

# The Cultural Evolution

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

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

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

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



Merck, or Toyota.

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

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

### Creating A Plan

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

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

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

#### **Culture Change Today**

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

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

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

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

## Making Culture Change Work

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

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

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

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

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

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

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

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

## How Beverly Fared

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

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

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

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

## Four Stages Of Culture Change

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

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

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

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

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

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

### For More Information

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

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

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

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

### Culture Change Creates Value

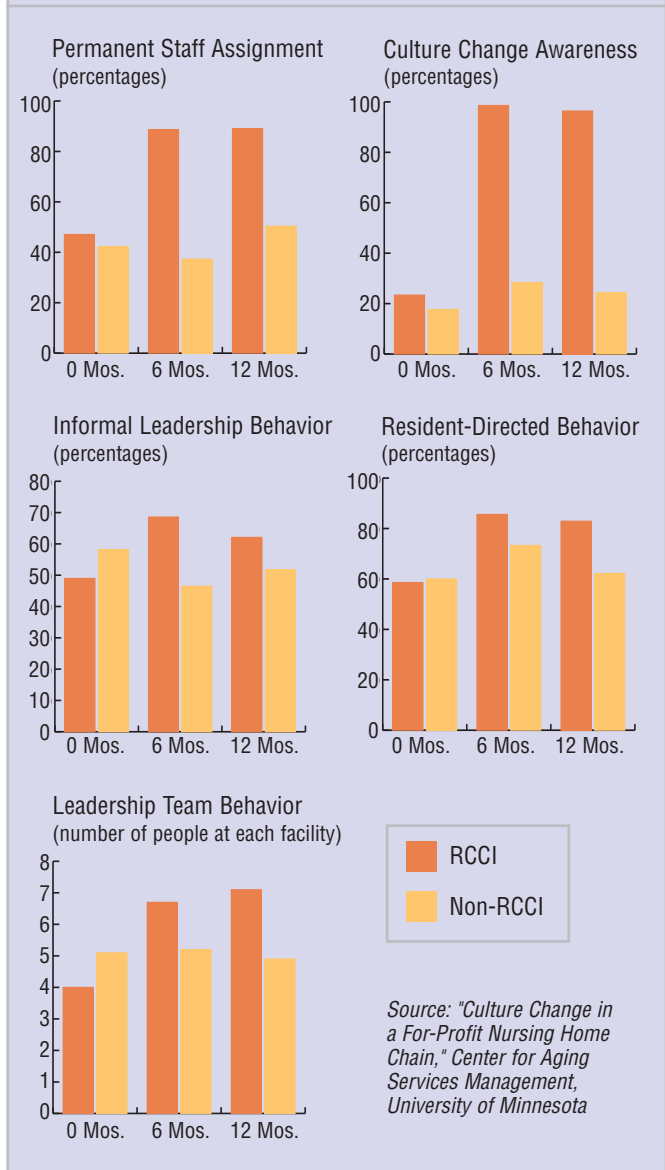
Evaluation of RCCI was complicated by two factors. First, a decision was made in 2004 to target RCCI in those facilities where the likelihood of success was the greatest. RCCI facilities were chosen based on key performance metrics tracked by Beverly Healthcare's internal "scorecard."

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

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

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

## Progress On Five CC Practices



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

of the sale from the effects of RCCI.

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

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

### Positives For Staff, Residents

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

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

■ *Choice and autonomy:*

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

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

Staff working in RCCI facilities had higher satisfaction with:

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

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

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

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

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

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

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

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

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## Coming Up

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