</td>
</tr>
<tr>
<td>Rural</td>
<td>6.5</td>
<td>5.8</td>
<td>7.0</td>
<td>2.2</td>
<td>.57</td>
<td>12.2</td>
<td>4.1</td>
<td>.13</td>
<td>1.5</td>
</tr>
<tr>
<td>Part of a Chain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>6.4</td>
<td>5.9</td>
<td>7.1</td>
<td>2.3</td>
<td>.31 *</td>
<td>12.1</td>
<td>4.2</td>
<td>.20</td>
<td>1.4 *</td>
</tr>
<tr>
<td>No</td>
<td>6.3</td>
<td>5.8</td>
<td>6.8</td>
<td>2.6</td>
<td>.75</td>
<td>12.6</td>
<td>3.8</td>
<td>.18</td>
<td>1.6</td>
</tr>
</tbody>
</table>

* = \( p \leq 0.05 \)
A regression analysis was also conducted and the results are presented below (see table 3.3). The dependent variable was the total culture change score, and the independent variables were the nursing home characteristics. Facility size and whether a facility holds for-profit or not-for-profit status have a significant effect on culture change score. The ownership variable was coded as 0 for the not-for-profit facilities, and 1 for the for-profit homes. The negative coefficient means that the not-for-profit homes scored higher on culture change compared to the for-profit homes. Looking at the size of facilities, the coefficient is positive; indicating that as the number of beds increases there is an increase in the culture change score.

No differences exist for the geographic setting of the facilities or whether they are part of a chain. The adjusted $R^2$ is quite small (.024), indicating that a number of factors influencing a facility’s progress in culture change are not included in the model.

Table 3.3
Regression Analysis of Facility Characteristics Predicting Culture Change Score

<table>
<thead>
<tr>
<th>Item</th>
<th>$\beta$ (SE)</th>
<th>$p$</th>
<th>$R^2$ (adjusted)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dependent Variable: Total Score</td>
<td></td>
<td></td>
<td>.024</td>
</tr>
<tr>
<td>1. Licensed Certified Beds</td>
<td>.029 (.009)</td>
<td>.002</td>
<td></td>
</tr>
<tr>
<td>2. For-Profit Nursing Homes</td>
<td>-3.978 (1.254)</td>
<td>.002</td>
<td></td>
</tr>
<tr>
<td>3. Part of a Chain</td>
<td>-.642 (.984)</td>
<td>.515</td>
<td></td>
</tr>
<tr>
<td>4. Geographic Setting Rural</td>
<td>-.046 (1.102)</td>
<td>.966</td>
<td></td>
</tr>
</tbody>
</table>

The overall picture reflects a relatively low degree of culture change in Ohio nursing homes. Culture change scores are significantly higher for not-for-profit facilities and larger nursing homes, however, overall scores are relatively low regardless of facility characteristics. These findings indicate that at this point Ohio nursing homes, on balance, have limited experience with culture change activities.
Chapter 4
Discussion and Conclusion

So far, nursing home culture change has been defined, presented, and discussed in the context of Ohio’s nursing home environment. The kinds of activities that promote culture change are described and explored, and then measured for Ohio nursing homes using the 2005 Ohio Long Term Care Survey.

The data analysis showed that not-for-profit facilities generally have made more progress in the culture change movement in Ohio compared to their for-profit counterparts. Also, the findings indicate that larger facilities typically employ more culture change activities than smaller ones. A closer, informal look at the data indicates pockets of culture change occurring at higher levels in certain urban areas in Ohio which also supports the finding of larger facilities employing more culture changing endeavors because facilities in urban areas tend to be larger. The key finding, however, was that culture change activities in Ohio nursing homes have been slow to take hold, in spite of a decade of increasing effort on the part of individuals, organizations, and coalitions.

Barriers to Culture Change

The 2005 Ohio Long-Term Care Survey asked nursing home administrators to report their insights regarding the types of assistance that would be helpful to them in furthering culture change in their facility. The two most frequently stated areas were about funding and the survey process. Comments about funding focused mainly on reimbursement rates and how that affected the homes’ ability to put any kind of change in motion. Regulations are also a big concern to many facilities, creating fear among staff and a mindset that says deviation from regulations is not allowed under any circumstance regardless of documentation or creative care protocols. Additionally, some facilities have a perception of surveyors being either uneducated about or unsupportive of culture change activities. One facility stated that it would help if surveyors possessed a cooperative rather than a punitive attitude.

Other comments pertaining to barriers to culture change included increasing community awareness, revisiting wage/salary issues, and one facility recommended that
the Ohio Department of Health (ODH) reexamine registered nurse coverage requirements. Very few facilities offered up positive comments about cooperative work with the state toward culture change. However, one facility stated that they are working closely with KeyPro and AOPHA in their effort.

Why are organizations resistant to change? Perhaps they are not. It could very well be that many organizations believe they are making the changes necessary for positive growth. According to the comments provided on the survey about barriers to culture change, it appears that several facilities feel limited in what they can do to implement culture change, yet they feel they are doing all they can at the present time.

The problem could very well lie with innovation. Innovation is not only an issue in the manufacturing industry; it can also apply to services. In the case of nursing homes, innovation is lacking. If one were to enter a business and ask, “What’s new?” most responses would include talk about new services or products that they offer. But what many businesses need, including nursing homes, is to reform their approach. Instead of providing care that is in line with the customer’s needs and desires, it appears that many facilities are following the industrial trend to align themselves with the hospital mode of care. This is not innovative. It is simply following a similar industry’s mode of operations, and hits home Aldrich’s (2000) point about the evolution of organizations and transformation. According to his statement about organizations being shaped by the contexts in which they are established, we should not be at all surprised at the nursing home industry’s tendency to follow the hospital industry, because the modern nursing home concept rose out of the hospital environment (Payne, 2006).

Benner discusses innovation at length in regards to process management programs and Total Quality Management (2005). Her points are geared toward manufacturing but are applicable to the service industry and to the culture change movement in nursing homes as well. She states that changing the culture in any organization “to embrace long-term innovation” is certainly challenging. When given the choice to try something “that is new and distant in time” most people will choose the short-term, measurable goal.

One of the recent challenges faced by nursing homes that have an important impact on the culture change movement is the shift to short-term care. Many facilities
now focus on rehabilitative services to accommodate those with acute care needs. What about the resident with chronic care needs who is likely a long-term customer?

Henderson and Vesperi wrote “…most nursing home placements are made due to lack of adequate community resources, not actual need for constantly supervised medical care” (1995, p. 37). Considering the decline of nursing home occupancy in the last decade alone, perhaps this is why some long term care organizations appear to not be concerning themselves with participating in the culture change movement. They are choosing to focus on the resident with acute care needs. Occupancy is down, they cannot afford to rebuild or remodel current physical structures, but projections indicate that the demand for a nursing home stay is slowly on the rise. That trend is expected to continue through 2020, and a stay in the nursing home will be of short duration that is rehabilitative in nature – which, in such cases, the medical model would likely be followed due to the acute nature of the illness.

So perhaps it is not necessary for all nursing homes to convert to the social model that represents the most radical form of culture change. If most or all nursing homes changed their physical structures and organizational practices to fit a more social model to meet the needs and desires of individuals with chronic illnesses, then where would those who need rehabilitative services go? Considering this contradiction, it is understandable that the culture change movement could affect some parts of a facility more than others; but the change is imperative nonetheless. It will challenge those facilities that want to serve all types and levels of need, and may ultimately force some facilities to choose one type of care based on core competencies and their evolving culture.

Since Henderson and Vesperi’s publication in 1995, there have been some developments in home- and community-based services for elders. Ohio’s state program (PASSPORT) is a significant supporter in the effort to keep elders in their own home while receiving a wide range of care services. This is contributing to the decline of nursing home use, but considering the growth of the older population, use of both entities is actually on the rise. The need for nursing home care is not diminishing. The levels and types of care needed in such facilities are changing, and this is why the issue of culture change is so important. Nursing homes are not just going to go away, so why not make
that environment one where owners and operators are not afraid to be innovative in the 
way services are delivered, where employees are free to interact with their customers on a 
personal level (after all, this is a business of personal matters), and residents can live as 
freely as they would in their private home? Surely a balance can exist.

Implications: Policy & Practice

Policy and practice issues are often interrelated and the arena of long-term care is 
no exception. “Pay us enough to actually do this!” is what one facility response stated 
regarding the type of assistance they felt would be helpful in their culture change efforts. 
Ohio has experienced a freeze in Medicaid reimbursement rates for several years in a 
row, affecting revenues for many facilities, thereby affecting their abilities to train and 
educate staff about culture change, implement new process systems, and build new or 
remodel old structures. Incentives from federal and state agencies would surely prove 
beneficial, but this would likely require aggressive measures that may seem too risky to 
many who have the power to change policy.

In December of 2006, the Centers for Medicare and Medicaid Services (CMS) 
issued a memorandum regarding culture change regulatory compliance, and provided 
inquiries on their website that were made by organizations going through the culture 
change process. (www.cms.hhs.gov/SurveyCertificationGenInfo/downloads/SCLetter07-
07.pdf). This document contains specific questions about federal regulations and what 
they mean as far as implementing culture change in nursing homes. An example of one 
question and answer is about the 14-hour rule. The 14-hour rule states that no more than 
14 hours shall pass between the evening meal and breakfast the following morning. These 
are very broad terms, and the general interpretation of most facilities is that they must get 
residents up, dressed, and to the cafeteria in time for breakfast or they will be violating 
this rule. However, CMS has come back to state the intentions of this rule and points out 
that it is stated in broad terms, leaving room for flexibility, resulting in facilities being 
able to simply offer food, such as a continental breakfast, upon a resident’s rising. This 
could be offered to the resident in his or her room without having to dress and go to the 
dining room or cafeteria for the meal.
Clearly, an important dialogue is occurring. The memorandum was disbursed to State Survey Agency Directors and now the onus is at the state level to familiarize surveyors with culture change initiatives. However, a potential gap could open here, as interpretations at this level may differ, resulting in facilities believing that some states support their culture change efforts while other states appear unsympathetic. Also, one can see that no change in policy has occurred in this example. Nor will one find a change in policy surrounding the other areas in question on the memorandum. What the federal agency has done is put responsibilities in the hands of state agencies, which has the potential to confuse matters. Perhaps a federal statement regarding culture change initiatives in nursing homes would provide clarity at all levels.

Culture change in nursing homes is a call for industry and facility leaders to step up and join forces with policy makers and researchers, as well as their competitors. There have been enough organizations in the industry that have achieved a changed culture to provide guidance to others who are just beginning. Learning from peers is the simplest, and perhaps the most valuable thing they can do to find their recipe for success in implementing culture change practices. Yet, so many times a facility will begin a new program and once the implementation process is underway, the program is left to survive on its own without being revisited or improvements made. It may even be a great program, but it falls by the wayside because key leadership either does not support it, or stress its importance in the larger scope of the facility’s mission and goals to staff members who are to carry out the program. Without constant revisiting and striving to improve a program on culture change efforts, the change will not be a lasting one.

Rabig et al.’s study results of the Green House model in Tupelo, Mississippi showed positive experiences for residents, family, and staff, and indicate that “because nursing home stock is aging, many physical plants are or soon will be slated for major rebuilding, thereby providing sponsors with an opportunity to consider Green Houses” (2006, p. 538). There is a great opportunity in this industry to continue growing, rather than maintaining the status quo. Industry leaders, like Mississippi Methodist Senior Services in Tupelo, Mississippi, have already recognized this opportunity and coupled with their vision for the future of their organization or the nursing home industry overall, have made great strides in the culture change movement.
However, the pace of culture change throughout the Ohio nursing home industry appears to be slow. One way to climb out of the rut would be to open the discussion to all the stakeholders in facility life. Imposing culture change through a top-down approach would likely have a negative impact on employee attitudes toward the change. Time, money, and other resources must be spent in order to educate all staff, residents, and extend into the greater community the desired outcomes, before expecting individuals to decide whether they want to participate in the change process or not.

Implications: Research

Future examination of the culture change movement in nursing homes across Ohio might best be conducted by taking the results from this study and performing interviews with a number of facilities that are at all levels of the culture change movement, plus a number of those who did not respond. Taking the perceptions of what culture change is in the context of a facility’s practices, organization, and structure would perhaps give us a clearer picture of the true state of the nursing home culture change movement in Ohio.

Also, more can be done with quantitative information. Perhaps this study did not ask the right questions, and perhaps using different nursing home characteristics as independent variables would provide better insight to examine and discuss Ohio’s nursing home culture change movement. Furthermore, following this movement over time as a longitudinal study would prove to be beneficial in that the successes of organizations could be measured and presented as recommendations and benchmarks for other organizations to reach toward. As always, much can be learned from mistakes, whether they be our own or someone else’s. A longitudinal study can provide the kind of information that tells us what has worked, what is currently working, and what hasn’t. If this information were to be shared across the industry, the likelihood that a true transformation will take hold increases because the less innovative and adventurous facilities could apply what has already been proven to be a successful endeavor. However, taking heed of Gibson and Barsade’s (2003) suggestion to organizations seeking to make changes, such facilities will want to have a clear understanding of their own culture before attempting to implement changes emulated from the pioneers.
Some facilities have made a commitment to moving forward with culture change efforts and by doing so have made it clear that they see a great need for changing the way they do things and to change the mindset that governs the industry. It is these facilities who are striving for the kind of evolutionary transformation described by Aldrich (2000). Facilities not so quick to join the effort are perhaps waiting for a guarantee that their efforts will not be in vain. Of course, there is no guarantee, but as facilities show success in their culture change efforts it is expected that the interest in culture change activities will continue to grow.
References

Massachusetts Extended Care Federation. Newton Lower Falls, MA.

pgs. 6, 186-187, 189, 221.

Programs Discourage Innovation?” Knowledge@Wharton.upenn.edu. November 30.

NURSING HOMES Long Term Care Management. pgs. 42-47.

Chappell, Neena L. (2001) in Linking Quality of Long-Term Care and Quality of Life.
Noelker and Harel eds. Springer Publishing. (pgs. 75-94).

Generations (supplement); pgs. 9-12.

Fahey, Monsignor Charles. (2003). “Culture Change in Long-Term Care Facilities:
Changing the Facility or Changing the System?” The Journal of Social Work in
Long-Term Care. The Haworth Press; 2:1/2, pgs. 35-51.

Gibson, Donald E. and Sigal G. Barsade. (2003). “Managing Organizational Culture
Change: The Case of Long-Term Care.” Culture Change in Long Term Care.
Practice Press.

Grant, Leslie and LaVrene Norton. (2003). “A Stage Model of Culture Change in
Nursing Facilities. Presented at The 56th Annual Scientific Meeting of the

Care: Nursing Home Ethnography. Bergin & Garvey, Westport, CT.

(supplement); 6-8.

Hofland, Brian and Debra David. (1990). “Autonomy and Long-Term Care Practice:
Conclusion and Next Steps.” Generations (supplement); 91-94.


www.centeredcare.org
www.cms.hhs.gov
www.culturechangetnow.com/pdf/artifacts.pdf
www.edenalt.com
www.ncbcapitalimpact.org
www.pioneernetwork.net
www.sagefederation.org
www.wellspringis.org
APPENDIX A.

2005 Annual Survey of Long-Term Care Facilities
Nursing Homes 1/1/05-12/31/05

Final Section on Facility Organization, Structure, and Practices
Facility Organization, Structure, and Practices

The following questions address facility organization and practices. Please check the characteristics in each section below that best describe your nursing home only.

1. Staff roles. What aspects of staffing and decision-making listed below best describe your facility? Check all that apply.

   Nursing care staff (STNAs, LPNs) are permanently assigned to a group of residents, a particular unit, or a particular neighborhood.

   Non-nursing staff (e.g. housekeeping, dietary) are permanently assigned to a group of residents, a particular unit, or a particular neighborhood.

   Scheduling is centralized in the facility.

   Some staff groups (e.g. day shift or another grouping) are allowed to schedule for their group.

   Staff scheduling is managed by teams in each unit, neighborhood, or household.

1a. Resident charts are maintained in a:

   - Centralized nurse station.

   - Nursing office.

   - Charting room.

   - Residential desk or kitchen in each household or cluster.

2. Decision-Making. What aspects of decision-making listed below describe your facility? Decisions we refer to here are staffing, scheduling, activities—decisions that affect the way the facility is run on a day-to-day basis—not decisions related to individual resident care. Check all that apply.

   Decisions about daily activities, scheduling of resident care, and management of day-to-day life in the facility are primarily made by management (administration, DONs, department heads).

   A group process is used to elicit input from residents and/or families.

   A group process is used to elicit input from all types of staff, including frontline caregivers.

   Input from groups other than managers has a significant impact on the outcomes of major decisions such as strategic planning, budgeting, purchasing, etc.

   Input from groups other than managers has a significant impact on the outcomes of minor decisions such as parties, group activities, staffing assignments, etc.

   Groups that include residents and/or families make most of the decisions that affect life in the facility.

   Groups that include all levels of staff make most of the decisions that affect life in the facility.

STA4. What number of your residents, as of December 2005, were bedfast all or most of the time? (MDS G6.a)

[ ] 

[ ]
2a. Residents (either individuals or as a group) make decisions about: (Check all that apply).

- menus and food choices .........................................................................................................................
- when to get up ........................................................................................................................................
- when to go to bed .................................................................................................................................
- when to eat their meals ...........................................................................................................................
- when to bathe ........................................................................................................................................
- which activities are offered ....................................................................................................................
- other ....................................................................................................................................................

Please describe ........................................................................................................................................

3. Organizational Design. What aspects of organizational structure listed below describe your facility? Check all that apply.

- Our organization could best be described as a hierarchy, with an administrator/executive director at the top, department heads/managers/supervisors one level down, and staff organized by function within departments. .................................................................................................................................
- Department heads are primarily managers and supervisors; they rarely provide hands-on direct care to residents ........................................................................................................................................
- Leaders and managers are primarily found in the administration and management team (dept. heads, etc.) .................................................................................................................................
- We have identified "natural leaders" in all parts of our organization ........................................................................................................................................
- We have worked to improve leadership in all areas of our organization .................................................................................................................................
- Department heads are assigned to a particular unit or group of residents ........................................................................................................................................
- We do not have department heads; our staff is organized into teams with "team leaders" or a similar title that manages each team ........................................................................................................................................
- We have work teams that are self-directed; there is not one identifiable, consistent leader ........................................................................................................................................
- We have a position that might be called a "neighborhood coordinator", i.e. someone who initiates planning the activities and care of a particular neighborhood or group of residents ........................................................................................................................................
- Functions such as dietary, maintenance, and the business office are organized as support services for each unit/household/neighborhood ........................................................................................................................................
4. Staff Development. What staff development activities have been done in your facility?
   Check all that apply.
   
   Workers are trained to assume multiple roles such as activities, direct care, or dietary depending on what is needed.
   
   All of our staff have had sensitivity training on working with older adults.
   
   At least one of our staff is trained in facilitating support groups.
   
   All of our staff have been trained on respecting the values and preferences of others.
   
   All of our staff have been trained in teamwork.
   
   All of our staff have had training in conflict management.
   
   Upper level administrators and department heads have been trained in conflict management.
   
   Middle managers and/or supervisors have been trained in conflict management.
   
   Frontline staff have been trained in conflict management.
   
   All of our staff have had training in leadership.
   
5. Physical Environment. What aspects of the environment listed below best describe your facility?
   Check all that apply.
   
   Residents are able to make their rooms unique through such options as choosing furniture or paint.
   
   Residents have free access to a kitchen with a stove or cooktop, a sink, and a refrigerator.
   
   Residents are involved with the care of live plants.
   
   residents are involved with caring for fish, birds, cats, or dogs that live here.
   
   The facility is organized into clusters or neighborhoods that relate to staffing, not just physical layout.
   
5a. The facility is organized into clusters or neighborhoods that relate to staffing, not just physical layout
   IF NO, skip to section 6.
   
   Each cluster or neighborhood has its own dining area where meals are regularly served.
   
   Each cluster or neighborhood prepares meals for their residents.
   
   Each cluster or neighborhood conducts activities for their residents at least 2-3 times per week.
   
   On average, there are ____ residents in each cluster or neighborhood.
6. Community Integration. Please check each statement below that is true for your facility. 

Check all that apply.

- We have a childcare center in our facility.
- Residents go on outings in the community at least once a week.
- Members of the community regularly use our facility (club meetings, polling place, park district classes, etc.).
- We have programs in conjunction with our local schools (students volunteer, residents read to young students, etc.).
- Our volunteers primarily assist the staff with whatever needs to be done.
- Our volunteers primarily spend time one-on-one with residents.
- Therapy animals visit regularly.
- We provide transportation for residents to attend religious services or other individual social activities outside the facility.
- We regularly plan activities that residents and their families attend together.
- In an average week, all residents spend time with someone other than staff and other residents.
- We regularly assist groups of residents in planning their own outings (e.g. providing transportation to a concert, purchasing tickets at a group rate, etc.).
- We easily accommodate spontaneous activities such as providing tea and snacks for unexpected resident visitors.

7. Ohio nursing home leaders face many challenges and are at different points in changing the culture of their facilities. The Pioneer Network defines culture change as "an ongoing transformation based on person-directed values that restores control to elders and those who work closest with them. This transformation includes changing core values, choices about the organization of time and space, relationships, language, rules, objects used in every day life, rituals, contact with nature, and resource allocation." What culture change activities describe your facility as of April, 2006? Check all that apply.

- We have not worked on culture change.
- A vision for culture change has been developed.
- A plan for culture change has been developed.
- Our mission statement reflects culture change.
- Our values statement includes person-directed values.
- Managers (administrators, directors, supervisors) have been educated about culture change.
- Staff have been educated about culture change.
- Culture change projects have been implemented.
- Culture change projects have been evaluated.
- Other

Please describe
8. We’d like to know a little bit about your facility. Please check all of the statements below that describe your facility.

   This facility is a member of the Association of Ohio Philanthropic Homes and Services for the Aging (AOPHA).  
   This facility is a member of the Ohio Academy of Nursing Homes.  
   This facility is a member of the Ohio Health Care Association.  
   This facility is a member of the Quality First coalition.  
   This facility is a registered Eden Alternative facility.  
   We are a member of the Ohio Person-Centered Care Coalition.  
   Our facility is based on the Greenhouse Concept.  

9. What types of assistance, if any, are needed to further culture change in your facility? Check all that apply.

   Leadership training.
   Staff training.
   Training modules.
   Consultant to work with us on culture change.
   Audiovisual and/or print resources on culture change.
   Additional financial resources.
   Change in regulations. Please describe.

Please describe

Other. Please describe.

The Ohio Nursing Home Family Satisfaction Survey will be conducted later this summer. In order to help us estimate the number of Family Surveys needed in your facility, what is your CURRENT census?

Thank you for completing this questionnaire. Please return it in the envelope provided or fax it to Scripps Gerontology Center at 513-529-1476. If you have comments about any of the issues addressed in the survey, please include them on the back of this page.

If someone in your facility is willing to serve as a resource or wants to learn more about culture change please provide contact information. This contact information will be provided to the Ohio Person-Centered Care Coalition for follow-up.
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