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

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

“Those early efforts mark a major milestone for the culture change movement,” says Larry Deans, executive vice president and chief administrative officer at Golden Living. “It’s the first time ever that a big company like ours tried a resident-centered care approach.” Prior to RCCI, most CC models had been tested by nonprofit organizations on a more limited basis, Deans says.

Why would a large publicly traded company (like Beverly Healthcare) adopt a corporate strategy to implement CC? Investing in RCCI was undoubtedly a gamble. It required $7.5 million in capital costs and $2.0 million in implementation costs. How could corporate leaders justify these expenditures to the board of directors and shareholders at a time when the business case for CC was still ill-

Leadership Drives Successful Culture Change, Organizational Excellence

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

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

Research about Golden Living’s RCCI underscores just how profoundly leadership affects organizational culture and successful organizational transformation. Researchers from the University of Minnesota found that culture change (CC) failed to take hold in nursing facilities where leadership competencies were weak or where there was turnover in key facility leadership.

Five leadership competencies—focused visionary, strategic management, caring leadership, communication, and supporting change—accounted for three-quarters of the differences seen in culture across Golden Living’s nursing facilities. Research done by My InnerView on an independent sample of nursing facilities found that these same five competencies predict clinical, workforce, and financial performance.
defined? “We didn’t have the numbers, so it took a leap of faith,” says Andrea Clark, senior vice president of clinical services for Golden Living. “We just knew in our hearts and minds that this was the right thing to do. If we ever thought it wouldn’t produce clinical, quality-of-life, and financial results, we would not have gone down this path. In order to maintain the support of corporate leaders and board members, we had to prove its value,” she says.

Not-for-profit organizations (and privately held firms like Golden Living) may be in a stronger position to implement CC successfully compared to publicly traded entities driven by quarterly financial results. The former can more easily justify the long-term investments in capital and human resources needed to reach more advanced stages of CC development. It is common wisdom that it takes three or more years for an organization to develop from an institutional to a neighborhood or household model. (See Part One of this series for a description of these models).

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

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

Making The Business Case

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

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

- A culture of excellence
- Workforce commitment
- Leadership strengths

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

“We now have data showing how companies consistently outperform their peers,” says Neil Gulsvig, president and chief executive officer of My InnerView, Wausau, Wis. “These are the industry leaders or top performers who set benchmarks for the best-in-class. They consistently do better than their peers on metrics we’ve been tracking.”

**Workforce Commitment Key**

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

![Figure 1](Image)

**CC Impact On Bottom Line**

Revenues Per Resident Day

Expenses Per Resident Day

Profits Per Resident Day

EBITDA Per Resident Day

<table>
<thead>
<tr>
<th>Year</th>
<th>RCCI</th>
<th>Non-RCCI</th>
</tr>
</thead>
<tbody>
<tr>
<td>2003</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2004</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2005</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

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

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

**Bottom Line Results**

RCCI and non-RCCI facilities were matched by geographic region. Researchers from the University of Minnesota collected data comparing these facilities on revenue, expenses, profits, earnings, payer mix, and occupancy. Annualized data are shown in Figures 1 and 2 comparing the four quarters of 2003 (the year before RCCI started), 2004 (the year when RCCI started), and 2005 (the year after RCCI started). The fact that RCCI
was implemented incrementally raises questions about what the appropriate time frame should be for making these before and after comparisons in financial performance.

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

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

Corporate managers made the strategic decision to invest corporate resources in better-performing facilities. The rationale for this decision was that better performers are more likely to implement CC successfully. This decision made it more difficult to show a return on investment given that RCCI facilities were better performers from the start.

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

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