FROM THE TOP TO THE BOTTOM, FROM THE BOTTOM TO THE TOP: SYSTEMICALLY CHANGING THE CULTURE OF NURSING HOMES

FINAL PROJECT REPORT FOR THE

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1. INTRODUCTION

This report describes an ambitious project, the objective of which was to stimulate and support major organizational change – "culture change" – in two large and highly respected nursing homes (hereafter NH), over a period of three years. The project has had an impact on hundreds of NH residents, family members and on hundreds of NH staff. The facilities have received considerable attention from the long-term care industry and from the media for their efforts, and have been visited by staff from scores of other NHs as well as by researchers, policymakers, reformers and regulators – professionals from all over the United States, and Europe and other countries as well.

The innovations have been challenging to implement and sustain because in many cases they confront directly the logic of society's long-term care apparatus – including not only the firmly established practices of the NH industry, but also the State and federal regulatory agencies to which NHs are accountable. The changes have also been rendered more challenging because of adverse industry-wide trends in the *population of elders being served* in NHs and in *front-line staffing*. The population being served is becoming steadily needier, so that this effort to nurture a sense of home, belonging and meaningful social engagement is occurring at just the time when medical requirements are also increasing. The increase in need has meant a general increase in cost, and an increase in the need for staff. These needs also produce fiscal pressures – despite the important and, indeed, sacred character of the work of hands-on care -- tend to add to stress and reinforce the negative aspects of the work (hard work, low pay and low status within and beyond the institution).

As many participants and observers have reported and as our research and evaluation document, the impact of this effort has been overwhelmingly positive. It has resulted in innovative practices and accomplishments that are being modeled by other long-term care facilities.

Because of the magnitude of change undertaken and because of these challenging industry-wide conditions, this work could not have occurred, and the results could not have been achieved, without the support of the van Ameringen Foundation.

2. THE PROBLEM

Despite the dedicated efforts of many who work in America's NHs, those who live in even the best of traditionally designed facilities typically experience boredom, loneliness and helplessness (Thomas, 1996). NHs are built, operated and regulated on a medical/hospital model that prioritizes medical treatment and gives little systematic attention to quality-of-life issues. A major 1987 change in Federal law regulating NHs changed this situation only slightly. Because of the general negative reputation of NHs, many people claim they would rather die than enter one, some report contemplating suicide to avoid it, and many become depressed at the prospect or in reaction to the reality of living in a NH. Although such an attitude does not characterize everyone who contemplates entering a NH, much evidence suggests that these are indeed common and pervasive reactions of citizens to life in NHs.

This project was based on the Pioneer approach to NH reform. The Pioneer approach takes as a point of departure a set of interrelated premises: 1) fundamental, **systemic problems** exist in the basic structure of the NH as an institution; 2) such structural problems require fundamental, **systemic change**; 3) within these problematic structures, **many dedicated, hard-working and well-intentioned staff and leaders struggle** to provide quality of life as well as quality of care; and 3) the task of making systemic change can be most effectively led by **excellent traditional institutions** who are willing to take rather public risks of leadership in an uncertain and uncharted path of structural change that has become known as **culture change.** .

3. WHAT WAS PLANNED

In this project, **culture change** was originally conceived as involving several changes in the organization of everyday life and in the organization of staff work in two excellent, traditional NHs, Fairport Baptists Homes (FBH) and the Jewish Home of Rochester (JHR). These changes were designed to promote individualization and personalization of care, and to provide residents greater choice and opportunities with

respect to meaningful social engagement in everyday life, to provide a greater sense of community belonging, and to enrich lives by reintroducing elements of a natural homelike environment, including the presence of pets, plants and children. To bring about such changes in the resident quality of life required new kinds of activities and practices on the part of staff. It was intended that these changes would have direct implications for existing institutional practices and policies. They were envisioned to entail ***an elimination of the practice of moving residents when care needs change*** (an event that is usually dreaded by the resident in question and that disrupts established relationships that may be developing among staff and residents). They were envisioned to involve ***cross-training of staff*** (to eliminate the rigidity and inefficiency that can occur when staff work only in one specific task – e.g., nursing or housekeeping). The changes were also envisioned to produce a greater awareness of staff at all levels of the resident's experience, and greater involvement of all staff in structured ***opportunities for social interaction such as community meetings***, and other social events. Other planned changes involved providing of the ***presence of pets, plants and children*** in the nursing-home environment, and to provide a ***greater range of resident choice in scheduling, activities and taste*** in such matters as timing of bedtime and waking, and bathing. Here, some of the most dramatic planned changes in both facilities occurred around ***breakfast***.

These intended innovations were modeled after the successful experiences of a few Pioneering NHs around the country; to our knowledge, however, no facility had tried to bring together as many strategies of innovation all at once, as these two homes sought to do. If they could be successfully implemented, it was expected that a higher quality life for residents could be achieved, and some of the negative experiences typifying the lives of NH residents could be supplanted by a more positive culture in which residents could join and participate, and from which they could benefit.

In laying the groundwork for this ambitious program of change, FBH and JHR differed in one crucial respect: JHR attempted to implement culture change in the context of an existing physical plant and an existing organizational structure, while FBH's culture change was implemented to coincide with the opening of new and remodeled units that reconfigured residential arrangements, "From Hallways to Households." Long hallways of units that housed up to 60 residents were replaced by household clusters of about 8 residential rooms built around a kitchen and central living area. This architectural change necessitated some changes in the division of labor and staff organization at FBH that were not experienced at JHR. The JHR has a recently constructed physical plant with some excellent features, but it is built on the traditional NH model. Ideally, this comparative design permitted some assessment of how the intervention might work under different institutional conditions.

4. WHAT WAS DONE

Grant funds were used to support staff training and organizational development to support the desired changes. Project funds were used to mobilize resources differently in different parts of the project. In the first 12-16 months of the project, money was spent mainly for staff education/re-education in Pioneer values and principles. This education took several forms. First***, consultants and educators, including staff from established Pioneer homes, were brought in to work with staff at both JHR and FBH.*** Funds enabled all floor staff to be released from regular duties to attend all-day or multi-day training sessions covering a range of topics, including 1) how to think about and value elders, 2) how to enhance staff understanding and implementation of residents' wishes in matters ranging from bathing to room décor, and 3) how to participate in and lead unit-based community meetings. ***The funds also supported visits by FBH and JHR staff to other facilities*** in New York, Wisconsin, Washington and California, ***and to Pioneer reform conferences*** in Seattle, San Francisco and St. Louis as well as here in Rochester.

As a result of an assessment of the benefits and limitations of the consultant visits, a strategic shift in the focus of the intervention occurred in both homes in mid-1999. ***The shift led to a focus on developing leadership skills of unit leaders, and to developing teamwork among unit teams. This shift called for a different type of expert intervention, and consultant use shifted heavily away from national Pioneer leaders to local organization process experts***. This pivotal shift inspires the title of this report: It was a shift from the use of outside experts to help impart leadership values (by providing direct information and inspiration), to using them to work more closely with staff in dealing with internal organizational processes

that inhibited efforts at culture change. In both homes, the shift was entailed by a recognition of the fact that the work of the consultants in instructing on how to do front-line work did not address many important structural issues in leadership in the facilities-as-a-whole and leadership on the units, and that without staff at that level feeling supported, committed and empowered to exercise leadership, individual workers were largely unsupported and on their own on the units. While the organizational cultures and processes of the two facilities were quite different, a consequence of both was a lack of support and leadership for the Pioneer model on the front lines of care. Sometimes, efforts to follow Pioneer principles put primary care staff at risk for violating home policies (as when taking extra time to listen carefully to a needy resident causes an aide to get behind schedule, or when supporting a residents' efforts to obtain a favorite food forbidden by medical order.) Such circumstances create a heightened need for a clear message of support for culture change from leaders, and for open communication in general, and especially about challenging aspects of the change effort.

One response from both homes was the contracting of organizational consultants skilled in leadership training and team building. At FBH, the consultant conducted a series of educational programs on team building on all three shifts, and also worked with staff to understand the vision and mission of the Home's culture change effort, and to find ways to realize that vision in practice. She also worked with leadership teams to help them transition their changing roles, and as a resource to staff who are now empowered with a greater scope of discretionary decision-making. This circumstance should, simultaneously, give them flexibility to deploy their efforts most effectively in helping residents, and also give them a greater sense of intrinsic motivation and engagement in their work.

At JHR, the consultant met several times with all disciplines, and worked intensively with the leadership team and with the nurse managers, meeting with each group regularly through 1999 and 2000. Responding to the interest and commitments of motivated staff, her efforts with nurse managers focused on a subgroup of 5 nurse managers who began to involve social workers, rec. therapists and other staff more directly in team-building and leadership training. Here too, an emphasis has been on defining areas of discretion within which staff are empowered to take more initiative in decision-making in matters affecting residents on their units.

Other, more specific changes are detailed in the accompanying reports by Garth Brokaw, FBH President, and Mercelle Jackson, JHR Administrator.

5. RESEARCH AND EVALUATION

The evaluation of the culture change effort was focused on two fundamental questions: *1) Does the intention to bring about culture change actually lead to a changed culture,* and 2*) to the extent that culture change does occur, what are the consequences for staff and residents?*

Culture was evaluated by several dimensions, including a) level of activity; b) rates of social interaction of various types; c) shared knowledge; and d) shared sense of residential belonging. **Staff** change was evaluated by means of a survey concerning job commitment and work stress, through informal interviews, and by measuring staff turnover**. Resident** change was evaluated by means of health, medications, mortality and identity coherence on the individual level, and by data from incident reports on the collective level. This report will be followed by a *Research Appendix,* which will describe the design, methods, sampling and analysis of empirical findings in detail. Here, we summarize only the main findings of trends and ethnographic work over the three years.

1. Does the intention to bring about culture change actually lead to a changed culture? Our empirical indicators of culture change are of three main types: 1) structured observation of interaction and activity patterns; 2) observational and archival data indicating changes in NH practices; 3) ethnographic data through informal and participant observation and interviewing, which provided evidence for aging in place change in the type and amount of knowledge or quality of relationships shared among residents. Additionally, there are certain general and relatively straightforward "categorical" changes in practice. The project had called for categorical changes in the following areas: 1) presence of children, plants and animals; 2) changes in the nature of morning activities (getting up and breakfast); 3) development of multi-disciplinary teams; and 4) aging in place.

As background to understanding these changes, it is important to note that the organizational change processes underlying the culture change efforts differed dramatically in the two facilities, in both their timing and their content. At FBH, cost-sensitive building construction deadlines drove the implementation of new architecture, and new architecture drove the implementation of new modes of organization, since in some respects it required/permitted different routines and practices. A dramatically new and different physical environment both supported and required discontinuity with the past. At JHR, where very limited physical change occurred and where the effort was to implement culture change without radically changing the home's existing routines and policies, leadership followed an established cultural tradition of moving with care and deliberation, and described their change process as "evolutionary." Often, the highly developed and interlocked systems proved impossible to change in isolation, and challenging to change interactively. Such circumstances were fruitfully addressed through group process work of the organizational consultants. Still, as Mercelle Jackson's report indicates, for JHR, it was "… a game of inches." Nevertheless, meaningful organizational change occurred, such as the relocation onto the nursing units of professional workers and rec. therapists whose offices had previously been in a central locationon the first floor, far away from residents. Clearly, substantial positive changes are evident in organizational practices, in resident and staff outcomes in both facilities.

Of no less importance than changes that have been accomplished, is the fact that the *commitment to and consciousness of the ongoing need for culture change has become quite integral to the organizational culture of both facilities.* This is consistent with one of the fundamental Pioneer principles, that culture change is never fully realized; it is irreducibly a *process* and not a definable "program" whose installation can be certified.

The four categorical innovations are most straightforward. First, regarding **pets**, JHR purchased a specially trained *therapy dog*, Zack, who visits residents throughout the facility on a daily basis. Although he initially lived on the secure unit, problems arose in finding a suitable staff division of labor to care for Zack.) Consequently, he has recently begun to be taken home at nights by a staff member. Other staff bring their pet dogs to work, and two rabbits who live in the JHR's day services unit are often be visited by mobile residents. At FBH, staff are encouraged to bring in suitable pets, and staff dogs can be observed on any tour of the building. On one unit, the birth of puppies of a aide's dog became a major event around which social life became organized for a period of about two weeks. Additionally, both homes have pet birds. Added to FBH's population of 4 cats have been two new cats, both of whom arrived when their owners entered as residents. In both homes has a systematic initiative for expanding plants in the environment received much attention, but both have increased the presence of children. At FBH, the new physical plant includes a childcare center right on campus, and every day groups of children come to spend time in the NH. At JHR, a program of visitation of classrooms from local schools and pre-schools has been expanded. Beyond these changes, increased family involvement (see below) has also increased the presence of children, pets and plants.

Second, concerning **morning routine and breakfast**: Change here has been a major focus in both facilities. In FBH, the physical rearrangement with small numbers of residents clustered around fully functional kitchen was intended to enable flexibility and resident choice in the timing of getting up and of having breakfast, and in the breakfast menu. This intent has been quite fully realized. Additionally, both facilities now prepare breakfast fresh on each unit. JHR rewired their facility to support "breakfast buffet" prepared of food prepared fresh on each unit, something that was first piloted on a single unit prior to the commencement of culture change as a facility-wide project. The staffing of the breakfast buffet at JHR remains a problem, and has actually compressed the time window for breakfast because of time constraints imposed by the dual system of food preparation currently operative. The replacement of prearranged trays of food delivered on a cart from a central kitchen with morning smells of fresh cooking are universally recognized as a welcome change, but flexibility of serving time has not yet been achieved.

The development of **teamwork skills,** which have involved a new emphasis on direct communication and cooperation across disciplines on each unit, are the result of an effort that is still ongoing at both homes. For these important efforts, the role of the organizational consultant has been crucial. At JHR, from these efforts have emerged a Pilot Group of staff – mainly nurse managers, social workers and top administrators –

who meet regularly to deal with difficult issues of institutional systems and processes that frustrate or contradict efforts to increase resident choice. At FBH, the organizational development effort has been built upon the initial culture-change commitment to cross-training of staff. In both facilities, greater clarity in face-to-face communication and in organizational structure, roles and lines of authority have been central objectives, with the intent of empowering staff, including frontline staff, with a clear sense of an appropriate scope of their own decision-making and cooperation..

Although implemented at FBH only, **aging in place** was an important change (as was the concomitant practice of *integrating residents with different care needs*.) These changes appear to have had structural repercussions that facilitated several important changes evident in the ethnographic findings. Aging in place meant that "resident mobility" – the often-involuntary and dreaded transfer to a different care level -- no longer exists. The new policy allows residents to keep their rooms as long as they choose. Over the three years of observation that this change has been implemented, we know of only three cases in which residents were involuntarily moved within the facility. Previously, this happened routinely. Resident integration was initially resisted by high-functioning residents, who said things like "we don't want to eat with droolers." However, some found a meaningful role in helping needier residents during meals and at other times, and others gradually realized that the new arrangement meant that they themselves would not have to move, should their condition worsen. The practice has now been quite well institutionalized at FBH.

This policy change produced a change in the consciousness of both residents and staff, who recognize that they are together "for the duration," and who are therefore have both the time to develop relationships, and a different kind of expectations, which can motivate the development of meaningful and enduring interpersonal relationships, and a sense of community belonging. One may get a sense of this by walking through a unit and observing the familiarity a resident manifests in petting a staff member's dog who has come in for the day. But the most powerful indicators are often available only through detailed knowledge of the nature of relationships. Although it is not universal throughout the facility, we have observed numerous incidents indicating a new vibrancy and resilience in human relationships, such as the following:

> Esther was resistant to the idea of coming to the home. She had virtually no family, however, and gradually developed meaningful social connections with staff on her unit. Although she suffered from CHF, she was an unrepentant smoker, and was famous for getting staff to wheel her outside for a cigarette. Eventually, a health crisis developed when Esther failed to respond to treatment for a fairly routine infection. She needed to be hospitalized and both she and the staff knew that there was a good chance she would not survive this illness. When she resisted going to the hospital, the staff promised her that they would not let her die in the hospital, but be sure to get her "back home". As feared, she did not respond to the hospital treatment and all her systems began to shut down. She was brought back to the NH by an incredulous and resistant ambulance crew who demanded to know why they were transporting someone so ill OUT of the hospital. However, as Esther was wheeled through the front door of the facility, she suddenly perked up, offered one of her trademark winks to a passing staff member, and her expression changed to a broad smile. An ambulance attendant said, "Now, I understand." About four hours later, in her own bed and in the company of caring staff, who had become caring friends, Esther died. It was a good death, staff members said, because she was "back home."

The phrase "getting back home" is not uncommon to hear uttered by NH residents, but it almost always means getting out of the NH. To see an event in which the NH is truly home to a resident comprises, therefore, a significant indicator of change. The development of such meaningful relationships within a bounded space that also becomes infused with meaning as "home", is unlikely without an *aging-in-place* policy, and without "continuous assignment" – regular assignment of an aide to the same set of residents. Continuous assignment is become institutionalized as a matter of policy at JHR, as it is at FBH.

Our structured measures of culture are designed to document whether residents manifest increased levels of activity and decreased levels of agitation or withdrawal, as they can be observed in ordinary, everyday-life situations. We found that the "metabolism" of everyday social intercourse proved, on most units in both

homes, remarkably stable and resilient. However, in both homes, substantial increases in activity and decreases in disengaged behavior occurred in secure "Special Care Unit" (for residents at risk for wandering). Modest positive changes in levels of activity and in staff-resident and resident-resident social interaction were observed in other units at FBH as well. Thus, even on the robust and institutionalized patterns of daily social metabolism, we found positive change associated with the culture change effort, in both facilities.

Family involvement and/or visitation also increased in both facilities. In both cases, this appears to have been at least partly as a result of the Pioneer model. At JHR, a culture-change inspired "Partnering With Families" initiative provided a mechanism for families of new residents to meet those of existing residents as well as staff. At FBH, the attractive and spacious new households, with accessible kitchens proximate to residents and family, made a difference. However, the inviting aspects of the new physical plant have also been supported by an emergent staff culture that, in virtually all cases we have observed, encourages family participation in meal preparation while still conforming to state regulations. Residents also use the kitchen, and there have been occasional (although to our knowledge rare) conflicts over its use, as when staff complain that a resident is "monopolizing the kitchen." Given the kinds of domestic disputes that tend to go on in people's homes, we regard such a "problem" as a precise indicator of *homelikeness* – an underlying goal of culture change.

2. To the extent that culture change has occurred, what changes in residents can be associated with it? To gauge whether change in resident conditions and/or quality of life might be associated with culture change, we conducted repeated interviews with residents to get a sense of ***identity coherence***, a cognitive construct that measures mental health; we also traced health changes. Identity coherence is a complex, multi-dimensional measure (see the Methodological Appendix) that indicates the degree to which one has a stable and congruent sense of who one is, and of the meaning of one's life. Much research evidence indicates that, in contemporary U.S. societies, both *institutional placement* and *the experience of aging itself* pose relentless and potent threats to the integrity of one's sense of self. The hypothesis was that culture change might enable residents to maintain a more vibrant and engaged sense of self, in ways that could be traceable through this measure. In those cases where health permitted, we conducted three identity interviews with residents over the three-year period. While our analysis of these data is not fully completed, the strong trend that has emerged so far is one of remarkable stability over time, in both facilities. This finding would admit of at least two plausible interpretations; 1) that culture change is not associated with change in identity, and 2) that the fact that identity coherence is not *reduced* under conditions of culture change (as it may be under conditions of old age and institutionalization more generally) may indicate that culture change helps enable residents to maintain a stability of identity. For some of the individual residents we have come to know quite well, a powerful case can be made in defense of the second interpretation. We do not yet have sufficient data to support this claim on a population basis, however.

Since ***physical condition*** is also a factor in quality of life, and one that may be impacted by change efforts in unknown ways, we also tracked facility-wide data on falls, infections and other resident incidents over a four-year period (using 1997 as the base year), as well as mortality. In brief, these data revealed consistent (albeit moderate) reductions in falls and respiratory infections. Although there are two single-year exceptions, the general four-year trends show year-to-year reductions in falls and fractures in both homes. Non-fracture injuries (skin tears, bruises) showed small fluctuations from year to year in both homes. At FBH, there were declines in the non-fracture injury rates through the first two years of the project, but these rates increased in 2000. In general, then, the culture change effort was accompanied by a general tendency of reduced incidents. This is especially noteworthy, because skeptics of the Pioneer model have predicted that the greater resident freedoms and increased levels of activity that are the aspiration of the Pioneer model could create greater risks of injury. We found no evidence of such an outcome.

A notable drop in respiratory infections occurred in both facilities in the year 2000. The mortality rate remained stable at JHR over the four-year period, despite the steadily increasing acuity of health problems of residents being admitted. At FBH, a complex and interesting pattern occurred, with a substantial decline from 1997 to 1999 (from a rate of .36 in 1997 to .27 in 1999 (a 25% reduction over the 3-year period.) Many people

believed this drop was at least in part attributable to the encouraging changes in quality of life and opportunities for activity brought by culture change. However, in the year 2000 the trend of steady decline reversed sharply, returning to .36. Although this reversal appears, on the surface, to undermine the proposition that culture change may be associated with a reduction in mortality, this pattern is partially explained by an unusual "selection bias" in the admission process: In 2000, in part as a result of a spillover effect from the FBH's new Transitional Care Center, the cohort of long-term care admittees was composed of residents with a wider array of needs than was previously the case. Several admissions in the year 2000 were to provide "comfort-care" during the last few weeks of a terminal illness. Thus, 10 of the 64 people who died in long-term care in 2000 had been in the home less than 6 months, and several of these actually died in less than 1 month. Obviously, the assumption of a stability of characteristics in the succeeding cohorts of newly admitted residents is required for meaningful year-to-year comparisons; during the year 2000, this assumption was violated due to the compositional changes in the cohort of 2000 admittees. In any case, the reductions were accomplished despite a steadily increasing "case mix" at FBH (from .94 in 1997 to 1.08 in 2000.)

3. To the extent that culture change has occurred, what changes in staff can be associated with it?
To gauge whether change in staff conditions and/or quality of life might be associated with culture change, we conducted intensive interviews with staff, we administered facility-wide staff surveys dealing with stress, engagement and values at two points during the project, and we examined staff turnover rates. The survey provided clear evidence of some shifting value priorities for staff. In both homes, the change was toward an increased predisposition to "resident-centeredness" in the stated priorities and values of staff. At FBH, staff simultaneously reported greater stress (which staff often attributed to working in a new kind of setting and being called upon to perform a wider range of tasks with little reduction in pre-existing tasks) and greater engagement and commitment (attributed to the sense of hope and possibility offered by a new and more flexible style of operating in a new environment.) JHR survey results indicated stability on these characteristics throughout the study period.

While there were some exceptions, the general trend over the four-year period has been toward reduced staff turnover for each facility as a whole, and for nurses and aides in particular. When occasional reversals to the trend are observed, they remain lower than in 1997, the base year. Given the national labor shortage in long-term care, this is not a trivial accomplishment even when the reductions are modest. Senior management of both facilities believe that these gains have been achieved through greater attention to integrating staff into unit teams, or to more general aspects of the culture change models.

Cost. Attempts to estimate the impact of culture change on operating cost have been rendered difficult by the extraneous variables related to factoring in the new capital costs of a large new mortgage and of making the transition to a different system of operation over the last 24 months or so. When data for the year 2000 becomes available, we will be in a better position to comment on the cost outcomes associated with culture change. This information will be provided in the forthcoming Methodological Appendix.

6. SUMMARY

Neither facility has reached Nirvana in its culture change effort. Leadership and dedicated staff are equally aware that the implementation of Pioneer culture-change principles in the everyday institutional life is occurring in an imperfect and fragmentary way. Yet in both facilities, there are powerful indicators that substantial progress toward culture change ideals has been made, and that it has benefited both residents and staff, and that a commitment to, and consciousness of the need for, continuing self-reflection and change has been institutionalized. The evidence of culture change and the benefits for individuals that are associated with it is substantial (as the forthcoming Appendix will detail); for residents, it is in many cases incalculable in terms of the expanded horizon for living that has been provided. Yet no less substantial than the tangible changes that have been accomplished, is the manifest commitment to making an effort to further the goals and Pioneer principles, and to make the culture change effort an integral part of the ongoing life of the facility. In both homes, a systematic concern with identifying, respecting and responding to the *residents as whole persons* with important characteristics beyond their medical needs is becoming institutionalized, and in both homes leadership is committed to furthering this process. The development of this new set of

commitments clearly would not have become placed so squarely in the main line of operations and policy review and change as it has, if it were not for the support afforded by this grant.

This report would not be complete if we did not conclude by noting explicitly the challenge posed by innovations that are at variance, not only with the standard operating procedures of the long-term care industry, but also with an entrenched and powerful systems of nursing home funding, regulation, accountability and evaluation. Although highly respected as established and quality homes by State regulators, both of these facilities have been punished by the State Survey process through which their work is evaluated – because, for example, the logic of the hospital-based model of assemblyline food preparation and service does not square well with fresh, on-the-spot food preparation and homestyle dining, or because the commitment to "aging in place" creates an institutitional caution about moving residents even if they "should" be moved according to a narrow technical definition. Such contradictions between the salutary aspects of culture change and the mandate of regulators have led to new and different kinds of interaction between these homes and regulators, in which regulators are also being challenged to consider the implications of culture change, of resident-centered care, of residents as whole persons, for their work. While still in its early stages, this is an important development in blazing a trail on which other facilities may follow, it is hoped, without all of the externally imposed difficulties that these two facilities have had to confront. In this respect as in others, they have surely demonstrated that they are Pioneers in the true and best sense. This achievement, which is and will continue to benefit their own nursing home residents and those of other nursing homes who are learning from them, could not have been realized without the generous support of the van Ameringen Foundation.