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Medicare and Medicaid Reimbursement Rates for Nursing Homes Motivate Select Culture Change Practices But Not Comprehensive Culture Change

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Abstract

Components of nursing home (NH) culture change include resident-centeredness, empowerment, and home likeness, but practices reflective of these components may be found in both traditional and "culture change" NHs. We use mixed methods to examine the presence of culture change practices in the context of an NH's payer sources. Qualitative data show how higher pay from Medicare versus Medicaid influences implementation of select culture change practices, and quantitative data show NHs with higher proportions of Medicare residents have significantly higher (measured) environmental culture change implementation. Findings indicate that heightened coordination of Medicare and Medicaid could influence NH implementation of reform practices.

Keywords

nursing home; culture change; Medicaid; Medicare; mixed methods

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INTRODUCTION

Galvanized by extensive criticism of nursing home (NH) quality and demands for reform across public and private sectors, a culture change movement has been growing within the national NH industry over the past 25 years (Koren, 2010). The movement seeks improvements in quality through “deep systematic change” (Fagan, 2003) and “to radically transform the nation’s NHs” (Rahman & Schnelle, 2008) “from impersonal health care institutions into true person-centered homes offering long-term care services” (Koren, 2010, p. 1). In a national study of culture change in NHs that are certified by the Centers for Medicare and Medicaid Services (CMS), we found nursing home administrators (NHAs) consider resident mix, including resident payment sources, in deciding to implement culture change practices, and many NHs attempt to maximize financial opportunities by serving short-stay and private-pay, rather than long-stay, residents (Shield, Looze, Tyler, Lepore, & Miller, 2014). In this paper we examine how such financial considerations relate to implementation of specific culture change practices.

Although the culture change movement does not prescribe a single set of practices, central components of culture change include providing resident-directed and resident-centered care, empowering the employees who work most closely with residents, and creating homelike environments (Koren, 2010). Practices range from those that are less complex, such as allowing residents to choose when they go to bed, to more complex, such as involving staff and residents in organizational decision making (Sterns, Miller, & Allen, 2010). Numerous groups have formed to help guide NHs through this multifaceted transformation, including nearly 30 state culture change coalitions. Several models of culture change also have been developed that combine the core components of culture change and provide NHs with an implementation framework and guidelines for practice. The evidence base for NH culture change is still developing (Koren, 2010), but research suggests beneficial outcomes for the quality of resident care and life (Kane, Lum, Cutler, Degenholtz, & Yu, 2007), satisfaction among residents’ family members (Lum, Kane, Cutler, & Yu, 2008), staff members’ sense of empowerment (Loe & Moore, 2012), and business performance (Coulmont, Roy, & Dumas, 2013). Some detrimental outcomes of culture change efforts, such as increased fall risk among residents, also have been reported (Brownie & Nancarrow, 2013) and may be related to allowing greater resident autonomy (Grabowski et al., 2014).

Comprehensive culture change—wherein environmental, staff empowerment, and resident-centered care practices are implemented—is complex in that it entails multifaceted structural reform (Brownie & Nancarrow, 2013). Flattening the traditional organizational hierarchy and involving residents and direct-care workers in planning and implementing changes that empower them are components of such comprehensive transformation (Misiorski & Kahn, 2008). To understand such complexity, mixed-methods studies are increasingly recognized as important (Fetters, Curry, & Creswell, 2013) and are specifically highlighted as needed when examining culture change (Grabowski et al., 2014).

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How Do Culture Change Practices Relate to Medicare?

Comprehensive culture change is rare but the proportion of US NHs where select culture change practices are implemented has substantially increased in a short amount of time (Miller et al., 2013). Studies show that financially incentivized competition for higher-paying residents influences NH practices (Zinn, 1994; Zinn, Mor, Feng, & Intrator, 2007). NH competition for higher-paying residents is essentially competition for Medicare residents; Medicare covers short-stay rehabilitative or subacute NH care at approximately $500 to $600 per day, while Medicaid covers long-term NH care at about $125 a day (Gleckman, 2013). While Medicaid residents continue to predominate (Center on Budget and Policy Priorities, 2013), the Medicare market has been, and continues to be, the most rapidly growing sector of the NH industry (Eskildsen & Price, 2009), and studies show that NHs implementing rehabilitation care diversification achieve better economic performance (Zinn et al., 2007). It is thus conceivable that even though Medicare residents may require more intensive care practices, the higher reimbursement rates associated with caring for a greater proportion of Medicare residents may enable NHs to finance adoption of more costly culture change practices. Furthermore, in their efforts to continue to attract Medicare residents, NHs may focus on adopting those practices believed to attract Medicare residents, who are able to choose the NH to which they will be discharged from a hospital (CMS, 2013). Thus, although many NHs may not embrace a central ethos of comprehensive cultural transformation, select culture change practices (perhaps those preferred by Medicare residents) may be present in these NHs.

Although increasing implementation of culture change practices has coincided with increasing prevalence of Medicare residents in NHs, no prior studies have examined culture change in the context of serving Medicare residents. This gap in research leaves in question how interest in serving higher-paying residents may relate to implementation of specific culture change practices. We use qualitative and quantitative data to examine how the attractiveness of serving Medicare residents appears to influence culture change implementation and how the prevalence of Medicare residents is associated with the (measured) implementation of specific culture change practices.

METHODS

This paper draws on a unique data set from a mixed-methods study of NH culture change (Miller et al., 2013; Shield et al., 2014) and distinctly integrates quantitative and qualitative findings. Data derive from interviews conducted with a subsample of NHAs who first participated in a national survey. Utilizing an explanatory sequential design (Fetters et al., 2013), survey data were initially examined, and the interview participant sample was based on preliminary findings from survey analysis. Interview data were examined to identify themes regarding how implementation of culture change practices relates to resident mix. Survey data were linked to CMS Online Survey Certification and Reporting (OSCAR) data from annual NH inspections. Finally, findings from qualitative (interview) data analysis and from quantitative (survey and OSCAR) data analysis were integrated to examine their coherence. In this analytic stage, we considered whether the findings from the types of data

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confirm and/or expand the findings from the other types of data (Klassen, Creswell, Plano Clark, Smith, & Meissner, 2011).

Qualitative Data

Qualitative data derive from in-depth interviews conducted with 64 NHAs sampled from 11 states where culture change adoption is prevalent (Doty, Koren, & Sturla, 2008), including at least two states from each major US geographic region. Sampling of NHs accounted for various levels of health deficiencies per OSCAR data and for the presence of culture change practices per our survey findings. Diverse characteristics of the NHA sample, including their tenure at their current NHs (mean ± SD = 9.0 ± 17.7) and the NHs' characteristics, have previously been reported (Shield et al., 2014). Three investigators (authors ML, RS, JL) completed all interviews.

Interviews first explored NHAs' views and experiences of implementing culture change practices in their NHs, as well as related motivations, strategies, facilitators, barriers, and impacts. We excluded the term *culture change* from the interview guide until after questions about specific culture change practices were discussed to limit social desirability bias (Tourangeau & Smith, 1996). When NHAs did not explicitly mention "culture change" on their own during the early stages of the interview, we asked them about culture change before the interview ended. Interviews were conducted by phone and lasted approximately 30 minutes each; they were audiorecorded and transcribed, and transcripts were checked for accuracy by the interviewers.

Analysis of interview data entailed iterative identification and refinement of codes and themes. We first developed a preliminary coding tree, including major codes and subcodes, based on topics in the interview guide. We revised the coding tree over the course of coding interviews based on interview data. For example, we removed any preliminary codes that did not apply to the interview data and added new codes as needed to address interview data (coding tree presented in Tyler, Lepore, Shield, Looze, & Miller, 2014). Five team members (ML, RS, JL, DT, SM) independently coded each interview, applying relevant codes to a line-by-line reading of each transcript. During twice-monthly in-person meetings, the team reviewed all coding decisions made by all team members to assure consistency across coding decisions. All coding decisions matched or were reconciled by consensus among all team members. The team reached consensus by reviewing and discussing interview data and alternative interpretations. We used the software program Atlas.ti to manage coded data, particularly to facilitate sorting of interview segments by codes.

During team discussions, candidate themes (including subthemes) under consideration by the research team were proposed. We sought evidence contrary to these candidate themes (i.e., interview segments indicating opposing perspectives), and revised, further developed, or rejected themes during analysis meetings. Definitions of codes, coding decisions, and discussions related to themes were recorded in an audit trail, which helped assure shared understanding of coding and theme decisions across team members over time (Lincoln & Guba 1985). One major theme identified was that NHAs consider resident mix in deciding to implement practices (Shield et al., 2014). Examining this theme in greater detail, we sought to identify how competition for Medicare residents relates to culture change.

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Accordingly, utilizing Atlas.ti, all data were compiled that were coded as pertaining to "Resident mix (e.g., short-stay, rehab, dementia)" or "Responses to NH populations (e.g., short-term/rehab, dementia, bariatric)," and all coded data were searched to compile additional interview segments pertaining to "Medicare," "short-stay," "short-term," "post-acute," "sub-acute," or "rehab." Furthermore, the full interview transcripts from which these segments were drawn were also compiled. These compiled data were reexamined to identify and reach team consensus on themes related to how competition for Medicare residents relates to culture change. Codes utilized for these analyses addressed types of culture change practices (environmental, staff empowerment, resident-centered care), as well as motivations/rationale for these practices, strategies for practice implementation, facilitators and challenges/barriers to practice implementation, and outcomes of these practices. Candidate themes were proposed during team discussions; evidence contrary to these candidate themes was sought, and the themes were revised, further developed, rejected, or accepted through team consensus. Our analytic strategy—whereby all interviews were coded by all team members and consensus was established on all coding decisions and themes—helped to assure the rigor of the qualitative analysis and enhance the trustworthiness of our findings (Curry, Shield, & Wetle, 2006). Greater detail about the parent qualitative study is reported elsewhere (Shield et al., 2014).

Quantitative Data and Statistical Analyses

Primary quantitative data derive from a nationally representative survey of NHAs and directors of nursing (DONs) conducted from August 2009 to April 2011. The survey was administered to a stratified, proportionate random sample of NHAs and DONs at 4,149 NHs, a contact was identified at 3,539 of these NHs, and surveys were completed by 62.6% of contacted NHAs (n = 2,215) and 61.6% of DONs (n = 2,164). Survey details have been thoroughly reported (Miller et al., 2013). To address the research question posed in this article, we examined survey data attending to the implementation of culture change practices in NHs, operationalized by NHAs' and DONs' responses to a series of questions related to resident-centered care (4 items), staff empowerment (7 items), and environmental practices (8 items). Environmental culture change practices assessed in the survey include residents having private rooms, residents living in small households or neighborhoods with kitchen and dining facilities, and kitchen areas being accessible to residents and families 24/7. Resident-centered care practices assessed in the survey focused on resident decision making and choice, such as residents having choice in meal times, waking times, and activities offered. Staff empowerment practices assessed in the survey included cross-training, engagement in planning activities, and staff collaborating to cover shifts amid staff absences. Responses to survey items were scored and summed to create separate scores for the three domains. Utilizing composite resident-centered care, staff empowerment, and environmental scores, we categorized NHs into one of four groups (~quartiles), ranging from low to high practice implementation in each domain.

We used OSCAR data to identify an NH's percentage of residents on Medicare and linked these data to the survey data on levels of culture change practice implementation. Adjusted Wald tests were used to discern differences in the survey domain scores by prevalence of Medicare residents.

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Qualitative and Quantitative Data Integration

We integrated the qualitative and quantitative findings by comparing the identified themes with the identified associations between culture change practice implementation and the prevalence of Medicare residents in NHs. For this paper, findings are merged in a contiguous narrative reporting first the qualitative and then the quantitative results, as well as in a joint display (Fetters et al., 2013). Integration of quantitative and qualitative data in this manner provides a rich perspective of how and why competition for Medicare residents relates to culture change, while also revealing details about specific practices implemented with a focus on Medicare residents.

RESULTS

Four subthemes were identified in relation to competition for Medicare residents and culture change; one theme addresses culture change motivations as expressed by NHAs and three themes address culture change implementation strategies (Table 1). Regarding culture change motivations, we find Medicare residents are a primary concern of NHAs. Regarding implementation strategies, we find that (a) several environmental culture change practices are implemented for Medicare residents; (b) select resident-centered care practices are implemented for Medicare residents; and (c) no staff empowerment practices are implemented for Medicare residents. Survey findings corroborate qualitative themes, which in turn expand insights gleaned from survey findings.

Medicare Residents Are a Primary Concern of Nursing Home Administrators

During interviews, NHAs reported that payer mix affected their decision making. The shifting composition of NH residents, from fewer Medicaid to more Medicare, and the importance of the Medicare market were described by several NHAs. Administrators emphasized that attracting Medicare residents is financially important. As one NHA explained:

> You have to attract the Medicare Part A resident because the Medicaid rates don't even cover our cost, so that's it in a nutshell. And the better marketing . . . and better networking you can do to bring in that type of a resident, the Medicare patient, then you will have . . . a better cash flow to . . . do things that . . . you want to do to make it more attractive.

Similarly, another NHA reported:

> [T]he supreme patient that everybody's vying for is their short-term rehab, get the Medicare . . . they come in, they go home, and it's not long-term . . . you can turn your beds over easier that way. . . . I've been here 20 years, but many years ago, we had 8 admissions in one year . . . we were just bottlenecked . . . now we have at least 8 to 10 admissions a month, so it's very different, that's the new patients, not doing long-term care anymore, to be honest.

It is clear Medicare residents are a prime financial motivator for NHAs. We also found implementation of culture change practices is related to considerations of Medicare residents, as detailed next.

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Several Environmental Culture Change Practices Are Implemented for Medicare Residents

According to NHAs, environmental practices, including practices aligned with culture change—such as providing private rooms and making kitchen areas available for residents and families—are commonly implemented to attract or improve the experience of Medicare residents. The following interview segment evokes this strategy:

> [W]e remodeled our transitional care unit . . . it grew from 19 beds to 39 beds and it's dedicated to our short-term rehab patients. The entire . . . wing of the facility was completely remodeled, all new resident rooms, new bathrooms, all new common areas, new bathing facilities. We added a lot of new amenities. We added flat screen TVs . . . wireless Internet services . . . a resident computer with a desk area . . . a kitchenette for families and residents while they're here for their short-term stays. So we very much changed the environment to cater toward our short-term rehab patients. . . . It accounts for about 30% I would say of my residents. . . . But then the remainder are long-term care. . . . We've really focused a lot on . . . the amenities that we offer to our patients when they're here for short-term rehab . . .

Several NHAs emphasized that for short-term residents environmental practices aim to get the residents back home (in contrast, practices for long-stay residents emphasize making them at home). For example, privatizing rooms is a practice promoted by culture change but many NHAs reported private rooms are used to attract Medicare residents—to meet their preferences and support them in getting back home. This perspective is reflected in the following interview segment:

> [W]e just got done with a remodel . . . we now have 35 private suites for our home again units. This is our unit where our folks come in from the hospital. . . . They like coming in because they come from the hospital and they [had a] private room and then they come to us and get to be in a private room . . . it helps with the healing process. It helps with them getting better to go home.

In contrast to singling rooms, some environmental practices implemented to attract Medicare residents are not considered to be core culture change practices. For example, with regard to Medicare residents, several NHAs emphasized the importance of adding amenities, such as providing short-stay residents with cell phones. One NHA explained, "We have plans to get us a . . . flat screen TV and a Wii. . . . [T]hings that are . . . going to make it less institutional and . . . where people don't mind coming for short-term rehab and then going home."

Medicare residents' short lengths of stay in NHs help to motivate other environmental practices as well, including practices that appear to counter the culture change movement's goal of making NH environments homelike. For example, given the aim of getting Medicare residents back home, some NH practices reduce residents' need to bring personal furnishings to the NH. Furthermore, attending to Medicare residents, some NH environments are intentionally designed to be more like a hospital or rehabilitation center than a home:

> While some of our programs are designed specifically for short-term care and . . . we look at ourselves more of a hospital-like rather than a homelike . . . some of our

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> areas are designed to feel more like a rehab center than a home. . . . We encourage the rehab and let's . . . get you home more than, you know, putting up all your household stuff and pictures and all that.

To attract Medicare residents, NHs implement many environmental practices considered reflective of culture change; however, only select resident-centered care practices are implemented targeting Medicare residents.

Select Resident-Centered Care Practices Are Implemented for Medicare Residents

Enhancing residents' choices of meals and dining services, including meal times and locations, are two primary resident-centered care practices advocated by culture change and reported by NHAs in the context of attracting Medicare residents. Describing these efforts for short-term rehab units, NHAs reported adding continental breakfasts, "offering a lot more choice as far as food," and trying "to make it more like a restaurant and they have as many choices as possible."

The relevance of these practices was characterized by some NHAs as contingent upon residents' cognitive functioning, which was depicted as ranging from high among Medicare residents to low among those long-stay residents with dementia. In this regard, enhancing residents' choices of meals and dining hours was identified by some NHAs as more relevant for Medicare residents in comparison to those residents with cognitive deficits, because Medicare residents have "a lot more of that choice type of mentality."

Such heightened resident choice and decision making are core artifacts of the culture change movement; however, NHs implementing these practices may not embrace the ethos of comprehensive cultural transformation. Similarly, staff empowerment also is a central component of culture change, but these practices are not found to be implemented with a focus on Medicare residents.

No Staff Empowerment Practices Are Implemented With a Focus on Medicare Residents

No staff empowerment practices were depicted by NHAs in relation to serving Medicare residents, but one staff-focused practice associated with variations between short-stay and long-stay residents was reported by NHAs. Specifically, some NHAs reported efforts to assign staff to residents with similar care needs and consistently assigning staff to units for short-stay, long-stay, or memory-impaired residents. Administrators emphasized the value of this practice in terms of teamwork and efficiency, characterizing staff assigned to a group of residents with similar needs as best able to work together to meet residents' needs, whereas diversity among residents would challenge staff to provide different levels of services.

Quantitative Findings

Quantitative findings show how a NH's percentage of residents on Medicare (by quartile) relates to the survey data on levels of culture change practice implementation. In NHs with a higher percentage of Medicare residents, the extent of reported environmental culture change practices (per average survey score) is significantly higher (15.5 in 4th quartile versus 13.2 in 1st quartile; $p = .02$). Also, with a higher percentage of Medicare residents,

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the extent of reported resident-centered care practices (per average survey score) appears somewhat higher (14.5 in 4th quartile versus 13.4 in 1st quartile), but this difference is not statistically significant. The prevalence of Medicare residents is not significantly related to staff empowerment domain scores.

Integrating Qualitative and Quantitative Findings

Quantitative results support qualitative findings. Figure 1 shows the quantitative and qualitative findings in an integrated joint display (Fetters et al., 2013). The figure presents the quantitative associations and qualitative themes related to staff empowerment, resident-centered care, and environmental practices together. The quantitative associations are presented at the top of the figure, the related strategy themes are presented directly below the quantitative associations, and the one motivation theme is presented at the base of the figure.

In NHs with a higher percentage of Medicare residents, the extent of reported environmental culture change practices (per average survey score) is significantly higher (see Figure 1; $p = .02$), and several environmental culture change practices, such as singling rooms, are reported by NHAs to have been adopted for Medicare residents. Also, with a higher percentage of Medicare residents, the extent of reported resident-centered care culture change practices (per average survey score) appears somewhat higher, though not significantly, and select resident-centered care culture change practices, such as allowing residents to choose meal times, also are qualitatively reported by NHAs to have been adopted for Medicare residents. Finally, the prevalence of Medicare residents has a nonlinear relationship to staff empowerment domain scores, which reflects the qualitative finding that staff empowerment practices, such as cross-training, are not implemented with a focus on Medicare residents. Collectively, these findings help explain how differences in payment for short-stay and long-stay residents influence implementation of specific culture change practices in nursing homes.

DISCUSSION

Many environmental practices reflective of NH culture change and the resident-centered practice of expanding dining choices are becoming more prevalent with the increasing diffusion of resident-centered approaches to care; however, we find that the presence of these practices is not necessarily indicative of an effort toward comprehensive culture change. The presence of these practices may instead reflect NH efforts to attract (higher-paying) Medicare residents. Therefore, these culture change practices may be found in a range of NHs, including those that have comprehensively applied a model of culture change, those that are incrementally implementing select culture change practices on a journey to more comprehensive cultural transformation, and those traditional NHs that are implementing these practices without broader culture change goals. Through our mixed-method approach, we qualitatively show how the higher rates paid by Medicare for short-stay residents influence implementation of select culture change practices to attract these residents and quantitatively show that these practices are more prevalent in NHs with higher proportions of Medicare residents. In addition to shedding light on the influence of payment

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levels on NH reform efforts, this study shows that the presence of a culture change practice within an NH does not necessarily indicate a specific motivation for this practice; even traditional NHs implement some culture change practices.

Although Medicare residents are relatively costly for NHs to care for in terms of employing the rehabilitation professionals necessary to provide their services (Spector, Limcangco, Ladd, & Mukamel, 2011), NHs also appear to profit from these residents. In fact, Medicare residents are perceived to be vital to the financial viability of NHs. The potential for financial gain from implementing select culture change practices may help explain why increasing implementation of some practices is observed while similar growth in more comprehensive NH culture change implementation is not (Miller et al., 2013). According to the NHAs we interviewed, competition for Medicare residents motivates implementation of several environmental and food service culture change reforms but no staff empowerment practices. Concordantly, we find that in NHs with more Medicare residents, environmental culture change practices are more prevalent, and resident-centered care practices (e.g., food service) appear somewhat more common, but staff empowerment practices are not any more widespread. Specific environmental culture change practices reported to be implemented with a focus on Medicare residents include single rooms and kitchen spaces for residents and families. Resident-centered care practices reported to be implemented with a focus on Medicare residents include enhanced meal choices. Such targeted implementation of culture change practices to attract and satisfy higher-paying Medicare residents reflects the "proactive strategic leadership" observed in other NH research that found "diversification into subacute and rehabilitative care has a positive impact on occupancy and payer mix performance" (Zinn et al., 2007, p. 1213). Thus, implementing culture change innovations to meet the needs and preferences of subacute/rehabilitation (e.g., Medicare) residents also may help NHs achieve better economic performance, which in turn can finance more innovation, such as costly environmental redesign.

The extrication of select practices aligned with culture change from the deeper goal of shifting the NH paradigm is comprehensible in the current reimbursement context; however, such selective, Medicare-targeted implementation of culture change practices may help maintain rather than transform the cultural status quo of these NHs. Nursing homes with private rooms, family-friendly kitchens, and heightened choice around meals might meet the preferences of select (e.g., Medicare) residents but do not necessarily function in a more resident-centered manner nor are they necessarily more empowering for residents or staff. Our interviews suggest that some NHs are adopting the most financially attractive culture change practices and not the more radical aspects of the culture change movement (e.g., empowering staff and flattening the organizational hierarchy).

Findings raise questions about how selective (including Medicare-targeted) approaches to culture change influence outcomes. Studies are needed that examine how long-term residents fare, such as in quality of care and quality of life, when NHs are focused on short-term Medicare residents. Furthermore, staff satisfaction, retention, and turnover are critical to the sustainability of an already strained long-term care workforce (Institute of Medicine, 2008), but staff empowerment practices are not implemented with a focus on Medicare residents. Future research addressing a compilation of outcomes for residents (Medicare and

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Medicaid), staff, and NH financial performance resulting from specific culture change practices versus from comprehensive culture change are needed and would help inform payment policy most effectively to support desired outcomes.

Our previous findings suggest that higher Medicaid payment (via rates and incentives) motivates implementation of culture change practices, likely by providing more financial resources for innovation (Miller et al., 2013). The findings reported here suggest higher Medicare (versus Medicaid) reimbursement rates motivate NHs to implement specific culture change practices to attract the higher paying Medicare resident. As improved coordination of Medicare and Medicaid has been highlighted as a potential strategy to improve resident outcomes, such as reducing hospitalizations (Intrator, Zinn, & Mor, 2004), our findings suggest that such heightened coordination also could influence NH implementation of reform practices since reimbursement rate differences steer practice implementation. Importantly, research on the effects of comprehensive culture change and select culture change practices for different types of NH residents would help inform future payment policy aimed at advocating for specific practices and/or outcomes for specific types of residents.

Limitations

Although there are important strengths of our mixed-methods research approach, study limitations and opportunities for future research are recognized. First, interview reports by NHAs are subject to social desirability bias: NHAs may have reported what they thought interviewers wanted to hear (Tourangeau & Smith, 1996). The interview guide was designed not to lead discussion of culture change, but social desirability bias may have deterred or heightened discussion of certain topics nonetheless. Further, this study did not assess NH residents' or other staff perspectives, and future research should obtain such perspectives. Future research examining residents' perspectives could help clarify how Medicare residents learn about and choose NHs.

Conclusion

The NH industry has transformed from primarily providing long-term housing and chronic care services for the oldest adults to increasingly providing short-stay housing and rehabilitative care for younger groups (Eskildsen & Price, 2009). These changes coincide with increasing implementation of culture change practices in NHs. In NHs striving for a comprehensive culture change, certain practices are expected, but implementation of these practices is not necessarily indicative of an NH's commitment to culture change. Rather, culture change practice implementation is influenced by concerns about attracting and satisfying higher-paying Medicare residents. It is important to recognize that quality outcomes of culture change practices may differ across resident types and other stakeholder groups. Research on the effectiveness of culture change practices for achieving desired outcomes across diverse NH residents, various levels of staff, and other measures of operational performance will provide critical information on the value of specific approaches to culture change. This knowledge can help guide the culture change movement and the NH industry to a cultural status quo of NHs in which residents' quality of life is optimal, staff are maximally empowered, and financial performance is sustainable. This

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paper brings to light how NH competition and Medicare and Medicaid payment policies may serve as barriers or facilitators of such culture change.

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References

Brownie S, Nancarrow S. Effects of person-centered care on residents and staff in aged-care facilities: A systematic review. Clinical Interventions in Aging. 2013; 8(1):1–10.10.2147/CIA.S38589 [PubMed: 23319855]

Center on Budget and Policy Priorities. Policy basics: Introduction to Medicaid. 2013. Retrieved from http://www.cbpp.org/cms/index.cfm?fa=view&id=2223

Centers for Medicare and Medicaid Services (CMS). Revised Appendix A, Interpretive guidelines for hospitals, condition of participation: Discharge planning. 2013. Retrieved from http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-13-32.pdf

Coulmont M, Roy C, Dumas L. Does the Planetree patient-centered approach to care pay off? A cost-benefit analysis. The Health Care Manager. 2013; 32(1):87–95. [PubMed: 23364422]

Curry, L.; Shield, R.; Wetle, T. Improving aging and public health research: Qualitative and mixed methods. Washington, DC: Gerontological Society of America/American Public Health Association; 2006.

Doty, MM.; Koren, MJ.; Sturla, EL. Culture change in nursing homes: How far have we come? Findings from the Commonwealth Fund 2007 National Survey of Nursing Homes. New York, NY: The Commonwealth Fund; 2008.

Eskildsen M, Price T. Nursing home care in the USA. Geriatrics & Gerentology International. 2009; 9(1):1–6.

Fagan, RM. Pioneer network. In: Weiner, AS.; Ronch, JL., editors. Culture change in long-term care. New York, NY: Haworth Press; 2003. p. 125-149.

Fetters MD, Curry LA, Creswell JW. Achieving integration in mixed methods designs-principles and practices. Health Services Research. 2013; 48(6 pt 2):2134–2156. [PubMed: 24279835]

Gleckman, H. Nursing home use by Medicaid seniors is plunging. 2013. Retrieved from http://howardgleckman.com/blog/2013/07/nursing-home-use-by-medicaid-seniors-is-plunging/

Grabowski DC, O'Malley AJ, Afendulis CC, Caudry DJ, Elliot A, Zimmerman S. Culture change and nursing home quality of care. The Gerontologist. 2014; 54(Suppl 1):S35–S45.10.1093/geront/gnt143 [PubMed: 24443604]

Institute of Medicine. Retooling an aging America: Building the health care workforce. Washington, DC: The National Academies Press; 2008.

Intrator O, Zinn J, Mor V. Nursing home characteristics and potentially preventable hospitalizations of long-stay residents. Journal of the American Geriatrics Society. 2004; 52(10):1730–1736. [PubMed: 15450053]

Kane RA, Lum TY, Cutler LJ, Degenholtz HB, Yu T-C. Resident outcomes in small-house nursing homes: A longitudinal evaluation of the Initial Green House Program. Journal of the American Geriatrics Society. 2007; 55(6):832–839. [PubMed: 17537082]

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Klassen AC, Creswell J, Plano Clark VL, Smith KC, Meissner HI. Best practices in mixed methods for quality of life research. Quality of Life Research. 2012; 21(3):377–380. [PubMed: 22311251]

Koren MJ. Person-centered care for nursing home residents: The culture-change movement. Health Affairs. 2010; 29(2):312–317. [PubMed: 20056692]

Lincoln, YS.; Guba, EG. Naturalistic Inquiry. Thousand Oaks, CA: Sage; 1985.

Loe M, Moore CD. From nursing home to Green House: Changing contexts of elder care in the United States. Journal of Applied Gerontology. 2012; 31(6):755–763.

Lum TY, Kane RA, Cutler LJ, Yu TC. Effects of Green House nursing homes on residents' families. Health Care Financing Review. 2008; 30(2):35–51. [PubMed: 19361115]

Miller SC, Looze J, Shield RR, Clark M, Lepore M, Tyler D, Sterns S, Mor V. Culture change practice in U.S. nursing homes: State Medicaid reimbursement policies and organizational attributes of practice implementers. The Gerontologist. 2013; 54(3):434–445. [PubMed: 23514674]

Misiorski S, Kahn K. Changing the culture of long-term care: Moving beyond programmatic change. Journal of Social Work in Long-Term Care. 2005; 3(3/4):137–146.

Rahman AN, Schnelle JF. The nursing home culture-change movement: Recent past, present, and future directions for research. The Gerontologist. 2008; 48(2):142–148. [PubMed: 18483426]

Shield R, Looze J, Tyler D, Lepore M, Miller SC. Why and how do nursing homes implement culture change practices? Insights from qualitative interviews in a mixed methods study. Journal of Applied Gerontology. 2014; 33(6):737–763. [PubMed: 24652888]

Spector WD, Limcangco MR, Ladd H, Mukamel D. Incremental cost of postacute care in nursing homes. Health Services Research. 2011; 46(1 pt 1):105–119. [PubMed: 21029085]

Sterns S, Miller SC, Allen S. The complexity of implementing culture change practices in nursing homes. Journal of the American Medical Directors Association. 2010; 11(7):511–518. [PubMed: 20816340]

Tourangeau R, Smith TW. Asking sensitive questions: The impact of data collection mode, question format, and question context. Public Opinion Quarterly. 1996; 60(2):275–304.

Tyler DA, Lepore M, Shield RR, Looze J, Miller SC. Overcoming resistance to culture change: Nursing home administrators' use of education, training, and communication. Gerontology & Geriatrics Education. 2014; 35(4):321–336. [PubMed: 24266678]

Zinn JS. Market competition and the quality of nursing home care. Journal of Health Politics, Policy and Law. 1994; 19(3):555–582.

Zinn JS, Mor V, Feng Z, Intrator O. Doing better to do good: The impact of strategic adaptation on nursing home performance. Health Services Research. 2007; 42(3 pt 1):1200–1218. [PubMed: 17489910]

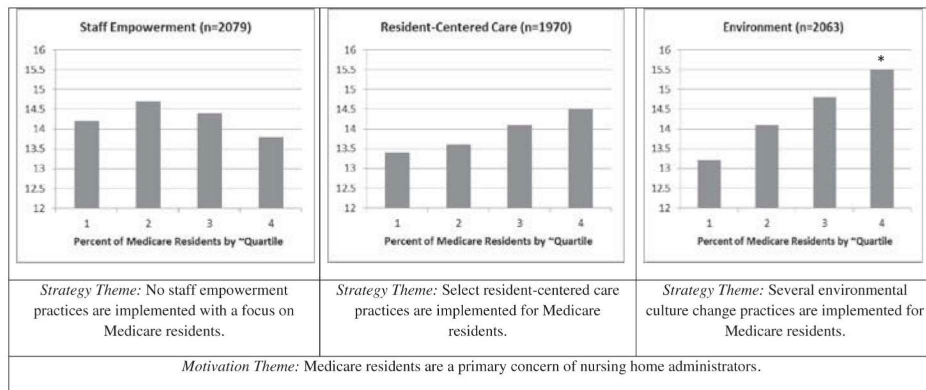

FIGURE 1.

Joint display of quantitative and qualitative findings: Survey scores on extent of culture change practices implemented per domain by percentage of Medicare residents (quartiles). Statistical comparisons made with 1st quartile as reference group. $^{*}p < .05$.

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TABLE 1

Themes

Motivation theme
• Medicare residents are a primary concern of nursing home administrators.
Strategy themes
• No staff empowerment practices are implemented with a focus on Medicare residents.
• Select resident-centered care practices are implemented for Medicare residents.
• Several environmental culture change practices are implemented for Medicare residents.