Original Article

Diffusion of Palliative Care in Nursing Homes: Lessons From the Culture Change Movement

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Abstract

Context. Studies have found that nursing homes (NHs) that rely heavily on Medicaid funding are less likely to implement innovative approaches to care, such as palliative care (PC) or resident-centered approaches commonly referred to as "culture change" (CC). However, a nationally representative survey we previously conducted found that some high Medicaid facilities have implemented these innovative approaches.

Objectives. The purpose of this study was to identify the factors that enable some high Medicaid NHs to implement innovative approaches to care.

Methods. We conducted telephone interviews with 16 NH administrators in four categories of facilities: 1) low PC and low CC, 2) low PC and high CC, 3) high PC and low CC, and 4) high PC and high CC. Interviews explored strategies used to overcome barriers to implementation and the resources needed for implementation.

Results. We had expected to find differences between low and high NHs but instead found differences in NHs' experiences with CC and PC. Since the time of our national survey in 2009–2010, most previously low CC NHs had implemented at least some CC practices; however, we did not find similar changes around PC. Administrators reported numerous ways in which they had received information and assistance from outside entities for implementing CC. This was not the case for PC where administrators reported relying exclusively and heavily on hospices for both their residents' PC needs and information related to PC.

Conclusion. PC advocates could learn much from the CC model in which advocates have used multipronged efforts to institute reform. J Pain Symptom Manage 2015;49:846–852. *Published by Elsevier Inc. on behalf of American Academy of Hospice and Palliative Medicine.*

Key Words

Nursing homes, long-term care, palliative care, patient-centered care, diffusion of innovation

Introduction

Diffusion of palliative care (PC) and other innovative models of care in nursing homes (NHs) is a persistent challenge in the U.S. and many other countries.[1–3] In the U.S., this is especially true in the case of facilities that rely heavily on Medicaid, the government program that funds health care for the poor and finances much NH care. For this study, NHs were considered high Medicaid if 80% or more of their residents' care was supported by Medicaid. Multiple studies have found that high Medicaid NHs often have lower quality care, worse outcomes for residents, lower staffing, and a host of other troubling issues.[4–6] These facilities also have been found to be less likely to implement innovative approaches to care,[7] such as PC or resident-centered approaches commonly referred to as "culture change" (CC).[8] However, a nationally representative survey we

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previously conducted with NH administrators and directors of nursing as part of another study found that some high Medicaid facilities have implemented these innovative approaches.[9] To identify the factors that enable some high Medicaid NHs to implement innovative approaches to care, we examined two types of innovation in NHs: PC and CC.

For this study, PC was defined as care provided to individuals with serious or life-threatening illnesses who may not qualify for or choose to enroll in hospice, which in the U.S. is care provided at the end of life as a benefit of the Medicare program (the U.S. health care program for those aged 65 years or older). PC is provided for anyone with a chronic illness by an interdisciplinary team. The team supports patients and families in their psychosocial needs and addresses patients' physical, intellectual, emotional, social, and spiritual needs while facilitating patient autonomy, access to information, and choice.[10]

CC was defined, for this study, as practices aimed at making nursing facilities more homelike and less institutional by providing care that is more resident-centered and focused on the preferences and desires of care recipients.[11] NH CC has been operationalized through physical changes, such as removing nursing stations, and organizational changes, such as increasing the autonomy of direct-care workers.[12] Specific practices include resident choice in dining, bathing, and sleep times; consistent assignment of nurse aides; and provision of private rooms.

Research on the diffusion of innovation in health care organizations has focused primarily on two types of diffusion: diffusion of innovation among individuals within the same organization and diffusion of innovation among organizations.[13] Both types of diffusion are necessary for the successful implementation of innovation; each relies on complementary sets of factors for their success that are both internal and external to the organization. Internal factors previously found to be related to implementation of innovation are the characteristics of the organization itself, such as size,[14] and the characteristics of the leaders adopting the innovation, such as their communication styles and interpersonal skills.[15] External factors include attributes of the environment, such as interpersonal relationships among leaders in different organizations,[16] mass media attention to the innovation, and the intentional spread of the innovation by formal networks and champions.[17]

One difficulty in applying previous findings on the diffusion of innovation to high Medicaid NHs is that most previous research has focused on hospitals and, in particular, the experiences of above average organizations often characterized as "early adopters." Little research has focused specifically on the NH environment;[18] even less attention concerns the special challenges faced by high Medicaid NHs. Therefore, the purpose of this study was to determine the factors that allow these types of facilities to implement innovative approaches to care, including PC and CC.

Methods

We conducted 16 qualitative telephone interviews with four administrators in each of four groups of high Medicaid facilities identified using data from a previously conducted national survey.[9] Using Online Survey Certification and Reporting data that are collected annually for most U.S. NHs, we identified the NHs that participated in our previous survey that had at least 80% of their residents' care paid by Medicaid. Using the CC and PC scores derived from our survey data, we then categorized these facilities by the extent of their PC and CC practice implementation. The four categories of facilities were as follows: 1) low PC and low CC, 2) low PC and high CC, 3) high PC and low CC, and 4) high PC and high CC. The interviews with four administrators from each category took place between September and November 2013. Interviews explored innovations implemented, strategies used to overcome barriers, how facilities began the process, the external and internal resources needed and used, and the role of outside networks/groups, among other factors.

Our previously collected survey data included a set of items on CC, including questions about physical environment, staff empowerment, and resident choice and decision making (i.e., resident-centered care). These survey questions were used in previous CC surveys and had good measurement properties.[19] The survey also asked a series of questions related to PC knowledge and practices. These questions were derived from the validated NH "Palliative Care Survey" by Thompson et al.[20] To reduce measurement error and increase data validity, cognitive-based interviews of the draft survey items were conducted.[21] Development of the CC and PC scores is detailed elsewhere.[9,22]

We randomly selected NHs in each of the four categories, and their administrators were mailed introductory letters explaining the purpose of the study and then called to schedule a convenient time for a telephone interview. Data collection was systemized by use of a standard interview protocol that was pilot tested with three NH administrators. Based on feedback from each pilot interview, the interview protocol was revised by the study team. This study was approved by our university's Institutional Review Board.

We began each interview by briefly defining CC and asking the administrator what practices came to mind