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The Culture Change Movement in Long-Term Care: Is Person-Centered Care a Possibility for the Looming Age Wave?

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About the Author

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I. Introduction

In a time when our population is aging at the fastest rate in history, a movement is under way to change the culture of long-term care.[1] This is timely given that nursing homes are often cited as places to be feared,[2] which is reinforced by media reports of poor care and abuse in them. In a 1997 *Journal of the American Geriatrics Society* article, the authors found that more than half of hospitalized adults reported that they were unwilling to live permanently in a nursing home or that they preferred death over living permanently in a nursing home.[3] Despite this reluctance, each year more than 1.4 million people spend time living in the nation's 16,000 nursing homes[4] and nine out of 10 children can expect one of their parents or their spouse's parents to spend time living in a nursing home.[5]

Traditional nursing homes align with what Erving Goffman described as "a place of residence and work where a large number of like-situated individuals, cut off from the wider society for an appreciable period of time, together lead an enclosed, formally administered round of life."[6]

Within Goffman's framework, nursing homes are a place where elders live a rigid, cutoff life with limited autonomy until death. This may be why Bill Thomas, MD, well-known leader of the culture change movement in long-term care, calls himself an "abolitionist" of the traditional nursing home.[7] His goal is to replace traditional nursing homes with more humanized care approaches such as his Green House model, a quintessential iteration of the culture change philosophy.[8] Given the doom and gloom expressed in the aforementioned paragraphs, it seems wise to widely adopt culture change in long-term care; however, there is more to the story. The purpose of this article is to clarify the issues surrounding the culture change movement and its future.

This article will further educate readers about culture change and person-centered care in long-term care facilities, a key practice used within the movement. It will provide information about how widespread the movement is in the United States. The article will also discuss some of the challenges of the movement raised in *The Gerontologist* in 2014,[9] along with suggested possibilities for overcoming these challenges. Finally, the article will discuss the role of government and policy in advancing the movement, in-

1 Nancy Hooyman et al., *Aging Matters: An Introduction to Social Gerontology* 11 (Pearson 2015).

2 Gary S. Winzelberg, *The Quest for Nursing Home Quality: Learning History's Lessons*, 163(21) Archives Internal Med. 2552, 2552 (2003).

3 Thomas J. Mattimore et al., *Surrogate and Physician Understanding of Patients' Preferences for Living Permanently in a Nursing Home*, 45(7) J. Am. Geriatrics Socy. 818, 820 (1997).

4 U.S. Dept. of Health & Human Servs., *Long-Term Care Providers and Services Users in the United States: Data From the National Study of Long-Term Care Providers* 105, Table 4 (2016).

5 Susan M. Hillier & Georgia M. Barrow, *Aging, the Individual, and Society* 291 (10th ed., Wadsworth Cengage Learning 2015).

6 Erving Goffman, *Asylums* xiii (Aldine Publg.

Co. 1961).

7 *See generally* Bill Thomas, Changing Aging With Dr. Bill Thomas, *The Culture Change Movement Is Over*, http://changingaging.org/blog/the-culture-change-movement-is-over (Jan. 27, 2015) and *The Way of the Tiger*, http://changingaging.org/blog/the-way-of-the-tiger (Feb. 2, 2015).

8 *Homes on the Range: The New Pioneers*, PBS documentary (Dale Bell 2014).

9 *See generally* Victoria Shier et al., *What Does the Evidence Really Say About Culture Change in Nursing Homes?* 54(Supp. 1) Gerontologist S6 (2014).

cluding value-based purchasing practices that states have implemented to provide financial incentives for the adoption of person-centered care.

II. Background

The need to provide care for frail elders is longstanding. Most of this care was traditionally provided through the family or informal networks; however, even in the 20th century, abandoned elders were provided for in poor houses and later almshouses, which were essentially rudimentary precursors to today's nursing homes.[10] In 1935, more funds became available through the enactment of Social Security, which provided money that elders could use to pay for their own care. With more money available to pay for care, public criticism arose about the quality of care in available care settings.[11] Social Security pensions were not allowed to be used for government housing such as the poor houses or almshouses, which contributed to the rise in other types of care models. The 1960s marked the next substantial reform movement as Medicare and Medicaid programs began funding care to providers that opted to become licensed. Regulations, licensing specifications, building code standards, and financial reimbursement structures followed to ensure quality of care. Thus, the number of nursing homes rose dramatically during the 1960s and 1970s.[12]

In the 1980s, consumers, lawsuits, and state and federal reports criticized nursing homes for poor quality.[13] In 1987

Congress passed the Omnibus Budget Reconciliation Act (OBRA '87), with a goal of ensuring that nursing homes strive for high standards of well-being for residents.[14] The reform placed resident's rights and quality of life as equal priorities with quality of care.[15] In addition, the Act brought in enforcement agencies to monitor nursing home performance. Catherine Hawes reported that the reform has produced change in nursing homes, including improved accuracy of information in residents' medical records and care plans, decreased use of physical restraints and indwelling catheters, and increased presence of advance directives and incontinence supports.[16] Even though OBRA '87 made provisions for improving quality of life, the primary improvements have been in quality of care. In 2001, Rosalie Kane suggested that quality of life was not being equally addressed:

> Even if there were no quality-of-care problems in nursing homes, conventional nursing homes arguably fail the quality test because of the severe strictures on life in these settings. Put simply, the total disenfranchisement associated with living in a nursing home is too high a price to pay for even high-quality technical care.[17]

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10   Michael B. Katz, *Poorhouses and the Origins of the Public Old Age Home,* 62(1) Milbank Meml. Fund Q.: Health & Socy. 110, 132 (1984).

11   Winzelberg, *supra* n. 2, at 2552–2553.

12   *Id.* at 2553.

13   Catherine Hawes et al., *The OBRA-87 Nursing*

Home Regulations and Implementation of the Resident Assessment Instrument: Effects on Process Quality, 45(8) J. Am. Geriatrics Socy. 977, 978 (1997).

14   *See generally* Omnibus Budget Reconciliation Act of 1987, Pub. L. No. 100-203, 101 Stat. 1330, Subtitle C: Nursing Home Reform (1987).

15   Sara Hunt, *Residents' Rights: Curriculum Resource Material for Local Long-Term Care Ombudsmen* 9–10 (National Long-Term Care Ombudsman Resource Center 2005).

16   Hawes, *supra* n. 13, at 981–983.

17   Rosalie A. Kane, *Long-Term Care and a Good*

In reaction to this, a small grassroots movement began in the late 1980s that later became known as the culture change movement in long-term care. Leaders of this movement founded the Pioneer Network in 1997, which increased the voice of the movement.[18] The movement has endeavored to deinstitutionalize traditional models of care and replace them with person-centered, holistic models.

III. Culture Change in Long-Term Care

A. Definition

The culture change movement in long-term care targets the improvement of quality of life for residents living in nursing homes; however, a uniform definition of what it is and how it works in practice does not exist.[19] Though there is no straightforward definition, there are multiple conceptualizations and examples of the practices espoused by the movement. For instance, a variety of models are widely accepted as examples of culture change in action, including the Eden Alternative, the Green House model, the Live Oak Regenerative Community, the Wellspring program, Planetree, and the household/neighborhood model.[20] The term "culture change" as it pertains to long-term care can refer to individual components of care as well as comprehensive, organization-wide change.[21] However, there seems to be consensus that culture change was meant to be expansive in nature rather than limited to individual components or practices.[22]

Even though various models differ, Mary Jane Koren identifies some unifying features within models that comprehensively integrate culture change, including 1) individualizing care; 2) creating homelike environments; 3) promoting close relationships among staff, residents, families, and communities; 4) empowering staff to respond to resident needs and work collaboratively with management to make decisions about care; and 5) improving quality continuously.[23] She also describes how these five critical features translate into practice.[24]

Traditional nursing home care thwarts resident autonomy and decision-making. Conversely, individualized care supports elders as they make decisions every day about their lives and care. Residents direct all care and services offered by the home as much as possible.[25] Nursing home systems and practices concerning food delivery, medication administration, bathing, sleep, incontinence management, and so forth are transformed to be more flexible to accommodate choice and an individualized experience.[26]

Quality of Life: Bringing Them Closer Together, 41(3) Gerontologist 293, 296 (2001).

18 David C. Grabowski et al., *Who Are the Innovators? Nursing Homes Implementing Culture Change*, 54(Supp. 1) Gerontologist S65, S65 (2014).

19 Christine E. Bishop & Robyn Stone, *Implications for Policy: The Nursing Home as Least Restrictive Setting*, 54(Supp. 1) Gerontologist S98, S100–S101 (2014).

20 Audrey S. Weiner & Judah L. Ronch, *Models and Pathways for Person-Centered Elder Care* 15–16 (Health Professionals Press 2014).

21 Nikki L. Hill et al., *Culture Change Models and Resident Health Outcomes in Long-Term Care*, 43(1) J. Nursing Scholarship 30, 30–31 (2011).

22 Sheryl Zimmerman et al., *Transforming Nursing Home Culture: Evidence for Practice and Policy*, 54 (Supp. 1) Gerontologist S1, S3 (2014).

23 Mary Jane Koren, *Person-Centered Care for Nursing Home Residents: The Culture-Change Movement*, 29(2) Health Affairs 312, 313-314 (2010).

24 *Id.*

25 *Id.* at 313.

26 *See generally* Kan. Dept. for Aging & Disabil-

Culture change in long-term care seeks to transform institutionalized settings from hospital like environments to homelike environments.[27] Some nursing homes have moved to smaller living environments, called "households" or "neighborhoods," where a small number of residents live. These spaces contain smaller living rooms and kitchens, where institutional markers such as overhead paging and medical carts are eliminated.[28] These smaller settings lend themselves well to the next key feature of culture change in long-term care, the development of close relationships. This practice is often called "consistent assignment," where nurse aids consistently work with the same residents to foster familiarity and caring.[29]

To truly support resident decision-making, care staff such as nurse aides must have the ability to respond to residents without running decisions through the chain of command. Therefore, culture change aims to flatten the nursing home hierarchy and encourage high levels of engagement throughout all levels of the organization.[30] Through this process, nurse aides are empowered with decision-making authority, thus allowing them to respond at the bedside to resident needs.[31]

Quality excellence is highly valued within culture change in long-term care; thus, continuous quality improvement processes are essential to the adoption of culture change practices. Strong quality improvement processes, which incorporate tracking and measurement of outcomes, are essential in capturing the impact of culture change on organizations adopting it.[32]

Deep organizational change is necessary for realizing culture change in long-term care and requires extensive reconceptualization of the structure, roles, and processes of care to transform nursing homes from health care institutions to person-centered homes.[33] Person-centered (or person-directed) care is a bedrock principle of the culture change movement, and the term is often used interchangeably with the term "culture change." According to the Pioneer Network, person-directed values include patient/resident choice, dignity, respect, self-determination, and purposeful living.[34]

To achieve deep organizational change in nursing homes, the culture must change, hence the term "culture change." Edgar Schein studies culture in a context broader than long-term care and contends that there are three levels of culture: 1) artifacts, 2) espoused beliefs and values, and 3) basic underlying assumptions.[35] Artifacts are the most superficial level of culture, representing visible and felt structures and processes and observed behavior.[36] These might include objects,

ity Servs. & Kan. St. U. *PEAK 2.0 Criteria 2015–2016*, http://www.he.k-state.edu/aging/outreach/peak20/2015-16/peak-criteria.pdf (accessed Apr. 2016).

27 Margaret P. Calkins, *Creating Home in a Nursing Home: Fantasy or Reality?* 1, https://www.pioneernetwork.net/Data/Documents/Calkins-Fantasy-or-Reality-Paper.pdf, (accessed Apr. 2016).

28 Koren, *supra* n. 23, at 313.

29 *Id.*

30 *Id.*

31 *Id.*

32 *Id.* at 314.

33 David C. Grabowski et al., *Culture Change and Nursing Home Quality of Care*, 54 (Supp. 1) Gerontologist S35, S35 (2014).

34 Pioneer Network, *Introduction*, http://www.pioneernetwork.net/Consumers (accessed Apr. 2016).

35 Edgar H. Schein, *Organizational Culture and Leadership* 26 (3rd ed., John Wiley & Sons 2004).

36 *Id.* at 25–26.

structures, programs, materials, and advertising. Often the artifacts are what homes concentrate on changing first because they are tangible; however, homes that do not go past this level of culture do not experience deep organizational culture change. Organizations must go into the other two levels of culture: espoused beliefs and values, which are a person's sense of "what ought to be, as distinct from what is,"[37] and basic underlying assumptions, which are things within an organization that "become so taken for granted that [one finds] little variation within a social unit."[38] A home that has comprehensively adopted culture change has addressed all three levels of culture.

B. National Implementation

Although culture change has become widely accepted as a best practice and is even supported by national policies such as OBRA '87 and other new legislation such as the Affordable Care Act of 2010,[39] implementation has been slow. A 2007 Commonwealth Fund study surveyed nursing directors in 1,435 nursing homes. The directors were asked whether their homes had adopted 1) practices that make care more resident-directed, 2) a work environment with decentralized decision-making, and 3) a physical environment that is more homelike.[40] Only 5 percent of nursing directors indicated that their homes comprehensively met the description of a culture changed home.[41] Approximately one-third reported adoption of some culture change practices and another third indicated that they were planning to begin adopting such practices, leaving approximately one-third of nursing directors indicating no current or future adoption of culture change practices.[42] Susan Miller and colleagues conducted a similar study, finding a slight increase in culture change adoption, with 13 percent of directors of nursing in 2009 and 2010 reporting that culture change had "completely changed the way they care for residents" in all areas of the home[43] compared with 5 percent in the 2007 Commonwealth Fund study.[44]

Though implementation of person-centered care is not yet widespread, recent policy continues to push for implementation. The Affordable Care Act calls for transformation of both institutional and community-based long-term care services and supports into a more patient-centered system.[45] In July 2015 the U.S. Department of Health and Human Services (HHS), Centers for Medicare & Medicaid Services (CMS), released proposed regulation changes for nursing homes. The proposed regulation changes include multiple person-centered directives and comprehensive person-centered care planning.[46]

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37 *Id.* at 25.

38 *Id.* at 28.

39 Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

40 Michelle M. Doty et al., *Culture Change in Nursing Homes: How Far Have We Come? Findings From The Commonwealth Fund 2007 National Survey of Nursing Homes* vi, The Commonwealth Fund, Pub. No. 1131, http://www.commonwealthfund.org/usr_doc/Doty_culturechangenursinghomes_1131.pdf (May 2008).

41 *Id.* at viii.

42 *Id.*

43 Susan C. Miller et al., *Culture Change Practice in U.S. Nursing Homes: Prevalence and Variation by State Medicaid Reimbursement Policies*, 54(3) Gerontologist 434, 439 (2014).

44 Doty et al., *supra* n. 40, at viii.

45 124 Stat. 119.

46 *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 2. Summary of the Major Provisions*, Federal Register, https://www.federalregister.gov/articles/2015/07/16/2015-17207/medicare-and-medicaid-programs-reform-of-requirements

Despite the significant need for culture change in nursing homes, why has its adoption been underwhelming? A literature review reveals several reasons, including the lack of evidence-based outcomes of culture change, the increasing health complexity of elders now living in nursing homes, high turnover rates and staffing shortages, the regulatory environment, and the reality that organizational change is difficult.

A 2014 study by Shier and colleagues underscores the lack of empirical evidence that culture change efforts produce positive outcomes.[47] A recent comprehensive literature review concluded that studying culture change is challenging for two important reasons: 1) culture change has remained amorphous in its definition and currently lacks a solid framework for understanding and 2) multiple methodological dilemmas exist in setting up studies in nursing homes related to culture change implementation.[48] A knowledge base and outcomes are critical in pushing homes to adopt culture change. As Shier and colleagues point out:

> Nursing homes considering change need evidence-based guidance in how to invest scarce resources and operationalize culture change; residents and families need guidance for selection decisions; and fiduciaries need evidence-based metrics for recognizing and promoting best practices through policy, public reporting, and reimbursement.[49]

Shier and colleagues also call for more studies employing quasi-experimental design that follow nursing homes over time and include a strong analytical framework for conceptualizing culture change in practice.[50]

Numerous studies have noted that nursing home residents have become more acutely impaired over the past 30 years.[51] Hospitals are increasingly pressured to move people out quickly, and nursing homes are now serving elders with these acute needs.[52] The increasing complexity of the care needed by residents, which results in increased demands on staff time and skills, and the decreased ability of increasingly impaired residents to actively direct their care contributes to slow integration of culture change. This evolution in the field means that organizations must equip their staffs differently to deal with these demands and that budgets are constrained further as nursing homes provide more services without reimbursement.

Staff turnover in nursing homes also has been an issue for years, with nurse aide turnover especially high.[53] One study found that the average yearly turnover rate for nurse aides was more than 100 percent in many nursing homes.[54] High turnover compromises relationship development, which is critical to the delivery of individualized care, and thus under-

-for-long-term-care-facilities#h-13 (July 16, 2015)

47 Shier et al., *supra* n. 9, at S7.

48 Zimmerman et al., *supra* n. 22.

49 Shier et al., *supra* n. 9, at S7.

50 *Id.* at S14–S15.

51 David C. Grabowski, *The Economic Implications of Case-Mix Medicaid Reimbursement for Nursing Home Care*, 39(3) Inquiry 258, 259 (2002).

52 Vincent Mor et al., *Changes in the Quality of Nursing Homes in the US: A Review and Data Update,* http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.516.5718&rep=rep1&type=pdf (Aug. 15, 2009).

53 Nicholas G. Castle et al., *Nursing Home Staff Turnover: Impact on Nursing Home Compare Quality Measures,* 47(5) Gerontologist 650, 650 (2007)

54 *Id.*

mines an organization's ability to implement culture change. In addition, training is paramount to a staff's ability to deliver person-centered care, and the continuous training of new workers necessitated by high turnover is expensive and difficult to maintain. Another concern is the scarcity of specialized staff in the health care field in general, such as licensed practical nurses and registered nurses, which poses further challenges to the culture change movement.[55] To enable organizations to deliver person-centered care, specialized staff, especially nurses, is essential. Lacking such staff, organizations are ill-equipped to implement culture change. There is promise that turnover rates in nursing homes that have implemented culture change will decrease.[56]

Although federal regulations and policies demonstrate support for person-centered care, an underlying gap exists between these regulations and policies and putting person-centered care into practice. The primary problem, nationally, lies in the different and sometimes conflicting regulatory requirements nursing homes must navigate. One source of regulations, CMS, is responsible for producing and maintaining federal regulations for all nursing homes certified to accept Medicare and Medicaid residents.[57] CMS regional offices hold state agencies accountable for enforcement of the federal regulations. In addition, each state has its own nursing home licensing requirements that must parallel, yet are allowed to exceed, federal requirements. Further complicating matters, states have different approaches to licensing, the survey and inspection process, the investigation of complaints, and the identification and enforcement of deficiencies.[58] Consequently, navigating regulations while implementing culture change is extremely complicated. This hybrid regulatory scheme leaves less time and energy to devote to care and to the implementation of culture change. Though challenges exist, various stakeholders vested in culture change have met with federal regulators to work through the barriers.[59]

A final reason culture change has not been widely adopted is the reality that deep, meaningful organizational change is hard work and takes time.[60] W. Warner Burke contends that one of the major hurdles to large-scale organizational change is limited knowledge on how to plan and implement the change.[61] Continued research focused on the process nursing homes undertake to implement person-centered care[62] could yield a body of much needed knowledge, including best practices and implementation strategies that are effective in helping nursing homes implement culture change and avoid costly mistakes. Instead of leaving them to determine how to implement culture change on their own, nursing homes

55	Peter McMenamin, American Association of Nurses, *RN Retirements—Tsuanami Warning!,* http://www.ananursespace.org/browse/blogs/blogviewer?BlogKey=398c2049-1b0d-405e-b065-0b0cea4eec59&ssopc=1 (Mar. 14, 2014.

56	Pioneer Network, *Positive Outcomes of Culture Change: Staffing,* http://www.pioneernetwork.net/Providers/Case/Staffing (accessed Apr. 2016).

57	Kieran Walshe, *Regulating U.S. Nursing Homes: Are We Learning From Experience?* 20(6) Health Affairs 128, 130 (2001).

58	*Id.* at 131.

59	Pioneer Network, *Federal Policy and Regulation,* http://www.pioneernetwork.net/Policy/Federal (accessed Apr. 2016).

60	W. Warner Burke, *Organizational Change: Theory and Practice* 9–10 (4th ed., Sage Publications 2014).

61	*Id.*

62	Shier et al., *supra* n. 9, at S15.

could also benefit from receiving additional support and tools.

C. Incentives for Implementation

Because nursing home quality has historically been lacking, some states use pay-for-performance (P4P) or value-based purchasing models to incent nursing homes to improve their quality. Rather than paying nursing homes for the quantity of services delivered, P4P or value-based purchasing models reimburse nursing homes based on the quality of care they deliver.[63] To evaluate quality and performance, states implementing P4P or value-based purchasing must evaluate homes against specified metrics.[64] In the initial six states that implemented P4P or value-based purchasing, evaluation of quality included measures related to staffing, nursing home inspection outcomes, clinical quality indicators, resident quality of life, and customer satisfaction.[65] Medicaid is a primary payer of all bed days in nursing homes (51 percent);[66] therefore, incentive payments through the Medicaid reimbursement program may be a promising way to encourage nursing homes to improve quality, including the quality of life for residents.

By 2010, 14 states had implemented or planned to implement P4P models.[67]

The incentive payments in these states are based on a wide variety of measures, including "staffing, regulatory deficiencies, resident satisfaction, and clinical quality" as well as less standard measures such as "occupancy, efficiency, Medicaid use, and culture change."[68] At the time of the study, only two states, Colorado and Oklahoma, had P4P incentives specifically for culture change.[69] In March 2015, 65 state policymakers, long-term care researchers, and other stakeholders met to share information on state initiatives related to P4P or value-based purchasing. The conference, sponsored by the Minnesota Department of Human Services, Purdue University School of Nursing, and University of Minnesota School of Nursing, was supported by a grant from the HHS Agency for Healthcare Research and Quality. At this conference, representatives from Kansas, Utah, and Ohio reported including culture change components in their P4P models. These three states joined Colorado and Oklahoma in incenting culture change. Minnesota's Performance-Based Incentive Payment Program does not specifically target culture change efforts; however, facility proposals may include actions conducive to culture change implementation.[70]

Susan Miller and colleagues found that states with P4P reimbursement models

63   Rachel M. Werner et al., *State Adoption of Nursing Home Pay-for-Performance,* 67(3) Med. Care Research & Rev. 364, 364 (2010).

64   Greg Arling et al., *Medicaid Nursing Home Pay for Performance: Where Do We Stand?* 49(5) Gerontologist 587, 589 (2009).

65   *Id.* The initial states that implemented pay-for-performance or value-based purchasing are Georgia, Iowa, Kansas, Minnesota, Ohio, and Oklahoma.

66   Erica Reaves & MaryBeth Musumeci, *Medicaid and Long-Term Care Services and Supports* 4 (Kaiser Fam. Found. 2007).

67   Werner et al., *supra* n. 63, at 367. States with

pay-for-performance programs were Colorado, Georgia, Iowa, Kansas, Minnesota, Ohio, Oklahoma, Utah, and Vermont. States with planned pay-for-performance programs were Arizona, Indiana, Maryland, Texas, and Virginia.

68   *Id.*

69   *Id.*

70   *See generally* Valerie Cooke et al., *Minnesota's Nursing Facility Performance-Based Incentive Payment Program: An Innovative Model for Promoting Care Quality*, 50(4) Gerontologist 556 (2010).

that incent culture change seemed to have higher levels of culture change adoption than states without these incentives.[71] The authors also found that nursing homes in states with P4Ps that incent culture change scored higher across all practice domains investigated, including the physical environment, staff empowerment, and resident choice and decision-making, which are indicators of person-centered care.[72] This demonstrates the potential for P4P policies to promote the positive qualities of culture change regardless of nursing homes' motivation to adopt the practices associated with culture change.

Although several states are moving to P4P models and some states incent culture change specifically, states vary significantly in how this done. Some states incent quality by tying reimbursement dollars to the inputs of producing high-quality care while others pay homes once outcomes are produced.[73] This means that some states increase payments when a home engages in the process of implementing change while others increase payments once changes are in place and outcomes are demonstrated. The resulting question, then, is: Which approach is more effective in producing quality outcomes?

The measurement of quality resulting from various qualifying implementations (each state has different specifications about what qualifies for payment) under different state P4P programs has not been studied. More studies are needed to understand how process and outcome incentives impact quality improvement in nursing homes. Studies such as these will be complicated by the absence of well-established culture change outcomes, which

are outlined earlier in this article. Thus, it is important to move forward with establishing valid culture change outcomes before wide adoption of outcome-based P4P models takes place. Establishing uniform, valid culture change outcomes for nursing homes will help ensure that actual culture change is being encouraged through incentives.

IV. Conclusions and Future Directions

Culture change has been shown to be a positive approach to improving the quality of life of elders living in nursing homes. Much anecdotal evidence supports this conclusion, such as stories from providers, residents, and families; however, there is little empirical evidence that culture change produces better clinical outcomes than other models of care. Lack of empirical evidence may be related to the methodological challenges of studying a concept as complex as culture change and organizations as complex as nursing homes. Methodological challenges are likely to lessen as more nursing homes implement culture change and more efforts are made to operationalize culture change.

In addition, P4P reimbursement models show promise for incenting adoption of culture change in the states that have pursued this approach. As more states consider this approach for encouraging homes to adopt culture change, some fundamental questions must be answered by research, such as the following: a) Do extrinsic motivations such as financial reimbursement motivate the deep organizational change necessary to cause a nursing facility to adopt, implement, and maintain culture change? b) Are P4P models truly incenting higher quality? It is important to address these questions and those noted earlier in this article as more states become interested in implementing P4P programs.

71   Miller et al., *supra* n. 43, at 440.

72   *Id.*

73   Werner et al., *supra* n. 63, at 373.

The historically poor quality of care in nursing homes is improving, but improvements in quality of life have fallen behind.[74] Our population is growing at the fastest rate in history; therefore, as Bill Thomas believes, it is time to abolish the traditional nursing home and innovate new models of care.[75] Culture change holds much promise for improving the quality of life for elders in nursing homes. There is no time like the present to advocate for more provider and consumer interest in culture change as well as further research to add to the empirical evidence for culture change.

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74   *See generally* Katz, *supra* n. 10.

75   *See generally* Thomas, *supra* n. 7.