

The Cultural Evolution

Part Two: Culture Change Or Perish: The Business Case

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

This is the second installment of a three-part series about Golden Living's continuing crusade to instill the values of culture change (CC), or person-centered care, throughout all of its nursing facilities, which are now called Living Centers. Part One last month reviewed a program called the Resident Centered Care Initiative (RCCI), which was evaluated by a research team from the University of Minnesota.



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

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

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

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

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

Leadership Drives Successful Culture Change, Organizational Excellence

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

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

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

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

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

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

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

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

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

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

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

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

Making The Business Case

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

What’s Deep Systems Transformation?

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

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

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

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

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

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

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

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

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

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

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

- A culture of excellence
- Workforce commitment
- Leadership strengths

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

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

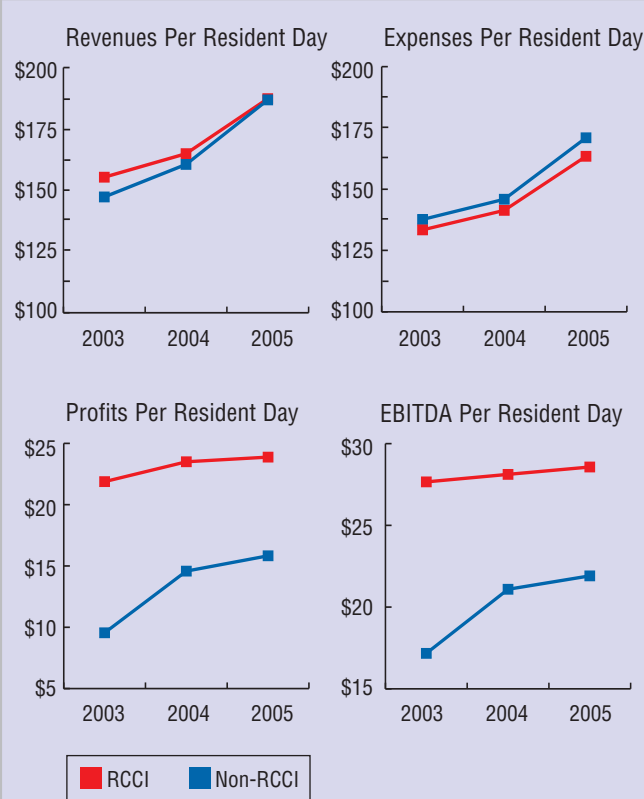
InnerView, Wausau, Wis. “These are the industry leaders or top performers who set benchmarks for the best-in-class. They consistently do better than their peers on metrics we’ve been tracking.”

Workforce Commitment Key

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

Figure 1

CC Impact On Bottom Line



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

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

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

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

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

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

Bottom Line Results

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

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

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

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

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

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

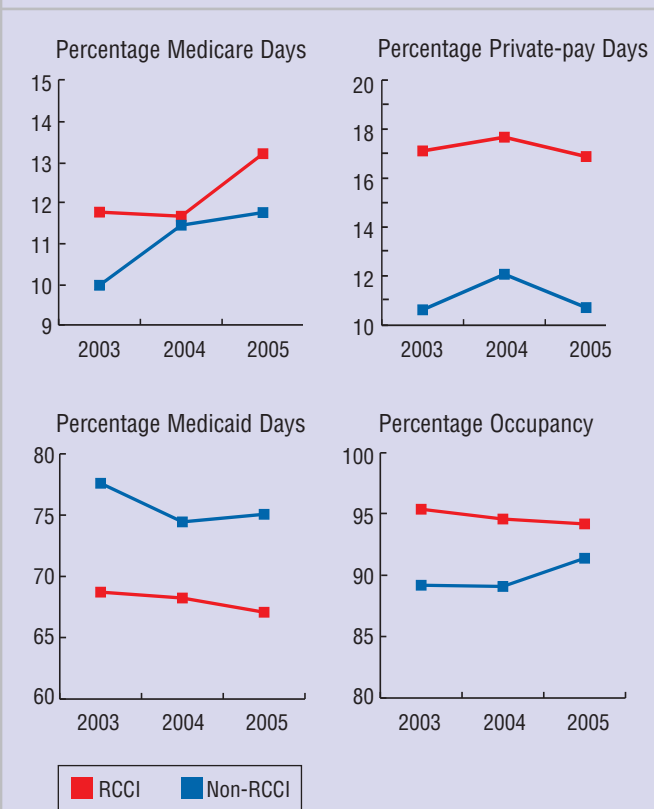
Both profits and earnings per resident day (EBITDA) showed greater differences between the RCCI and non-RCCI facilities in 2003 before RCCI began. However, these differences in profitability and earnings are due to selection bias. RCCI had little effect on payer mix and occupancy, so it had little impact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

Looking At Expenditures

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

Figure 2

CC Impact On Payer Mix And Occupancy



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

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

Coming Up

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

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

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

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

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

LESLIE A. GRANT, PHD, is associate professor and director of the Center for Aging Services Management at the University of Minnesota. He is a principal at Wausau, Wis.-based My InnerView, an applied research company that promotes quality improvement through evidence-based management. EDWARD MCMAHON, PHD, is national director of Alzheimer's care and quality of life at Golden Living, Ft. Smith, Ark. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and should not be attributed to the fund or its directors, officers, or staff.