Provider

AMERICAN HEALTH CARE ASSOCIATION
NATIONAL CENTER FOR ASSISTED LIVING

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Bills Would Stifle SNF Arbitration

Advancing Excellence Renews Mission

The Future Of CULTURE CHANGE

INVESTING *In* *Culture*

Long term care leaders speculate about why it works.

A growing, critical mass of long term care (LTC) leaders is recognizing that the adoption of person-directed care—or culture change—serves to improve a broad base of key performance measures. More and more LTC leaders are changing their workplace practices, de-institutionaliz-ing their physical environments, and embracing person-directed care in order to get to the next level in terms of quality.

As person-directed care gains wide-spread acceptance as an alternative to more traditional, institutional frame-works, there is a general consensus that it is more than just the "right" thing to do.

Community members at Julia Temple Center, Englewood, Colo., work with master garden-er Cindy Wildfong to make Fairy Gardens as part of the facility's new horticulture program.

DAVID FARRELL
& AMY E. ELLIOT

Change

Christopher House staff and community members celebrate the holidays by making gingerbread houses.

A recent study from The Commonwealth Fund found that between 30 to 40 percent of all nursing facilities are currently implementing some principle of culture change that fosters resident-directed care, such as allowing residents to determine their own schedules and become involved in decisions about their facilities, decentralizing decision making to empower direct care workers, and consistently assigning the same assistants to residents. The study also found that the more culture change principles are embraced, the greater the increase in staff retention and occupancy rates and the greater decrease in operational costs.

Despite this indicator of progress, transformational leaps in quality are limited to a few providers, while many others are struggling to create deep, systemic change that improves not only quality of care but the quality of life for residents, their families, and also staff.

The adoption of person-directed care is a catalyst for quality of care and quality of life in LTC settings. To advance

Greeley, Colo.-based Fairacres Manor community member Roy Moser horses around during Horse and Carriage Ride Day during National Nursing Home Week, celebrated in May.

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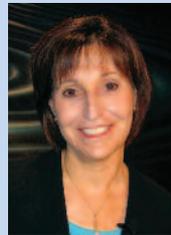
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person-directed care, LTC leaders need to hear from their peers. Provider interviewed LTC leaders regarding the value of investing in the implementation of person-directed care as an avenue to improve quality.

PROVIDER: In your opinion, what aspects of person-directed care drive organizations to consider these types of transformations?

BRUCE YARWOOD: The marketplace is demanding that the type of service we provide be driven by their expectations. To stay in business, we have to do more than the "old" nursing home stuff. We need to create a culture and environment of positive experiences for the residents—all the way from the food they eat, to the staff that serve them, to the therapy they receive. Not only is the culture changing in terms of what people are demanding, but the marketplace is forcing change through economics.

DAVID HORAZDOVSKY: Our main motivators must be driven by a resident-, family-, and staff-centered orientation. What it boils down to is that it's the right thing to do. Certainly, there could be positive financial and regulatory benefits if it's done well. However, there is more likelihood for success if there is a primary dedication to quality on which success is built. What we've experienced is positive outcomes with that dedicated focus.

FRAN KIRLEY: It's the value that we can show from those dynamic programs that makes a difference with the family and the resident. If we can continue to show those kinds of results and that the financial side is there, it will be a grassroots effort. That's where it happens. It doesn't happen by saying, "Everybody's got to have culture change." It has to happen when the culture within the organization and the facility sees the value added with patient-directed care and sees it as a better outcome and a better way to do business. It's an exciting dynamic time in our industry. It's an exciting time to be here.

BERNIE DANA: Culture change is a

byproduct of adopting a broad and disciplined approach to quality management and quality leadership. Ten years ago, implementing this kind of change was considered cutting edge. Now, person-directed or customer-focused care is a model that cannot be ignored. This is what consumers expect, and they know to ask for it.

Transforming an organization requires a lot of hard work and commitment. Once understood, I believe that there are two basic motivations that can drive an organization to change. You can see it as a moral imperative or as good business. I think it is both. Even so, I would suggest that the moral imperative is an internal motivation and the business model is external motivation. Lasting change comes when we are internally motivated.

JIM GOMEZ: For many, it's simply a sincere desire to do the best for the residents. Clearly, a motivator is consumer-driven demand for a more homelike, humanized, and personalized living and healing environment. In addition, there is a growing awareness regarding the connection between better resident outcomes and lower staff turnover in organizations that have adopted person-directed care.

ANNA ORTIGARA: Residents and families greatly value resident choice and control over daily decisions. Transforming the workforce is attractive to providers to decrease turnover rates and have consistent assignments. I believe that deep system change is attractive to only a handful of leaders due to the belief that it won't be supported by regulation and reimbursement. Actually the Green House homes are having very good results on state surveys.

PROVIDER: If the "case for quality" is defined as beneficial outcomes for both organizations and consumers, what organizational changes have the greatest impact on the case for quality?

DANA: It has to start with a shift in thinking from regulatory compliance to a real focus on meeting the expectations of the customer (defined as the resident and the resident family). For too many long term care facilities, it's ingrained in

HOW PAY–FOR–PERFORMANCE PROGRAMS

Key stakeholders offer their insights into whether state pay-for-performance (P4P) programs give providers incentive to implement person-directed care and enhance quality.

GEORGIA
Neil Pruitt, P4P in Georgia: "I can't speak for other companies, and it may be too early to tell, but we aligned our business drivers to match the Georgia P4P measures.

"Unlike other state P4P programs, in Georgia we placed a lot a weight on patient quality of life and employee quality of work-life measures as measured by satisfaction scores and staff stability measures. In addition, what is unique about Georgia's P4P system is

that inspection results are not part of the formula. Instead, the following four clinical outcome quality measures are utilized—pressure ulcers, restraints, and pain rates in both long-term and short-stay resident groups. As you can see, there is a nice balance with our P4P program metrics.

"Most importantly, our goals are aligned with the national Advancing Excellence campaign and are measured through publicly tracked data. The state of Georgia is to be commended for reaching out to the provider community in designing the program. It is truly a partnership between the state, the Georgia Health Care Association, and the provider community."

COLORADO
Jeff Jerebker, P4P in Colorado: "Our basic costs are not being covered by Medicaid in Colorado. Under this unique P4P system, we can start to fill that reimbursement gap while at the same time move a critical mass of facilities to adopt innovative changes leading to better care and quality of life.

We studied other states' P4P models but found that most of the performance measures are clinically based.

"In Colorado, beginning in July 2009, providers can earn up to $4 per day for each Medicaid recipient, based on the number of points they achieve using a 0 to 100 scale.

"What is so unique about our point system is that 70 percent of points a facility can earn are geared to resident quality of life, and a facility must demonstrate that they have implemented specific culture change practices such as enhanced dining programs and consistent assignment.

"Pay-for-performance programs will change the behavior of for-profit facilities if the program is designed well and if the profit incentives specifically target those areas where we want change. By focusing so heavily on quality of life and the implementation of certain culture change practices we know that quality outcomes will also improve. There is a link between quality of life in a facility and the clinical outcomes of care."

them to simply comply with regulations, to pay close attention to the clinical aspects of things, and to try to not have bad surveys. So, everything gets focused in on that kind of regulatory compliance.

Culture change starts with how you think. What do my customers and families want? How do I know? How do I begin to provide for and meet these expectations? When that ends up trumping regulatory compliance, you can start to have culture change.

KIRLEY: Changes that deliver a care model that is clinically based and resident-directed where people control their decisions. For example, we now have an innovative dining program called "Continuous Dining" so residents can eat breakfast from 5:30 in the morning until 10:30, then lunch is from 11:00 to 3:00, and dinner is from 4:30 to 8:00. We created the model in the past year, we've rolled it out to a couple of buildings, and we've seen tremendous customer satisfaction and tremendous improvement in weight management. Simple things work with amazing outcomes.

BARBARA FRANK: Staff stability and consistent assignment have a tremendous impact on quality and overall performance. Consistent assignment supports caring relationships between staff and residents. These caring relationships are what draws staff to this work and keeps them. Stability and consistency allow staff to work better with each other, which reduces stress and allows staff to provide more consistent care to residents. This consistency improves care outcomes.

When staff work with the same residents every day, they can anticipate what residents need and recognize small subtle changes that can be red flags. Staff also know just what to do personally for each resident to help them feel better. Then, through culture change, if staff can go by the resident's own daily rhythms instead of trying to make the resident adjust to a facility schedule, residents thrive and staff's work is more rewarding.

NEIL PRUITT: We have taken specific steps to make person-centered care operational in each of our centers. First,

ARE WORKING OUT

MINNESOTA
Patti Cullen, P4P in Minnesota: "Our P4P started in 2006 and, we believe, providers did change their practices under the P4P program for a few reasons: 1.) state Medicaid rates do not cover the cost of providing care so providers are motivated to achieve the maximum reimbursement rate; 2.) public reporting of each provider's "report card" whose measures, in part, match the P4P performance measures; and 3.) the report card allows a provider to see other providers' scores, thus spurring competition to have the highest ranking (five stars) in their geographic region.

"Since 2006, across the state, customer satisfaction scores and quality indicators have improved. Minnesota providers' adoption of the principles of person-directed care were considered when the program was established.

"About 20 percent of the total P4P points that a provider can receive are tied to measures of quality of life derived from resident and family satisfaction scores. Of all the measures on the report cards, this is probably the one that consumers conducting an Internet search for a facility for their loved one in Minnesota can relate to best.

"Survey results and other clinical measures are confusing for consumers, but satisfaction is something they can relate to and understand. Providers were strong advocates that satisfaction survey results should be a part of the P4P program in Minnesota."

OHIO
Pete van Runkle, P4P in Ohio:
"Probably the most significant policy issue that exists [in Ohio] is that P4P doesn't affect everybody. So, trying to gauge the impact is really difficult to do, because there are only about 20 percent of the providers where the quality incentive affects their rate (that number will presumably increase over time).

"However, one of the achievements of pay for performance has been to raise the provider's awareness and raise the significance of the customer satisfaction piece. They've always been interested, but now they are paying even more attention both in terms of participation and in terms of what their results are—and that's a good thing. Customer satisfaction is something that they should be paying attention to. Homes are making an effort to get customer satisfaction surveys out to families and get enough of them back to get a statistically valid sample. Even with resident satisfaction, there is greater participation, which is a great outcome.

"For providers, to support pay for performance is the right thing to do. Whether or not we have concerns about the details of pay for performance, the goal is our goal, which is quality.

"Unfortunately, with it not affecting as many providers as it ultimately will, it's a little early to draw too many conclusions. However, I support having it as part of the reimbursement system, and it puts the spotlight on quality and on the performance measures that we've agreed are important."

we created a direct-care clinical nursing position called the senior care partner (SCP). The SCP is a nurse who takes the time to sit down with the patient and their family members on a consistent basis throughout their stay and communicates with them regarding their progress toward mutually agreed upon goals, as well as what to expect next. The SCP empowers patients and families by taking the time to listen to their goals and expectations and then including them in the care planning process focused on meeting those goals.

PROVIDER: What outcomes are most reflective of these organizational changes that embrace person-directed care?

HORAZDOVSKY: The outcomes that we have seen include that of decreased staff turnover, highly developed direct care staff skills, and increased staff satisfaction on surveys. Likewise, we've seen increased family and resident satisfaction in the survey process that we follow, and we've seen positive financial outcomes primarily generated from a more stabilized census. We've improved minimum data set accuracy, which relates to better reimbursement. We've seen decreases in negatives for residents—stress, pain, incontinence—and an increase in the positives for residents such as rehabilitation, improved relationships with residents and families, and good survey outcomes.

BRAD SHIVERICK: The ultimate outcome is a measure of how changes impact the resident. The satisfaction of the resident, or their family proxy, is the best measure of how effective the changes have been. The most impactful measure of the capability of the organization to accomplish change is the commitment, loyalty, and stability of the staff. The best measure of the efficacy
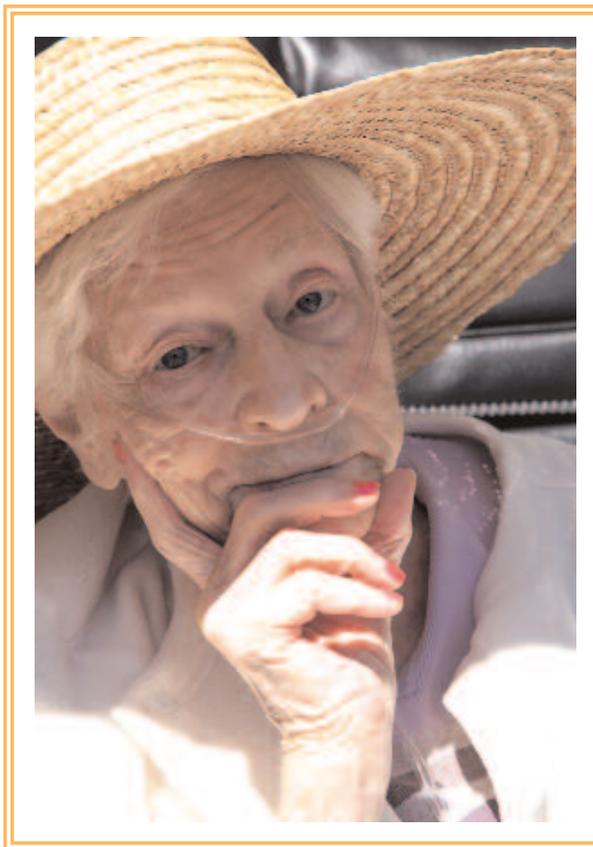
Ann Bramble, a community member of Christopher House in Wheat Ridge, Colo., relaxes outside.

of the change, after achieving success with the first two, is the financial success of the organization.

KIRLEY: Where we've seen these programs develop, we've seen improvements in the census; we've seen improvements in the quality of the payer mix—which translates to better financial outcomes and better rewards for the staff, which reduces turnover. Now, the staff feel very satisfied with their responsibilities in their job every day. When you're doing more exciting things at work, people show up, there is not as much overtime, and people are managing their resources more effectively. It's the whole management dynamic that you're operating under to be a creative workforce so that people want to be there, [which results in] a higher census, and the costs per patient day go down.

FRANK: There's a palpable change in

the stress level—for everyone. Everyone works better together, and they are better able to troubleshoot and resolve problems that do come up. Think about the stress generated by working short. Once there's regular staff stability, people immediately feel the benefit.

PRUITT: Patient, family, and staff satisfaction have increased significantly. Our occupancy rates have gone up, and the quality measure rates are improving. At the same time, we are maintaining similar overall operating costs, but we are achieving better quality outcomes.

ORTIGARA: Quality indicator improvement; satisfaction of staff, the elders, and their families; systems that work. Elders just having a normal life and day—and not becoming institutionalized. Simply, I see people more engaged with people. These changes result in families visiting more and staying longer and joining in for dinner and activities.

RICK MILLER: Decrease in staff turnover; improved customer satisfaction (residents, families, and staff); decreased citations, as with a good quality improvement system the facility will be acting proactively to solve problems as opposed to reactively; better resident clinical outcomes, financial results, and reputation.

PROVIDER: What are some of the potential investment costs to the organization?

ORTIGARA: The up-front costs associated with re-engineering workforce, educating and coaching for self-managed work teams, and re-education of leadership team to guide the new workforce model. For organizations that want to take on environmental redesign, the building costs are significant. We need something like the Hill

Burton Act to help providers build new environments. The reimbursement (especially Medicaid in most states) might cover the operating costs—but perhaps not the capital costs.

HORAZDOVSKY: There are definitely investments necessary in the area of labor. Staff training for competency, cross training, and leadership training for support of culture change are some examples. Also, equipment to ensure that staff have the appropriate tools and resources to perform the task in an efficient way, and having things such as state-of-the-art mechanical lifts and clinical documentation systems are some examples of investments that we have found are important.

KIRLEY: The education of the staff is really the time and the financial effort. For example, the Continuous Dining Program we initiated may have cost us a little bit more money in labor but we think the outcome is well worth that investment. Quality of care for our residents and knowing that we, as an industry, are going to pay-for-performance means a satisfied customer brings me new business. And, with a satisfied customer, my liability issues are less, my turnover is less. It makes that organization much more successful.

DANA: Let's be honest, making a transformational change requires an initial investment. The biggest investment is in the attitude change. This requires training and developing people in the organization through a continuous commitment to teaching quality management, teaching process improvement tools, enabling staff at all levels to participate in improvements, and providing technology that supports gathering and analyzing data.

Over time, all staff should be taught problem solving and decision making, team skills, root cause analysis, and effective customer service. Supervisors should be taught conflict resolution, communication styles, and effective performance evaluations. It's about addressing the issues that are barriers to good performance rather than forcing employees to change. And it's about getting the right people on board—making changes in how to hire, select, and retain employees.

JEFF JEREBKER: There certainly are some investments to be made in staff and leadership education, changing care and dining systems, environmental changes, and costs associated with retaining your best staff. But we are essentially shifting costs from institutional practices to person-centered care practices—but it's been my experience that the total costs remain flat. Most providers considering adopting an open

A resident at July Temple Center, Englewood, Colo., learns new skills using It's Never 2 Late's adaptive computer system.

dining program like ours want to know if our budgeted food costs are significantly higher than the average in Colorado. Our food costs are slightly higher—maybe 10 percent. But we have reduced so much plate waste, and the residents are happier. In addition, our open dining program has virtually eliminated resident weight loss.

PROVIDER: Are you aware of any barriers (such as regulatory, financial, and organizational) that occur at various stages of implementation?

FRANK: Staff stress and instability are the biggest barriers at the beginning. It's hard to innovate when all efforts are needed to maintain daily coverage. Many people label staff concerns as resistance because they don't see that staff feel stretched just managing what they already have to do. Taking on more or disrupting how they do their work feels impossible. Employees worry about what could go wrong for residents and what surveyors will say.

Staff "resistance" or opposition often indicates a concern that needs to be addressed for successful implementation of any initiative. When these concerns are taken seriously and changes allow staff to put people first, staff support change and join in.

HORAZDOVSKY: Generally, we've found that there are really no prohibitive financial barriers, but there must be awareness on the part of leadership that there will be an initial financial investment, specifically in the area of training and education. There have been few regulatory barriers—especially if leadership knows their regulations well before implementation and there is the commitment to communicate with state survey agencies on the front end. So, those can often be mitigated with good communication.

GOMEZ: Economic realities are a barrier. For example, reimbursement rates are not structured to provide [an] individualized program of care. The reality is that residents are served in a system that pays for about three hours a day of nursing care, much less for social services and activities.

Organizations that seek to individualize care have to "staff up" as much as they can, cross-train departments to be able to serve the residents' needs (that is, admin, dietary, and activity staff become certified nurse assistants to

help with dining, toileting), and be very creative in scheduling staff.

Unfortunately, there is no way to provide private rooms under [the] current reimbursement structure. Innovations can cost money. However, organizations have to be willing to commit the resources, not just talk about it. Reports from facilities that have adopted these changes say that the additional expenses are offset by higher resident census and lower staff turnover and absenteeism.

MILLER: There is an overwhelming resistance to implementation that is related to resources in terms of time—"I don't have the time to do another project right now."

In addition, the risk facilities may feel in terms of survey citations—while the requirements actually support these changes, there is still the fear of citation if a facility were to stop doing something they have been doing that is not in alignment with culture change.

Finally, financial incentives are in the future—many facilities operate in the here and now—so benefits in the future are not appreciated.

YARWOOD: The regulatory system is based on penalties instead of rewards. There's not one reward in that entire system. So, the AHCA [American Health Care Association] mantra is to look at a system five to 10 years out that recognizes quality and quality measures that are things such as staffing, turnover, reduced re-hospitalization and are not based on the case of peas that is three inches off the floor in the store room. Let's not worry about some of the stuff we are worried about. Let's get to the root causes of how to make things better. In doing that, the whole culture of how we perform is going to change also.

JOHN ELLIOT: Think about rural America. In rural West Virginia, I have three facilities where we are the only health care system in the county. And we could do Meals on Wheels or we could do home health. In fact, in one of them, we were doing triage for the emergency response vehicles before they went to the hospital in the next county. All of those things are possible, but they are not allowed because of regulatory restrictions. It's been a frustrating 25 years trying to be innovative.

To me, health care has been interesting because even with a problem-solving and outcome-oriented approach, a lot of very good solutions can't be implemented when we run into regulatory nightmares.

DANA: We need a government who is empowered to create incentives. Let's look at it from a broad standpoint. One major problem is in our facilities. So many facilities were built 40 or 50 years ago. Those will have to be replaced. It's difficult to implement person-directed care when there is not enough room, residents have to share toilets, etc.

There needs to be an infusion of financing to make it possible for organizations to make these kinds of changes if they want to. No, that shouldn't necessarily be the driving point for culture change, but it ought to be a sustaining point. An infusion of capital is not the creator of momentum, but the accelerator of momentum. If we don't get that accelerator, it will make it really difficult to sustain change.

KIRLEY: I spent my entire morning today talking about how we renovate these buildings. I can't build new ones everywhere. So, how do I take a 30-, 40-year-old building that's designed like a wagon wheel and make it into a state-of-the-art nursing home? We're brainstorming that right now. Everybody wants a private room, but that may not be financially viable when you've got a statewide tax system that hasn't made an enhancement to the capital infrastructure of its Medicaid rate in years.

PROVIDER: What could be done to facilitate or incentivize more widescale adoption of person-directed care?

HORAZDOVSKY: More educate, educate, educate—less of regulate, regulate, regulate (especially the onerous punitive kind of regulations). Open up more opportunities for learning and make them readily available. Promote sharing of models that have demonstrated successful implementation. Classically, the work that our associations do has real success with this, and we have to communicate our successes and go along in partnership with one another. It's hard to go about this alone. We need all of our stakeholders in partnership with one another to advance this important cause.

YARWOOD: We're doing it right now with Advancing Excellence. The most important part of the Advancing Excellence initiative is not the benchmarking, but who is sitting around the

For More Information

CULTURE CHANGE ADOPTION

A recent study of the penetration of the culture change movement in the country's nursing facilities supports the thoughts and observations of the long term care leaders interviewed for this article.

According to findings from "Culture Change in Nursing Homes: How Far Have We Come?" by The Commonwealth Fund, "The survey highlights important lessons, including the finding that the more a nursing home has adopted culture change principles, the greater the benefits that accrue to it, in terms of staff retention, higher occupancy rates, better competitive position, and improved operational costs."

■ For a report on the culture change survey, see *Provider*, July 2008, page 15.

■ For the full survey, go to www.commonwealthfund.org:80/publications/publications_show.htm?doc_id=684709.

table (government, industry, nurses, consumers, doctors). We've got 28 people on the Executive Committee to govern. Never before have so many volunteered to come together. What we are trying to do, as a group, is figure out what is the best way to make this happen in a positive way. The culture is one of help and support and teaching people how to do a better job.

SHIVERICK: The business case for quality is a powerful message to organizations that articulates that their investment in quality will provide a return that can be redirected to either the bottom line or to further investments in quality. If the business case for person-directed care can be clearly articulated, it will be appealing for other providers.

MILLER: The government could focus on the facilities that are doing it right as opposed to highlighting all the poor performers. I believe the AHCA/National Center for Assisted Living Quality Award program assists with this goal. Investing in education and training for staff at the facility level. Unless we have highly qualified staff, remodeling buildings and implementing new programs will not provide quality care.

BONNIE KANTOR: As with any movement, we need to create an "army of advocates" to make change happen and "stick." We believe that we need to encourage and empower baby boomers to be discerning consumers of nursing home care for themselves and for their aging parents. Because, until the boomers demand that we as a country change our culture of long term care, it won't happen. We need to develop guides and related information for consumers to help them select facilities that are practicing person-directed care.

We also believe that there needs to be a national Web-based clearinghouse and online resource that can foster the dissemination of tools and guidelines and support education and training. We also need to further engage academia.

With few exceptions, academic institutions have not been active players in

Christopher House community member Joan Sims lives "High on the Hawg" during the Colorado Health Care Association's 2nd Annual Poker Run to raise money for its scholarship fund.

the culture change movement. This lack of training and education in person-directed care and principles remains a pervasive barrier to the broader spread of person-centered care and related innovation.

In Conclusion

Delivering high-quality, person-directed care and achieving profitability in nursing facilities are not two mutually exclusive goals. In fact, they are very closely linked.

According to Pinon Management's Jerebker, "Our best-performing facilities—from a clinical, regulatory compliance, and resident quality-of-life perspective—also have the highest profit margins. And they use their profit wisely by making investments in their staff,

equipment, and physical plant."

The LTC leaders interviewed for this article articulated that well-executed investments and implementation in person-directed care are catalysts for achieving these goals and provide a foundation for transformation in practice.

Good Samaritan's Horazdovsky agrees that these types of investments are critical to success.

"Like all things, it is one of dedicating yourself to the ongoing training for staff at all levels," he says. "So, it is the commitment to the organization and a dedication to provide the resources to obtain the outcomes and to place a high value on staff competency. [As leaders], we have to say that it is important, we are going to invest in it, and we are going to celebrate when people achieve these levels." ■

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