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An Unintended Consequence of Culture Change in VA Community Living Centers

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Abstract

Objective: Although a growing body of evidence suggests that culture change and its corollary, person-centered care improves resident outcomes in the nursing home setting, little is known about the effect of culture change in a postacute setting in which patients receive skilled nursing and rehabilitation services for a relatively short period of time before returning home.

Design: Data for this study were collected as part of a larger project to understand the impact of Veterans Health Administration (VHA) policies to shift the mission of VHA Community Living Centers (CLCs) from long-stay custodial care to short-stay skilled nursing and rehabilitative care.

Results: Although qualitative data collected during interviews from site visits to eight geographically diverse CLCs suggest an increase in the quality of life and care for veterans, interview data also indicate an unintended consequence. Specifically, staff described how aspects of the homelike environment, relationship-based care delivery, and attention to veterans' preferences that characterize culture change can prolong a veteran's length of stay beyond treatment completion. In addition to providing skilled nursing and rehabilitation, VHA CLCs also

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serve a latent function of providing a comfortable home and a peer community for veterans to connect and socialize with one another. A congregate living environment for persons with the shared symbolic status of being a veteran is unique to VHA CLCs. Strong bonding among peers and staff as well as staff respect for veterans' service to the country may increase their sense of obligation to keep veterans past their expected discharge date.

Conclusion: Our findings suggest that the complexities of culture change and veteran-centered care in a short-term care setting may be underrecognized. We discuss how findings may also be relevant for the non-VHA sector.

Keywords

Veteran-centered care; person-centered care; culture change; discharge

The Veterans Health Administration (VHA) is the largest integrated health care system in the United States with more than 1,700 sites of care serving just under 9 million veterans per year.¹ In 2005, the VHA adopted culture change principles that were comparable to the nursing home community at large, and in 2011, the Veterans Administration created the Office of Patient-Centered Care and Cultural Transformation to support the system's efforts to transform the health care experience for veterans. Unlike the previous health care priorities that focused primarily on diseases and conditions of veterans, this new model of relationship-based care delivery centered on the whole-person approach. This new shift is often referred to by interchangeable terms such as *patient-centered care*, *person-centered care*, and *Veteran-Centered Care* (VCC).^{1,2} With this approach, medical providers and veterans work in partnership to identify veterans' values, needs, and goals to create a more personalized health care experience. These cultural transformation efforts extend beyond primary care and acute care, to include long-term care (ie, nursing homes) and postacute care (short-term rehabilitation settings). In the VHA, both long-term care and shorter-term rehabilitative, post-acute care are provided by Community Living Centers (CLCs; formerly Nursing Home Care Units) within the VHA network. Typically, CLCs are located on one or more wards of the medical center, but some are stand-alone facilities located on the medical center grounds, and a few facilities are free standing, off medical center grounds.

In response to the 1999 Veterans Millennium Health Care and Benefits Act's (H.R. 2116) mandate to rebalance long-term care through the development of community-based options to the nursing home, the Geriatrics and Extended Care Services (GEC) leadership promoted a shift in CLC care focus from long-stay custodial care to short-stay (<90 days) care with the goal of timely return to the community, defined as completion of veterans' treatment goals. Once the site of primarily nursing home care, the VHA CLC is now "a component of the spectrum of long-term care that provides a skilled nursing environment and houses a variety of specialty programs for persons needing short- and long-stay services."³ In 2004, approximately 22% of CLC admissions were long stay (>90 days), and 78% were short stay (<90 days). By 2011, the proportion of stays that were long stay decreased to 16%. However, the average short-stay length of stay remained constant at 25 days during this time period. Thus, the GEC's goal of decreasing admissions anticipated to be long stay was realized, but not the related goal of decreasing short stay length of stay.⁴ On average, about 80% of the average daily census in CLCs comprise long-stay and 20% short-stay patients. In

2011, about 76% of veterans categorized as short stays from CLCs were discharged to the community, 19% to the hospital, and 5% to a community nursing home.

CLCs are expected to provide veteran-directed, goal-oriented care, consistent with veteran-centered care and other principles of culture change in long-term care settings more generally.³ The following is a description of VHA CLCs on the website of the U.S. Department of Veterans Affairs.

A Community Living Center (VA Nursing Home) used to be called a nursing home.

Unlike many nursing homes in the past, a Community Living Center resembles “home” as much as possible. There are activities for Veterans of all ages. There are family-friendly places for visiting. Veterans are invited to decorate their rooms. And, pets are allowed to visit or live in the Community Living Center.

Veterans may stay for a short time or, in rare instances, for the rest of their life. It is a place where Veterans can receive nursing home level of care, which includes help with activities of daily living (e.g., bathing and getting dressed) and skilled nursing and medical care.

The mission of a Community Living Center is to restore each Veteran to his or her highest level of well-being. It is also to prevent declines in health and to provide comfort at the end of life.

(Department Of Veterans Affairs, 2016)³

Much of the impetus for the cultural transformation of patient care in CLCs stemmed from the “culture change” movement. The “culture change” movement is a term used to refer to the social movement and respective policy and practice changes that emerged from different sources including a report from the Institute of Medicine, which was the impetus for the Nursing Home Reform Act (OBRA, 1987) and, more recently, grassroots efforts of advocacy groups to improve quality in U.S. nursing homes.^{5–11} At the national level, culture change initiatives have been widely adopted by the Centers for Medicare and Medicaid Services (CMS) and the Department of Veterans Affairs. For example, both entities have adopted the Artifacts of Culture Change Tool created by CMS to assess nursing homes and VHA CLCs on the degree to which they have implemented important elements of culture change that lead to a more home-like environment, resident-centeredness, and staff empowerment.^{12–14} Studies have shown that by implementing cultural transformation policies and practices, nursing homes can improve quality and outcomes.^{12,15,16}

What is not known about culture change efforts in VHA CLCs are their unintended consequences and the ways in which they might influence organizational and veteran outcomes. The purpose of this article is to highlight the intersection of culture change principles and the VHA’s system-wide effort to shift care focus from long-term to short-term care with timely discharge to the community when treatment goals are met. Qualitative data are from 99 interviews conducted with leadership and staff during site visits to eight VHA CLCs collected as part of a larger study of changes in VHA CLCs as VHA GEC moves toward rebalancing long-term care.

CLC Recruitment and Site Visit Protocols

This study, including the process for gaining informed consent from participants, received approval from the Institutional Review Board. Data for this study were collected from eight CLCs. A pool of candidate CLCs was selected for recruitment to the study to ensure diversity in size and geographic location in our sample. Leadership of the selected CLCs was first contacted by e-mail and invited to participate in the study. Follow-up phone calls were made to those who were interested in answering questions about the study. For those CLCs willing to participate, the study was further explained, a contact person identified, and a date for the site visit was scheduled. A total of eight CLCs (our target sample size) out of 11 contacted CLCs agreed to participate in the study. Two sites were from each of the four U.S. census regions: Northeast, Midwest, South and West, and the average daily census of the eight sites ranged from 22 to 140 patients. Before the site visit, an e-mail was sent to CLC staff explaining the study, asking for volunteers to be interviewed, and alerting them to the dates the research team would be visiting.

During the 3-day site visit, researchers observed interdisciplinary team meetings, admission screening meetings, physical therapy sessions, and other daily activities of the CLC. Researchers wrote field notes during these observations and debriefed with one another at the end of each day about what was observed. Potential interview participants were introduced to the research team by the contact person, and the interviews were scheduled. Examples of staff and administrators who were interviewed included the medical director, the CLC director, social worker, director of nursing, certified nursing assistants, floor nurses, activities and physical therapy staff, and the MDS coordinator. All participants were consented individually at the beginning of their interview. Twelve to 16 interviews were conducted with staff and residents at each CLC. Interviews were audio recorded and transcribed for data analysis.

Interviews with frontline staff focused on changes in the CLC that they had witnessed or had knowledge of, their experiences with cultural transformation, and their perspectives on how CLC processes may or may not contribute to the timely discharge of residents back to the community, with timely discharge defined as the point when veterans' CLC treatment goals were met. Members of the CLC leadership team were interviewed about CLC policies and procedures, especially with regard to discharge planning. They were also asked about their perception of the CLC's mission, goals regarding treatment, how care processes affect length of stay, and their views of barriers to and facilitators of discharge and placement goals. Veterans were interviewed about their discharge plans and how the CLC care environment and care practices were helping or hindering their ability to be discharged to the community in a timely fashion.

Qualitative Data Analysis

As part of the larger study, interview data were analyzed using a modified grounded theory approach.¹⁷ Thus, while some coding labels emerged directly from the content of the data, others represented a priori categories and domains from the research aims and targeted questions in the interview protocol.^{18,19} In this way, unexpected findings, as well as

anticipated areas of interest were captured. A coding scheme was developed and refined following team discussion to capture the domains of interest from the interview questions and other relevant interview data. To begin the coding, all research team members read all interviews for the first two sites multiple times and individually made notations to code the material. In subsequent and repeated group meetings, team members then refined the coding scheme and code definitions and came to consensus about the interpretation of the material, with team decisions recorded in an audit trail. After hand coding and vetting interviews from the first two sites, coding became more standardized with increased familiarity with the coding scheme. Interviews from all eight sites were then coded by subteams of two team members, using QSR International's qualitative data analysis software NVivo, Version 10. Members of these subteams rotated, and the entire team convened regularly to discuss and resolve discrepancies and confirm the final codes in the transcripts. Throughout the analysis, team members noted potential emerging themes defined as patterns of ideas and concepts expressed across interviews. Once coding was completed, the entire team discussed the potential themes to determine how prevalent they were across the interviews.

Over the course of our analysis, several themes related to culture change emerged under the larger theme of frequently mentioned barriers to timely discharge. We organized these subthemes into categories that roughly parallel aspects of culture change as discussed in the literature.¹²

Findings

A Home-Like Environment

Consistent with hallmarks of culture change, staff at all eight CLCs described intentional efforts to make the CLCs less institutional and more home-like. These efforts took place within a system-wide context to uncouple negative stereotypes about long-term care. For example, our findings suggest that the facilities' new name, Community Living Centers, was meant to invoke a sense of home and community to veterans whether admitted for a short or long stay.

A certified nursing assistant (CNA) described the efforts of CLC leadership to be more home-like and less like a traditional nursing home, saying:

I have worked in nursing homes before, and from what I gather, the focus currently here is to change the atmosphere from that of a nursing home, and I use that term in its pejorative sense, to more of a home away from home for the people who are here regardless of how long they're here for.

In addition to the name change at the facility level, a physical therapist described changes to the ways in which staff referred to residents.

We used to call veterans patients, and now, I kind of retrain my brain to refer to each person and each individual that lives here, or stays here for a short time, as a resident.

In one CLC, name changes were reflected in the language used to describe traditional patient wards. "*They know what street they live in. There's a Fish Street, there's an Apple Street,*"

described a care coordinator. Additionally, various areas of the facility were redesigned to enhance comfort and privacy. For example, one director of nursing describes the transformation of shower rooms to spas:

We took our institutional shower rooms, which is what they were called, with three shower stalls and a tub, where once upon a time, we would have a resident in every stall and another one in the tub with little issue with privacy and dignity there. To having revamped it to only one resident in there at a time, even if it's designed for more. Making it look like your bathroom at home.

Regardless of length of stay, residents are encouraged to personalize their rooms while living at the CLC to make it as home-like as possible. One registered nurse reported, “(We do) *just whatever to make them as comfortable as possible in their little tiny space.*” A nurse manager described the ways in which residents personalized shared rooms at the CLC saying:

We've tried very hard to make them more easy [sic] on the eye, more pleasing. Not to look so institutional. We've allowed the veterans to bring a lot of their own things, and shop. Everybody shops online here. We have Internet for everybody. So it can get challenging as well, because they'll go shopping and they'll, you know, buy stereos. They'll bring their own big flat screens, and, and, you're like, “Okay. [Laughing] Where are we going to put all this?” [Laughter] ‘Cause we don't have all private rooms, which would be the ideal. Maybe someday, but we're not there yet.

Not only can veterans personalize their environment, but staff can do so as well. For example, a CNA described wearing their own clothes, rather than traditional scrubs or uniforms.

“Start with the employees being that they don't wear traditional scrubs, and being that they're different, so they may dress different, uh, they may wear their hair different. It gives an individual look, versus your standardized assimilated look. So a resident can say, ‘The woman in red,’ or ‘The guy with the big glasses,’ and it, uh, that versatility, I think, you know, is kind of refreshing, ‘cause it's different than being in a facility where everybody's wearing the same, looking the same.”

These homelike characteristics continued in descriptions of the flow and rhythm of daily life at the CLCs. Staff describe a variety of entertainment options to choose from each day, including creative arts, off-site shopping trips, social hours, coffee groups, Wii Nintendo gaming, musical performances, and cooking classes among others. According to staff, for some veterans, the CLC was, “*the nicest place they've ever lived.*” A physician said, “*they're pretty pampered*” when referring to the entertainment options available to residents.

Staff described these home-like comforts as having the unintended consequence of creating an environment that veterans don't want to leave. “*They love it. They love it so much, sometimes they don't want to leave.*”

A director nursing said:

“I actually had a resident that was discharging the other day, and he says to me, you know what your problem is? He goes, you take too good care of the patients. Your food is too good, and you baby everybody, and that’s why nobody will leave.”

Resident-Centered Care

Resident-centered care refers to the ways in which veterans choose such activities as wake and sleep times, bathing schedules, medication times, and therapy times. “*We’ve changed our medication administration times, for example, to adjust to the majority of residents’ choices.*” During interviews, staff described the process of veteran-directed care in formal care plan meetings with staff. An MDS coordinator explained:

Narrowing our focus to really what’s important for them to be able to be successful and, I mean, we can write this care plan, and it could mean nothing to them as we use [sic] to do in the past; I mean, our care plans before were 28 pages, you’re laughing. It took forever, there were mini books, and, you know, and how many of those items did we really focus on to help them with and, and we’re talking to them about it, and before we use [sic] to write it for them, and now we’re talking to them and getting their opinion, what do you think would help, and I think that makes a big difference. You know, actually listening to them.

Honoring resident choices for care was described in two ways. First, in the context of the culture change philosophy, references to a veteran being included as an important member of the care team, and his or her voice being heard. “*Everything should start with how the veteran’s willing to live his life.*” A nurse manager explained:

“I became a nurse 9 years ago, but [when] I was bringing my dad into the VA, he was always talked at and told what to do. I told what was best for him. And this switch to patient-centered care where we now ask our veterans, what do you want out of this stay? What would get you to where you want to go? What are, what are your goals? It’s the whole shift from, you know, it’s a power struggle. (Laughter) Who’s in charge here? The veteran!”

The second rationale for honoring resident choices about their care was expressed in the context of reverence to veterans’ service. One case manager described the right to make choices in the following way:

“I am myself a veteran, and I don’t want to be told what to do. I want to be taught about what’s best for me, what [the] recommendations are, but at the end of the day, it, my decisions about what I do are my decisions. This is what all of our veterans have fought for, all of ‘em served in the service for. That’s what my dad fought in World War II for, was the right to make our decisions not have somebody come and tell you have to do this, right? We fought for freedom, and that freedom should extend to health care.”

Encouraging veterans to make choices and participate in the care team was less clear when it came to the discharge process. While previously in the same stay, listening to the veteran’s voice was paramount to delivering good care, it became less clear what to do when a veteran said he didn’t want to be discharged. “*Once people get in here, they often don’t want to*

leave, so that makes it even harder, cause how do you tell someone you can't stay?" asked a medical director.

Quality of Relationships Between Staff and Veterans

The quality of the relationships created between staff and veterans is another reason some veterans want to stay at the CLC as long as possible, saying for example, "*You get that extra attention. You get to know them. We're creating bonds and somewhat of friendships 'cause it's not just me telling you what to do.*" Staff describe these bonds as emerging in the context of consistent assignment stating, "*The veterans love it.*" "*I like the consistent assignment because I know what to do for them. I know their treatments.*"

Knowing a resident well and understanding his treatment plan was also described as supporting veterans' healing and rehabilitation goals. For example, a CNA explained:

"The patient will listen to the staff a lot better with, with a relationship. When they have a, like I could sit there and talk to [him] like any of my patients. Look, if you don't do this, how are you gonna go home? You know, what are you going to do when you go home?"

However, this same relationship also contributed to veterans' desire to stay at the CLC. A social worker said:

"I think the reason why veterans don't want to leave is because it is great here. Um, that's the reason why. I mean, you see veterans talking to staff, staff talking to veterans. I mean it's it's a really nice environment."

Staff members describe this sense of familiarity and belonging as leading to an extended discharge date. For example, one physician said:

"It's a familiar environment, they (the residents) know a lot of the staff. They're frequent fliers that know a lot of staff. They come frequently for the respite, and then they, they want to stay, and pretty soon, it's 6 months later, and you're still trying to discharge them (laughing)."

Strong relationships between staff and veterans also contributed to difficulty enforcing discharge time frames. An RN described what happens when a veteran who has been discharged wanted to return to the CLC:

"Because we are so nice to them [laughter], and we have fun here, they, you know, we had a guy that left and then went to a nursing home, came back in like 2 weeks, and he's like, it's so boring there, and it was terrible, so they let him come back."

Maintaining Connections to Other Veterans

In addition to providing medical and rehabilitative care, CLCs serve as a latent function of connecting veterans socially. For example, staff shared that some residents don't want to move to another nursing home because they are too attached to their peers, who are also veterans and mostly male. This composition of peers is unique to VHA CLCs compared to non-VHA CLCs. A director of nursing explained:

“There’s some vets that we have here that I’ve known since [year], and uh, we care about them just like they’re our family, and that’s real, you know; we’re so blessed to have that opportunity, to have that continuity. And to know that they’re safe and secure. A lot of the male vets don’t like to go to outside nursing homes ‘cause they’re all female. They like to talk about the war stories. You don’t know how many John Wayne movies I’ve bought for them. They love them.”

Discharge from the VHA CLC interrupted the sense of solidarity and belonging that developed among veterans and staff. For example, a registered nurse described discharge as a, *“loss of connection to their veterans. And we become attached to them also. Truly, we really do.”* “*We are family.*” A physician described:

“You know what, that actually can be a barrier, because another case comes to mind of a veteran who came in for respite, and he’s always loved coming to the CLC and will think of any excuse not to go home, and we’ve seen patients even kind of sabotage their care in order to stay longer because, and you know, and it just tells me that their home environment probably is so lonely and maybe just, you know, it’s, it’s hard to know, but they do. They love socializing with the other vets, and just all the things that we do here for them, um, yeah, that can be another obstacle, too.”

Summary and Discussion

The purpose of this article was to report on an unintended consequence of culture change on timely discharge of veterans from VHA CLC facilities. As Johnson et al. (2013, p. 27) point out, “Serving in the military is an experience that has no counterpart in civilian life.”²⁰ As such, models of person-centered care within VHA CLCs are unique from non-VHA nursing homes. Findings from the larger qualitative study align characteristics of good discharge planning to principles of culture change. For example, partnering with veterans and families on the care plan, managing expectations about discharge, coordinating transitions of care, and developing relationships with veterans were identified as facilitators to timely discharge. In this sample of VHA CLCs, some of those same components of culture change were also identified by staff as barriers to timely discharge.

Staff acknowledged language as creating mixed messages, such as referring to short-stay facilities as “community living” centers and short-stay patients as “residents,” terms with a connotation of a long-term care arrangement. Environmental changes to make the facility more home-like, including invitations to personalize the rooms and entertainment options contributed to veterans wanting to stay longer than their treatment plan. Hallmark behaviors of VCC, such as fostering personal connections and quality relationships between staff and veterans through processes such as consistent assignment, may also contribute to some veterans staying longer than necessary.

Consistent with VCC, staff accommodated veterans’ requests to direct their care, including medication times, therapy schedules, and preferences for daily care (ie, wake times, showers, etc.). Veterans’ requests to stay longer than their allotted rehabilitation time, however, created a dilemma for staff, especially among veterans with whom they have forged a special friendship. The development of a caring friendship was supported by aspects of VCC such

as consistent assignment, increased partnering with the veteran in the care plan, and personalized care.

Limitations

This study has several limitations. First, although efforts to ensure diversity in size and geographic location were made in the recruitment of CLCs, the sample size is small relative to the total number of CLCs in the VHA Network (134). As such our qualitative research findings are not generalizable to all nursing homes and possibly not even to all VHA CLCs. Second, not all staff members in site visited CLCs participated in our project. It is possible that the perspective of staff members who did not participate are different from those who were interviewed.

Implications

While there are some noted differences in the philosophies and implementation of models of culture change in long-term care, culture change, as a concept, has largely been conceived as a long-term care model (ie, a situation in which the facility is the resident's home). Within the context of short-term care, however, complexities of culture change may, unintendedly, create barriers to achieving the system-defined goal of discharging patients once their treatment goals are met. While implementing culture change in this setting may be very successful in improving quality of care, it also creates the dilemma that some veterans are reluctant to leave. This suggests that the current model, originally conceived for nursing homes providing long-term care, may require adaptations or additional staff training to avoid this unintended consequence. Future studies need to explore the daily experiences of staff, including issues of moral distress for staff who want to honor patient preferences and organizational imperatives simultaneously.

Future efforts should explore veterans' perceptions of contradictory messages in short-stay CLCs, such as using terms like "living," "home," and "resident" for persons receiving care in that setting for 90 days or less. Particularly for veterans whose own homes are in substandard housing, or who may experience episodes of homelessness, such language may contribute to their reluctance to leave the CLC.

Finally, further research should determine whether this phenomena of an unintended consequence of culture change also affects dually eligible patients in non-VHA skilled nursing facilities as well. For example, among non-VHA patients, dual eligibility to qualify for Medicare and Medicaid is correlated with living alone, lower socio-economic status, and lower rate of home ownership.²¹ Dual-eligible patients can have longer length of stay in postacute settings and have less incentive to return home because quality of life in the nursing home is better compared to living in the community.²¹

Conclusion

In addition to providing skilled nursing and rehabilitation services, VHA CLCs also serve a latent function of providing a peer community for veterans to connect and socialize with one another. In this context, discharge from the facility represents the end to relationships for

veterans and staff, a bond that has developed, in part, due to the components of culture change, such as personalized care and consistent assignment. A congregate living environment for persons with the shared symbolic status of being a veteran is unique to VHA CLCs. Strong bonding among peers and staff, as well as, staff respect for veterans' service to the country may increase their sense of obligation to keep veterans past the date that the interdisciplinary team has determined the veteran can be safely discharged. Our findings suggest that the complexities of veteran-centered care, as a unique derivation of culture change models, may be under-recognized and, not yet, fully understood.

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