Commentary

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Implications for Policy: The Nursing Home as Least Restrictive Setting

Key Words: Nursing home, Culture change, Resident-centered care

The culture change movement has emerged as an answer to a public policy challenge: How can a nursing home, as a facility providing services under one roof to unrelated individuals with disabilities, ensure that every resident "attains and maintains his or her highest practicable level of physical, mental and psycho-social wellbeing" (Omnibus Budget Reconciliation Act, 1987)? And can a nursing home simultaneously become "the most integrated setting appropriate to the needs of qualified individuals with disabilities" as required by the regulations carrying out the Supreme Court's 1999 decision in Olmstead v. L.C. (U.S. Administration for Community Living, 2013)?

Care for persons with disabilities in the least restrictive setting is so important that public policy has moved ahead to support resident-centered care in nursing homes even though the evidence base concerning culture change is still developing. As the Introduction to this supplement notes, "the train has left the station" (Zimmerman, Shier, & Saliba, 2014). Policy champions situated at state and federal levels are persuaded by the concept and have set in motion a number of policy initiatives to foster culture change. At the Federal level, the Centers for Medicare & Medicaid Services have pursued efforts to encourage culture change through changes in survey and certification requirements for Medicaid, inclusion of resident experience in the latest Minimum Data Set instrument, and dissemination of organizational transformation through the Eighth Statement of Work contract for state Quality Improvement Organizations. The Administration for Community Living Long-Term Care Ombudsman Program promotes person-centered practices for residents of long-term care facilities in a manner aligned with culture change efforts. States have pursued a variety of avenues to foster person-centered services in nursing homes (Stone & Bryant, 2013). They have used statutory or regulatory authority to flex rigid, traditional nursing home regulation that can impede culture change; enabled state officials' participation in coalitions and working groups facilitating the diffusion of culture change models (Beck, Gately, Lubin, Moody, & Beverly, 2014); and supported technical assistance activities to spark and sustain implementation. Some states have developed pay-for-performance payment systems for Medicaid nursing home care that encourage adoption of elements of resident-centered care (Miller et al., 2013). Although not funded or implemented, demonstrations of nursing home culture change were included in the Patient Protection and Affordable Care Act at §6114 (Hawes, Moudouni, Edwards, & Phillips, 2012; Wells & Harrington, 2013).

Although policy supporting person-centered care has moved forward, scholars are simultaneously developing an evidence base to evaluate impact, understand adoption patterns, and guide implementation strategies for the culture change concept. The policy questions implicit in this research are first, whether culture change as currently defined and implemented provides outcomes better than the outcomes of standard practice, making it worthy of public policy support; and second, if so, how can public policy encourage adoption and implementation of resident-centered nursing home care. After examining how the diverse collection of studies and reviews in

this supplement relate to these two questions, we broaden the discussion to consider two additional issues: First, how research, practice, and policy might be better supported by a policy-driven definition of culture change that recognizes the centrality of a least restrictive setting; and second, how definition and measurement could support public consumer information and thus the private and public market demand for resident-centered care.

Impacts of Culture Change on Quality

As the centerpiece of this volume, Shier and colleagues provide a rigorous, systematic review of the evidence for the impacts of culture change developed in research conducted over the last half decade (Shier, Khodyokov, Cohen, Zimmerman, & Saliba, 2014). Measurement using validated tools for resident and family satisfaction and health outcomes showed that culture change interventions or clusters of interventions had few negative impacts, but also seldom resulted in statistically significant improvement. Thus, the evidence base about culture change defined and measured in this way cannot yet be used to choose the most effective practices from a culture change toolbox or to advocate for culture change as a path to improved clinical quality or quality of life for residents.

However, a fundamental aspect of culture change is its effort to achieve systemic, organization-wide transformation. Nursing homes pursuing culture change typically adopt specific practice interventions over time (for example, homelike dining, preferred bathing, sleep–wake choice, and consistent staff assignment) (Bowman & Schoeneman, 2006; Grant, 2008). They expect each of these practices to improve quality of care or quality of life. But the goal is to reach full implementation of practices that work together to provide a resident-centered setting for residents. In their review of culture change evidence, Shier and colleagues spread a broad net, including studies that targeted one or more of the six domains identified by Koren (2010): Resident direction, homelike atmosphere, close relationships, staff empowerment, collaborative decision making, and quality improvement processes. But only 5 of the 36 studies reviewed by Shier and colleagues targeted all five of the major culture change domains (a sixth, continuous quality improvement, is less often featured in culture change initiatives). Thus, the review encompassed both partial and more complete implementations of culture change.

Data from the Pioneer Network, used by three studies in the supplement, were developed in a different way: Rather than identifying specific practices, the culture change designation relies on the opinions of culture change experts, who were asked to nominate nursing homes that "exemplify settings engaged in sustained culture change innovation" (Elliot, Cohen, Reed, Nolet, & Zimmerman, 2014; Grabowski, Elliot, Leitzell, Cohen, & Zimmerman, 2014; Grabowski, O'Malley, et al., 2014). This enabled Elliott and colleagues to observe which practices were clustered in the "deep culture change" homes. Grabowski and colleagues compared outcomes for these transformed homes with those of a comparison group identified using propensity scores. The deep-culture-change homes significantly reduced survey deficiencies over the observation period compared with nonadopting nursing homes. However, the adopters did not improve on the standard nursing home quality indicators any more than the nonadopters (Grabowski, O'Malley, et al., 2014).

The outcome measures used in existing culture change outcomes research are an issue for policy in themselves. Existing measures for clinical quality are well validated, but culture change is not directed at improving the dimensions of care that they capture. Clinical quality measures will likely show improved outcomes for providers that focus on them, for example, where a nursing home is run like a mini hospital; but such a setting is rather far from the ideals of least restrictive or homelike (Eaton, 2000). In that regard, it is notable that Grabowski and colleagues did not find diminished clinical quality for culture change adopters, countering the concern (characterized as a "misguided notion" [Zimmerman, Shier, et al., 2014]) that a focus on quality of life may reduce quality of care. Both policy and research would gain from development of outcome measures capturing the goals that transformation to resident-centered care is trying to achieve, emphasizing the concept of least restrictive environment as well as clinical quality, individualized care, and customer satisfaction (Shier et al., 2014).

Public Policy for Culture Change Adoption

The research in this supplement concerning adoption and implementation of the culture change model, although not explicitly focused on public policy, suggests roles for public–private

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partnerships; presents two examples where adopting nursing homes have evolved new resident-centered practices within the constraints of regulations; attests to the influence of Medicaid payment policy; and implicitly raises questions about equity of access to resident-centered care.

Beck, Gately, Lubin, Moody, and Beverly (2014) describe how dissemination of ideas about culture change can be supported through a public–private coalition enlisting multiple state policy makers and encouraging collaborative learning across nursing home leaders. This kind of collaboration has the potential to focus regulators on quality of life outcomes rather than restrictive structure and process regulations, so that new configurations of inputs and person-centered processes of care can prevail. Such a refocus of state survey activities, also supported by Quality Improvement Organizations, may explain the finding noted earlier that deep-culture-change nursing homes achieved more improvement than standard homes on state survey items (Grabowski, O'Malley, et al., 2014).

Regulatory requirements and scope of practice acts constrain what personnel can do in nursing homes. The Greenhouse model challenges registered nurses to work with universal aides in new ways as they implement culture change while adhering to scope of practice regulations and professional norms (Bowers & Nolet, 2014). The researchers document several approaches to provision of small-house care within these constraints and supply information that could be the basis for flexing these regulations to support person-centered services in a homelike environment. Nursing homes adopting culture change workplace practices consistent with a high-performance work system may also need to work around the regulations for health care personnel (Bishop, 2014).

In another example suggesting the importance of regulation, the addition of mouth care standards to the Minimum Data Set instrument signaled a renewed policy focus on an area of care not previously highlighted. Culture change practice was not far behind, with an individualized, resident-centered approach to mouth care (Zimmerman, Sloane, et al., 2014).

The generosity and attributes of Medicaid payment rates can have a large impact on what nursing homes provide. Research on adoption of culture change reveals that adoption is more likely where state Medicaid payment rates are higher (Grabowski, Elliot, et al., 2014) and that higher payment rates are associated with capital improvements that are markers of culture change, including single rooms and household configurations (Miller, Cohen, Lima, & Mor, 2014). If Medicaid rates do not recognize an enhanced value for resident-centered services, culture change nursing homes transforming their workplace practices will be unable to compensate the frontline workforce for the additional value they produce through resident-centered care (Bishop, 2014).

Two findings of these studies and other adoption and implementation research portend a challenge for public policy: Culture change is more likely to be adopted and more fully implemented in nonprofit nursing homes and those serving a higher proportion of residents who are not funded by Medicaid (Grabowski, Elliot, et al., 2014; Miller et al., 2014). On average, nonprofit nursing homes supply more expensive care and serve a higher proportion of private-pay residents than for profit homes. Private-pay residents and Medicare postacute patients, that is, those not funded by Medicaid, are more numerous in resource-rich nursing homes. Thus, the press for culture change may further heighten the divisions among nursing homes, so that relatively resource-rich homes will provide personalized care to private-pay residents and relatively resource-poor homes will provide more standardized services to Medicaid residents; if this trend evolves, the "tiers" decried by Mor and colleagues will be reinforced rather than blurred (Mor, Zinn, Angelelli, Teno, & Miller, 2004). This could be countered by greater consumer understanding of the value of resident-centered services, discussed subsequently, and greater public willingness to pay for them for publicly funded residents through the Medicaid rate.

Defining Resident-Centered Nursing Home Services

Homelike as Least Restrictive Environment

As noted in the Introduction to this supplement (Zimmerman, Shier, et al., 2014), the most challenging problem facing research on policy concerning resident-centered care may be the very definition of culture change. How the nursing home environment functions for the *residents*—regardless of how this is attained—should be the key to determining whether a least restrictive setting is actually being created for diverse individuals.

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By compiling lists of the features found in self-designated or expert-designated culture change nursing homes, scholars and evaluators have in effect asked providers and experts whether "home" has been created for residents (Bowman & Schoeneman, 2006; Elliot et al., 2014). For example, Elliot and colleagues catalog features of expert-identified culture-change homes that are staff activities ("direct care workers clean up in the kitchen") or building characteristics ("stove/cooktop on unit") and others that focus on the heart of the matter, restrictions on residents, or lack thereof: "residents can get a snack"; "residents have access to outside area"; and "residents have some choice in mealtime." The latter features embody functional flexibility for residents that is implemented through the job design and environmental features.

Capturing functional resident centeredness is a good first step, but the rights listed in the OBRA '87 statute and regulations may be an even better yardstick both for assessing culture change against its own goals and for assessing any nursing home's achievement of a least restrictive setting. They include the right to freedom from physical restraints; to privacy; to accommodation of medical physical, psychological, and social needs; to participation in resident and family groups; to be treated with dignity; to exercise self-determination; and to communicate freely (Omnibus Budget Reconciliation Act, 1987; Wiener, Freiman, & Brown, 2007). A nursing home supporting resident choice about schedules, food, mobility within and outside the home, relationships, and companionship is aiming to overcome the restrictions that the traditional nursing home setting imposes on the personal autonomy and participation in a community that are aspects of a meaningful life. Preferences as understood by committed staff may substitute for personal autonomy for residents with severe cognitive impairment, but there is almost always a realm for choice. In the best case, a transformed nursing home offers prospective residents the choice required by the Olmstead decision, namely, life in a less-restrictive setting. If public policy is committed to the OBRA '87 principles, public programs should be reaching beyond clinical quality as well while striving to assure that all nursing homes provide good quality care (U.S. Government Accountability Office, 2008). Rather than focusing on a list of factors assumed to support choice and look like home to outside observers, the definition of culture change could then focus on the realized availability to residents of choice itself.

It is also important to remember that individuals with varying background, cultural heritage, or idiosyncratic tastes may rate aspects of culture change differently. For some, a single room for sleeping may be less important than a sunny common area that is inviting to visiting family; for others, as long as they can keep their own food in a refrigerator and ask an aide to microwave a snack, a cooktop on the unit may be less important than a TV screen large enough to see, an accessible outdoor garden like the one they had at home, or easy access to one's own religious services. At last, emerging research is asking the residents rather than experts, administrators, or staff to prioritize culture change attributes and has found wide variation in what residents prefer (White et al., 2012). Research could uncover more about resident preferences for the elements of person-centered service and the attributes of a homelike environment as diverse residents understand home.

Market Information for the Least Restrictive Setting

Policy could work to improve the matching of residents with settings they prefer through public market information. Aging and Disability Resource Centers are adopting person-centered planning to help each client understand his options for services across the continuum. The private-pay market for aging services has already expressed the preference for a homelike environment through demand for assisted living (Alecxih, 2006). In recent years, public policy has stressed provision of information to consumer–decision makers in many aspects of health services, but especially nursing homes. The Web site Nursing Home Compare posts clinical quality measures for every nursing home, and recently the Five Star System has begun to disseminate a summary measure. Research suggests that this information has not been easy for consumers to use, but competition for consumers on the basis of quality has had some impact (Park, Konetzka, & Werner, 2011). Expanding measures to capture resident autonomy and quality of life could help prospective residents and their families make better informed choices as they consider both community-based and nursing home alternatives. This would support aspects of culture change to the extent they are desired by consumers.

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Understanding resident experience is especially important for publicly paid services. Medicaid programs may soon be in the position of asking, how much reduction of institutional restriction, that is, how much "home," can state budgets buy for nursing home residents whose care is paid for at the Medicaid rate? To support the next steps in policy development, scholars should analyze the effectiveness and costs of the various pathways toward a less-restrictive nursing home that can be homelike for residents. Research on the full costs of providing person-centered Medicaid services in the community as well as in nursing homes could help public payers understand larger policy choices.

Culture Change Nursing Home as Least Restrictive Setting

Ultimately, some would argue that the best way for public policy to improve quality of life for nursing home residents is to discharge them to the community. This view is embodied in the Community First program, efforts to rebalance Medicaid services away from residential care, and other initiatives (Centers for Medicare & Medicaid Services, 2012, 2013). Indeed, the nursing home's role in the array of long-term services and support options has changed dramatically over the last 30 years as older adults with chronic disability increasingly seek to stay at home and use community-based services, including home care and assisted living. Age-specific rates of nursing home use have fallen, and an increasing proportion of nursing home beds is being used for postacute care (Alecxih, 2006). However, a residential setting offering 24-hr licensed nursing care and substantial personal assistance may still be the least restrictive accommodating place to live for some older adults and persons with disability—better from the perspective of autonomy and dignity as well as quality and cost. Broadening the scope of research to consider quality of life for persons in similar situations choosing care in a resident-centered nursing home or care in the community could bring this into focus. Optimal public policy may simultaneously deinstitutionalize some nursing home residents while deinstitutionalizing the nursing home as a setting for others by supporting the transformation to resident-centered care.

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