

Nursing Home Culture Change: Legal Apprehensions and Opportunities

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There continue to be serious deficiencies in the quality of life available to many nursing home residents in the United States. One significant response to this undesirable situation is the nursing home “Culture Change” movement, which attempts to improve the nursing home environment—and consequently residents’ quality of life—by making facilities less institutional and more homelike. One of the impediments often interfering with the adoption and implementation of culture change in specific facilities is apprehension by staff, administrators, and governing boards about potential legal liability and regulatory exposure if residents suffer injuries that might arguably be attributed to facility conditions or policies that were inspired and encouraged by the culture change movement. This article addresses and responds to the provider liability and regulatory apprehensions that impede the progress of culture change in nursing homes, using proposed new dietary services standards as an example.

Key Words: Law, Liability, Regulation

The aging enterprise has made tremendous progress over the past couple of decades in developing home- and community-based long-term care

alternatives (Grabowski et al., 2010; Hahn, Thomas, Hyer, Andel, & Meng, 2011) and increased public funding for those efforts (Government Accountability Office, 2012). Nevertheless many older Americans remain highly dependent upon nursing homes for their care and quality of life (Bilimoria, 2012). The quality of life available to many nursing home residents is still seriously deficient, if not neglectful (Bassen, 2009). One significant response to this undesirable situation is the nursing home “Culture Change” movement, which attempts to improve the nursing home environment—and consequently residents’ quality of life—by making facilities less institutional and more homelike.

One of the impediments often interfering with the adoption and implementation of culture change in specific facilities is apprehension by staff, administrators, and governing boards about potential civil (tort) liability and regulatory exposure if residents suffer injuries that might arguably be attributed to facility conditions or policies that were inspired and encouraged by the culture change movement. This article addresses and responds to the provider liability and regulatory apprehensions that may impede the progress of culture change in nursing homes, using

recently published New Dining Practice Standards as an example.

Nursing Home Culture Change Movement

Historically, nursing homes in the United States have functioned, and been regulated at the federal and state levels, as total medical/residential institutions (Watson, 2010). Nonetheless, the restrictive, regimented atmosphere of nursing homes is slowly changing. There is a broad commitment within the American long-term care industry to the transformative concept of “Culture Change.” This movement originated in 1997 and has increasingly gained popularity, with more than half of nursing homes indicating they either have adopted culture change or are committed to adopting it (Tjia, Gurwitz, & Briesacher, 2012). A nursing home’s commitment in this regard, it should be realized, can range from sincere commitment to the Culture Change ideal to simply adding cosmetic touches without fundamentally changing the way that the nursing home actually embraces resident autonomy and staff judgment. Culture Change has been promoted by the Pioneer Network, a small group of prominent long-term care professionals who have joined together to advocate for person-directed care with the vision of “a culture of aging that is life-affirming, satisfying, humane and meaningful” (<http://www.pioneernetwork.net/AboutUs/About/>). The Culture Change movement is embodied in and exemplified by progressive long-term care initiatives such as the Eden Alternative (Thomas, 1996), the Wellspring Program of the Beacon Institute (http://www.lifespan-network.org/beacon_wellspring.asp), the Green House Project (Jenkins, Sult, Lessell, Hammer, & Ortigara, 2011; Jenkins, Thomas, & Barber, 2012), and the Advancing Excellence in America’s Nursing Homes Campaign (<http://www.nhqualitycampaign.org>).

The Culture Change movement is premised on a belief in person-centered care, encompassing sincere consideration of and fidelity to the values and wishes of nursing home residents, their families, and their direct caregivers (Koren, 2010; White et al., 2012). According to Miller and colleagues (2010), “NH culture change aims to transform both NH physical environments and organizational systems; it is about deinstitutionalizing services and individualizing care.”

Central aspects of culture change embrace support of resident dignity and freedom to an extent not embraced within the more traditional institutional

mind set. Culture change features include collaborative decision making including resident control over dining and sleeping schedules, a warmer and more homelike climate, a concentration on close relationships among residents and staff that has been empowered by—for example—consistent assignments and rewards for teamwork, and especially attempts to improve not just the quality of professional services (important though that goal is) but also the quality of resident life (Sterns, Miller, & Allen, 2010). Examples of nursing home practices reflecting an organizational commitment to culture change would be permitting and encouraging the regular presence of pets and children on the premises, including residents and families in care-planning sessions, and allowing residents to voluntarily take on responsibilities such as maintaining plants.

New Dietary Standards

Another example of an excellent culture change opportunity is in the area of dining practice standards. Federal nursing home regulations pertaining to Dietary Services require that the facility “provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs of each resident” (42 Code of Federal Regulations § 483.35). To accomplish that goal, the regulations prescribe dining-related details regarding staffing qualifications, staffing quantity, menus and nutritional adequacy, food preparation and presentation, therapeutic diets, meal frequency, assistive devices, paid feeding assistants, and sanitary conditions. Procedures for surveying and enforcing compliance with these regulatory provisions, including use of the “Dining Area and Eating Assistance Observation” worksheet (Form CMS-523), are specified at 42 Code of Federal Regulations § 488.110. The individual states also may impose their own additional, specific requirements for facilities within their respective jurisdictions.

In 2010, the Pioneer Network, www.pioneernetwork.net, and the federal Centers for Medicare and Medicaid Services (CMS) sponsored *Creating Home in the Nursing Home II: A National Symposium on Culture Change and the Food and Dining Requirements*. A set of research papers were commissioned by CMS from experts Carmen Bowman, Linda Bump, Karyn Leible and Wayne

Matthew, Linda Handy, Denise Hyde, Robin Remsburg, Judah Ronch, and Sandra F. Simmons and Rosanna M. Bertrand. These papers were posted online (<http://www.pioneernetwork.net/Events/CreatingHomeOnline>) and formed the basis for a stakeholder workshop held on May 14, 2010 that was attended by 83 national leaders. At that workshop, stakeholders' comments on the background papers were reviewed.

One of the recommendations emanating from this workshop was that a national stakeholder workgroup be formed to develop agreed upon, evidence-based individualized standards of dietary practice moving away from traditional diagnosis-related treatment to individualized care supportive of self-directed living. The workgroup developed and documented Proposed New Dining Practice Standards, which were reviewed and revised by a Food and Dining Clinical Standards Task Force with representation from organizations comprised of professionals in the various disciplines that work in nursing homes (administrators, dietitians, medical directors, occupational therapists, consultant pharmacists, directors of nursing, and certified nurse assistants), as well as relevant government agencies (Centers for Medicare and Medicaid Services, Centers for Disease Control and Prevention, and Food and Drug Administration).

The product of this process, supported by a grant from the Hulda B. and Maurice L. Rothschild Foundation and embodying the original goal of individualized care and self-directed living, was published in August 2011 of "New Dining Practice Standards" (Pioneer Network & Food and Dining Clinical Standards Task Force, 2011). This document contains 10 new practice standards, which are intended not only to be consistent with the federal standards that have been in place since publication of the 1990 regulations effectuating the nursing home provisions of OBRA 87 but also to provide guidance for improved and modernized implementation. These practice standards are predicated on the best available research and current thinking of the various organizations represented on the Task Force and concern the following topics: Individualized nutrition approaches/Diet liberalization; individualized diabetic/calorie controlled diet; individualized low sodium diet; individualized cardiac diet; individualized altered consistency diet; individualized tube feeding; individualized real food first; individualized honoring choices; shifting traditional professional control to individualized support of self-directed living. In

practice, the various individualized diet standards might be implemented, for example, by beginning with a regular diet and monitoring how the resident does, rather than by assuming that a restricted diet is always necessary because of the resident's specific clinical diagnosis.

Legal Apprehensions

Regarding the nursing home culture change movement generally, a number of commentators and service providers have suggested that providers' apprehensions about potential exposure to negative civil liability and regulatory consequences for deviation from traditional, disease-focused practices have acted as an impediment to more timely and effective person-centered action. In a 2007 survey of nursing homes, 56% of responders cited regulations as an impediment to culture change adoption (Doty, Koren, & Sturla, 2008). In a later survey, almost 38% of nursing home responders agreed that regulations act as a barrier to culture change (Miller et al., 2010). Other impediments cited by survey respondents included cost and institutional size.

By way of background, important changes in requirements for nursing homes that participate in the Medicare and Medicaid programs became effective in 1990. As part of the Omnibus Budget Reconciliation Act of 1987 (1987), Congress enacted the Nursing Home Quality Reform Act, 42 United States Code § 1396r (Subcommittee on Health and the Environment of the Committee on Energy and Commerce, U.S. House of Representatives, 1987). This statute is modeled on many of the recommendations made in an Institute of Medicine report (1986) that Congress had directed the Health Care Financing Administration (HCFA) (CMS' predecessor agency) to commission. The 1987 law amended the Social Security Act to require substantial upgrading in nursing home quality and enforcement in several areas, including residents' rights, restrictions on the use of physical and chemical restraints, individualized care plans based on individualized annual assessments, and more extensive training of nurses' aides who provide hands-on care to residents. On February 2, 1989, HCFA published final regulations to implement most of the provisions of the Nursing Home Quality Reform Act. Following some delays, these regulations became operable on October 1, 1990, 42 Code of Federal Regulations chapter IV, subchapter C, part 483.

Ironically, according to one set of commentators, “Although OBRA was developed with the intention of promoting residents’ rights, its emphasis on quality of care and health outcomes had the unintended consequence of increasing the orientation of nursing homes on medical outcomes rather than on quality of life.” (White-Chu, Graves, Godfrey, Bonner, & Sloane, 2009, p. 370). This is largely due to OBRA’s requirement that nursing homes “must provide services and activities to attain or maintain the highest practicable physical, mental, and social well-being of each resident in accordance with a written plan of care.” Too frequently, incompatible federal or state regulations stand in the way of innovative practice, with application for waivers from the regulations left as the only viable avenue for creativity (Koren, 2010).

Studies have demonstrated that relatively few nursing homes swiftly implement evidence-based recommended care practices (Wipke-Tevis et al., 2004). It must be noted that providers’ apprehensions about adverse potential civil liability or regulatory entanglements are only one of several reasons for the frequent gap between research-based innovations and daily practice in nursing homes. Besides the pervasive liability and regulatory climate that envelop the delivery of nursing home care in the United States, “few NHs qualify as innovative organizations, for as a whole they are ... often understaffed and hierarchical and employ direct-care staff composed largely of low-wage workers with little formal training and high turnover rates.” (Rahman, Applebaum, Schnelle, & Simmons, 2012). Nevertheless, although providers’ apprehensions about possible liability and regulatory sanctions are only part of the explanation, those apprehensions must be confronted as one important part of the innovation story.

Nursing home providers are generally apprehensive because many of them feel threatened. First, the extensive regulatory environment contributing to provider unease is multifaceted. Among other things, its components include the following: the federal Medicare/Medicaid regulations alluded to earlier, 42 Code of Federal Regulations Part 483, Subpart B; other federal regulations, such as those promulgated under the Health Insurance Portability and Accountability Act concerning the confidentiality of medical information, 42 Code of Federal Regulations Part 164, and the Occupational Safety and Health Act regarding the working conditions of employees,

29 Code of Federal Regulations § 1910; state licensure requirements; private accreditation requirements, such as those of the Joint Commission, with which compliance is especially essential for participation in managed care arrangements; the threat of federal criminal prosecutions or civil lawsuits based on allegations of program fraud and abuse, including the submission of claims for payment for substandard care; and state prosecutions for abuse and neglect of residents by facility staff.

Regarding potential civil (tort) lawsuits seeking monetary damages, providers fear malpractice litigation brought against them by or on behalf of residents claiming intentionally or negligently inflicted injuries and breach of contract claims tied to marketing promises made to attract new residents in an economically competitive marketplace. The perception of some providers that civil litigation against nursing homes is essentially an irrational process frequently unconnected to actual wrongdoing is reinforced by research finding that the best performing nursing homes are sued only marginally less frequently than poorly performing facilities (Studdert, Spittal, Mello, O’Malley, & Stevenson, 2011).

The general provider anxiety about potential civil liability and regulatory consequences affects providers’ attitudes about making significant changes in the arena of dining practices (Tanner, 2010). This is a particularly sensitive area; a study by the U.S. Department of Health and Human Services’ Office of the Inspector General found that, within the time period examined, surveyors checking compliance with federal Conditions of Participation cited almost 43% of nursing homes for deficiencies in the dietary services category (Levinson, 2008). Regarding modifications recommended in the 2011 New Dining Practice Standards, there have been many anecdotal reports of providers expressing anxiety about potential lawsuits. Concerns have been cited about potential civil (tort) liability claims brought by family members or advocacy organizations on behalf of residents who have suffered some injury that can arguably be attributed to the facility’s departure from traditional practices focused on optimizing strictly medical outcomes. Providers worry, for example, about stroke related to high blood pressure, which is related, in turn, to permitting the resident to deviate from a low-sodium diet, or the resident choking on the steak that the resident requested.

In certain respects, nursing home providers' apprehensions about perceived increased exposure to civil liability claims connected to alterations in dining practices as part of the culture change movement is very reminiscent of providers' earlier widespread anxious reaction and resistance to implementation of provisions relating to reduction in the use of physical and chemical restraints contained in OBRA 87 and its implementing regulations. When the restraint reduction provisions of OBRA 87 were first promulgated, the nursing home industry for the most part loudly (and erroneously) (Capezuti, Strumpf, Evans, Grisso, & Maislin, 1998) lamented that "untying" residents would lead to a high incidence of avoidable injuries. It was imagined that demented individuals would begin getting out of their chairs or beds and walking around and falling down and that those injuries in turn would serve as the impetus for a spate of personal injury tort lawsuits against facilities and their staffs initiated by or on behalf of injured residents. There needed to be an investment of substantial efforts by change agents to educate recalcitrant providers that although restraint reduction actions might conceivably lead to some resident injuries and hence some litigation claims, overall resident physical and mental well-being was likely to be substantially enhanced and injuries reduced. Indeed, providers needed to be educated that the number and severity (Miles & Irvine, 1992) of injuries suffered by victims of restraints that were improperly prescribed, applied, and/or monitored would be worse (Braun & Capezuti, 2000; Brooks, 2000; Meyers, 2002). It was only when providers were convinced of the evidentiary basis for the OBRA restraint reduction provisions, and the associated likelihood that careful, methodical substitution of reasonable alternatives to restraints would probably reduce rather than expand the liability exposure of facilities and their staffs (Dunbar, Neufeld, White, & Libow, 1996), that substantial and sustained reductions in the use of physical and chemical restraints in nursing homes really began to occur.

The educational efforts to change provider attitudes, and ultimately their behaviors, regarding restraints took place over a number of years (and continues to go on) and involved many committed proponents from medical, nursing, legal, pharmacological, rehabilitation, and other professional backgrounds. This long campaign of attrition against provider misunderstanding and recalcitrance took the form of a barrage of articles

in the professional (Braun & Capezuti, 2000) and lay literature, presentations around the country to organizational and individual institutional audiences, countless individual conversations and communications, organizational endorsements, and the careful nurturing of support and engagement of allies at high public policy levels (U.S. Senate, Special Committee on Aging, 1989). A similar set of efforts may be necessary now to successfully promote the New Dietary Practice Standards and other emerging aspects of the culture change paradigm.

Responding to Liability and Regulatory Apprehensions About the New Dining Practice Standards and Culture Change

Significant progress in convincing nursing homes to adopt and implement the New Dining Practice Standards as part of embracing culture change more comprehensively may well require investing in the same sort of concerted, sustained educational and advocacy efforts engaged in earlier in the restraint reduction context. These efforts must be directed toward nursing home providers, regulators, and the courts.

Education About Autonomy and Risk Management

One prong of the effort should be devoted to educating providers about the value of basing actions—including more individualized, person-centered dining practices—on the informed, voluntary choices asserted by individual nursing home residents or their decisional surrogates. This is important not just as an ethical matter promoting the principle of autonomy (Agich, 1993) but also for lawsuit and liability risk management purposes. Even (perhaps especially) when the wishes of a resident or surrogate (for instance, for a tasty diet) deviate from traditional, medical outcome-driven practice (often a bland low-salt diet), the resident's or surrogate's choice and the informed, voluntary, and competent underpinnings for that choice should be documented timely and completely. Such documentation can serve to justify the provider's practice against subsequent claims of substandard care that might be asserted by a private party or a governmental agency. A thorough and accurate discussion between nursing home personnel and the resident or surrogate should take place, during which the reasonably foreseeable potential risks and benefits of alternative avenues are communicated

in understandable and unbiased lay language (e.g., “Eating foods high in salt content may increase your risk of having a stroke.”). Ultimately, respect for the dignity of the resident demands that the resident or surrogate be permitted to negotiate and assume responsibility for the risks chosen. The nursing home should be allowed to plead the resident’s or surrogate’s express, documented assumption of risk as an affirmative defense (Goldberg & Zipursky, 2006; Hall & Schneider, 2009; Meyers, 2002; Noah, 2004; Steklof, 2010). Attorneys and the courts must be educated in this regard.

Education About Clinical Practice Guidelines

Another avenue to promote provider acceptance of the New Dining Practice Standards is to educate providers about the value of evidence-based clinical practice guidelines (CPGs) or parameters in establishing and proving the clinical standard of care to which providers should, and will, be held legally accountable in civil litigation (Graham, Mancher, Wolman, Greenfield, & Steinberg, 2011; Weisz et al., 2007). Such CPGs are exemplified by the New Dining Practice Standards, which were promulgated through a consensus process by a task force broadly representative of national experts in the relevant field after a methodical, critical review of available research data.

One of the (many) criticisms that has long been leveled against the traditional American tort system for adjudicating claims alleging professional negligence is that this system makes findings regarding the applicable civil standard of care only retrospectively. That is, an individual jury announces its verdict only after the act or omission purportedly deviating from the acceptable standard of care has occurred. The decision of an individual jury regarding the acceptable standard of care under the circumstances, and whether the defendant deviated from it, is a finding of fact (not a judgment of law), and hence, it is unique to the particular case. Therefore, under this system, the individual jury’s findings have no broader precedential authority regarding tort law and provide scant, if any, prospective guidance to providers about how they ought to behave in the future to avoid civil liability claims. The CPG or parameters movement in medicine is an attempt to rectify this tort system defect by informing providers prospectively about the range of acceptable conduct depending upon the clinical situation (Rosoff, 2012).

There is a pragmatic, prudential incentive for providers to follow pertinent CPGs, besides an ethical obligation (Brant-Zawadzky, 2012) to treat patients/residents in a manner consistent with the most current relevant evidence concerning benefits and risks. Increasingly, state legislatures and the courts are formally permitting defendants to introduce evidence-based CPGs during litigation as proof of the applicable standard of care to which the defendant provider should be held accountable (Ellis v. Eng, 2010; Hinlicky v. Dreyfuss, 2006). In effect, CPGs may serve as a “safe harbor” for providers who comply with them (Pope, 2012). Because of this trend, it is highly likely that many potential plaintiffs (and their contingency fee attorneys) contemplating the filing of negligence claims against health care providers are deterred once they examine the clinical record and determine that care was rendered consistently with relevant CPGs.

Thus, as the New Dining Practice Standards become more widely accepted and followed by nursing home providers and as attorneys and the judiciary become more knowledgeable in this arena, compliance with the Standards is likely to serve as a significant deterrent to litigation in the first place and as the basis for a strong defense against any claims that are brought. This is because of the Standards’ potential evidentiary value in court to help prove the applicable standard of care for tort liability purposes. Indeed, a facility’s failure to comply with the New Dining Practice Standards may eventually become an influential factor in decisions by plaintiffs’ attorneys to file lawsuits alleging negligence, and such failure probably will be admissible at trial by plaintiffs as at least some evidence that negligence took place. This will be especially true if the Standards become codified in federal or state regulations; if that occurs, deviation from the regulatory standard may be introduced in civil litigation as proof of negligence per se.

Ameliorating Anxiety About Regulatory Sanctions

The Regulations Themselves.—Third, besides educational and advocacy initiatives aimed at ameliorating nursing home providers’ apprehensions regarding civil tort liability for cooperating with residents’ and surrogates’ choices made under the New Dining Practice Standards, attention also must be paid to providers’ concerns about potential survey agency administrative sanctions for deviating

from current regulatory requirements. Anxiety about adverse regulatory findings and penalties is understandably widespread and persistent within the nursing home provider community to begin with (Kapp, 2003), and it is foreseeable that this anxiety—and consequent defensive practice—would extend with full force to the area of dietary services.

In 2011, the CMS promulgated new procedural guidelines to be used in its nursing home survey process, the Quality Indicator Survey (QIS), 42 C.F.R. § 488.110. The QIS is intended to focus surveyors' attention more on person-centered outcomes (namely, whether residents are being properly nourished) and less on the process of care (such as how close together in time a day's meals are served). The QIS encourages surveyors to interview and observe residents and their families to understand goals and preferences specific to each resident. However, according to § 488, "Although the onsite review procedures have been changed, facilities must continue to meet all applicable Conditions/Standards, in order to participate in Medicare/Medicaid programs." In other words, despite a substantially revamped survey process, the underlying protection-oriented regulations and interpretive guidelines in practical effect dictate that provider behavior probably will remain mainly unchanged (Forrest, Long, Kuhn, Alonzo, & Frazier, 2012).

To make nursing homes more comfortable and homelike in all respects for their residents, we must accomplish a review of existing regulations and amendment or removal of those regulations that impede culture change, including those that stand in the way of implementation of the New Dining Practices Standards. CMS has made a start in this direction by, for example, changing regulatory guidelines to identify resident choice over preset daily schedules as a resident right. "Residents have the right to have a choice over their schedules, consistent with their interests, assessments and plans of care. Choice over 'schedules' includes (but is not limited to) choices over the schedules that are important to the resident, such as daily waking, eating, bathing, and the time for going to bed at night." (Centers for Medicare & Medicaid Services, 2012). The next logical move would be for CMS to amend its present regulations, at least through incorporating explicit reference in its long-term care interpretive guidelines for surveyors, regarding dietary activities to directly incorporate the New Dining Practices Standards.

Interpretation and Enforcement.—Sometimes, though, the greatest barrier to nursing home culture change is not the actual wording of the regulations or interpretive guidelines, but instead the often inconsistent and incoherent manner in which those words are interpreted and enforced at the ground level by state employees who regularly survey facilities and issue them citations for perceived noncompliance (Miller & Mor, 2008). Because providers envision their own regulatory exposure expansively, aversion to action that might entail any degree of potential risk results. The actual and/or perceived frequent inaccuracy and nontransparency of surveyor interpretation and enforcement of regulations (Schnelle et al., 2009a, b) exert on nursing home providers a distinct reluctance to advance beyond well-entrenched historical practice.

The new QIS process may help in this context, but it will in no way diminish the imperative for intensive, ongoing regulatory review and education of state surveyors to inculcate them with the principles and goals of culture change and a commitment to discharge their quality oversight function in a less punitive, more collaborative fashion (Stone, Bryant, & Barbarotta, 2009). Significant knowledge and attitudinal discrepancies between nursing home staff and state surveyors must be addressed and reduced, if not (ideally) eliminated (DuBeau, Ouslander, & Palmer, 2007; Woolley, 2011). Pilot efforts in this regard undertaken by the Rhode Island survey agency through its Individualized Care Pilot Project to train its surveyors about the goals of nursing home culture change may serve as a useful model for other states (Miller et al., 2010; Rhode Island Department of Health, n.d.). Additionally, CMS has commissioned, through the Pioneer Network, the creation of a video training module on the New Dining Practice Standards and viewing this video—expected to be released in late 2012—will become a mandatory part of each state surveyor's training in the future. Culture change advocates also should take advantage of available opportunities to partner with local Medicare Quality Improvement Organizations to influence state survey agencies in a progressive direction (Centers for Medicare and Medicaid Services, 2002).

Additionally, representatives of the nursing home industry and experts regarding the dietary Standards should meet regularly with resident advocates and long-term care ombudsmen to clear the air and jointly anticipate potential problems and devise strategies to prevent or ameliorate

them. Proactive communication and collaboration with these possible adversaries in a noncrisis setting is preferable for all concerned parties to suffering avoidable conflict after difficulties have occurred either because residents' preferences are overridden or bad clinical outcomes result from implementation of residents' risky choices.

Conclusion

The total institution paradigm of nursing home care clearly is no longer tolerable in a modern era in which the populace values individual dignity, respect, and (to the maximum extent possible) self-determination. The emerging culture change movement is built on a firm commitment to innovation. Some of the status quo alterations on the way to a more person-centered, homelike resident experience are novel and their outcomes are not yet proven. However, if society truly is serious about improving the quality of nursing home residents' lives, then regulatory agencies and the judicial system must accommodate thoughtful innovation and its uncertain consequences in a manner that rewards and stimulates, rather than punishes and disincentivizes, nursing home culture change.

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