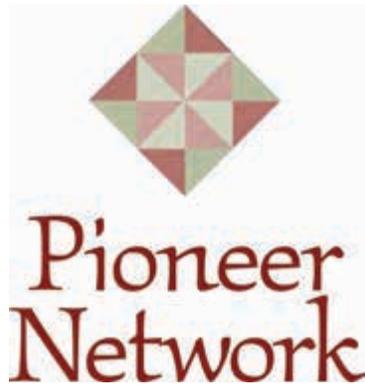


Pioneer Network

Case Studies in Person-Directed Care

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Case Studies in Person-Directed Care

Case studies are designed to extract from adopters common features that promote successful implementation and sustainability. Each highlights culture change from pre-transformation to implementation while focusing on the resulting impact and returns for residents, staff and organizations.

In Pioneer Network case studies, impact is categorized by quality of care/life improvements (most directly affecting residents and family), staffing impact and organizational impact. Organizational impact is defined as impact in quality and/or staffing impact that increases revenue and/or decreases operational costs for the organization

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Providence Mount St. Vincent – A Case for Sustainability

Case studies are designed to extract from adopters common features that promote successful implementation and sustainability.



Executive Summary

Motivation for Change: A series of behavioral studies and resident feedback helped to identify a “culture of dependence” that was ultimately misaligned with the organization’s values and mission.

Goal of Change: A resident-directed community where residents maintained control and choice over their lives – “A Continuum of Community.”

Assessment Steps: Visited other organizations implementing change; Evaluated steps to be the Provider of Choice and the Employer of Choice; Conducted meetings with staff, residents and employees to discuss transformations and engage these stakeholders in the change process; Members of the leadership team “worked on the floor” and took on the role of the resident; Analyzed processes and environment to determine change priorities.

PRE-TRANSFORMATION	POST-TRANSFORMATION
Four floors of skilled nursing units with approximately 56 beds per unit.	Nine 20 to 23 person skilled neighborhoods.
A small centrally located dining and activity space. Design of spaces physically separated residents and staff.	Staff and resident workspaces are no longer segregated. All spaces in community are designed to promote residence independence.
Lack of autonomy for residents in activities and schedule. Staff were task driven and organized work around delivery of care and staff preferences.	Activities are meaningful. Residents maintain personal schedules based on preferences. Resident choice is documented in the care plan.
Staff-resident interaction not a priority. Centralized departments.	Consistent assignment of residents with care assistants. Staff are cross-trained and able to help residents with multiple requests.

Examples of “AH HA” Moments: 1) The locus of control just had to be closer to operations for success; 2) Change is systemic and requires more than just one change; 3) Jobs change when an organization transforms to a resident-directed focus; 4) Even though physical transformations are complete, resident-directed care won’t work without the underlying systems.

Impact on Quality: Consistently high Resident Satisfaction Assessments; Full census; Improvement of quality indicators from pre- to post-implementation; 95% of staff and 100% of residents interviewed utilized words that describe The Mount as a cohesive unit (e.g. family, team, home).

Impact on Business: Turnover decrease from 50 to 15%; Average length of tenure for a CNA at The Mount is 7.6 years; The Mount scores consistently high on staffing surveys; Very modest estimates put cost savings of lower turnover and increased retention at \$270,000 per year.

Organization

Type: Non-for-profit; part of a regional, multi-organization chain.

Administrator: Tom Mitchell Regional Administrator: Charlene Boyd

Providence Mount St. Vincent, a thriving continuing care retirement community located in West Seattle, is owned and operated by the Sisters of Providence and Providence Health & Services. “The Mount” offers a variety of residential and community services including:

- Nine 20 to 23 person skilled “neighborhoods”;
- 109 studio and one-bedroom apartments for assisted living;
- 20-bed, short-term, subacute medical rehabilitation;
- Adult-care health program for nonresidents;
- Licensed intergenerational childcare center.

Providence Mount St. Vincent is West Seattle’s largest employer with 476 staff members from 32 countries, and also has more than 200 volunteers. Medicare, Medicaid, Third Party and Private Pay are all accepted payment types. Medicaid (56%) and Private Pay (44%) are the primary payment sources for residential care neighborhoods.

History



**Photo of
Sisters of
Providence**

Founded as the St. Vincent Home for the Aged in 1924 by Sr. Mary Conrad Kratz, The Mount has a long and rich history of compassionate care administered by the Sisters of

Providence. Prior to the person-directed innovation of the 1990's, The Mount operated for 30 years as a more traditional, institutional model. Although known for clinical excellence, The Sisters' tradition of providing compassionate care, spiritual ministry and quality of life existed within an environment driven by regulators and medical charts that ultimately resulted in loneliness and isolation for residents.

A series of behavioral studies at The Mount in the early 1990s revealed that a typical resident napped or sat idle for 68 percent of the day and interacted with another person for only seven percent of the day (Fey, 1995; Richardson et al., 1997). Residents reinforced those findings by expressing feelings of boredom and loss of independence.

In 1991, a leadership team identified this problem as a "culture of dependence" that was ultimately misaligned with the organization's values and mission. They opted for an organizational transformation, but they first reflected on common themes creating a culture of dependence in the systems and environment to target for change.

Common System and Environment Themes Prior to Implementation



Photo Prior to Culture Change Implementation

Common Themes in The Mount's Processes and Systems Prior to Implementation

Centralized departments;

Lack of autonomy for residents in dining or choice of meals;

Lack of autonomy for residents in activities;

Lack of autonomy for residents in bathing schedules;

Language supported a culture of dependence (e.g. "patient," "ward," "floor" and "unit");

Residents identified by medical conditions or level of care;

Staff-resident interaction was not a priority;

Staff were task driven and organized work around delivery of care and staff preferences.

Common Themes in The Mount's Physical Environment Prior to Implementation

Institutional sterile environment (modeled after a hospital environment);

Long halls and hard surfaces;

Floor, wall and ceiling materials designed for durability and ease of maintenance;

Tight spaces clogged and crowded with people and equipment;

Four floors of nursing units with approximately 56 beds per unit;

Double-loaded corridor approximately 300 feet long;

A small centrally located dining and activity space;

Design of spaces physically separated residents and staff.

Strategies for Planning

Welcome to the Community of Providence Mount St. Vincent

The Mount is an exceptional intergenerational community in which the qualities of personal choice, dignity, compassion and respect are woven into residents' daily lives. The setting is home-like, staff members are welcoming as well as professional, and a rich variety of activities and health services give residents options that help them retain their independence. Residents at Providence Mount St. Vincent make their own decisions about how they like to live. Staff members are here to help them celebrate life and their individual capabilities while retaining the control and dignity they have known all their lives. And for seniors who live elsewhere, the Mount provides many supportive activities and programs to help them remain physically and mentally active.

Excerpt from The Mount Welcome Packet (appearing in both resident and staff welcome packets) articulating the current and ongoing vision resulting from the planning process.

In 1991, a strategic planning team-consisting of a new facility administrator, an assistant administrator, a psychologist/researcher, two architects, two nursing managers, a physical therapist and a social worker targeted the processes and environmental artifacts that supported a culture of dependence for change. Their goal: *A resident-directed community where residents maintained control and choice over their lives- A Continuum of Community.*

Charlene Boyd, current Regional Administrator of Providence Mount St. Vincent, was a member of the planning team. Even in those early planning stages, she envisioned a true "home" for the residents of The Mount. The sustainability of this plan is evident nearly 20 years later. In case study interviews, multiple staff were quoted as stating, "*Charlene always reminds us that this is their home.*"

In a case study interview, a member of the planning team described achieving success with early and ongoing transformations. She explained, "*We are always asking: What is our intention? How do we change our behavior?, What are the systems to support our changes?*" In the early days, Bob Ogden was an essential component to posing the big questions leading to better and more sustainable results.

Other tips for early and ongoing planning:

Visit organizations already implementing change (Mount employees visited Benedictine Nursing Home in St. Cloud, Minn);

Aim to be the “Provider of Choice” and the “Employer of Choice” (see The Mount Welcome above used for both residents and staff) and ask the tough questions to achieve that goal;

Conduct meetings with staff, residents and employees to discuss transformations and engage these stakeholders in the change process. According to a member of the planning team, *“In terms of training or communicating to the staff, our structure was really leading by example. We had meetings with the family, residents and staff to achieve high involvement.”*;

Have members of the leadership team “work on the floor” or take on the role of the resident to better understand staff and residents’ perspectives of day-to-day life in the organization. This exercise helped The Mount team to realize that *“the locus of control just had to be closer to operations”* resulting in a change to organizational structure that empowered staff;

Analyze processes and environment to determine change priorities. *“It’s really systemic. You can’t change just one thing.”*

Case Study and Assessing Impact



One of The Mount’s Neighborhood Dining Areas (Post-Implementation)

The case study at Providence Mount St. Vincent incorporated review of 41 quantitative data sources (financial, staff, operations, resident, outcomes), 36 sources of organizational data (descriptive, educational materials, human resources, communications, marketing, operations), and 28 interviews in the following areas:

- ∞ Regional Director and Administrator
- ∞ Operations Support
- ∞ Planning & Development
- ∞ Neighborhoods (including Neighborhood Coordinators and Resident Assistants)
- ∞ Sub acute Care
- ∞ Assisted Living
- ∞ Adult Day Health
- ∞ Housekeeping
- ∞ Intergenerational Learning Center
- ∞ Clinical Services
- ∞ Human Resources
- ∞ Marketing
- ∞ QI Compliance and Risk
- ∞ Sisters of Providence
- ∞ Residents
- ∞ Family Members

The Mount case study was designed to identify qualitative and quantitative elements to track and support the effects of this innovation on organizational outcomes. The model represents an ongoing sustainability process including innovation, evaluation (analysis and measurement), additional change management, and resulting subsequent implementation based on previous experience. This ongoing change management strategy requires measurement of person-directed impact on outcomes. In Pioneer Network case studies, impact is categorized by quality of care/life improvements (most directly affecting residents and family), staffing impact and organizational impact. Organizational impact is defined as impact in quality and/or staffing impact that increases revenue and/or decreases operational costs for the organization.

To analyze and track innovative processes to resulting outcomes, five common themes were identified in *Resident Systems* (most directly affecting quality of care/life) and *Overall Organizational Systems* (most directly affecting staff). Common themes are highlighted in the tables below and discussed in further detail on subsequent pages.

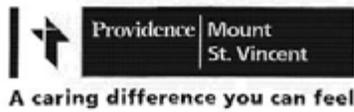
RESIDENT SYSTEMS

- 1) Create an inclusive community and “home” for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus.
- 2) Work is organized around maintaining resident’s autonomy and preferences with inclusive language supporting residents to be “known” as individuals instead of medical conditions.
- 3) Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization.
- 4) A relatively flat organizational structure with the resident at the top of the organizational chart is prioritized (allowing for effective communication among and between inter-disciplinary teams and residents).
- 5) Staff-resident interaction is a priority and staff “know” residents.

ORGANIZATIONAL SYSTEMS

- 1) Create an inclusive community for staff that is constantly communicating and reinforcing a resident-directed focus through formal and informal educational opportunities and relationship building.
- 2) Through a flat organizational structure, employees feel empowered to help control quality, waste, and problem-solve throughout the community.
- 3) Leverage the value-added potential of inter-disciplinary, cross-trained teams throughout the organizational structure to take advantage of synergies in the organization.
- 4) Leadership actively pursues engagement and supportive strategies with staff.
- 5) The Mount utilizes data, process-maps and problem-solving approaches to support staff and resident-focused transformation.

Resident Systems Transformations



The Nursing Center Neighborhoods are living clusters for about 20 residents. Each neighborhood has its own staff of professionals who offer 24-hour care in a home-like atmosphere.

At left is an Example of Marketing Information on The Mount's Nursing Neighborhoods

The goal of each care team within the neighborhood is to respond to each resident's needs and personal choices. Each staff member is there to honor the dignity and diversity of residents, and to make every effort to encourage and help restore wellness.

“You can have all of the best intentions in the world, but without the systems and structure to maintain the change, it won't last.” - Charlene Boyd

An organization has to *“find the initial fit and then keep going back and implementing changes to support the needs of the organization.”*

To achieve this type of continuous implementation, new systems are constantly developed in each area of the community based on residents' and staff members' needs. Staff at The Mount then share successful transformations so the larger network can benefit and adopt best practices when possible.

Based on case study findings, the below examples expand on the list of Resident Systems from Assessing Impact (previous page) and describe systems discovered through The Mount's ongoing organizational transformations. These are the systems identified as most likely to affect resident and family outcomes.

The below transformations are based on the Resident Systems table (displayed on the **Assessing Impact** page) and are those most likely to affect resident and family outcomes. Examples are listed below each strategy.

1) *Create an inclusive community and “home” for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus.*

- ∞ A resident-directed focus is utilized in marketing materials, so that residents and families are introduced to expectations regarding resident-directed care at an early stage.
- ∞ There are no uniforms at The Mount to delineate between community members and staff.
- ∞ Resident choice is respected. ***“I don’t want to work somewhere without banana ice cream.” - A staff member commenting on how happy a resident was when her favorite ice cream was ordered for her.*** Other examples: residents’ dogs and cats are welcome and each neighborhood has a “neighborhood cat”; residents’ preference of no cell phone use is respected.
- ∞ Payment for services is transparent to all residents and most staff (i.e. others do not know which residents are utilizing Medicaid). When residents spend down in community areas such as Assisted Living, they stay in their apartments and utilize Medicaid as a payment source.
- ∞ Family education regarding person-directed care and support is a priority.
- ∞ Death and dying are honored. ***“We want to be with them, particularly in their final journey.” - Sister of Providence***

2) *Work is organized around maintaining resident’s autonomy and preferences with inclusive language supporting residents to be “known” as individuals instead of medical conditions.*

This will vary by the needs of each community area. Examples below:

- ∞ Nursing Care Neighborhoods - The Mount utilizes consistent assignment of residents with care assistants which leads to a relationship and “knowing” individual preferences. Staff are cross-trained and able to help residents with multiple requests (going to the restroom, brewing coffee, doing laundry, fixing a sandwich, and eating). Activities are meaningful. Residents maintain personal schedules based on preferences. Each neighborhood maintains mixed acuity levels. Resident choice is documented in the care plan. ***“We encourage residents to tell us how they want it.” - Neighborhood Coordinator.***
- ∞ Short-term Sub-acute Medical Rehabilitation - Unlike other parts of the community, this area still has a clinical focus and older adults utilizing sub-acute, short-term services prefer to be called “patients” instead of residents. In addition, the rehabilitatory and therapeutic nature of stays requires a more structured

schedule. To accommodate a person-directed focus, therapy will ask individual preferences and schedule services accordingly. For example, if a patient is not a “morning person” therapy will be scheduled in the afternoon. Older adults also have choice on elements from diet to meal times and bring in their own street clothes.

- ∞ Assisted Living Apartments - The Mount’s assisted living apartments operate with a “Hand in Hand” program. Along with family members and staff, each resident (even the frail and those with dementia) help to determine how much assistance he or she needs. All residents pay one fee and receive however many or few services they need or desire based on the negotiated service plan. As long as the assisted living program is able to meet their needs, residents move from their apartment only if they choose to do so themselves. ***“It’s not modeled after a hotel like other places. You can have chandeliers and pianos, but without relationships, it won’t work.” - AL staff member.***

3) *Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization.*

- ∞ Each neighborhood has a shared staff of about 18 people including: a neighborhood coordinator, resident assistants, recreational therapists, food and nutrition workers, a social worker, nurse, spiritual care worker and housekeeper. Similar types of coordination occur in other parts of the community.
- ∞ The inter-disciplinary team also allows for organizational balance where staff are empowered to concentrate on more than one aspect of the community. ***“Clinical still cares about clinical and regulatory but we also balance that with caring about our ‘home’ for residents.” - Neighborhood Coordinator (and RN).***

4) *A relatively flat organizational structure with the resident at the top of the organizational chart is prioritized (allowing for effective communication among and between inter-disciplinary teams and residents).*

- ∞ ***We are always trying to make life better for the residents. When I have new ideas, our administrators listen.” - Resident Assistant.***
- ∞ Tom Mitchell, The Mount’s Administrator, attends resident council meetings to understand pervasive concerns and act on resident needs (during the case study visit, initiatives in dining and laundry were as a result of this attendance).
- ∞ ***“This is the residents’ house, and we work to meet their needs. They are the boss.” - Resident Assistant.***

5) *Staff-resident interaction is a priority and staff “know” residents.*

- ∞ It is an expectation that staff and residents alike learn about one another’s lives, hobbies and interests. “I’m committed to the resident, respect, compassion and a good relationship. We get along well and I want them to be happy.” - Resident Assistant (of 20+ years).

Organizational Systems Transformations

“There is a difference between training and education. Education is the classroom and literature. Training is the one-on-one teaching them ‘what to do if’..... Both are important and we do both at The Mount.” - Neighborhood Coordinator.

The below “overall” organizational and staff transformations are based on the Organizational Systems table (displayed on the [Assessing Impact](#) page) and are those that will most likely affect staff and organizational outcomes. Examples are listed below each strategy.

1) *Create an inclusive community for staff that is constantly communicating and reinforcing a resident-directed focus through formal and informal educational opportunities and relationship building.*

- ∞ The Mount’s inter-disciplinary leadership team participates in weekly meetings that focus on resident-directed concepts as part of the agenda For example, leadership team members completed a Resident Sensitivity Exercise (see the form below), compared differences and preferences and then contemplated a life based on someone else’s schedule and preferences.
- ∞ The Mount maintains journal and publication subscriptions (examples from the case study include Assisted Living Consult, Modern Healthcare, Gerontological Nursing, RN, McKnights, and Long-term Care News). The Education Department scans publications and provides employees with summaries of relevant journal articles (employees can request the full copy for those articles of interest).
- ∞ The Mount provides in-house training with a person-directed focus. For example, dementia training is provided to employees and The Mount works with all staff to create some standardization tools for regulatory issues.
- ∞ Training includes “plugging” all levels of staff into available resources. *“What takes a lot of time for a Resident Assistant is not knowing what resources are available. When you have access to resources and know what’s available, you*

have that extra 30 minutes to spend getting to know residents. I prioritize extra training with staff, one-on-one, so they understand where the resources are and resources are within an arm's reach.” - Neighborhood Coordinator.

2) Through a flat organizational structure, employees feel empowered to help control quality, waste, and problem-solve throughout the community.

- ∞ In case study interviews, staff use words like “organic” and “flexible” to describe problem-solving at The Mount. This means focusing on resident choice instead of working on maintaining hierarchical constructs. *“We focus on resident choice instead of paper.” - Neighborhood Coordinator.*
- ∞ Neighborhoods have their own budgets and receive monthly variance reports to help guide spending.
- ∞ To achieve maximum outcomes, each staff member’s “role” includes understanding multiple areas of focus and many are cross-trained. *“Our staff are generalists and need to know many areas.” - Mount staff member.*

3) Leverage the value-added potential of inter-disciplinary, cross-trained teams throughout the organizational structure to take advantage of synergies in the organization.

- ∞ The Mount leadership encourages inter-disciplinary teams to problem-solve among and between themselves. *According to one staff member, “We typically don’t use work requests or paper bureaucracy. Everyone can just call each other, and you can get things done pretty quickly with a phone call.”*
- ∞ The Mount takes advantage of organizational synergies. For example, The Mount’s Occupational Therapist also educates employees on injury and preventive wellness. In another example, the intergenerational childcare center is used by employees for daycare (providing a convenient and cost affordable option).
- ∞ Staff engage in regular communication within and between teams to explore best practices and lessons learned. For example, neighborhoods meet regularly to discuss team needs, but neighborhood coordinators also schedule breakfast with each other to share experiences and best practices. *One staff member commented, “People are free of judgment or repercussions across teams.”*
- ∞ Staff report that the Medical Director and Nurse Practitioner are extremely accessible and supportive of person-directed care in clinical issues.

4) *Leadership actively pursues engagement and supportive strategies with staff.*

- ∞ After 5 months with The Mount, new employees meet with the administrator. The purpose of this interview is for leadership to ask-“What can we do for you? How do you like the job?” *According to Charlene, “After the first few minutes, employees realize that it is about them and getting their opinion and feedback. We really want to know about their experiences and how we can help.”*
- ∞ The Mount helps to support education and scholarship for employees (tuition reimbursement and scholarships for CNA’s and LPN’s).
- ∞ There are numerous examples of The Mount engaging with employees on a personal level including providing Christmas bags with toys for the children of staff. *“The Mount is a family and great support system. I’m able to feel safe and provide for my family. I wouldn’t move and wouldn’t leave. I take care of people here and feel like they take care of me. Charlene and Tom help me, care about the residents and care about employees... they are good people.” - Mount staff member.*

5) *The Mount utilizes data, process-maps and problem-solving approaches to support staff and resident-focused transformation.*

- ∞ During the case study visit, the Administrator, Tom Mitchell, was utilizing process maps and analysis to reduce wait times at the “Cafe” for residents. Residents enjoy the tray line and picking out their own food; however, this was causing a queue. By utilizing data (# of meals served) and observation (where dietary staff can help residents), The Mount identified approaches to ameliorate the problem.
- ∞ *“Leaders are accountable for social interactions, budget and clinical responsibilities, so we use toolboxes [data and process maps] to get things done.” - Neighborhood Coordinator.*

Your daily routine and the benefits of resident directed care!

When I have a choice, I like to wake up at 6 am/pm

The first thing I like to do when I get out of bed is take a shower

If I could have whatever I wanted for breakfast, it would be Toast
cream cheese

When I have time to watch TV, I like to watch CSI / Law & Order

When I have free time, I like to walk

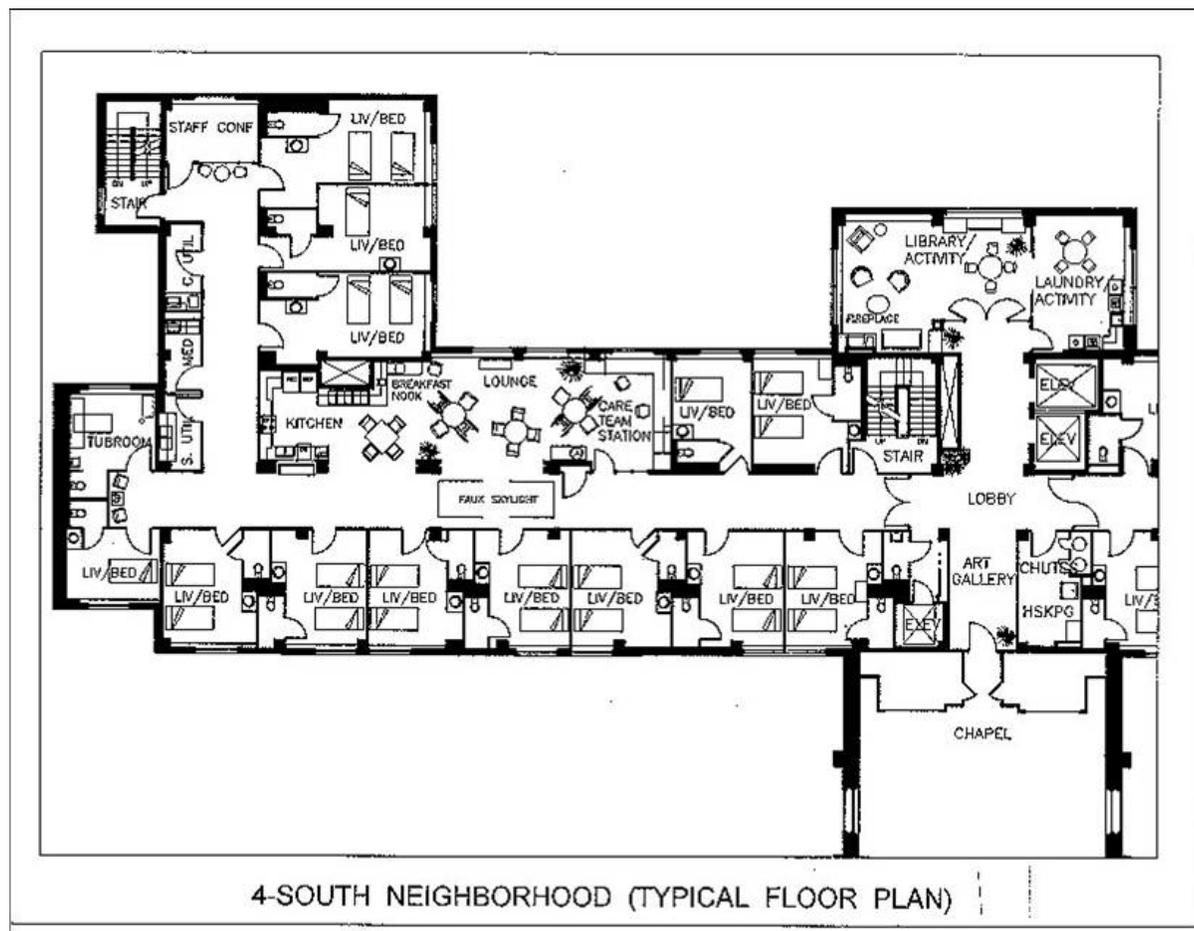
I like to bathe (when) AM with a shower / tub

Right before bed I like to relax by Knitting

I like to go to bed at 11pm am/pm

The Above Example is of a Resident Sensitivity Exercise Used in Leadership Meeting

Physical Environment Transformations



“Form follows function.” – Charlene Boyd

“These changes aren’t just inspired by cosmetics but by real environmental changes that support the resident.” – AL staff member.

“Before culture change, patients used to sit with their backs against the wall. There was nowhere to sit and talk or to do activities.” – Staff member.

Transformation to the physical environment took five years and \$9 million in renovations. Major changes include:

NEIGHBORHOODS

- Floors are divided into nine 20 to 23 person “neighborhoods”;
- Each has a spacious kitchen with round tables and all the usual home supplies, from tablecloths to tea kettles;
- Residents’ favorite snacks and drinks are stocked in the kitchen and available at any time;
- Steam trays support delivery of food from the central kitchen;
- Staff and resident workspaces are no longer segregated. At the far end of the kitchen space is the open care station for social workers, nurses and other staff;
- A laundry room is available for each neighborhood;
- Rooms are private or semi-private (for 2 residents) and remodeled to provide space for resident’s personal belongings;
- Each neighborhood has a distinct personality with changes in style and color;
- Multiple inviting settings for spontaneous interaction;
- Each neighborhood has access to a solarium designed as a green house;
- A game room;
- A library;
- An intergenerational classroom complete with an aviary.

ASSISTED LIVING APARTMENTS

- Remodeled to promote independence;
- Showers with grab-bars replaced bathtubs;
- Microfridge in each apartment;

INTERGENERATIONAL LEARNING CENTER

- Shared spaces on various floors;
- Permanent intergenerational classroom on the third floor nursing neighborhood;
- Classrooms on first floor with windows to the main hall (so that residents can peek in to classroom activities);
- Playground visible from sub-acute and neighborhood floors. Residents in these areas can hear children laughing and playing.

SHORT-TERM, SUBACUTE MEDICAL REHABILITATION

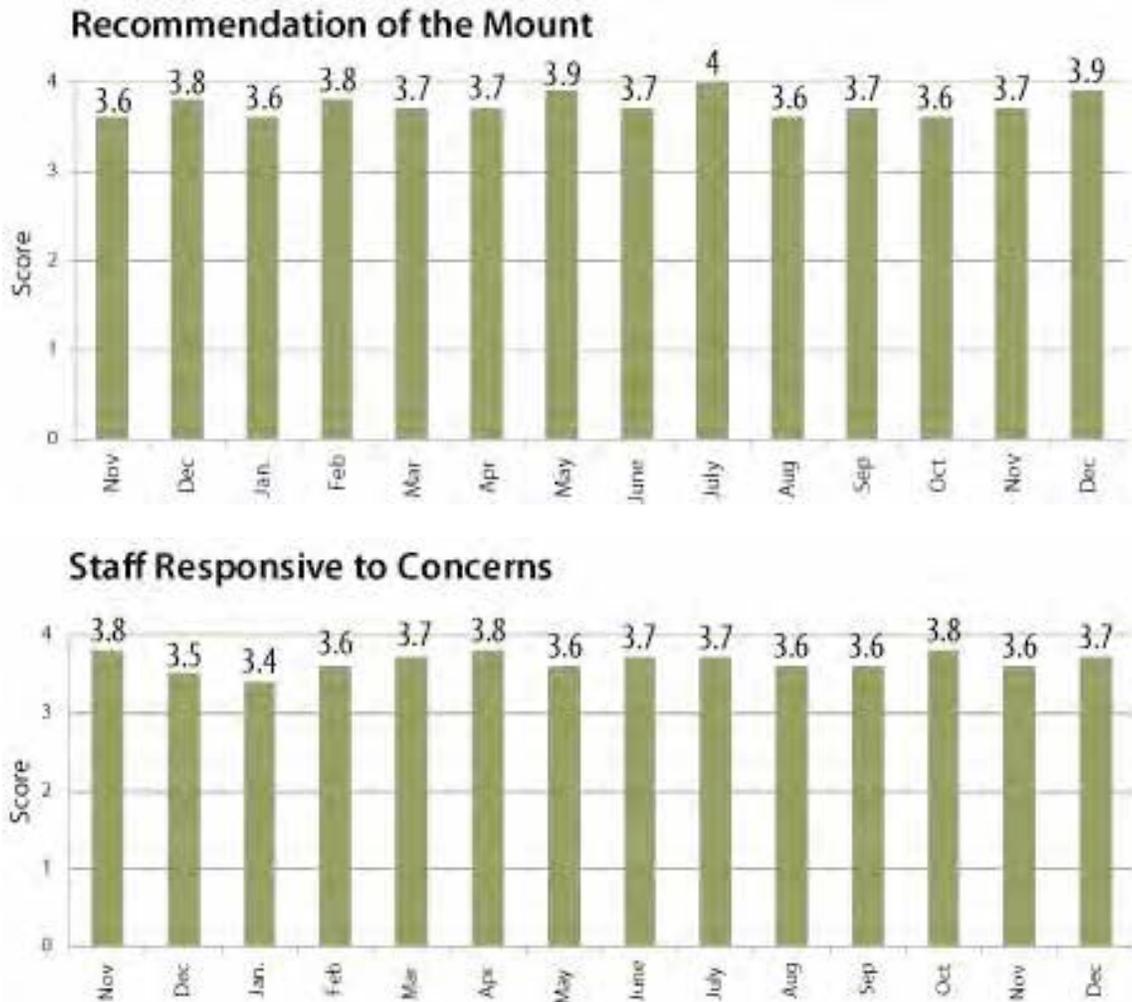
- Kitchen and dining area similar to neighborhoods.
- Mini meeting areas.
- Open environment for nurses' station. *"99% of the day someone can find a nurse or staff."* – Staff member.
- Computerized medical records.

Other Examples

- ∞ Remodeled and open therapy areas in Adult Day Health;
- ∞ A cosmopolitan "Cafe" with an open buffet tray line where all members of the community can dine;
- ∞ An Emilie's Treasures Thrift Boutique – Donated items from The Mount and outside community provide the inventory for this unique shop. Case study interviews and observations revealed it to be a favorite meeting place in the community. Proceeds from purchases benefit the foundation and residents in need;

- ∞ A Wellness Clinic provides services like acupuncture and foot care and is open to staff as well as residents;
- ∞ Lounge areas containing computers and the Never 2 Late system.

Quality of Life Impact



“I hear a lot of people say, I don’t know what would have happened to me if I hadn’t moved here. You don’t feel old. For some reason you fit in” – Resident of The Moun

Quality of Life Quantitative Findings

- ∞ The Mount internally surveys older adults receiving subacute medical rehabilitation services before they return home. In all 16 measures, The Mount consistently maintains high averages on a 4 point scale (all averages above 3.2 and most averages at 3.5 or above). The graphs above provide instructive examples of outcomes and tracking mechanisms.

- ∞ The Mount maintains high averages in Resident Satisfaction surveys including ranking in the 97th percentile of the 2006 Press Ganey Nursing Home Survey national results for the response indicating that “residents were likely to recommend services.” The highest scores of the Press Ganey survey are from those questions relating to relationships.
- ∞ The Mount consistently maintains a close to 100% occupancy rate (to be discussed in more detail on Organizational Impact findings).

Quality of Life Impact Qualitative Findings – Engagement of Residents (measured through resident interviews)

1) *Create an inclusive community and “home” for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus.*

- ∞ The “Hello Phenomenon” was observed during the entire term of the case study. Every staff member said hello to each passing individual in halls and common spaces. *“There is something about going through the hall and every person that works here says hello, asks how we’re doing and calls us by name.”- Resident of Assisted Living. “The people were all so friendly. They said hello I knew then this is where we had to be.”- Resident of Independent Living.*
- ∞ *“I like the fact that they allow you so much independence. That this isn’t a facility. This is home. The people here are so friendly. There are so many little touches. They just think of everything”- Resident of Nursing Neighborhood.*

2) *Work is organized around maintaining resident’s autonomy and preferences with inclusive language supporting residents to be “known” as individuals instead of medical conditions.*

- ∞ *“We have men and women in their 90’s who look like they are in their 60’s. They have kept themselves active socially. We play pinochle and bridge, have conversation groups, Wii bowling. Play horseshoes. There is just something for everyone. We have lots of field trips. People read a lot. There is a computer available for the residents with a touch screen program so they don’t have to work the keys. We have intergenerational art and music and a lot of our people volunteer there.” – Resident of Assisted Living.*
- ∞ *“What I enjoy the most is that there are very few people that sit around and talk about how awful it is to be old. They are too busy.” – Resident of Independent Living.*
- ∞ *“When I had to be in a wheelchair, I thought my life was over. Even though, I have pain, I’m in wheelchair, I can’t do much – I actually do a lot. I do*

needlework, I work on the computer, I read. It's certainly different than what I imagined it to be, but it is probably one of the happiest times in my life." – Resident of Assisted Living.

3) Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization.

∞ *"I like the way they have teams of people. The nurse, social worker, somebody from spiritual care, someone from therapy divided into neighborhoods and each neighborhood has its own cat. Ours is Sunshine."* – Resident of Nursing Neighborhood.

∞ *"It's very cohesive. All the different types of professions all work together. Something that I learned early on is that any person working here will do anything. They are not just confined to one job."* – Resident of Nursing Neighborhood.

4) A relatively flat organizational structure with the resident at the top of the organizational chart is prioritized (allowing for effective communication among and between inter-disciplinary teams and residents).

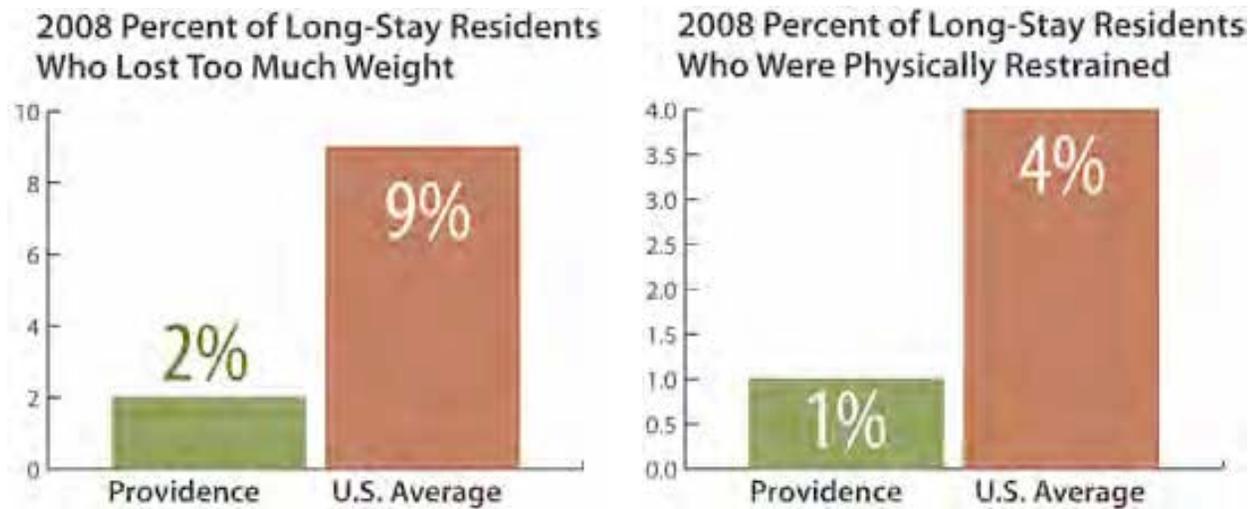
∞ *"The Mount never says what the least we can do and still be accredited like other places I've been. This place says, we'll do anything."*- Resident of Assisted Living.

5) Staff-resident interaction is a priority and staff "know" residents.

∞ *"The aides are wonderful – one always asks how I am feeling and says 'If you're not happy, I'm not happy'. When I wake up in the morning, the first thing I hear is laughter. It is wonderful to hear that."* – Resident of Nursing Neighborhood.

∞ *"She has 6 children and 4 of them are at the daycare center downstairs. One of her little boys is growing so fast. I go down to see him all of the time."*- Resident of Assisted Living after an aide visits the apartment to take her blood pressure.

Quality of Care Impact



“When you care for people you need to care for the whole person including their emotional and spiritual self.” – Sister of Providence.

Quality of Care Impact Quantitative Findings

- ∞ An internal study that compared resident health in 1995 and 2001 found that the number of residents who needed an indwelling catheter fell from 12 to 1; the number reporting a decline in activities of daily living fell from 82 to 3; the number reporting weight loss fell from 20 to 3; the number requiring body restraints fell from 22 to 2; and the number of residents with pressure ulcers fell from 11 to 2.
- ∞ Although tracked as percentages instead of number of residents, 2008 Centers for Medicare & Medicaid Services quality indicator data remained consistently strong with many measures significantly out-performing the national average including only 3 percent of residents with indwelling catheters and only 7 percent of residents whose ability to move about and around their room worsened. The percentage of residents who lost too much weight was also well below the national average at 2 percent. Seven percent of long-stay, high-risk residents had pressure sores while 1 percent of long-stay, low-risk residents had them. Only 1 percent of residents were restrained. (see above graphs).

Quality of Care Impact - Qualitative Findings

1) *Create an inclusive community and “home” for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus.*

- ∞ *“Clinical still cares about clinical and regulatory but we also balance that with caring about our ‘home’ for residents.” [As an example] “We have a resident that loves to spend time with me. She has diabetes and typically doesn’t enjoy exercising. So, I ask her if she wants to join me when I need to leave the neighborhood for a few minutes. It’s the clinical value added of having her walk a 1000 feet a few times a day coupled with spending time with her and building a relationship.” – Neighborhood Coordinator*

2) *Work is organized around maintaining resident’s autonomy and preferences with inclusive language supporting residents to be “known” as individuals instead of medical conditions.*

- ∞ *In one example, a resident of a Mount neighborhood was losing weight and staff were concerned. This elder, an English woman, loved to drink tea. In this instance, the staffs’ understanding of the resident’s likes and preferences was extremely powerful. Working with dieticians and clinical care, staff utilized traditional English “tea times” to fortify her tea. The result was an elimination of weight loss for the resident and proud, empowered staff.*

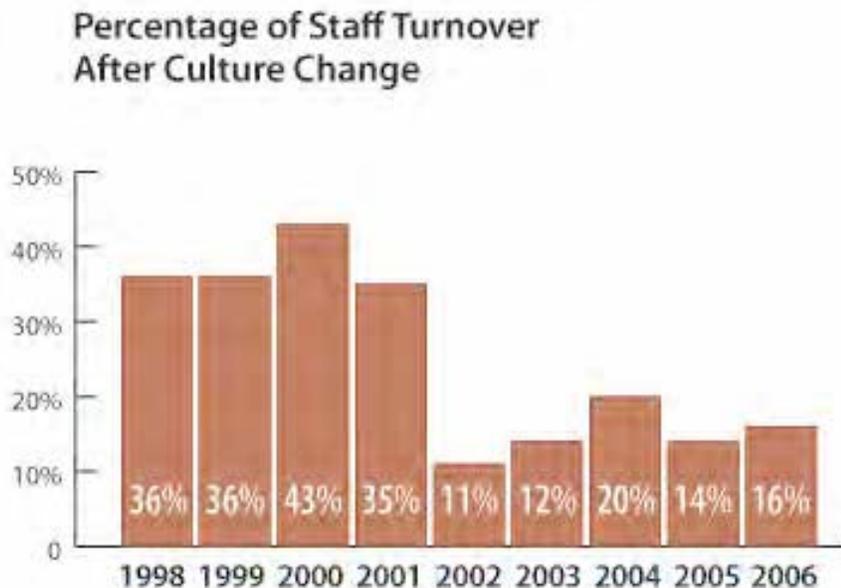
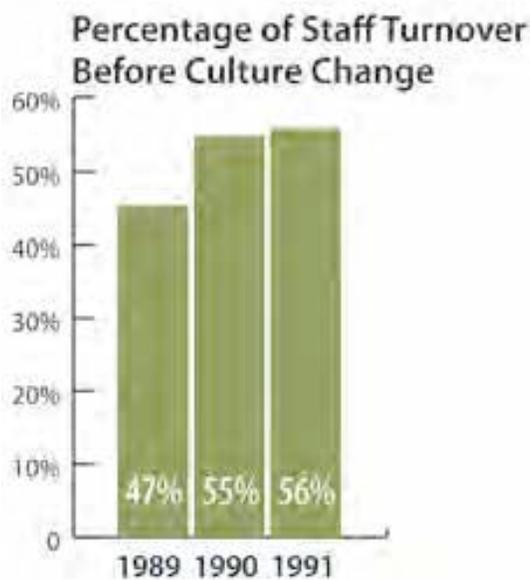
3) *Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization.*

- ∞ *“Our social worker captured the social history and communicated his story to the neighborhood staff directly. We didn’t have to read about him on paper and his story never went through more than two people before it was heard. We know he likes the Sea Hawks and he’ll enjoy the activities where all of the men get together”- Neighborhood Coordinator explaining how she was able to comfort the wife of an incoming resident with such personal and specific information about the husband.*
- ∞ *“If we can develop a creative, reasonable way to do it, we’ll do it. Who would want to give up their home?” – AL staff describing ways to support residents with increasing frailty to stay in apartments.*

4) *A relatively flat organizational structure with the resident at the top of the organizational chart is prioritized (allowing for effective communication among and between inter-disciplinary teams and residents).*

Excellent clinical care occurs within the context of a decentralized model. Although each nursing neighborhood has a unique culture, this requires additional information, education and training to establish some standardization in assessment of areas such as pain. Instead of dictating to a senior clinical staff member, the development of standardization methods is achieved by asking questions and communicating with teams to understand differences and similarities in the current process and then educating each team on new processes. The Mount reports success with this type of assessment.

Staffing Impact



We aim to be an “Employer of Choice” – Charlene Boyd.

“At first people may come to work here just to pay the bills, but they stay for the relationships.” – HR staff member.

Staff Impact Quantitative Findings

- ∞ Turnover percentages decreased significantly from pre- to post-culture change. The above graphs display that annual employee turnover at The Mount fell from 50 percent prior to the implementation of the “neighborhood” model to 15-18 percent voluntary turnover in 2006-2007. Very modest estimates put cost savings of lower turnover and increased retention at \$270,000 per year (nearly 2 million dollars in savings from 2000-2008).
- ∞ Even with over 400 staff, retention and average years of service for most positions is greater than 5 years. Average length of tenure for a CNA at The Mount is 7.6 years. *“Retention is through the ceiling. I’ve never worked at an organization like this where it’s common to find out people have been here for 10-20 years.” – Neighborhood Coordinator.*
- ∞ The Mount scores consistently high on staffing surveys. As with resident surveys, this is particularly true for questions directed at relationships or commitment to residents.

Staff Impact Qualitative Findings

1) Create an inclusive community for staff that is constantly communicating and reinforcing a resident-directed focus through formal and informal educational opportunities and relationship building.

- ∞ 95% of staff interviewed utilized words that describe The Mount as a cohesive unit (e.g. family, team, home). *“I don’t feel like they are old. I see them as young. I spend more time here than with my own family. For some residents, we are their only family.” – Mount staff member.*
- ∞ 100% of staff demonstrated knowledge of culture change principles. *“This is their home and they are letting us come into it.” - Staff member of 5 years. “The difference is that before [culture change] it was us telling them. Now, it’s them telling us. They aren’t ‘patients’ anymore. This is their home and we let them tell us what they want to do.” – Staff member of 20 years.*

- ∞ The Mount maintains a diversity committee that celebrates the staff. ***“We try to model it (not just with the residents) but with each other.” – Mount staff member.***

2) *Through a flat organizational structure, employees feel empowered to help control quality, waste, and problem-solve throughout the community.*

- ∞ 90% of staff interviewed at The Mount reported that they felt empowered to reach-out to fellow employees to brainstorm on operational issues. For example, one of the neighborhood coordinators observed that resident assistants were over-serving residents at meal times (leading to food waste). The neighborhood coordinator solved this problem by scheduling an “in-service” for staff on serving and portioning. The outcome was positive for residents, staff and the organization (substantially controlling waste and food costs).
- ∞ Staff indicated that, when compared to previous employers, this type of empowerment was unique to The Mount and resulted in a reduction of time, resources and expense to solving day-to-day problems.

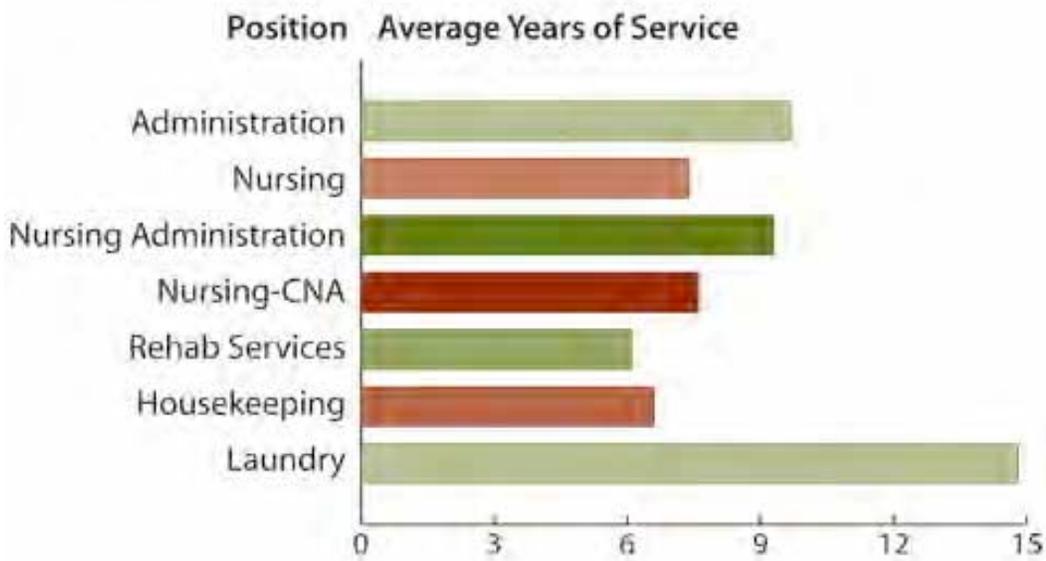
3) *Leverage the value-added potential of inter-disciplinary, cross-trained teams throughout organizational structure to take advantage of synergies in the organization.*

- ∞ ***“We work as a team. Just like I learn from the residents, I learn from my team members. We share a lot of knowledge with each other” – Resident Assistant.***

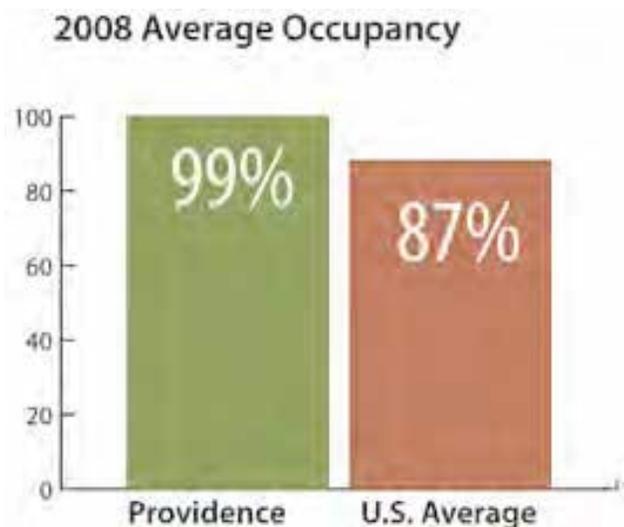
4) *Leadership actively pursues engagement and supportive strategies with staff.*

- ∞ Staff benefits at The Mount support staff and incentivize retention (e.g. discounts for the Childcare Center, discounts on beauty and clinic services, bereavement leave, and employees can donate sick leave to each other). ***“When an employee has to take a leave of absence, we try to keep their job open.”- HR Staff member.***
- ∞ Leadership actively pursues staff feedback. For example, Mount employees were promised a “Casino Night” for a 90% response on the staff satisfaction survey (the response rate was achieved and the Casino night provided for staff and families). ***“They (leadership team) look for feedback from us. They ask us what we think and give us more responsibility.” – Resident Assistant.***

Organizational Impact



Organizational impact in case study findings is defined as impact in quality and/or staffing impact that increases revenue and/or decreases costs for the organization. These are outcomes related to The Mount’s efforts to be a “Provider of Choice” (resulting in higher revenues) and “Employer of Choice” (resulting in lower costs).



Organizational Impact Quantitative and Qualitative Findings

- ∞ The above graph on average years of service describes the organizational advantages of staffing impact. Very modest estimates put cost savings of lower turnover and increased retention at \$270,000 per year.

- ∞ The above average occupancy graph illustrates the organizational advantages of quality impact. Even at an extremely conservative scenario of \$50,000 total yearly revenue per resident, The Mount still generates \$1,200,000 in additional revenue over the national average (200 bed assumption).

Market Reality – Consumers want choices, and the choices (food, activities, schedule) provided by The Mount elevate market position.

Labor Market Reality- Staff generally want to feel listened to by leadership and empowered to make residents happy. With this structure, retention goes through the roof.

The above findings point to return on investment for The Mount from culture change efforts. Findings are consistent across years and indicate that The Mount has achieved sustainability in ongoing culture change efforts. Case study findings also revealed additional examples of quality improvements that lead to cost efficiencies (examples below).

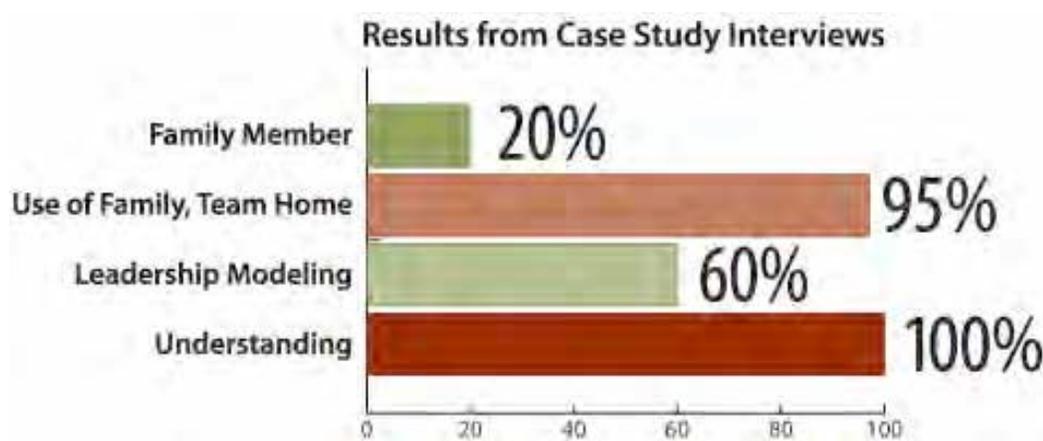
- ∞ A private pay nursing neighborhood resident was having trouble adjusting to her new environment (and would likely have left) until she met and formed a friendship with the neighborhood cat (cost of cats \$500 a year). Measuring return on investment as yearly revenue of private pay versus the Medicaid rate equates to a return in the tens of thousands of percentage points. The investment also translated to the resident's quality of life and sparks conversations with the staff and her family.
- ∞ *“As neighborhood coordinators, nurses are looking at environmental things as well.” – Neighborhood Coordinator.* For example, a neighborhood coordinator noticed a rug that she felt needed some securing to prevent a fall. She generated the repair (cost of repair-negligible estimate \$50). With the average healthcare cost of a fall (according to the CDC) of \$19,040, the ROI for empowering nursing staff to view the bigger picture is also in the tens of thousands of percentage points. Of course, quality of care and life are also significantly improved by avoiding this type of trauma.
- ∞ The Mount's policy of empowering employees and encouraging problem-solving extends to recognizing the talents of staff members. One employee began a career at The Mount by answering phones. His ability to provide excellent customer service to residents and employees was quickly recognized and he was identified as a perfect candidate for operations support. During case study interviews, this

employee was identified as the person who “fixes” everything. Examples include his ability to set-up electronics by simply purchasing equipment (\$77) as opposed to calling for an outside company to consult and do the job (\$1000 cost). In another example, there was an issue with TV reception that was burdensome to residents and staff. The staff member identified the problem and fixed it himself eliminating the need to call an engineer and pay a fee. Residents and staff were thrilled with the quick fix.

Additional Examples of Revenue Enhancement from Culture Change Transformations:

- ∞ *“The best advertising is word of mouth.”- Mount staff member.* Community-based programs such as Adult Day and the Intergenerational Learning Center generate referrals. So, although those programs may not operate with the highest margins in the community, they still increase occupancy in the higher margin areas and lower advertising costs. Since employees take advantages of those services for families, these programs also increase employee retention.
- ∞ The Wellness Clinic and Emilie’s Treasures generate revenue with high margins.
- ∞ The inclusion of the outside community in Mount activities adds to quality of life and atmosphere while also generating financial support. For example, designers decorate Christmas trees that are auctioned off generating as much as \$107,000 to resident programs.

Additional Case Study Findings



Case study interviews exhibit a high level of congruence between stated goals of leadership and the support for those goals from residents, staff, Board and community members. Examples of these results are discussed below and illustrated in the above graph:

- ∞ 20% of staff interviewed also utilized Mount services for a family member (either for intergenerational childcare or a parent or grandparent in the community) indicating integration and trust of relationships.
- ∞ 95% of staff and 100% of residents interviewed utilized words that describe The Mount as a cohesive unit (e.g. family, team, home). Perhaps this statement is best exemplified when former Mount employees choose to come back to the community after retirement and make it their home. One of these former employees, now a current resident, sees the person-directed philosophy as similar for staff and residents in the community. As a former staff member and current resident, she states, *“It is the same loving, supportive care for whatever you need physical, emotional, spiritual (no matter your background).”*
- ∞ A consistent finding in The Mount case study was the importance that leaders place on modeling person-directed care practice for staff and elders. In interviews, 60% of the leadership team used the word “modeling” as the predominant method of mentoring staff in culture change.
- ∞ As stated previously, 100% of staff and residents demonstrated understanding and knowledge of culture change principles.

Board Support: The Mount’s Board, not only supports culture change activities, Board members take pride in encouraging ongoing work. Many Board members have personal experiences with The Mount and several Board members have family members residing in the community. Board members are deeply involved and interested in culture change and look forward to updates. Administrator, Tom Mitchell, and Regional Administrator, Charlene Boyd, report on culture change at Board Meetings. Programs supporting residents and employees such as sponsoring families and providing food bags for employees during holidays are examples of programs unanimously approved by the Board.

Community Support: Quality care, committed staff and exemplary leadership often lead to a community reputation which improves occupancy and market competitiveness. The Mount receives local and national recognition for innovation in the workplace. This level of support leads to high impact and return for culture change investment.

Challenges and Lessons Learned



- ∞ **Change doesn't happen overnight and leadership must stay the course.** It's not a magical practice. It's consistency. For example, adopting language like "home" and "neighborhood" takes time but is important to transform action. Ultimately, complex interactions build the relationships and those take time to develop and understand. According to Charlene Boyd, *"There were more stops and starts than we expected. You test something, try, learn... You do what's needed to change the foundation of the work, but it takes longer than you think."*
- ∞ **Sustainability requires constant innovation.** This means that The Mount spends time and resources maintaining the resident-directed focus. Thus, The Mount is constantly re-investing back into the organization (making it difficult to track all of the positive quality and financial outcomes).
- ∞ **Relationships and engagement are tangible and observable outcomes for staff and residents at The Mount but difficult to measure.** *"Having good relationships in life is one of the greatest challenges for all of us – this is an extension of that."*- Mount staff member.
- ∞ **Jobs change when an organization transforms to a resident-directed focus.** Tasks formerly done by administrative and licensed nursing staff are now shared by the team including resident assistants. Switching to a resident-directed focus also requires ingenuity and innovation by staff to organize work around residents' schedules. For example, interaction and activities need to be available for residents

that stay up later (as opposed to staff having all residents in bed by 7:00). **“The difficulty is accepting that you are not the one directing care and the schedule anymore.”** – Mount staff member.

- ∞ **The New Generalist Versus The Former Expert** – The creation of inter-disciplinary teams may be an adjustment for certain staff that want to slip back into role segregation. According to the case study, it can be especially difficult for clinical staff that are educated and often have experience in an acute care setting. For example, even though some resident’s have chronic conditions, they wouldn’t typically take their own pulse hourly in their home. The Mount attempts to acclimate clinical staff to this type of logic.
- ∞ **Flexibility Versus Rigidity** – Standardization of certain elements of quality of care (e.g. pain management) can be complex given that each nursing neighborhood is unique. This requires clinical leadership to be involved and aware of the dynamics of each neighborhood culture. Although the expectation of certain standardization in processes that equate to positive quality outcomes is more rigid, the respect and understanding of each neighborhood’s dynamics requires a level of flexibility.
- ∞ **Even though physical transformations are complete, resident-directed care won’t work without the underlying systems.** For example, renovations at The Mount occurred floor by floor. It became clear in the early days that some of the spaces were not being used how they were intended and were still staff driven. By the final phase on the 5th floor, the leadership team and architect were able to address these problems for a smoother transition.
- ∞ **Attributes of The Mount that may have eased the transformation** – The Mount is a part of a larger organizational structure (Providence Health & Services) which could lead to some economies of scale and scope in areas such as administration. Through Providence, The Mount is also able to offer employees extended benefits including sick, annual, and bereavement leave; life medical, and vision insurance; disability, and tuition reimbursement. These are attractive benefits to employees (although they still do not account for turnover improvements post-culture change that are significantly below national standards).

Summary



Upstairs Downstairs

Intergenerational Art Show Betty Perry 2007



Providence Mount St. Vincent is an example of an organization successfully implementing and sustaining ongoing culture change. Common themes in processes and transformations can be tracked to qualitative and quantitative outcomes for residents, families and staff that ultimately result in the well-being of the organization.

Although the process is ongoing and there are challenges along the way, for well over 10 years, person-directed care has provided a foundation for quality and a bright future for this community. From the “Hello Phenomenon” to the importance of banana ice cream, from statistically significant quality outcomes to millions of dollars saved, The Mount is truly a gold standard in culture change.

Links

Pioneer Network's Model of Investment and Returns-

<http://www.pioneernetwork.net/Providers/Investment/>

Providence Mount St. Vincent's Website -

<http://www2.providence.org/kingcounty/facilities/providence-mount-st-vincent/Pages/default.aspx>

Agency for Healthcare Research and Quality Profile of The Mount -

<http://www.innovations.ahrq.gov/content.aspx?id=1906>

Catholic Health Progress Jan 08 Article -

<http://www.pioneernetwork.net/Data/Documents/ProgressArticle0108.pdf>

Article in Ms. Magazine Spring 2007 -

<http://www.pioneernetwork.net/Data/Documents/msarticle.pdf>

Discussion of The Mount in Old Age in a New Age by Beth Baker -

<http://www.pioneernetwork.net/Store/>

Westminster Thurber – A Case for Implementation

Case studies are designed to extract from adopters common features that promote successful implementation and sustainability.



Executive Summary

Motivation for Change: Gradual education of the leadership team, Eden certification, and a new Executive Director with prior success in person-directed implementation.

Goal of Change: Transform the environment from a medical, task driven model to a person-directed, social model.

Assessment Steps: Started with the leadership team and training; Expected each member of the leadership team to become coaches and mentors in shedding traditional roles; Developed an orientation curriculum that reinforces the desired culture for all employees; Incorporated learning circles with employees and elders; Surveyed employees to determine grasp and acceptance of culture change principles.

Implementation Progress: Westminster-Thurber is currently in an implementation phase of culture change. Leadership and staff are fully educated in culture change principles via organizational communication, a culture change orientation curriculum and training (to be discussed in subsequent sections of the case study). However, operational areas of this CCRC are at varying stages of incorporating environmental, systems and process transformations.

PRE-TRANSFORMATION	POST-TRANSFORMATION	AREAS OF ORGANIZATIONAL DIFFUSION
Staff unaware of culture change or person-directed principles.	Orientation curriculum for all staff.	100% implementation.
Staff-resident interaction not a priority.	Consistent assignment of residents with care assistants.	100% implementation.
Leadership style is "command and control."	Leadership style is "serve and support."	Implemented in most areas. Westminster is searching for a DON to provide clinical leadership to support this style.
Residents and direct care workers are not involved in developing care plans.	The care planning process involves residents, their families and care partners.	100% implementation.
Lack of autonomy for residents in activities and schedule. Staff were task driven and organized work around delivery of care and staff preferences.	Activities are meaningful. Residents maintain personal schedules based on preferences.	- 100% implementation in the Pathway Home. - Activities and choice in schedule for rising time are implemented in most areas. - The Health Center is still in early implementation for full scheduling based on personal preference.

Centralized departments and scheduling by management.	Staff are cross-trained and able to help residents with multiple requests and utilize self-directed scheduling.	- 100% implementation in the Pathway Home. - Some use of cross-training and self-directed scheduling in other areas.
Environments are institutional and separate residents and staff.	Staff and resident workspaces are no longer segregated. All spaces in community are designed to promote resident independence.	Westminster is at varying stages of environmental transformation. Visit "Physical Environment Transformations" for more detail.

Examples of "AH HA" Moments: 1) Clinical leadership is a crucial component of success; 2) Change doesn't happen overnight and leadership must stay the course; 3) Underlying systems and certain logistics of the organization must change to support the implementation process; 4) It is essential to integrate resident-directed philosophy and expectations into the recruitment and interview process of new staff; 5) The development of an orientation curriculum assures that employees have consistent information and expectations.

Impact on Quality: Consistently high Resident Satisfaction Assessments; In the Pathway Home, staff observe combative or depressed behaviors of residents to be decreasing and engagement to be increasing; In the Pathway Home, staffing ratios far exceed Ohio's staffing regulations; The percent of long-stay residents who were physically restrained while in skilled care declined from 4% in 2008 to 1% in 2009 (4% below the national average).

Impact on Business: Nearly full census; Rehab studios admissions increased by 62% from 2005 to 2008; Use of agency staff decreased by 50% a year in 2007 & 2008; Annualized staff turnover decreased by 9.4% from fiscal years 2007 to 2008. One year post-implementation, the Pathway Home is Westminster-Thurber's most profitable operational area generating positive operating margins and occupancy waitlists.

Visit [Quality of Life Impact](#), [Quality of Care Impact](#), [Staffing Impact](#), and [Additional Case Study Findings](#) to learn more about outcomes and early- to mid-implementation signs of impact.

Organization



Photo of Trudy, a beloved 12 year-old Westminster-Thurber beagle, at the Halloween Parade with a resident friend (Trudy went to the parade dressed as “Snoopy”).

Type: Non-for-profit; part of a regional, multi-organization chain.

Executive Director: Steve LeMoine

Administrator: Michele Engelbach

Westminster-Thurber Community is a flourishing continuing care retirement community located in the heart of downtown Columbus, Ohio. It is owned and operated by Ohio Presbyterian Retirement Services, Ohio’s largest not-for-profit provider of continuing care retirement communities and services. Westminster-Thurber is an Eden Alternative Community with a mission to *“provide older adults with caring and quality services toward the enhancement of physical, mental and spiritual well-being consistent with the Christian Gospel.”*

Westminster offers a variety of residential and community services including:

- ∞ 82 person skilled nursing center;
- ∞ The Pathway Home – an elder-centered, skilled certified, home for 10 elders;
- ∞ 63 studio and one-bedroom apartments for assisted living;
- ∞ 155 apartments for independent living;
- ∞ 31 assisted living “memory care” apartments;
- ∞ 18 short-term, subacute medical rehabilitation studios;

- ∞ Senior Independence home care options (including serving more than 10,000 meals per month to homebound seniors in the greater Columbus area).

Westminster-Thurber has a diverse workforce of 300 employees (full, part time and contingent) coming from seven surrounding counties. Medicare, Medicaid, Third Party and Private Pay are all accepted payment types.

History and Implementation



Westminster-Thurber has been serving seniors and their families in the Central Ohio area since 1965 and is a member of the Ohio Presbyterian Services (OPRS) family. OPRS is the largest and most experienced provider of not-for-profit continuing care retirement communities and community-based services in Ohio and has been serving Ohioans since 1922.

Westminster-Thurber is currently in an implementation phase of culture change. Leadership and staff are fully educated in culture change principles via organizational communication, a culture change orientation curriculum and training (to be discussed in subsequent sections of the case study). However, operational areas of this CCRC are at varying stages of incorporating environmental, systems and process transformations.

The [timeline](#) on the following page outlines various implementation efforts. Parts of the case study will focus on the Pathway Home, as the most comprehensive example of culture change efforts to date. Other elements of the case study will address the overall organizational structure and challenges with complete organizational implementation and culture change transformation.

Implementation Timeline

1998: Organization begins to explore culture change, and first employees attend Eden Associate training.

2001: Much of the leadership team have become Certified Eden Associates and Westminster is a registered Eden home. The Leadership Team discusses efforts, but implementation is not organized and has not filtered down to front-line staff.

2002: Steve LeMoine joins Westminster as Executive Director. Steve has previous experience of leading a thriving culture change community in his former organization and “ramps up” culture change efforts at Westminster.

2002-2004: All Department Managers have attended training and are educated in culture change. Many employees attend as well. Leadership actively discusses and pursues efforts.

2004 - present: The Leadership team pursues strategies to engage employees, promote person-directed care and maintain high involvement.

2006 - present: Employees complete “Soil Warming Surveys” yearly to gauge culture change efficacy.

2007: Education Committee designs “World Makers” culture change orientation curriculum. Over 400 employees attend the training by March of 2007. Training becomes part of monthly orientation for new employees.

2008: Construction begins to transform a 10 bed “unit” for residents with advanced Alzheimer’s to a renovated “Pathway Home” (similar to a small house or Green House model). “Care Partners” are interviewed and chosen by residents and staff. Training occurs to prepare staff for household transformations.

May 2008: The Pathway Home opens.

2009: Where are they now? What challenges has Westminster-Thurber faced implementing culture change in the Pathway Home and the rest of the organization? Are there any measurable outcomes 1 year after the Pathway Home opened it’s doors? Read on to learn more...

Common System and Environment Themes Prior to Implementation



Common Themes in Westminster-Thurber's Processes and Systems Prior to Implementation

Medical, institutional model of care;

Lack of autonomy for residents;

Decision-making at the leadership or organizational level;

Language supported a culture of dependence (e.g. "patient," "ward," "floor" and "unit");

Residents identified by medical conditions or level of care;

Staff-resident interaction was not a priority;

Staff were task driven and organized work around delivery of care and staff preferences.

Note: Common themes in the physical environment are elucidated by describing the space transformed into "The Pathway Home" (Westminster's most expansive environmental culture change transformation to date).

Common Themes in the Pathway Home's Physical Environment Prior to Implementation

A 10 bed "unit" organized around staff spaces;

Aside from resident rooms, many spaces "belonged" to the institution;

Mostly semi-private shared rooms with shared toilet rooms;

Kitchen off limits to residents;

Portion controlled meals were delivered on trays;

Outdoor spaces were often challenging for residents to access and not relaxing environments.

Strategies for Planning

The Eden Vision for Westminster-Thurber

We envision a community of neighborhoods where people live and work to fulfill their highest purpose and potential every day of their life. We support one another in our neighborhoods to live lives where we:

Engage in meaningful and loving relationships

Pursue life interests and goals

Learn and grow as people

Find spiritual fulfillment

Live with excitement

and

Contribute to the common good of the community

The Eden Vision Statement for Westminster-Thurber. After it was introduced, employees signed a large poster of the statement indicating their support (the poster is framed and on display). New employees also sign a similar poster of the statement after “World Makers’ orientation (to be discussed in “Organizational Systems Transformations”).

In 2004, The Westminster-Thurber Leadership Team set out to change the work environment for those who live and work at Westminster-Thurber. The team wanted to take the environment from a medical, task driven model to a person-directed, social model. It started with self-reflection, identifying potential areas of individual growth and collective team building. Resources were supplied (books, group meetings, professional speakers, retreats, etc.) to grow the capabilities and skills of each member of the Leadership Team. The team decided to focus their educational efforts toward moving from an autocratic management style to a servant leadership style. The group met often to study books such as “Good to Great,” “The Fred Factor,” “The Secret,” and “Crucial Conversations,” to develop their own leadership style. The team saw tremendous growth in each person as they moved from manager to coach, mentor and facilitator. The team has grown in solid, professional relationships and accountability to each other.

The decision as a team to move away from autocratic managements styles towards a more servant leadership style came in spring of 2004. Westminster worked for over two years to instill the needed changes in leaders as well as the middle line supervisors and then assessed outcomes by providing a survey to employees to measure the culture change initiative in spring of 2006. Westminster felt that the changes weren’t deep enough and decided to develop the World Makers curriculum to totally immerse all 270 employees across the community to establish a firmer foundation.

Tips for early and ongoing planning:

- ∞ Start with leadership reflection by gathering the leadership team and focusing on the issues;
- ∞ Expect each member of the leadership team to become coaches and mentors and became accountable to each other in shedding the traditional manager role;
- ∞ Learn and discuss models of leadership. The Westminster team discussed the content of such books as “The Secret,” “The Fred Factor,” “Good to Great,” “Crucial Conversations,” “The 8th Habit,” and “What Are Older People For?”;
- ∞ Develop a curriculum that reinforces the desired culture and train all existing employees and new employees at orientation;

- ∞ Incorporate learning circles with all employees and elders to discuss problems and develop meaningful relationships with each other;
- ∞ Survey employees to determine grasp and acceptance of culture change principles. Don't be afraid to go "back to the drawing board" if results are inconclusive.
- ∞ Stay the course! "I'm not going to paint a rosy picture and say that it's easy. It takes time, but it is really worth it when it all comes together." - Westminster staff member.

Case Study and Assessing Impact

What Can You Do to Foster Friendships With Our Elders?

Talk to the Elder at every opportunity

While you are completing your daily tasks for our Elders, say things like:

- ∞ Tell me about what kind of work you did • Tell me about your family • Tell me about your home
- ∞ Tell me about vacations that you've taken
- ∞ Tell me about your spouse
- ∞ Tell me about your parents
- ∞ Tell me about your children, siblings, grandchildren, etc.

Include the Elder in your conversation with others *It is important that you include our Elders in conversations that you have in their presence. If you are chatting with another staff person, find a way to have the Elders join your conversation, rather than talking over them or about them. If you don't think it's appropriate for the Elders to join your conversation, then it's a conversation you should be having in private and not in front of them. The dining room is a particularly important place for you to have a conversation with our Elders. It makes the meal much more enjoyable for them.*

Excerpt from World Makers Orientation Curriculum

The case study at Westminster Thurber incorporated review of 22 quantitative data sources (financial, staff, operations, resident, outcomes), 34 sources of organizational data

(descriptive, educational materials, human resources, communications, marketing, operations), and 22 interviews in the following areas:

- ∞ Executive Director and Administrator
- ∞ Pathway Home and Care Partners
- ∞ Health Center
- ∞ Assisted Living
- ∞ Memory Care
- ∞ Activities
- ∞ Clinical Services
- ∞ Human Resources
- ∞ Marketing
- ∞ Dining
- ∞ Residents

The Westminster-Thurber case study was designed to identify qualitative and quantitative elements to track and support the effects of this innovation on organizational outcomes. Unlike the case study of Providence Mount St. Vincent, the model represents an implementation process describing innovation as it moves through a community from leadership, to staff, to residents and families.

In Pioneer Network case studies, impact is categorized by quality of care/life improvements (most directly affecting residents and family), staffing impact and organizational impact. Organizational impact is defined as impact in quality and/or staffing impact that increases revenue and/or decreases operational costs for the organization.

As with Providence Mount St. Vincent and case studies of sustainability, common themes were identified in *Resident Systems* (most directly affecting quality of care/life) and *Overall Organizational Systems* (most directly affecting staff). However, because Westminster is in an implementation phase, themes may not relate to the entire organization, and certain discussions will focus on the Pathway Home (Westminster's most in-depth and expansive organizational transformation to date).

Common themes are highlighted in the tables below and discussed in further detail on subsequent pages.

RESIDENT SYSTEMS

- 1) Create an inclusive community and “home” for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus.
- 2) Work is organized around maintaining resident’s autonomy and preferences with inclusive language supporting residents to be “known” as individuals instead of medical conditions.
- 3) Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization.
- 4) A relatively flat organizational structure with the resident at the top of the organizational chart is prioritized (allowing for effective communication among and between inter-disciplinary teams and residents).
- 5) Staff-resident interaction is a priority and staff “know” residents.

ORGANIZATIONAL SYSTEMS

- 1) Create an inclusive community for staff that is constantly communicating and reinforcing a resident-directed focus through formal and informal educational opportunities and relationship building.
- 2) Through a flat organizational structure, employees feel empowered to help control quality, waste, and problem-solve throughout the community.
- 3) Leverage the value-added potential of inter-disciplinary, cross-trained teams throughout the organizational structure to take advantage of synergies in the organization.
- 4) Leadership actively pursues engagement and supportive strategies with staff.

Resident Systems Transformations



Photo of Shelby (a much beloved Westminister-Thurber Community dog) celebrating her 13th birthday, in her pink tutu, at a party with residents. Scroll to the bottom of the page to see a photo of Shelby relaxing after her party.

Based on case study findings, the below examples expand on the list of Resident Systems from Assessing Impact (previous page) and describe systems discovered through Westminister-Thurber's implementation process of organizational transformations. These are the systems identified as most likely to affect resident and family outcomes.

The below transformations are based on the Resident Systems table (displayed on the **Assessing Impact** page) and are those most likely to affect resident and family outcomes. Examples are listed below each strategy.

1) Create an inclusive community and "home" for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus.

- ∞ A resident-directed focus is utilized in marketing materials, so that residents and families are introduced to expectations regarding resident-directed care at an early stage;
- ∞ Death and dying are honored. - A special session of grief counseling was conducted for staff members of the Pathway Home when the first resident passed away.
- ∞ There are no uniforms at the Pathway home to delineate between community members and staff.

2) *Work is organized around maintaining resident's autonomy and preferences with inclusive language supporting residents to be "known" as individuals instead of medical conditions.*

This will vary by the needs of each community area. Examples discussed below:

- ∞ The Pathway Home - The Pathway Home utilizes self-managed staffing with a care partner lead for each operational area (e.g., scheduling, dining, housekeeping). Staff are cross-trained and able to help residents with multiple requests (going to the restroom, doing laundry, fixing a sandwich, and eating). Care partners are aware of individual resident interests to help encourage residents to engage in meaningful activities. Residents maintain personal schedules based on preferences and get up and go to bed when they choose. The Pathway Home is beginning to maintain a mixed acuity level of residents. Resident choice is documented in the care plan, and care partners are included in meetings. ***"We have one resident that loves to play the Sudoku game on my phone. We have so much fun."* - Pathway Home Guide.**
- ∞ Assisted Living Memory Care Apartments and Health Center - Westminster maintains consistent assignment of staff with care assistants which leads to a relationship of "knowing" individual preferences. Activities are frequent and meaningful. Wii and It's Never Too Late are also utilized to increase resident engagement. Resident choice is documented in the care plan, and care partners are included in meetings. Residents can bring pets from home, or many adopt animals living in the community. ***"After her owner died, she came right into my room and never left. She is the light of my life."* - Resident of Health Center describing her adopted cat.**

3) *Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization.*

- ∞ In the Pathway Home, it is an ongoing goal (discussed weekly at Care Partner meetings) to create a home where life's activities revolve around the elder.
- ∞ Leadership and staff advocate for group-centered problem-solving approaches for resident and family issues.
- ∞ Employees undergo formal Peer Reviews as part of the evaluation process to focus on team synergies and "check" each other on team efficacy.
- ∞ Teams participate in new employee hiring and interviewing to maintain synergies and "fit" in the culture and organization.

4) A relatively flat organizational structure with the resident at the top of the organizational chart is prioritized (allowing for effective communication among and between inter-disciplinary teams and residents).

- ∞ *“We look at everything we do, in terms of how it affects the elders. So, for example, team scheduling is more than just a staff issue. We look at it from the elder’s perspective.” - AL Coordinator.*
- ∞ In the Pathway Home, care partners advocate for elders, and clinical staff respond to care partner concerns and observations regarding an elder’s health.
- ∞ Elders take part in the interview process. For example, elders and families helped to choose care partners for the Pathway Home.

5) Staff-resident interaction is a priority and staff “know” residents.

- ∞ It is an expectation that staff and residents alike learn about one another’s lives, hobbies and interests.
- ∞ New employees are coached to draw elders into conversations and ask about life experiences.
- ∞ *Spontaneous interactions and engagement are encouraged. “One day staff and residents gathered around the piano and we all sang for an hour. It was completely unexpected, but it was just a wonderful example of the culture that we want to create.” - Steve LeMoine, Executive Director.*



Photo of Shelby resting after celebrating her 13th birthday with residents

Organizational Systems Transformations



The below “overall” organizational and staff transformations are based on the Organizational Systems table (displayed on the [Assessing Impact](#) page) and are those that will most likely affect staff and organizational outcomes. Examples are listed below each strategy.

1) Create an inclusive community for staff that is constantly communicating and reinforcing a resident-directed focus through formal and informal educational opportunities and relationship building.

- ∞ A consistent finding in Pioneer Network case studies of culture change is the integration of resident-directed philosophy and expectations into the recruitment and interview process of new staff. Westminster Thurber utilizes Eden concepts to structure interview questions geared toward understanding new employee’s openness to valuing resident autonomy and choice. Questions include: Give me three words to describe an elderly person; How would you make a new resident feel welcome?; What do you think are some of the challenges a new resident faces when moving in to a long term care community? Applicants receive a packet stating, “As a prospective employee of Westminster-Thurber Community, we want you to understand our culture. Eden is a definite change in the way we look at long-term care culture change. You, as an employee, play an integral part in our family.”

- ∞ The team developed a curriculum for an eight-hour culture change educational course. The compilation of material became known as *World Makers*, taken from Dr. Bill Thomas' reference that each employee, everyday, can change the world for our Elders. The entire employee workforce was trained with the World Makers curriculum. The training instills the values and philosophies of Westminster's culture from the very beginning of an employee's tenure. The trainings are now offered monthly for all new hires and anyone from the community who wishes to attend. Training topics are extensive and include Dementia Caregiver Training, Eden Principles and Grief and Dealing with Loss. ***"We kept asking, how do we get this message [culture change] to everyone and how do we get them to hear the same information? So, that's when the Education Committee came up with World Makers. People are better informed and can speak to the whole vision, because they've all had the same information."*** - Member of Education Committee.

2) *Through a flat organizational structure, employees feel empowered to help control quality, waste, and problem-solve throughout the community.*

- ∞ ***"I communicate to staff that I'm a coach and a coach can't play all the positions on the team."*** - Assisted Living Coordinator.
- ∞ Peers will take part in the new hire process by showing potential employees around the organization and talking with them further. Often, employees gain more of an inside perspective through these conversations and share candid thoughts with HR staff (leading to ultimate hiring decisions).
- ∞ ***"We used to be a very punitive society. Now, employees feel empowered to make a difference knowing that they have room to grow."*** - Member of Leadership Team.
- ∞ Critical-thinking is valued and expected of employees. ***"They give me the freedom to do what I do best."*** - Westminster staff member.

3) *Leverage the value-added potential of inter-disciplinary, cross-trained teams throughout the organizational structure to take advantage of synergies in the organization.*

- ∞ To incorporate inter-disciplinary concepts in the Pathway Home, staff underwent extensive training including dining, cooking, laundry, housekeeping, nutrition, observation skills, maintenance, and activities.
- ∞ Westminster-Thurber develops teams to respond to all types of operational processes, such as HRT = Human Resource team that brought together the leadership to deal with employee issues, FAT = Financial action team, to review operational fiscal soundness, CAT = Capital action team, to review campus needs

and strategically plan for the future goals of the community. The team rotates leadership responsibilities so each person has an opportunity to strengthen their leadership skills.

- ∞ Westminster implemented peer evaluations as part of the formal HR evaluation process. *“They are just getting use to being accountable to each other.” - Member of Leadership Team.*
- ∞ *“Relationships are built which is why we tried to make it cross-departmental. We wanted folks to get to know each other.” - Member of Education Committee.*

4) Leadership actively pursues engagement and supportive strategies with staff.

- ∞ The Westminster leadership team regularly writes thank you notes to staff as part of the culture change process. *“One of the biggest things that we have pushed is recognition. We’ve had tremendous feedback from staff with the thank you notes and recognition of hard work. It’s a very powerful tool.” - Member of Leadership Team.*
- ∞ The leadership team relinquishes their control by incorporating peer interviews for new hires in each neighborhood of elders and care partners. The team also developed and implemented a peer evaluation tool for employees to use in evaluating their peers, in turn helping each other to grow.
- ∞ *“Before culture change we had a regimented leadership style. Everything was systematic and black and white. Now, we try to look at the whole picture to make sure that we coach, counsel and educate.” - Westminster staff member.*
- ∞ Westminster leadership sends representatives to various state and national professional meetings with the goal to identify new innovative ways of delivering better services. They expose employees to best practices with the expectation that employees will challenge or inspire leadership to do the right thing.

Physical Environment Transformations

Environmental changes can require capital intensive investments to rebuild or renovate existing structures or to build entirely new households. However, not all environmental transformations require significant financial investment. Westminster-Thurber continues to make changes to the environment with varying levels of financial outlay. In May of 2008, Westminster opened the Pathway Home. The Pathway Home required a five month renovation of an existing structure into a household model and is an example of

environmental transformations requiring substantial financial investment. However, Westminster is also in the early stages of establishing neighborhoods in its skilled nursing facility by making more minor environmental investments while still fully adopting system oriented changes including restoring decision-making and autonomy as close to the elder as possible. Examples of transformations to the Health Center at this stage of implementation include:

- ∞ Rooms reflect resident's unique life and personality in color, decoration and furnishings.
- ∞ Overhead paging has been eliminated.
- ∞ There are designated "neighborhoods" in the Health Center.
- ∞ Staff and elders decide how neighborhoods should be decorated.
- ∞ Nurses' stations have been removed.
- ∞ Pantry kitchens were added to neighborhoods so that elders may enjoy food anytime.

As the most extensive environmental transformation, the below example describes the Pathway Home. Transformation to the physical environment of the Pathway Home took one year and \$650,000 in renovations. Major changes include:

THE PATHWAY HOME

- Spaces belong to Elders and they have access to all areas of the house;
- Family/visitors ring doorbell and enter through the front door into the home's foyer (just like home);
- All private rooms with half-bath;
- Central hearth with adjacent open kitchen and dining areas;
- Short halls provide easy access to the heart of the home;
- Kitchen is at the center of the home;
- Elders have access to the kitchen and participate in planning and preparing the meal;
- Dining is around a long wooden table with family style meals;
- Outdoor space is easy to access, fenced, shaded with green lawns and plants.

Quality of Life Impact



“I brought in all of my personal belongings. I can’t wait to bring out all of my Christmas trimmings over the holiday.” - Resident of Health Center Neighborhood.

Early to Mid-Implementation Signs of Quality of Life Impact: Increased levels of resident satisfaction formally (surveys) and informally (verbally to peers and staff); Increased levels of engagement (especially in residents with chronic health conditions or dementia); Emphasis by residents and staff on relationships and community; descriptions of the organization as “home” or “family.”

Quality of Life Quantitative Findings

- ∞ Westminster surveys older adults receiving subacute medical rehabilitation services before they return home. Westminster consistently maintains high averages on a 4 point scale (most averages at 3.6 or higher). The graph above provides instructive examples of responses to questions regarding communication. Westminster scored particularly high (3.9) on questions related to quality of life such as “Staff listened to what I said.”
- ∞ A solid reputation for quality and community assists Westminster in consistently maintaining an occupancy rate for skilled services significantly above the national average (to be discussed in more detail in Organizational Impact findings).
- ∞ 60% of elders enjoy private rooms.
- ∞ 50% of Westminster elders choose to actively participate in the care of the animals that live in the community.

Quality of Life Impact Qualitative Findings

1) *Create an inclusive community and “home” for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus.*

- ∞ Westminster has introduced children into the daily lives of the community, and staff are encouraged to bring their own children to visit with elders. The Pathway Home residents hosted a “Tea Party” for their care partners’ children (girls wore tiaras and boys dressed up as pirates).
- ∞ Relationships are a core of the community. This is also exemplified by residents’ close relationships with community animals. Often, animals are adopted as strays into the community and then adopt a primary caregiver resident to care for them. ***“He was rescued from the pound. I was helping to care for him, taking him outside and keeping an eye on him. One day, I woke up and he was in my room. He never left. He chose me.” - Assisted Living Resident describing meeting his loving dog.***
- ∞ ***“Westminster-Thurber is a very special gem in the senior healthcare ocean. There was a good sense of community.” – Resident Rehab Studios.***

2) *Work is organized around maintaining resident’s autonomy and preferences with inclusive language supporting residents to be “known” as individuals instead of medical conditions.*

- ∞ Language has shifted from “resident” to “elder,” from “CNA” to “care partner,” and from “unit” to “neighborhood.”
- ∞ Elders’ rooms reflect their unique life and personality in color, decoration and furnishings. ***“I love my room.” - Resident of the Pathway Home.***
- ∞ Westminster has eliminated overhead paging.
- ∞ Nurses’ stations have been removed to create living space for the elders.
- ∞ Elders in neighborhoods may enjoy food at anytime of the day or night.

3) *Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization.*

- ∞ Care partners in the Pathway Home are universally trained and organize work and activities of daily life around residents’ needs and preferences.
- ∞ The Health Center has designated “neighborhoods” and staff and elders have participated in deciding how their neighborhoods should be decorated.
- ∞ ***“I feel well cared for by a caring group of people.” – Resident Rehab Studios.***

∞ *“The reputation of WTC is that it’s the best in Columbus. I agree.” – Resident Rehab Studios.*

4) A relatively flat organizational structure with the resident at the top of the organizational chart is prioritized (allowing for effective communication among and between inter-disciplinary teams and residents).

∞ Westminster utilizes Learning Circles as a communication tool with staff and residents. This has been a particularly effective tool in neighborhood meetings. One meeting is affectionately named, “Gabbing on Gladshire.”

∞ Westminster maintains consistent assignment of all staff in neighborhoods and the Pathway Home.

∞ Activities have been redesigned to meet the needs, requests and interests of elders.

5) Staff-resident interaction is a priority and staff “know” residents.

∞ A simple ice cream machine in the lobby allows staff to visit with elders. *“Anyone can go and get ice cream at anytime, it’s free and open, and there are no parameters. I’ve witnessed so many exciting interactions. Elders and staff just laugh and talk and share life.” - Westminster staff member.*

∞ In interviews, residents overwhelmingly respond that Westminster is a “home” with “family.” *“This is what I need to do at this point in my life, so it’s nice that it’s like a 2nd home.” - Resident of the Health Center.*

∞ *“When I think of Westminster, I think of the warmness of the people.” - Resident of the Pathway Home.*

Quality of Care Impact



Early to Mid-Implementation Signs of Quality of Care Impact: In real world implementation, quality of life impact will likely be evident before formal quality of care indicators reveal significant change. However, residents may rate clinical care higher (due to improvements in their overall experience). In addition, as the quality indicator most correlated with person-directed principles and care, use of restraints should decline. Weight loss and time in a bed or chair are subsequent indicators to follow, but these may not be evident until 2+ years implementation. Of course, the level of clinical improvement depends predominantly on the organization's performance pre-implementation as well as the support of clinical leadership (Medical Directors and Directors of Nursing) for person-directed care.

Quality of Care Impact Quantitative Findings

- ∞ As noted in the above graph, survey results for clinical care from residents of short-stay rehab are particularly high (on a 4 point scale). 100% of residents for the survey period rated the statement, "I was treated with dignity" a 4.0.
- ∞ In the Pathway Home, staff observe combative or depressed behaviors of residents to be decreasing and engagement to be increasing.
- ∞ In the Pathway Home, staffing ratios far exceed Ohio's staffing regulations with 1 Nurse to 27 elders and 1 care partner to 5 elders.
- ∞ The percent of long-stay residents who were physically restrained while in skilled care declined from 4% in 2008 to 1% in 2009 (4% below the national average).

Quality of Care Impact - Qualitative Findings

1) Create an inclusive community and "home" for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus.

- ∞ At the Pathway Home, the Activities Director created a "The Pleasure of Your Visit" notebook in which each elder has a page which describes activities that they enjoy. The book is intended as a resource for family members and outside visitors to help them be more interactive with elders during their visits.
- ∞ The Pathway Home has "Wii Wednesdays" and invites residents from other areas of the community to come into the home and participate.

2) Work is organized around maintaining resident's autonomy and preferences with inclusive language supporting residents to be "known" as individuals instead of medical conditions.

- ∞ At Care Partner Team Meetings in the Pathway Home, staff share ideas for assisting residents and maintaining a person-directed focus based on individual resident's preferences and concerns.
- ∞ *"They are in their own home, excited for their own choices, they can smell food cooking and do what they want. For us, it is knowing that we are making a big difference in their daily lives." - Pathway Home Care Partner on the benefits of the environment.*
- ∞ *"I worked in independent living for awhile, and I could see how different it was for those residents. For me, it's about bringing that same respect back here and helping these residents be as independent as possible." - Pathway Home Care Partner.*

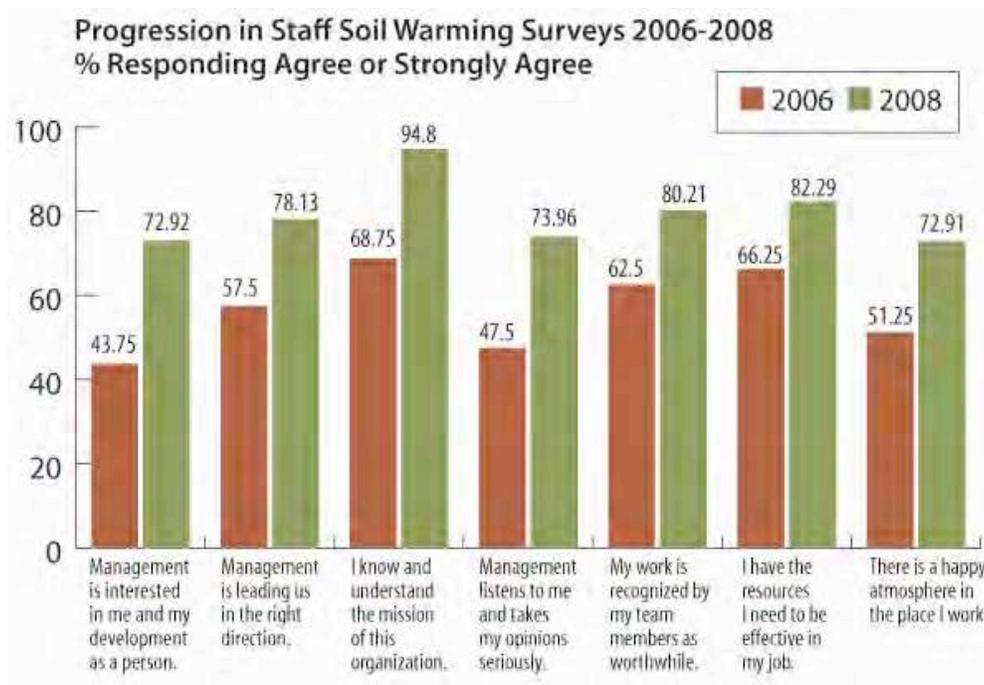
3) *Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization.*

- ∞ A clinical representative joins each weekly Care Partner Team Meeting at the Pathway Home. Residents' clinical issues are discussed and care partners share any concerns or observations.
- ∞ Weekly team meetings at the Pathway Home also focus on a clinical topic of discussion (e.g. improving nail care) for staff and resident input, innovation and problem-solving.
- ∞ *"We can't do it as individuals. We can stir up the pot, but it takes more than one person to keep it rolling." - Pathway Home Care Partner.*

4) *A relatively flat organizational structure with the resident at the top of the organizational chart is prioritized (allowing for effective communication among and between inter-disciplinary teams and residents).*

- ∞ Residents attend weekly Care Partner Team Meetings in the Pathway Home and can give input. For example, a care partner expressed concern over the position of a resident's TV, suggesting that it might be too hard for her to see. The resident was present at the meeting and stated that she was fine with her room arrangement. Thus, the problem was solved at the source.
- ∞ *"Our opinions matter here. They [leadership] want the home to reflect our style. It's more empowering and the decision-making is closer to us and the residents." - Pathway Home Care Partner.*

Staffing Impact



Early to Mid-Implementation Signs of Staffing Impact: Increased levels of staff satisfaction formally (surveys) and informally (verbally to peers and leadership team); Active understanding of culture change and person-directed principles by the majority of staff; Formal recognition of employees for excellence in person-directed care; Self-motivation, critical analysis, and problem-solving by front-line staff to incorporate person-directed principles.

Staff Impact Quantitative Findings

- ∞ Culture change growth has been exponential over the past few years as evidenced by increased employee satisfaction with over a 90% acceptance of culture change by employees.
- ∞ “Soil Warming” surveys indicate significant longitudinal increases from 2006 to 2008 in employees responding “Strongly Agree” or “Agree” to the following key culture change statements (see above graph):
 1. Management is interested in me and my development as a person.
 2. Management is leading us in the right direction.
 3. I know and understand the mission of this organization.
 4. Management listens to me and takes my opinions seriously.
 5. My work is recognized by my team members as worthwhile.

- 6. I have the resources I need to be effective in my job.
- 7. There is a happy atmosphere in the place I work.
- ∞ The interest of employees to take a more active role is evidenced by the increase in the number of line participants in the Eden associate training. In 2002, Westminster went from 5 certified Eden associates to over 60 associates in 2009.
- ∞ Annualized staff turnover for the entire organization decreased by 9.4% from fiscal years 2007 to 2008.
- ∞ Internal surveys indicate an 18.7% increase in employee understanding of culture change.

Staff Impact Qualitative Findings

1) *Create an inclusive community for staff that is constantly communicating and reinforcing a resident-directed focus through formal and informal educational opportunities and relationship building.*

- ∞ Westminster-Thurber won the 2008 AAHSA “Excellence in the Workplace Award” recognizing organizations that demonstrate effectiveness in fostering and advancing a healthy workplace culture.
- ∞ Westminster-Thurber hosted the 2008 International Eden Conference in Columbus, Ohio. Employees volunteered and donated their time to plan and staff the event.
- ∞ *“We all have to be a supporter of culture change and to help our community grow. That means being innovative and an out of the box thinker.” - Westminster staff member.*

2) *Through a flat organizational structure, employees feel empowered to help control quality, waste, and problem-solve throughout the community.*

- ∞ Leadership consults front-line staff for recommendations and input on new processes and systems. *“It’s revolutionary. It does take longer. It’s not easy to make it happen that way. But, the bottom line is the result is so much better, because we get it right the first time. We have employee buy-in right off the bat. How did we miss that for all of these years?” - Human Resources staff member.*
- ∞ *“We are a family, clicking on all cylinders. Ok, not all the time, just like a family. But, for the most part we are really clicking along. We say what we need to say, we talk it through and we move on.” - Westminster staff member.*

- ∞ On employee opinion surveys, employees overwhelmingly answer the question “Why do you stay at Westminster?” with reference to the family and community developed within the organization.

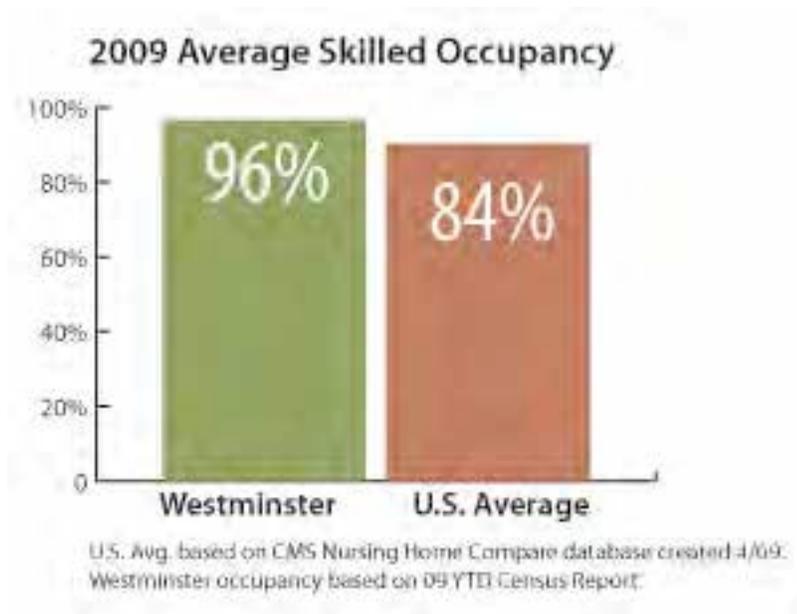
3) *Leverage the value-added potential of inter-disciplinary, cross-trained teams throughout organizational structure to take advantage of synergies in the organization.*

- ∞ Staff hold bi-weekly meetings where all associates come together to discuss creative and innovative ideas on how things can change and what steps are needed to accomplish it.
- ∞ *“I’ve seen the accountability piece of people knowing what we are doing here. We’ve learned the value of high involvement. You’ve just got to be involved with the process.” - Member of Leadership Team.*
- ∞ *“I finally see teams working together much more now. There is less friction all the way around.” - Westminster staff member.*

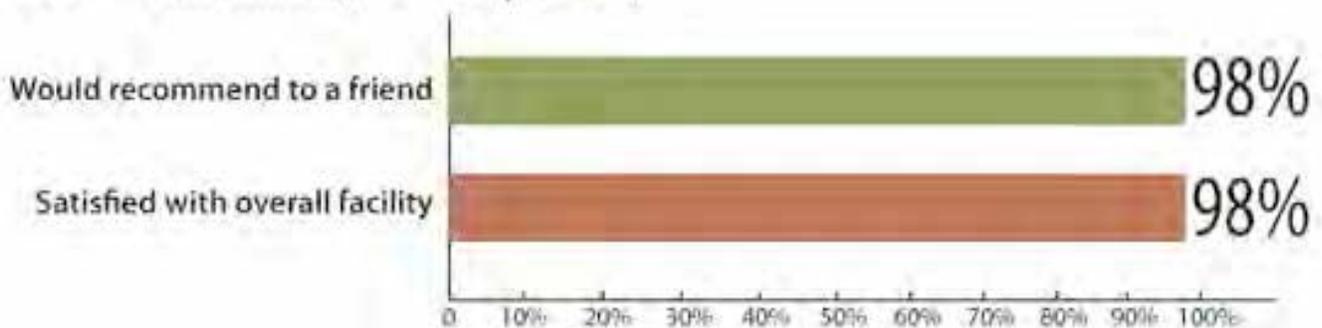
4) *Leadership actively pursues engagement and supportive strategies with staff.*

- ∞ *“I marvel at the communication in the learning circles. I love watching and listening to staff learn from each other and express themselves through active communication.” – Steve LeMoine, Executive Director.*
- ∞ *“I dropped the title of Manager and chose Coordinator instead. As far as I’m concerned, it describes more of what I do now.” – Member of Leadership Team.*
- ∞ *“We know what happens in the lives of our staff, and we talk to them on a personal level. That’s meaningful to people.” - Member of Leadership Team.*
- ∞ *“We write personal notes to each of our 300 employees in birthday cards, and many employees are shocked. Some even tell us that they haven’t received birthday cards or thank you notes before, so we know that it makes a difference.” - Member of Leadership Team.*

Organizational Impact



Overall Satisfaction (Short-Stay Rehab)



Early to Mid-Implementation Signs of Organizational Impact: Increased levels of occupancy; Reduction in the use of agency staff; increases to operating margins; Waitlists for residents; Reduction in turnover of leadership team; Reduction in turnover of front-line staff (may be negligible or slight until 2+ years post full implementation efforts); Strengthening of outside community support and volunteers.

Organizational Impact Findings - Organizational impact in case study findings is defined as impact in quality and/or staffing impact that increases revenue and/or decreases costs for the organization.

- ∞ The above average occupancy graph illustrates the organizational advantages of reputation and quality impact. Even at an extremely conservative scenario of

\$50,000 total yearly revenue per resident, Westminster-Thurber still generates \$600,000 in additional revenue over the national average (100 bed assumption).

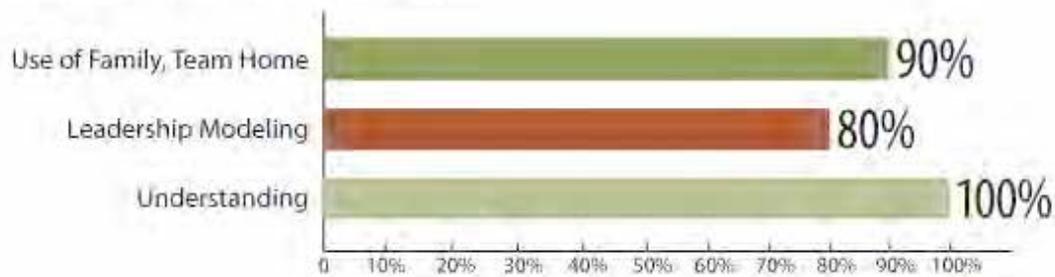
- ∞ Rehab studios have embraced culture change and garnered an impressive presence in the community. Admissions increased by 62% from 2005 to 2008. This is further illustrated by the above graph indicating that 98% of residents would recommend Westminster to a friend and are satisfied with the overall environment.
- ∞ Annualized staff turnover for the entire organization decreased by 9.4% from fiscal years 2007 to 2008.
- ∞ Westminster reduced agency staff by 50% a year in 2007 & 2008.
- ∞ Despite challenges, one year post-implementation the Pathway Home is Westminster-Thurber's most profitable operational area generating positive operating margins. Self-scheduling of staff has reduced use of agency personnel and the Pathway Home already has a lengthy waitlist for residents.

Case study findings also revealed additional examples of quality improvements that lead to cost efficiencies.

- ∞ Westminster's decision to educate the entire staff (labor costs) incurred unbudgeted expenses for training, which were absorbed in the operational budget. Resources for educational materials (books, supplies, etc.) came out of each department's training lines.
- ∞ Each team member gave sacrificially of their time to achieve culture change objectives. The sacrifice came through staff often staying late or taking work home. The non-monetary costs were in the commitment of Westminster staff, who realized the value and need for change, where the ultimate outcome would be to obtain a work environment built on establishing relationships, honoring each other, and working in teams to overcome obstacles.
- ∞ With this exception, all others costs were covered by donations or gifts from interested residents and family members who spoke of the noted changes they could see in management and staff.

Additional Case Study Findings

Results from Case Study Interviews



Case study interviews exhibit a high level of congruence between stated goals of leadership and the support for those goals from residents, staff, Board and community members. Examples of these results are discussed below and illustrated in the above graph:

- ∞ 80% of staff and 100% of residents interviewed utilized words that describe Westminster as a cohesive unit (e.g. family, team, home).
- ∞ A consistent finding in the Westminster case study was the importance that leaders place on modeling person-directed care practice for staff and elders. In interviews, 80% of the leadership team used the word “modeling” as the predominant method of mentoring staff in culture change.
- ∞ As stated previously, 100% of staff and residents demonstrated understanding and knowledge of culture change principles.

Corporate Support

One of Westminster’s leadership team members was asked to train all the staff development educators at the corporate office. Westminster has now shared the curriculum with the entire OPRS organization and has made it available on the intranet for use at each specific community. The leadership team has been asked to travel to other communities to train the trainers at each site.

Associations

In September 2007, World Makers training was presented at the Annual AOPHA Conference. In February 2008, several colleagues from the leadership team presented as keynote speakers for the Ohio Directors of Nursing Association, sharing the results of their culture journey and the impact of this training.

Community:

- ∞ Westminster sponsors many and various speakers to help improve the quality of life for elders (Community Involvement) as well as opening the World Makers training program to the greater community. Word of the training spread throughout Ohio and Westminster has received many inquiries regarding the training classes. Past participants have included elders from all levels of care, local university educators, family members, board members, and employees from others communities within the corporation.
- ∞ Westminster identifies local and state representatives and makes arrangements for residents to be exposed to them, both on campus and in the community.
- ∞ Westminster hosts political forums that address culture change. When issues are made at the local and state level, Westminster makes contact with legislators and invites officials to the campus to witness the needed changes or processes that speak to the importance of culture change and revision of policies.
- ∞ Westminster has developed a speakers bureau to speak on culture change.

Challenges and Lessons Learned



**Executive Director,
Steve LeMoine,
with elders at a
drumming circle.**

Clinical leadership is a crucial component of success. Westminster has spent many months searching for a Director of Nursing that “gets” culture change to provide leadership on person-directed care to the clinical team. Without this component, it has been difficult to more fully implement culture change in the Health Center environment.

- ∞ **Change doesn’t happen overnight and leadership must stay the course.** Many aspects of culture change and a high involvement environment take time for leaders

to learn and incorporate. It is often tempting to return to old management styles to fight the day-to-day fires of operations.

- ◇ *“On our leadership team, we have people who are much further along in their own journeys than others. We work in an environment that has been very top down for a long time. It’s a struggle even for me, because it seems quicker to make decisions in a room with 3 people. That buy-in and high involvement has been the biggest lesson. When I do it right, it goes well and it’s obviously the right thing to do. It saves you time in the long run.” - Member of Leadership Team.*
- ◇ *“There are days when we wonder, are we making a difference? The answer has always been yes, but you have to work through any discouragement.” - Member of Leadership Team.*
- ∞ Your organization may have changed, but the rest of the world hasn’t. Part of the process is taking additional time to educate partners, surveyors, family members and existing employees rooted in institutional practice.
 - ◇ *“We encourage family members to also work directly with Care Partners, so those closest to the residents are part of the solution. But, that’s not always what families want to hear. They want someone in charge to make directives.” - Member of Leadership Team.*
 - ◇ *“There have been employees that just don’t get it. We spend so much time coaching, counseling and educating, but you can’t let those people linger if they don’t fit with the changes.” - Member of Leadership Team.*
 - ◇ *“What would I do differently? We started the Pathway Home without getting enough people onboard first. It was such a big undertaking. Staff from other parts of the community didn’t always understand and families were occasionally confused. We’ve had to go back and address that [educate stakeholders not involved from the beginning] and it takes time.” - Member of Leadership Team.*
- ∞ Jobs change when an organization transforms to a resident-directed focus. This means that the underlying systems and certain logistics of the organization must change to support the implementation process. This also requires sensitivity to staff while also empowering staff to embrace critical-thinking and problem-solving.
 - ∞ In the Pathway Home, certain concepts have taken months or nearly a year to fully incorporate. For example, care partners had concerns with replacing everyday scrubs with “regular” street clothes. Reasons are financial (purchasing new clothes can be difficult financially for care partners), logistical (the pockets in scrub tops provided extra space for care items), and operational (direct care staff in the Health

Center still wear uniforms). Ultimately, scrub pants were accepted into the dress code, "aprons" solved the problem of extra pockets for storage, and Neighborhood Coordinators are using changes in the Pathway Home to educate Health Center staff about future implementation efforts in their areas.

- ∞ Self-directed teams are a new concept for all involved and require additional guidance and support to function. This is especially true of communication regarding the division of work between day and evening workers. Who will mop the floors? Who will fold the laundry? Weekly team meetings help to raise the level of communication for these issues.

- ∞ **Implementation is an investment and, although relationships and engagement are tangible and observable outcomes for staff and residents, return on investment is difficult to measure in early- to mid-implementation stages.** While the Pathway Home is one of the soundest operational areas in terms of finance and budget, it did take many months for it to become profitable. Organizations should be aware of investment and forecast predicted returns for a 2-5 year timeframe. [Note: For guidance on potential outcomes in implementation, visit [Quality of Life Impact](#), [Quality of Care Impact](#), and [Staffing Impact](#).]

 - ◇ *"The budget process is still very corporate driven, and the bottom line is, if we don't manage our budget, none of us have jobs. No money, no mission." - Member of Leadership Team.*
 - ◇ *"We struggle with: how do we make the best payroll labor budget, and live within our means, and still have all of this awesome programming and all of these great educational opportunities?" - Member of Leadership Team.*
 - ◇ *"It's hard to measure how many times people were friendly to you today. You have to be aware of other expectations to measure going in." - Westminster staff member.*

Summary

An Author's Note on Animals in the Community: All at Westminster-Thurber are quick to tell visitors that plants and animals are not the reason that this Eden community works. It's *relationships* that form the foundation for success.

I'm the first to agree, but Westminster-Thurber is a bit unique. They don't just honor elder "people" in the community. They also honor quite a few "elder" animals. Without doubt, the way that these animals are treated exemplifies much of culture change, and I learned a great deal about community by watching the relationships of the animals at Westminster-Thurber.



On the importance of meaningful activities - It helps that the Activities Director, Jamie, is a bit of a Dr. Dolittle. All of the animals love her and she "knows" them. Shelby, the 13-year-old, is Jamie's assistant and spends lots of activity time with the elders. She just recently celebrated her birthday at a party with friends.

Several of the animals in the community were rescued. Through activities with elders, they "adopt" a primary person and move in with their new friend. Story after story proved to me that these animals "chose" their new homes.

Personal schedules based on preferences - During the case study, I wondered about a "day-in-the-life" of 12-year-old Trudy, the beagle. As it turns out, Trudy's bed is in the Activities office. Jamie keeps it dark so that Trudy can rest until her desired wake-up time (usually in the afternoon). Trudy then typically makes her way to Executive Director, Steve LeMoine's office, where another bed is located right underneath his desk. Steve feeds her "the best low-fat treats" and she sleeps and (very audibly) snores away much of the afternoon.

One day, I followed Trudy on a jaunt just to see what adventures awaited a beagle with full access to a CCRC. She visited two dining rooms looking for scraps, greeted many an elder with requests for goodies, and ended up under a resident's chair (the resident



was conveniently eating a big sandwich with lots of potential for crumbs). In short, Trudy spends her days doing just as she pleases, and everyone in the community respects her schedule and time!

An inclusive community and “home” - Perhaps this is best exemplified by the late Valentino. As evidenced by his name, Valentino was a charismatic rabbit who loved the ladies. I was there the day his babies were born and watched his reaction to the little puffs of fur. When the babies were old enough, we all had the opportunity to hold them. Elders, staff, and children - we all had the same thrill of cradling a new little life. Sadly, I recently found out that Valentino had died, and tears well up in the eyes of those who loved him at the mention of his name.



Fortunately, many of his babies were adopted by members of the community, so there are constant reminders of this unique character and friend.

In summary, through the animals of Westminster-Thurber, I learned the simplest of lessons:

- **A community is a place where they “get” you. You can spend time with your friends, and you can celebrate life. And, no matter how old you are, nothing is better than a baby bunny.**
- **A community is a place where you can do what you like, snore as loud as you want, and spend lots of time looking for the perfect sandwich.**
- **A community is a place where you are loved. Communities celebrate new life and mourn loss, because everyone is unique and special. Every life makes a mark and contributes to the community. It takes everyone to create a “home.”**

Teresian House - A Case for Sustainability



Executive Summary

Motivation for Change: A change of leadership and an organizational and strategic assessment revealed opportunities to enhance quality of life and care for residents.

Goal of Change: To fulfill the Sisters' commitment "to treat people in their charge with love, respect, and concern, employing a wholistic approach to care."

Assessment Steps: Surveyed residents, families and staff; Evaluated strengths and weaknesses of multiple aspects of the organization; Redefined mission and goals; Focused on areas of concern to create solutions; Created an organizational structure with the resident at the center.

PRE-TRANSFORMATION	POST-TRANSFORMATION
Five floors of skilled nursing units with many semi-private rooms.	Fourteen 12 to 20 person skilled neighborhoods with 100% private rooms and private baths. Carmel Garden for 50 residents suffering from Alzheimer's dementia.
A large centrally located dining space and separation of living and gathering spaces.	Dining areas in each neighborhood. Staff and resident workspaces are no longer segregated. All spaces in the community are designed to promote residence independence.
Large, centrally located nurses' stations	Cabinets incorporated into the living space now serve as work spaces for staff.
Lack of autonomy for residents in activities and schedule. Staff were task driven and organized work around delivery of care and staff preferences.	Activities are meaningful. A Resident Centered Care program helps residents to maintain personal schedules based on preferences. Resident choice is documented in the care plan. Staff is trained to identify physical, psychological, and emotional conditions that require special attention. Medical care and therapy is one-on-one for the resident to ensure individualized treatments and results.
Staff-resident interaction not a priority. Centralized departments.	Consistent assignment of residents with care assistants. Staff are cross-trained and able to help residents with multiple requests.

Examples of “AH HA” Moments: 1) Change doesn't happen overnight; 2) Educating surveyors can be challenging at first; 3) Initial turnover should be expected at the beginning; 4) Leadership is crucial.

Impact on Quality: Consistently high Resident Satisfaction Assessments; Full census; 0% use of restraints; 0% use of agency staff; 100% of staff and 100% of residents interviewed utilized words that describe Teresian House as a cohesive unit (e.g. family, team, home).

Impact on Business: Turnover decrease by nearly 20%; 40% of staff have been with Teresian House for 5 or more years; 100% of leadership staff have been with Teresian House for 10+ years; Teresian House experienced a 30% increase in admissions applications 1 year post implementation and a 45% increase by Year 4; Positive operating margins; Even at an extremely conservative scenario of \$50,000 total yearly revenue per resident, Teresian House still generates \$750,000 in additional revenue over the national average (100 bed assumption) and \$350,000 in additional revenue over the New York average (based on occupancy).

Organization



“I learned strongly that residents should make their own decisions about everything and dance to their own tune.” - Sister Pauline

Type: Non-for-profit organization served by the Carmelite Sisters for the Aged and Infirm
Administrator: Sister Pauline Brecanier
Teresian House is a modern, innovative skilled nursing home located in Albany, New York. The team at Teresian House is committed to a philosophy of resident centered living that “embraces the physical, spiritual, social, psychological and emotional needs of all who enter Teresian House.” To achieve a sustained commitment, the organization has continued to evolve through ongoing innovations in staffing, physical environment, technology, activities, and end of life care. Teresian House offers a variety of residential and community services including:

- ∞ 10 skilled neighborhoods (20 residents each);
- ∞ 4 Mount Carmel neighborhoods (12-13 residents each) • Carmel Garden for 50 residents suffering from Alzheimer’s dementia;
- ∞ Respite care (2 rooms);

∞ Licensed intergenerational childcare center for 65 children.

Teresian House employs over 400 full- and part-time staff. Medicaid (83%) and Private Pay (17%) are the primary payment sources for residential care neighborhoods.

History and Implementation



The Carmelite Sisters for the Aged and Infirm, founded by Mother Mary Angeline Teresa McCrory, opened Teresian House in 1974. Although the concept of resident centered care is core to the Sisters' commitment "to treat people in their charge with love, respect, and concern, employing a wholistic approach to care," the initial environment was not always supportive of this vision. One staff member remembered it as **"a sterile environment with no warmth. It was a typical health related facility. In the midst of the 70's, there was orange, yellow and green linoleum. We did have a beautiful large dining room, but there was just the one. It was difficult because residents had to eat at the same time. There was a safety issue, because residents were all coming down in the elevators at the same time and lining up inside and outside the dining room to be served. The lobby reminded me of an airline terminal."**

In 1987, Sister Pauline joined Teresian House as Administrator. Under Sister Pauline's leadership, in the early-1990's, Teresian House underwent an organizational and strategic assessment. One outcome of this process was a Dementia Program Pilot targeting the improvement of quality of life for residents with dementia. Interventions included providing smaller dining environments and staff sensitivity training. These efforts

culminated in the mid-1990's with the addition of a newly constructed, adjoining dementia care area for residents called Carmel Garden.

In 1995, Teresian House also began a Resident Centered Care program and Resident Centered End of Life care to target collaborative resident centered care for the entire home. Environmental transformations began in 1997 to remodel the existing structure to 100% private rooms clustered in 10 neighborhoods of 20 residents staffed by a resident centered care team.

Common System and Environment Themes Prior to Implementation

Common Themes in Teresian House Processes and Systems Prior to Implementation

Traditional top-down hierarchical structure;

Lack of autonomy for residents in dining or choice of meals;

Lack of autonomy for residents in activities;

Lack of autonomy for residents in bathing schedules;

Nursing unit managers led care by floor;

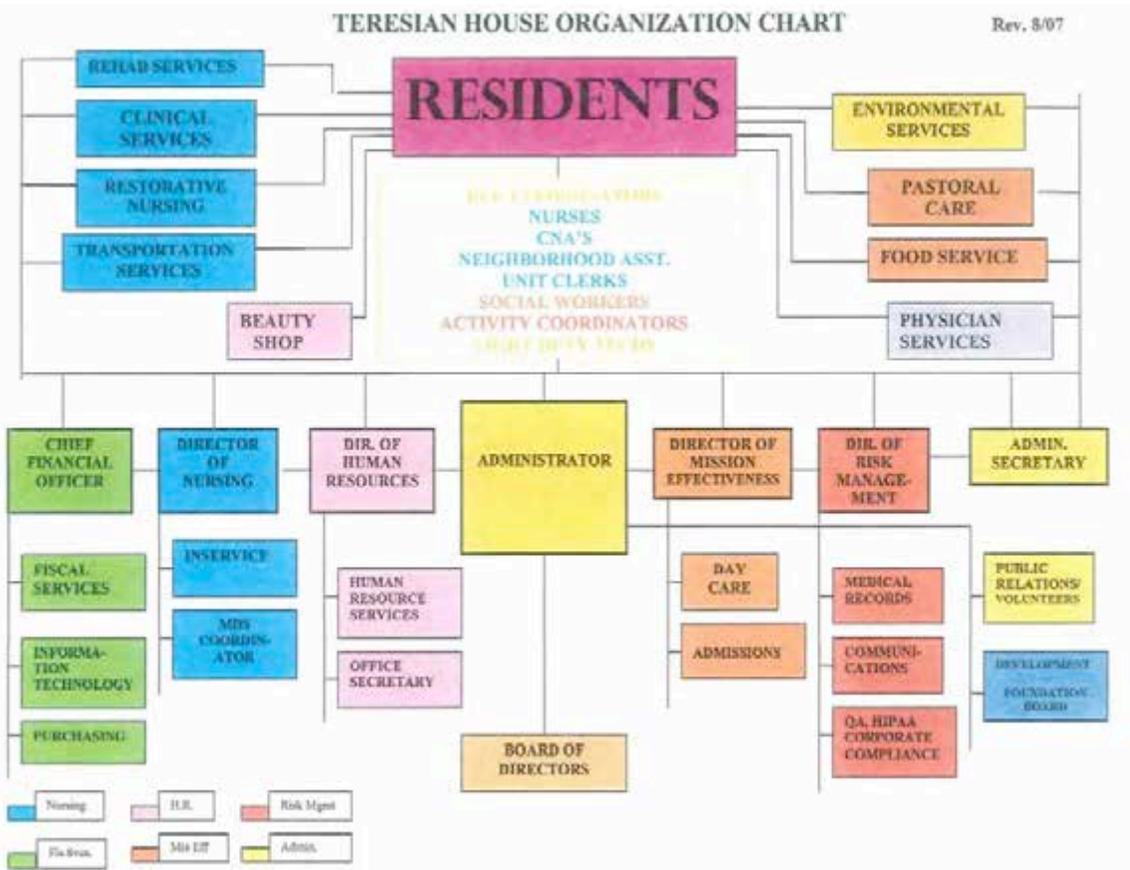
Some residents were restrained;

Staff were task driven and organized work around delivery of care and staff preferences.

Common Themes in Teresian House Physical Environment Prior to Implementation

Traditional institutional sterile environment;
 Hospital-like corridors;
 Private and semi-private rooms;
 Small chapel;
 Single large dining room;
 Overhead paging;
 Separation of living and gathering spaces;
 Large, centrally located nurses' stations.

Strategies for Planning



Tips for early planning:

- ∞ Survey residents, families and staff - In 1991, Teresian House conducted surveys of residents, families and staff. Many transformations were based on resulting comments and assessments.
- ∞ Evaluate strengths and weaknesses of multiple aspects of the organization - Teresian House evaluated the physical environment, staff and resident policies, care practices, and social interactions.
- ∞ Define or redefine mission and goals - Sister Pauline and her staff wrote mission statements and created goals to support personal and organizational missions.
- ∞ Focus on areas of concern and create solutions - A steering committee studied dementia care and created the Dementia Program Pilot.
- ∞ When embarking on change, involve all stakeholders - Teresian House held regular meetings with staff, families and residents to discuss environmental changes.
- ∞ Create an organizational structure with the resident at the center (see above Teresian House Organizational chart).

Core Values



- ∞ Promote dignity, personal worth, respect and kindness to people.
- ∞ Be responsive and supportive to the residents and families in dealing with their emotional and physical changes and needs.
- ∞ Provide wholistic care through **team effort and support that embraces the physical, spiritual, social, psychological and emotional needs** to all who enter Teresian House.
- ∞ Provide hope, healing and comfort in the autumn years of their lives.
- ∞ Enhance the quality of life for each resident by **providing optimal service in a homelike atmosphere.**
- ∞ Practice ethical standards consistent with the values and principles inherent in the teaching of the medical and moral directives of the Roman Catholic Church.
- ∞ Recognize the **value of the community as our partner in educating for cultural change.**
- ∞ Recognize that life is precious and should be preserved whenever possible and that death is the prelude to eternal life.

Resident Systems Transformations

Resident systems at Teresian House include the following transformations that provide a resident centered focus:

- 1) Create an inclusive community and “home” for residents, families, and the outside community that is constantly communicating and reinforcing resident choice.*
- 2) Work is organized around maintaining resident’s autonomy and preferences.*
- 3) Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization.*
- 4) A relatively flat organizational structure with the resident at the top of the organizational chart is prioritized (allowing for effective communication among and between inter-disciplinary teams and residents).*
- 5) Staff-resident interaction is a priority and staff “know” residents.*

Below are examples of resident systems at Teresian House that affect positive resident and family outcomes.

Admissions and Move-In

- ∞ Residents and families view the "Realistic Expectations" video (excerpt above) when touring the building or beginning the application process. The video provides a straightforward, honest account of potential difficulties during move-in and transition including a smaller living space, anxiety associated with the change, and shared congregate spaces.
- ∞ Admissions staff greet the resident to provide a familiar face during the move-in process.
- ∞ A welcome card and plant are placed in the resident's room by the Social Worker.
- ∞ The resident is also greeted by the Geriatric Technician (direct-care worker), Registered Nurse and Social Worker from their care team. They discuss sleeping, eating and bathing preferences of the resident to establish a plan for a daily routine.
- ∞ Staff assist the resident with move-in and set-up any equipment. Wi-fi is available in each room for computer use.
- ∞ The Social Worker and Activities Coordinator work with the resident and family to develop a comprehensive social history of the resident's life. This history is shared with the rest of the collaborative team.
- ∞ The GT calls family the day of move-in and the following morning to report on the resident's adjustment and to begin to establish a relationship with the family.

Resident Centered Living

- ∞ Residents work with a Resident Care Team that includes a Resident Care Coordinator (RCC), a Registered Nurse, Geriatric Technician, Social Worker, Activities Coordinator, Dietary, Housekeeping, Therapy, Pastoral Care, Maintenance and others.
- ∞ Consistent assignment of staff allows residents to develop relationships with those caring for their daily needs. "Before Sister Pauline, residents used to get up at 5:30 am. Now, that is gone. They get up leisurely when they want to." - Registered Nurse
- ∞ Pastoral care is established for residents of all faiths. Roman Catholic Mass is provided each day in the Infant of Prague Chapel and televised to residents that

wish to view it in their rooms. Protestant and Jewish services are also provided for residents of other faiths.

- ∞ Information technology is available to residents through Wi-fi access in all rooms, training and technical support from the IT department, and webcams for residents to “cyber” connect with friends and families across the country.
- ∞ Activities at Teresian House are extensive. In House Special Events also involve home-wide participation from residents, families and staff. Events include the Annual Wheelchair Bowl, St. Patrick’s Day Pub Night, Dancing with the Residents, the Halloween Spooktacular, and a version of American Idol.
- ∞ Staff is trained to identify physical, psychological, and emotional conditions that require special attention. Medical care and therapy is one-on-one for the resident to ensure individualized treatments and results. Plans are underway to minimize the need for residents to travel to hospitals including dialysis treatments, digitized medical records and portable, interactive computer systems to transmit diagnostic data.

Food and Enhanced Dining

- ∞ Food is available to residents 24-hours a day in neighborhood kitchens.
- ∞ Conversations between staff and residents at mealtimes are encouraged. Staff are provided information about the resident to support meaningful conversation. In addition, the Director of Rehabilitation created a notebook with “conversation starters revolving around foods, meals and cooking.”
- ∞ Tables have tablecloths, glass dishes, and full table settings. Adaptive equipment such as a built up spoon to reduce tremors is used extensively to promote resident independence.
- ∞ Condiments are offered for every meal including pureed food. “Would you eat a hamburger without any condiments? The same is true for a pureed hamburger. Lack of ketchup or the resident’s favorite condiments will affect the taste and ultimately their dining experience.” - Trainer for Dining Enhancement
- ∞ Cloth napkins are used instead of bibs.
- ∞ Pureed foods are “slurried” to maintain appeal.
- ∞ Music, lighting and atmosphere are all designed to promote a high quality dining experience.
- ∞ Kitchen cleanup occurs only after residents have finished their meals.
- ∞ Residents view their own meal tickets to establish accuracy.

Resident Centered End of Life Care - End of Life Care is highlighted at the end of this case study.

Organizational Systems Transformations

Organizational systems at Teresian House include the following transformations that provide a resident centered focus:

- 1) *Creating an inclusive community for staff that is constantly communicating and reinforcing a resident centered focus through formal and informal educational opportunities and relationship building.*
- 2) *Through a flat organizational structure, employees feel empowered to help control quality, waste, and problem-solve throughout the community.*
- 3) *Leveraging the value-added potential of inter-disciplinary, cross-trained teams throughout the organizational structure to take advantage of synergies in the organization.*
- 4) *Leadership actively pursues engagement and supportive strategies with staff.*
- 5) *Teresian House utilizes data, process-maps and problem-solving approaches to support staff and resident-focused transformation.*

Below are examples of organizational systems at Teresian House that affect positive organizational and staffing outcomes.

Staff Support

- ∞ Staff are introduced to culture change during the interview process. Potential staff view the video “Teresian House - Staff Make the Difference” while completing the application (excerpt above). The video candidly describes Teresian House expectations including supporting culture change and performing global duties.
- ∞ An Employee Emergency Assistance Loan Program is available for staff when financial emergencies arise. Loans are repaid, interest free, via biweekly deductions from payroll. “One employee blew the transmission in his car. Without the Loan Assistance Program, he would have lost transportation to work” - Teresian House staff member
- ∞ The Employee Community Assistance Counseling program helps staff to access government programs such as WIC or HEAP. The program coordinator is available to identify eligibility and to assist staff in completing applications for aid.

- ∞ The Employee Counseling Program provides a licensed therapist to meet with staff for counseling.
- ∞ Staff milestones of 5+ years of service are recognized and celebrated at an annual dinner.
- ∞ Tuition reimbursement and scholarships are available for staff to obtain additional degrees and/or certification.
- ∞ Staff have medical insurance and paid time off for vacation.
- ∞ Employees have the option to cash out personal leave before the Christmas Holiday. Staff can also donate this time to other employees unable to work due to sickness or family emergency.
- ∞ Numerous other benefits are offered to Teresian House staff including a free turkey for every staff member on Thanksgiving.

Resident Centered Living

- ∞ Training is provided to assist staff in performing cross-trained duties such as dining assistance and dementia sensitivity. Sister Pauline uses role-reversal techniques to literally put aides in resident situations from being wheelchair bound to being bedridden or to needing assistance with meals or bathing. During the case study, housekeeping staff were trained on assisting residents with dining. Staff began by walking into a dining room and identifying issues that might be distracting from the resident's perspective (e.g. lighting or loud music). Next, each took on a resident's role to simulate the resident's dining experience. Tickets for each staff member explained the role including dietary preferences and any additional requirements (e.g. pureed food). Food was then served incorrectly (e.g. pureed when it shouldn't be, without condiments). Dietary staff played the role of poor servers talking on the phone, forgetting coffee, serving cold food and not offering a choice of beverages. In this training, the housekeeping staff was quite animate in their roles yelling, "Miss, Miss, this is the wrong food and it is cold!" After the exercise, Sister Pauline, other trainers and staff discuss the importance of the dining experience. One trained remarked, "All the things we've seen affect choice, appropriateness, quietness and everything that makes the resident's experience more enjoyable." Staff were also coached on "slurrying" food such as donuts with liquid to soften food for residents with that dietary requirement while maintaining the appeal.

- ∞ Staff are consistently assigned to residents and are part of a Resident Centered Care Team. The team is led by a Resident Care Coordinator (RCC) and includes medical and nursing personnel, geriatric technicians, social workers, housekeepers, dieticians, pastoral care, therapists, activities and volunteers. Members of the care team meet weekly to discuss the resident's preferences and progress.
- ∞ Staff are cross-trained to perform many global duties including cooking, emptying the dishwasher or cleaning. All staff are expected to stop and check on residents if their call light is on.
- ∞ Staff is trained to identify physical, psychological, and emotional conditions that require special attention. Medical care and therapy is one-on-one for the resident to ensure individualized treatments and results. Plans are underway to minimize the need for residents to travel to hospitals including dialysis treatments, digitized medical records and portable, interactive computer systems to transmit diagnostic data.

Physical Environment Transformations



Transformations to the physical environment began in the mid-90s. Changes are ongoing based on needs assessments. Major changes to the physical environment include (but are not limited to) the following:

Constructed a new building, the Bishop Howard H. Hubbard Pavilion, to house Mount Carmel and Carmel Garden.
The Mount Carmel portion of the pavilion on the upper floor is designed as four neighborhoods around two courtyards each with 100% private rooms with private baths, a dining area, kitchen, living rooms and garden rooms.
The Carmel Garden Memory Center on the lower floor is designed similarly with the additional feature of protected areas inside and outside in the courtyards so residents can roam freely.
Remodeled the existing building into ten neighborhoods with 100% private rooms and private baths. Each with a kitchen, dining area and living room.
Bathing and showering rooms were remodeled.
Laundry areas were added on each floor.
Traditional nurses' stations were eliminated. Cabinets incorporated into the living space now serve as work spaces for staff.
Overhead paging was removed and the call station was replaced.
The lobby and chapel were remodeled.
Outdoor spaces were revamped including the addition of resident courtyards and shelters for shade.
Remodeled the main kitchen.
An intergenerational classroom was created in the existing structure.
A "Cyber Cafe" was added for resident computer use.
A state of the art rehabilitation room enhances resident therapies.

Quality of Life



“So eventually the home turned into a home, which is what it should be.” - 20+ year staff member

Early to Mid-Implementation Signs of Quality of Life Impact: Increased levels of resident satisfaction formally (surveys) and informally (verbally to peers and staff); Increased levels of engagement (especially in residents with chronic health conditions or dementia); Emphasis by residents and staff on relationships and community; descriptions of the organization as “home” or “family.”

Quality of Life Quantitative Findings

- ∞ 100% of residents enjoy private rooms. 88% of interviewees in the case study commented that private rooms are one of the most resident centered elements of Teresian House.
- ∞ Teresian House maintains high averages in Resident Satisfaction surveys . On a 2009 survey, only 20 out of 74 items ranked below a 4.0 (out of a 5 point scale), and zero items ranked below a 3.58.
- ∞ Teresian House consistently maintains a close to 100% occupancy rate (to be discussed in more detail in Organizational Impact findings).

- ∞ On a 2007 resident survey, 93% percent of residents responded positively to the question, “Do you feel that you are part of the Teresian House family?”

Quality of Life Impact Qualitative Findings – Engagement of Residents (measured through resident interviews)

Meaningful activities have an impact on the residents’ quality of life. - *“There are so many activities and I always participate. I danced in Dancing with the Residents with my speech pathologist’s husband. He’s only 40 and I’m 80!”*

The elimination of institutional environmental artifacts such as nurses’ stations and semi-private rooms have enhanced the residents’ experiences. - *“When I first moved here, we had to share rooms. My roommate had a different schedule. I love my private room so much more.”*

The emphasis on technology assists residents in maintaining contact with friends and families. - *“All these social activities are not for me. I like to stay in my room and the computer is my thing. The Wi-fi and technical help supports that. My brother is 90 and across the country, but we communicate everyday by e-mail.”*

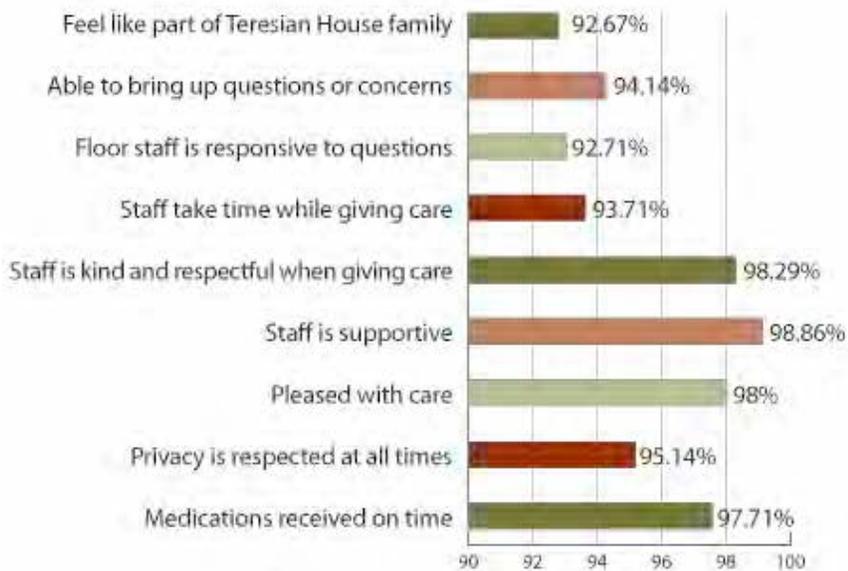
The fact that residents enjoy food from neighborhood kitchens at anytime of the day or night improves dietary intake and their social experiences. - *“We can have whatever we want from the kitchen, so it helps with liking the food. We have families that regularly come in and make family meals in the kitchen for residents. It’s fun.”*

Staff responsiveness to residents has a profound effect on daily life. *“When I first came, I would hear staff in the morning and I like to sleep in. I mentioned it to my RCC and it stopped immediately.”*

A commitment to supporting individualizing personal space is respected. - *“I can have practically whatever I want in my room. They’ve never denied me.”*

Quality of Care Impact

Percentage of Respondents (Residents) Answering Positively



“Sister always said that the resident’s happiness is the most important outcome.” - Resident Care Coordinator

Early to Mid-Implementation Signs of Quality of Care Impact: In real world implementation, quality of life impact will likely be evident before formal quality of care indicators reveal significant change. However, residents may rate clinical care higher (due to improvements in their overall experience). In addition, as the quality indicator most correlated with person-directed principles and care, use of restraints should decline. Improvements in weight loss, falls, agitation, pressure ulcers, and time in a bed or chair are also potential areas of impact. Of course, the level of clinical improvement depends predominantly on the organization’s performance pre-implementation as well as the support of clinical leadership (Medical Directors and Directors of Nursing) for person-directed care.

Quality of Care Impact Quantitative Findings

- ∞ In a 2007 Resident Survey, residents responded positively to questions regarding quality of care (see above). 98% indicated that they were pleased with care. 98.29% agreed that staff were kind and respectful when giving care and 97.71% stated that their medications were received on time.
- ∞ The percent of long-stay residents who were physically restrained while in skilled care in 2009 is 0% (4% below the national average).

- ∞ The percent of long-stay residents who spend most of their time in a bed or chair is 0% (4% below the national average).
- ∞ The percent of long-stay, high risk residents with pressure sores is 7% (4% below the national average).
- ∞ Teresian House operates with 0% agency staff. - *“It’s about the dedication of employees who care for the residents. Agency staff do not have the same level of commitment.” - Registered Nurse*

Quality of Care Impact - Additional Findings

- ∞ Rehabilitation is integrated into activities and daily life - Teresian House’s Rehabilitation Department won the 2009 “Innovation of the Year Award” from the New York Association of Homes and Services for the Aging.
- ∞ Staff view private rooms as supportive of quality of care. - *“The private rooms are so important medically as well. It’s quiet and residents are not interrupted when they sleep and can maintain their daily routines without interruption.” LPN with Teresian House for 20+ years.*
- ∞ *“We try not to send residents out to the hospital. It can be a traumatic experience for them and inconvenient for families. Many times we can do things and give them IVs here.” - Registered Nurse*
- ∞ Innovations in technology are embraced by Teresian House and improve the efficiency and quality of care. - Digitized medical records enhance the accuracy of treatment modalities and link medical providers to improve quality of care. Sister Pauline is also starting a “Tele-Medicine” program so that residents can receive medical treatment without ever leaving the home.
- ∞ Dining has improved weight loss - *“We deal with weight gain more than weight loss. Residents can go get a snack at anytime if they are able. The best thing that happened lately is that they roast meats on the floor a couple times a week – baked chicken – pot roast. Residents get to smell it cooking right on the floor and it’s good for their appetite.” - Resident Care Coordinator*
- ∞ Residents are able to age in place. - *“Before culture change, residents may start at the 6th floor and move down when their health worsened. By the 2nd floor, they were depressed and giving up. Now, we very, very rarely move a resident even if their acuity changes.” - Registered Nurse*
- ∞ Teresian House’s commitment to promoting independence affects health outcomes. - *“Lots of times they will actually improve and become more*

independent when they move in. We've had so many times when residents thought that they needed wheelchairs, but with encouragement and confidence, they are using a walker in no time!" - Teresian House staff member.

- ∞ Teresian House strives to work with residents in slowing the progress of degenerative diseases. - *"Lots of time that work isn't billable, so other homes will not allocate a person to do it. Sister supports it, and I've been able to help a lot of people just by working with them each week." - Director of Rehabilitation*

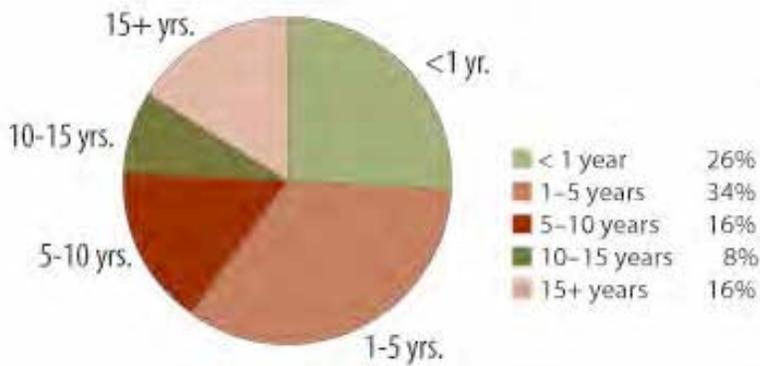
Staffing Impact



I'm going to stay here until I retire. Then, I'm going to live here. They'll give me a room on the 5th floor. I always tell my kids, when the time comes, you can put me in Teresian House. - Staff member

Early to Mid-Implementation Signs of Staffing Impact: Increased levels of staff satisfaction formally (surveys) and informally (verbally to peers and leadership team); Active understanding of culture change and person-directed principles by the majority of staff; Formal recognition of employees for excellence in person-directed care; Self-motivation, critical analysis, and problem-solving by front-line staff to incorporate person-directed principles.

Teresian House Staff Longevity



Staff Impact Quantitative Findings

- ∞ Even with over 400 staff, retention and average years of service are above average. 40% of staff have been with Teresian House for 5 or more years (see above graph) and are on career paths to maintain longevity.
- ∞ Retention of leadership is a key finding. Sister Pauline has been the Administrator with Teresian House for 20+ years and 100% of leadership staff have been with Teresian House for 10+ years.
- ∞ 100% of staff interviewed demonstrated knowledge of culture change principles.
- ∞ 100% of staff interviewed utilized words that describe Teresian House as a cohesive unit (e.g. family, team, home).
- ∞ Overall turnover decreased by nearly 20% from 1998 to 2008.
- ∞ Teresian House reduced agency staff to zero, enhancing internal staff's experience and saving money.

Staff Impact - Additional Findings

- ∞ Rehabilitation is integrated into activities and daily life - Teresian House's Rehabilitation Department won the 2009 "Innovation of the Year Award" from the New York Association of Homes and Services for the Aging. [Click here to learn more about this award-winning rehabilitation team.](#)
- ∞ Many staff members have family members living in Teresian House. Sister Pauline's own mother was a treasured resident for many years.
- ∞ Social Workers are an integral part of the Care Team and help with neighborhood activities such as dining and feeding. - *"They are the eyes and ears for residents, especially those that can't speak for themselves."* - Sister Patricia Brancaccio, Social Workers Coordinator.

- ∞ Staff volunteer their time to participate in resident activities. - *“I volunteer every Sunday with a resident choir.”*
- ∞ Leadership is constantly learning and striving to improve. - Teresian House leadership undergoes annual 360 evaluations from staff to self-evaluate and create goals for the coming year. *“I learned from the comments that I needed to be more visible to residents and staff. They missed me and the comments made me aware of that.” - Sister Pauline*
- ∞ Staff are invested in residents and families - *“The residents are my extended family. I like being able to extend my friendship to the family members as well to let them know that we are here to care and that we view it as our home too.” - License Practitioner Nurse*
- ∞ Staff are invested in each other. - *“We have such a good camaraderie and community. We’ve had weddings, baptisms, and my son was confirmed here. Everyone gets involved with each other. During hardships we all chip in and we donate our time.” - Resident Care Coordinator*
- ∞ Sister Pauline encourages open communication. - *“People are so surprised that we are so open with our Administrator and each other.”- Resident Care Coordinator*

This letter was written by CNA Carol Tallman following her completion of the Sensitivity Training Program with Sister Pauline

Yes Mrs. Jones. I’m here to answer your call bell, bathe you, dress you, undress you, assist you in brushing your teeth. I take you to your meals, ambulate you and see to it that you make all your appointments,. I’m here to care for you.

But wait there is more.

If you need to talk, I’ll lend an ear.

If you cry, I’ll do my best to comfort you.

If you need a hug, I’ll embrace you.

If you need a hand, I’ll reach out.

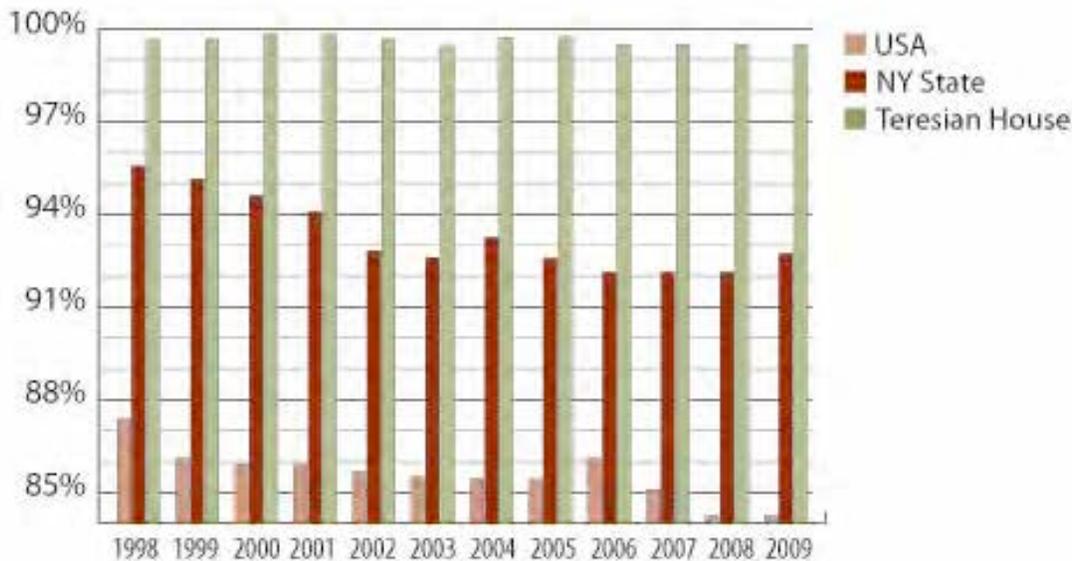
If you need a shoulder to lean on, I have two.

I’m not just here to care for you, I’m here to care....really care.

Carol Tallman

Organizational Impact

Teresian House Occupancy Versus NY and U.S. Average

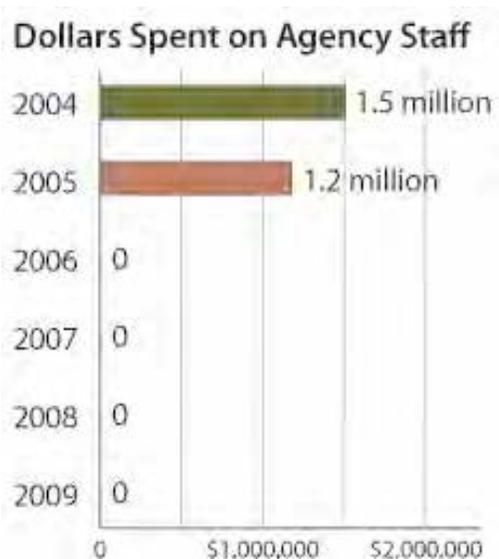


Early to Mid-Implementation Signs of Organizational Impact: Increased levels of occupancy; Reduction in the use of agency staff; increases to operating margins; Waitlists for residents; Reduction in turnover of leadership team; Reduction in turnover of front-line staff; Strengthening of outside community support and volunteers.

Organizational Impact Findings - Organizational impact in case study findings is defined as impact in quality and/or staffing impact that increases revenue and/or decreases costs for the organization.

- ∞ The above average occupancy graph illustrates the organizational advantages of reputation and quality impact. Even at an extremely conservative scenario of \$50,000 total yearly revenue per resident, Teresian House still generates \$750,000 in additional revenue over the national average (100 bed assumption) and \$350,000 in additional revenue over the New York average.
- ∞ In 2004, Sister Pauline and the leadership team committed to reducing agency staff. By 2006, Teresian House eliminated spending on agency staff (see below graph). Although many of those funds were re-directed to internal employees, the CFO estimates that Teresian House saves as much as \$700,000 in inefficiencies caused by agency use.
- ∞ Teresian House continually operates with healthy, positive operating margins.
- ∞ Teresian House experienced a 30% increase in admissions applications 1 year post implementation and a 45% increase by Year 4.

- ∞ Private pay percentages have increased since implementation.
- ∞ The Teresian House Foundation (founded in 1990) assists in fundraising to develop resident programs through “Friendraiser” events (raising \$2.5 million since 1990). The annual Friendraiser Gala at Saratoga in 2008 gathered more than 760 attendees.
- ∞ The Community Relations department at Teresian House manages extensive press and media relations. Local press have covered the Halloween Spooktacular, the Tulip Queen Fashion Show, and the Wheelchair Bowl.
- ∞ Word of mouth eliminates the need for admissions marketing, and Teresian House has a zero dollar marketing budget.
- ∞ Teresian House always has a lengthy waitlist for prospective residents (up to 1 and 1/2 years).
- ∞ Retirees and family members that have lost loved ones come back to volunteer. One of the key Environmental Services consultants had a family member who lived in Teresian House. He now donates his time (generating savings in consultant fees).



Additional Case Study Findings - Spotlight on Rehabilitation

The Rehabilitation Department at Teresian House won the 2009 “Innovation of the Year Award” from the New York Association of Homes and Services for the Aging for their incredibly innovative and successful programs that integrate therapeutic services into resident centered living. According to Kelli Hawver, Director of Rehabilitation, “**working**

within these innovative frameworks for long-term care requires creative problem solving and teamwork, as well as development of services provided out of the box.”

All of the therapists (physical, occupational and speech) work together as a team to develop these creative solutions, and below are a few of the “events” that attract home-wide participation of residents, families and staff:

- ∞ Dancing with the Residents is modeled after television’s Dancing with the Stars. Occupational Therapy coordinates the show and residents are chosen based on OT and PT recommendations. Residents dance with therapists, staff members, other residents or family members and are judged by a three person panel (just like the TV show).
- ∞ The Annual Wheelchair Bowl gives residents in wheelchairs the opportunity to leave it all out on the field each January in a modified, indoor football game. Residents in wheelchairs wear jerseys displaying their name and favorite team. Cheerleader residents are selected by the Speech Pathologist based on speech needs and other residents are chosen based on therapeutic needs for functional mobility. Residents and staff cheer on the teams in this tremendously popular yearly event.
- ∞ Starberry’s Place incorporates intergenerational theatrical activities with the Little Flower Day Care Center. Coordinated by the Speech Pathologist, residents portray forest animals in a small forest cottage setting and entertain the children who learn “why Grandma needs a walker and Grandpa sometimes forget things.”
- ∞ Technology is a core component of therapy and is utilized to improve coordination, language, endurance and movement. The Wii System was purchased with funds raised by the rehabilitation team. Kelli observed that **“We were definitely one of the first. We got it when the first came out.”** IN2L (It’s Never Too Late) also has demonstrated excellent value in the therapy department and residents report that it makes therapy more fun.



Challenges and Lessons Learned



- ∞ **Change doesn't happen overnight and leadership must stay the course.** - According to a Resident Care Coordinator, **"No matter the challenges, we never turned back."** To avoid slipping back into old habits, Teresian House staff emphasize openness and communication. Care teams meet weekly, monthly neighborhood meetings bring together residents and staff, other operational areas such as environmental services meet regularly, and culture change specific groups such as the "SPRING" team involve staff from all areas of the organization.
- ∞ **Implementation is an investment and, although relationships and engagement are tangible and observable outcomes for staff and residents, return on investment is tricky to measure.** -Transformations to neighborhoods mean a loss

of efficiencies in some areas and improvements in others. For example, Teresian House lost the efficiencies of a large centralized dining area but gained efficiencies from global inter-disciplinary teams. In another example, the current structure required hiring more social workers, but Teresian House experienced large savings in laundry. *“Overall, expenses are budget neutral, and we are attracting incremental revenues from the high quality of culture change.” - Mike DelBrocco, CFO*

- ∞ **Surveyors can be challenging at first.** - Initially, the Health Department was not onboard with resident centered care. *“They thought they loved the idea until they came in for survey, because it wasn’t controlled enough. They couldn’t believe that residents had access to coffee. Now, they are much better. The new Interpretive Guidelines will help.” - Registered Nurse*
- ∞ **Initial turnover should be expected in the beginning.** - *“Some of the social workers at the time just didn’t buy into it. They refused to do laundry or empty a dishwasher. The ones we have now really love it.” - Resident Care Coordinator*
- ∞ **It helps to love your leader.** - The mutual respect between Sister Pauline and the staff of Teresian House was evident throughout the case study. *“If she wasn’t doing this, it wouldn’t have worked. She was driven.”*
- ∞ **Innovate, Innovate, Innovate** - From Tele-Medicine to Dancing with the Residents, Teresian House embraces change with new programs and goals each year.

Summary - Spotlight on End of Life Care



Perhaps one of the best representations of resident focus at Teresian House is the Resident Centered End of Life Care program as described below.

- ∞ Communication is a paramount concern for Teresian House during the End of Life process. The Social Worker communicates with the family, resident and the hospital to assure a smooth transition into the Comfort Care Program. - *“I love that they bring them home to Comfort Care. We don’t send them out to the hospital to die. We talk to the family and let them stay here because this has become home and a lot of families feel a great burden of pressure lifted knowing that they can stay home. They are here, they are comfortable and they are surrounded by the people that they’ve come to know as family.” - Staff member*
- ∞ The Comfort Care Program is collaborative between the resident, family, Pastoral Care and staff. Meetings with the resident and family help staff to determine resident preferences for interventions, comfort and spiritual care. *“I was really happy when they started the End of Life Care program. What I like is that the program is so wonderful for residents that are cognitively impaired. The team really works with those residents and their families to determine what they really want.” - Staff member*
- ∞ Comfort care can include massages, lotion, soft music, special gowns and a calming atmosphere.

- ∞ Every effort is made to assure that residents do not die alone. Pastoral care visits the resident continually. *“Active listening is so primary. We talk about their losses, fears and loneliness. We let them do a life review and Pastoral Care is there to take that journey with them. We are walking with our residents on a road to transition. Our residents are so full of wisdom. It is wonderful to reminisce with them.” - Sister Joan Lewis*
- ∞ Families are offered rooms to stay overnight. Food and necessities are provided to ease family burden during the stay.
- ∞ When a resident dies, family and friends can sit with their loved one for as long as they want to say goodbye.
- ∞ Residents are escorted out of Teresian House covered in the Mourning Quilt. *“They are taken away with dignity on their journey.” - Sister Joan Lewis*
- ∞ Pastoral care offers the Infant Prague Chapel for wakes and funeral services. Memorial Mass is celebrated for all residents who pass away. *“About one-third of our residents and families choose to have their wake and funeral here. It is most important to support residents of all faith beliefs and the same with staff.” - Sister Joan Lewis*
- ∞ Staff write sentiments to share with the family.
- ∞ Staff support each other in the grief process. - *“The staff get very attached. They miss seeing them. We offer support to our staff individually.” - Sister Joan Lewis*

ElderHealth Northwest - A Case for Community Based Care

“Small Miracles at ElderHealth Northwest,” narrated by best-selling travel author, TV & radio host Rick Steves. (October 2009)

The ElderHealth Northwest case study was compiled by Mari Becker, MSW.

Organization



ElderHealth is dedicated to enhancing the quality of life for frail elders and people with chronic or terminal illnesses and disabilities. We respect the dignity of our participants and provide for them with care and compassion. We are committed, through our program of health and social services, to the independence and well-being of all participants and to providing respite for caregivers.

ElderHealth NW has been working in the greater Seattle area community for over 25 years and was among the first adult day health providers in the country. Over time, ElderHealth has expanded to offer a variety of services in accordance with its holistic mission statement.

ElderHealth supports elders through four Adult Day Health sites, an Adult Day Care Program, two Supported Living sites, In-Home Services, a Volunteer Companionship program, Mental Health Services and Care Consultations.

Adult Day Health Centers provide community-based long-term care and rehabilitation. They are designed to help frail elders and disabled adults maintain or improve their physical, social and cognitive functioning. Nursing, rehabilitation, mental health, life skills and recreation services combined with social programs help participants to remain living in their homes. ElderHealth’s adult day health sites offer five different programs, generally with a 6:1 participant/staff ratio:

- ∞ “General Program” for frail and physically challenged adults. The General Program includes stimulating activities and special events along with the usual health and rehabilitation services.
- ∞ “Structured Group” for adults with Alzheimer’s or dementia. With a low 4:1 participant/staff ratio, Structured Group provides personalized attention within a peaceful and safe environment including gentle socializing and meaningful activities. “Structured Group” is transitioning to a “Memory Care and Wellness” model, with goals to keep the mind and body as active, relaxed and healthy as possible.
- ∞ “Get Active Program” for developmentally disabled adults who enjoy group settings. Along with social and recreational activities, this program promotes independence in functional living and vocational skills, and includes training in personal hygiene care, transferring, and mobility.
- ∞ “TIME Program” for developmentally disabled adults who thrive in more individualized activities. TIME program is designed to increase socialization and attention skills, develop and improve motor skills and help people maintain independence while providing respite for caregivers.
- ∞ “Heads Up Program” for adults with acquired brain injuries. Heads Up strives to foster independence, responsibility, and integration into community life.

Adult Day Care provides for individuals with cognitive disabilities such as Alzheimer’s who do not yet require more intensive physical health care, while providing respite to caregivers. Adult day care involves four hours of social and recreational activities without the medical/rehabilitation component, and takes place at a day health site.

Supported Living Homes provide an alternative to larger institutional settings, with 24-hour care especially for those with Alzheimer’s and dementia or other chronic illnesses. With an average of 14 – 16 residents each, these two homes are ideal for those who do not want to leave their homes for an institutional setting and who need more personalized attention than can be offered in a typical large-scale facility. 25% of individuals in low-income supported living homes have moved directly out of nursing

homes and 100% of those living in supported living homes are technically nursing home eligible.

In-Home Services help to keep people living in their own homes as long as possible. Skilled home care aides assist with a variety of in-home tasks such as bathing and personal care, laundry, meals, cleaning and shopping.

ElderFriends, a volunteer companionship program, focuses on reducing isolation and loneliness through offering friendly visits twice monthly to older adults still living independently in the community.

A new **Mental Health Program** uses a case management model to address mental health needs of current clients receiving adult day health or homecare services, as well as new clients referred specifically for mental health services.

Care Consultation helps families by assessing eldercare needs, arranging for services, and recommending appropriate placement if needed.

As of June 2009, ElderHealth was serving over 1400 individuals each year. This includes 1120 involved in adult day health, 50 in supported housing, 150 receiving home care services, and over 120 matched with visiting volunteers. The newly added mental health program serves 54 clients and is growing.

The participant demographic breakdown includes:

- ∞ **Health Status** – 60-70% of the overall population ElderHealth serves is nursing home eligible and might otherwise be living in an institution:
 - ◇ 100% are chronically ill, terminally ill or disabled
 - ◇ 24% have Alzheimer’s disease
 - ◇ 60% have mental illnesses
 - ◇ 45% have had a stroke, brain injury or developmental disability
 - ◇ 31% have other chronic or terminal conditions
- ∞ **Income**
 - ◇ 97% are low-income
 - ◇ 71% are Medicaid-reimbursed; 29% are private pay
- ∞ **Ethnicity**
 - ◇ 70% Caucasian
 - ◇ 16.5% African American

- ◇ 7.5% Asian or Pacific Islander
- ◇ 3% Hispanic or Latino
- ◇ 1% Native American
- ◇ 2% Other

∞ **Age**

- ◇ Average age is 79 in elder programs
- ◇ Average age is 46 in specialized brain injury and developmental disability programs

As of June 2009, ElderHealth operated with a budget of over 10.5 million dollars. Sources of funding include:

History and Evolution



ElderHealth Northwest has evolved over the years, rising out of several organizational incarnations, many name changes and quite a few moves to new and better facilities. Below is a timeline of major milestones.

1975 Ravenna Day Center opens.

1976 Ravenna Day Center becomes Northwest Day Center.

1980 Capitol Hill Day Center opens.

1987 Capitol Hill and Northwest Day Centers merge to become Seattle Day Center for Adults.

1988 South Branch site opens.

1991 First Alzheimer's Program opens. Magnolia Adult Day Center opens.

1992 Snohomish Adult Day Health opens.

1994 Agency name changes to ElderHealth Northwest. North Branch site opens.

1996 Connection site added.

1997 ElderFriends volunteer companionship program joins ElderHealth Northwest.

1998 ElderHealth's first assisted living facility/day program opens Legacy House in partnership with the Seattle Chinatown International District PDA.

2002 ElderHealth opens the "Heads Up" program serving younger adults with acquired brain injury. ElderHealth acquires the Magnolia Adult Day Center.

2003 ElderHealth acquires Snohomish Adult Day Health and DayBreak programs. ElderHealth@Home serves first home care client.

2004 ElderHealth opens two supported-living homes, Gaffney House and Buchanan Place.

2006 First GAP (Get Active Programs) for Developmentally Disabled Clients opens.

2007 ElderHealth sites Ravenna and Snohomish start.

2008 ElderHealth opens a new branch in Marysville.

2009 State legislature cuts necessitate closure of two out of six Adult Day Health sites. ElderHealth initiates lawsuit on behalf of vulnerable elders who have lost services.

- ∞ In contrast to many organizations with a clear 'before and after' implementation story, ElderHealth's culture change principles were evident from the beginning. These principles developed further under the direction of a visionary leader, Nora Gibson. As a first year MSW student, Nora placed an elderly stroke victim in an adult day health center and was struck by how many problems it solved at once. Choosing to do her second year social work placement with this agency, Nora was amazed to find so many elders actually happy to be there, to be together. She became a social worker, and then Executive Director of the organization.
- ∞ As Executive Director, Nora was convinced that the need for adult day health centers would continue to grow. With that in mind, she encouraged the

organization to expand to have a broader geographical reach of services. Furthermore, she saw that people of color were vastly underrepresented in the long term care system and committed to particularly target communities of color.

- ∞ Nora notes two pivotal moments in the organization. First of all, the move to non-profit status was essential, to allow for fundraising and steady funding support. Secondly, ElderHealth's first purchase of an adult day health site allowed the organization to bypass the difficulty of constantly finding new locations when leases ran out. Furthermore, running a successful capital campaign and purchasing a permanent site developed the organization's confidence, and paved the way to take on new challenges such as starting a home care program.
- ∞ In the future, Nora hopes to build back the adult day health programs that were lost due to 2009 state budget cuts and maximize their potential. In addition, she aims to develop the residential model, having more supportive living homes which she believes is better than many other long term care options. She would also like to expand homecare. A final dream would be to establish residential options for people with brain injuries.

Key Principles



From its onset, ElderHealth has been committed to delivering person-centered care.

Across its many facets, ElderHealth exhibits key principles that create an environment in which the elders feel respected, cherished and empowered. These principles include:

- ∞ Orient staff in person-directed principles and model their use
- ∞ Keep organizational structure flat so that everyone's voice counts
- ∞ Cross-train staff to fulfill multiple roles
- ∞ Foster collaboration and a team work environment
- ∞ Encourage creativity
- ∞ Create non-institutional physical environments
- ∞ Support innovative, committed leaders who spread the vision throughout the organization
- ∞ Involve elders, families and variety of staff members in the care planning process
- ∞ Advocate intentionally for the poorest and frailest community members
- ∞ Communicate openly with family, medical and community resources
- ∞ Provide elders autonomy and choice in schedule, dining and activities
- ∞ Foster independence – allow elders to 'do for themselves' as much as possible
- ∞ Encourage elders to challenge themselves, grow and take risks
- ∞ Value people and relationships above tasks
- ∞ Treat everyone with respect and dignity
- ∞ Know each person

Resource Constraints and Fundraising



ElderHealth operates within a resource constrained environment with Medicaid reimbursement as the major source of funding. As of June 2009, the reimbursement rate in King County was \$57.44 per day for adult day health and averaging \$111 per day for supportive living. The supported living homes, licensed as ‘boarding homes,’ receive a lower reimbursement rate than ‘nursing homes.’ These rates do not cover the costs of operating the programs and facilities.

While Medicaid funding fails to fully cover costs, it also lacks stability. For example, the 2009 state legislative session cut rates for supportive living and home care by 3%, meanwhile cutting adult day health reimbursement for clients living in adult family homes. For ElderHealth, this meant a \$2 million dollar budget reduction, amounting to 20% of total operating budget. ElderHealth’s ‘signature program,’ Adult Day Health, remains often overlooked and underappreciated by legislators.

In this challenging financial environment, ElderHealth maintains viability by cutting costs in creative ways. ElderHealth uses rental facilities that charge less than market rate (i.e. public housing buildings and religious facilities). ElderHealth also relies on a strong volunteer force, with an average of 200 volunteers per year supporting its sites. This includes AmeriCorps members, service-learning students, college interns, family members and others in the community. As much as possible, ElderHealth uses pro bono services for needs such as printing, legal help, event facilities and supplies. Finally, ElderHealth supports its workers who are technically still low-wage workers with extra care so they remain committed to the organization’s vision.

Along with cutting costs, ElderHealth also proactively fundraises, bringing in 10% of its budget from contributions including grants and individual donors. The challenges of fundraising include lack of awareness about adult day health and lack of philanthropic support for elder-focused programs. At the same time, beneficiaries of ElderHealth are incredibly grateful for its services, and generous with their time and money. Furthermore, ElderHealth benefits from a stellar reputation in the community.

ElderHealth spends a bulk of its fundraising time writing grants and educating the public and its support base about the necessary services it provides. This includes email and hard copy newsletters, hosting one-on-one meetings, inviting community members to visit sites or volunteer, and encouraging strong contributors to invite their friends.

ElderHealth also hosts an annual breakfast, its main fundraising event. Finally, in challenging economic times, ElderHealth has had success building a broader donor base involving smaller contributions. ElderHealth's vendors such as cleaners, phone providers, landlords, attorneys have been especially eager to donate.

Quality of Life Impact



- ∞ 91% of the individuals ElderHealth served last year who had progressive illnesses and/or severe disabilities were able to maintain the highest quality of life as measured by the United Way of King County.

- ∞ *“I like everything at ElderHealth – the games we play, the exercise. I look forward to coming every day.” – Participant, Adult Day Health*
- ∞ *“Yes a staff person could run across the street and buy some tomatoes in 5 minutes, but what’s more important is to take a resident with them, have the resident choose the tomato– even if it takes 45 minutes. That’s OK; they’re able to take part in the community.” – Manager, Supported Living Home*
- ∞ *“Besides motivation, there is stimulation; if I didn’t come here, I would probably just sit in front of my computer at home.” – Participant, Adult Day Health*
- ∞ *“We tell staff it’s valuable to sing with the elders, or walk around the block. It’s not cheating, not being lazy--even if there are dishes to do. If an elder says they want to go outside, you drop what you’re doing and go outside with them. This goes a long way in making our care exceptional. Our vision is that each staff person would walk around the block and sing the elder’s favorite song, or when gardening, know the person’s favorite flower.” – Administrator, EHNW*
- ∞ *“As you get older, you can start losing out on choice – we want to give it back to them. We may let an elder run a group, or have control over different roles. When I get older, I don’t want someone telling me when to go to the bathroom or what to eat.” – Manager, Adult Day Health site*
- ∞ *“I see people who have the same problems as I do and it gives me inner strength, knowing I’m not the only one.” – Participant, Adult Day Health*

The following is a letter from the daughter of a resident of Buchanan Place (Supportive Living Home) to the Manager that illustrates many of the culture change concepts touching the lives of residents.

Dear Carla,

It has taken me awhile to be able to sit down and find the words to thank you for your care of my father. I miss him everyday. I find myself thankful and grateful for the great care you have given my father. I don’t really think I will be able to find the words to express how grateful I am, but I will do my best!

My dad was a great dad, he loved being a father and was always there to guide me in my life. When he became ill with dementia my love for him made me want to be sure that he was always treated with respect. This was no easy task. As his disease progressed we found more and more people, professionals and medical professionals, only saw my father as a disease. These people in

the caring profession only saw my father's symptoms and did not see the 87 years of a fully lived life. My sister and I had a rough journey through many different doctors and living situations.....until dad arrived at Buchanan Place.

All of the staff at Buchanan House saw my dad as a person. This gift, in the last few months of his life, gave him the dignity and respect that we all deserve. Not only did you see and treat my father as a person, but this also allowed my sister and myself to be able to return to being our father's daughters. We could lay down the role of advocates and simply be with, and love our dad.

In the months since his death I have taken great solace in knowing that in my dad's last days you were able to take him out in the back garden to smell the fresh air and feel the sunlight on his face. I hold onto your story of taking him to the local schoolyard to watch the children at play. I thank you from my heart for giving him these last joys in his life.

I always thought that I would be able to care for my father until he died, but I was not able to do that. I was so upset that he had to leave his home, the home he made for his family and lived in for over 50 years. However, all of you made Buchanan Place his home. When dad did die I felt that he died in his home, with love and care surrounding him. This is another great gift that I thank you for.

This may be the job that you do for your livelihood, but it is also God's work, and I thank you and will always have you in my heart, for the service and love that you give all of the residents at Buchanan Place, but especially the love, respect and dignity you gave my father.

As I said I don't think I can really put into words the thanks that I feel. God bless you.

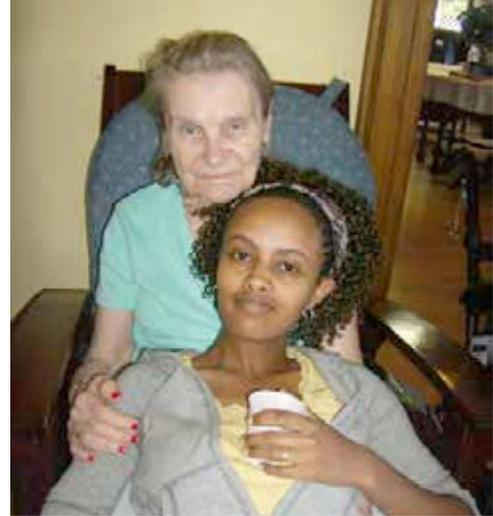
Quality of Care Impact



- ∞ 99% of those ElderHealth served last year who had physical, cognitive and/or developmental disabilities were able to maintain their independence as measured by the United Way of King County.
- ∞ 95% of the individuals ElderHealth served last year who had chronic illnesses were able to maintain their optimum health as measured by the United Way of King County.
- ∞ *“ElderFriends (volunteer companionship program) boosts elders’ self esteem, reduces depression, and gives them the opportunity to share stories. It stimulates a positive emotional response.” - Director, ElderFriends*
- ∞ *“The nurse gives me insulin, checks my blood sugar and makes sure I’ll be around for another day.” – Participant, Adult Day Health*
- ∞ *“The staff works as a team, and they’ll tell me if a client is acting differently. Our services really help with prevention.” – RN, Adult Day Health*
- ∞ *“I like coming here because of the social time and exercise. My brain isn’t as good as it could be. Coming to ElderHealth helps make it work better.” – Participant, Adult Day Health*
- ∞ *“The way we build relationships with our clients increases their follow through in terms of attendance and medical compliance. In a typical doctor’s appointment, they may see a nurse, check their blood sugars, and be told to come back in six weeks to check their numbers. But there’s not a big incentive to come back, no relationship there. At ElderHealth’s day health programs, the nurse is*

someone they may see each day and build an emotional connection with. That connection increases clients' motivation to follow treatments.” – Administrator, EHNW

- ∞ *“The nursing program keeps on top of everything – they fax the doctor, etc. It really helps.” – Participant, Adult Day Health*



Staffing Impact

- ∞ As of June 2009, ElderHealth employs 120 full-time and 229 part-time staff, and supervises an average of 200 volunteers.
- ∞ ElderHealth employee turnover was 30% in 2008, significantly lower than the national average for long term care facilities.
- ∞ ElderHealth is a NWJOBS.COM Peoples Picks 2009 Finalist.
- ∞ While most directors would shy away from unions and the potential costs they represent, Nora welcomed the opportunity for SEIU to unionize ElderHealth's workers in 2009. Nora realized that union backing meant more lobbying power in Olympia, and more chances to keep the funding which employs ElderHealth's staff and supports ElderHealth's clients.
- ∞ *“ElderHealth is pretty egalitarian. The ideas and input of every staff person are honored. For example, in the Adult Day Health Programs, there is a daily staff meeting. Situations are discussed, decisions are made, and everyone's input is solicited. Professionals may be present, but program aides' ideas are valued with as much validity as anybody else's. Even in decisions about the overall direction of the organization.” – Administrator, EHNW*

- ∞ *“There’s nothing I’m going to ask them to do that I’m not going to do myself. Showering people, cleaning up an accident – if it needs to be done, I’ll do it.” – Manager, Supported Living Home*
- ∞ *“The way ElderHealth cares for its clients is seen in the way it takes care of its employees. That’s one reason so many employees stay in the agency – you feel like you’re supported, like you’re on the same team. It’s the same way we treat the homecare aides – we make sure they’re taken care of, as supported as possible.” – Supervisor, Homecare*
- ∞ *“We’re really committed to what we do, and we see that from the top down – nobody can be more committed than Nora. She has the big picture, and makes you want to do all you can do. I hope I inspire people too.” – Manager, Adult Day Health site*
- ∞ *“ElderHealth has had great longevity among staff people. Some have been there 20+ years. If people didn’t have the chance to speak up and be taken seriously, they never would have stayed that long. We’re able to attract strong people – strong personalities, leaders -- in all levels. Some could have made more money elsewhere, but stuck with it longer because of the organizational culture and team dynamics.” – Administrator, EHNW*
- ∞ *“Our work culture gets passed on through positive leaders who ‘get it’ on a deep level. Then it gets picked up by the team. It’s the way we work with the clients and also the way we treat the staff. We go overboard to a fault to support a team member or staff member.” – Administrator, EHNW*
- ∞ *“Nora provides us with as much supervision as we think we need, which is nice – she trusts us enough to do our job. Staff feels empowered to do what they need to do, and if they need help, they can ask for it.” – Manager, Adult Day Health site*

Challenges and the Withdrawal of State Support in 2009



ElderHealth, like many organizations receiving state support, suffered huge losses in the 2009 state legislative session. The budget's first draft completely eliminated funding for Adult Day Health. With strong client and staff advocacy efforts in Olympia, and lobbying support from SEIU, ElderHealth was able to win back partial funding. However, funding was lost for clients living in Adult Family Homes, including 900 clients across the state. While the state viewed these clients as already covered by at least some kind of service, ElderHealth finds that they are often some of the most vulnerable participants, isolated in Adult Family Homes without friends or family checking in. Furthermore, services would be withdrawn abruptly - in less than two months.

While devastated by this outcome, ElderHealth rallied partners to craft a lawsuit to protect these vulnerable clients. Led by AARP, then funded by SEIU, the lawsuit made the case that all the participants in Adult Day Health had been granted services that were

deemed medically necessary, and the state was not giving itself enough time to reassess each client and make other arrangements for these needs (i.e. rehabilitation and therapy) to be met. In July, a judge ruled that the four plaintiffs could return temporarily to Adult Day Health until reassessment could take place, but did not grant the same rights to the rest of the 900 who are affected.

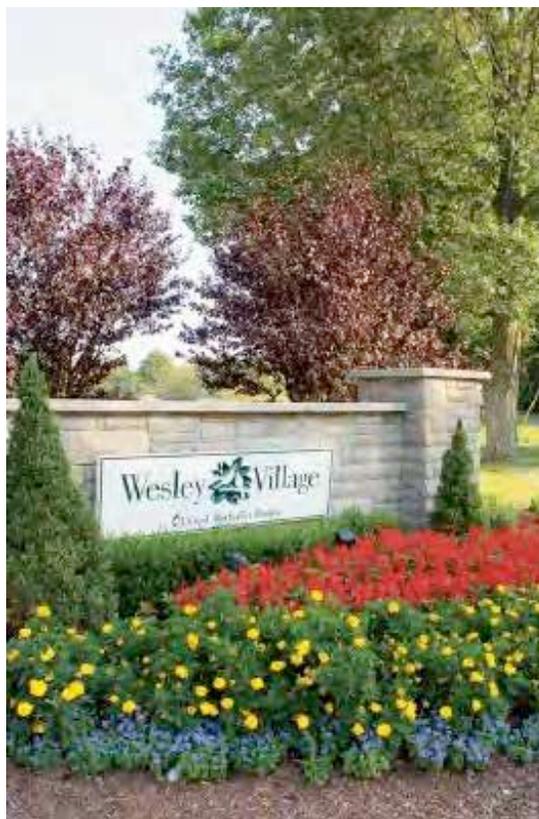
Besides the loss of services for those in Adult Family Homes, ElderHealth also suffered a 3% reduction in reimbursement for Home Care and Supported Living and loss of transportation services to its sites.

With these losses, involving 20% of its operating budget, ElderHealth has had to make significant changes. In July, ElderHealth closed two of its six Adult Day Health Centers, and laid off 40 staff people. From June to July, ElderHealth had a 40% reduction in clients, due to loss of funding for Adult Family Home clients, plus difficulties in supplying transportation to other clients.

After all these changes, in September, a federal judge ruled that all the elders who had lost services had been denied due process, and thus were temporarily eligible for Adult Day Health until the state could identify adequate alternative ways to meet their medically necessary services. But for ElderHealth, much of the damage had already been done. Many clients had lost mobility and several had died. While the ruling was a victory, it was only a temporary reprieve, and with sites already closed and employees already laid off, it is a challenge to provide at the past level of service.

According to Nora Gibson, Executive Director, these cuts were “the single most painful thing the agency has ever gone through.” She notes, “it was painful on multiple levels - putting so much out to try and win back state support, getting part of it, but losing it for the people who we personally view as most needing the service.” Both staff and clients feel a tremendous sense of loss, including “emotional trauma” from knowing who is no longer receiving services. In a way, this emotional pain is the price paid for being a caring, personalized organization that connects so deeply with its clients. “You can’t just look at people as numbers,” says Nora. She also notes the undercurrent of worry that the budget cuts, layoffs, and unemployment payouts would destabilize the organization and cause it to crumble. At this point, ElderHealth is staying afloat and persevering in what it does best – supporting elders in their desire to live independent and happy lives as long as possible.

Wesley Village - A Story of Planetree Continuing Care Implementation



This case study of Planetree Continuing Care implementation at Wesley Village in Shelton, Connecticut was created by Heidi Gil, Continuing Care Director for Planetree, and Julie Norko-Kopta, Planetree Coordinator at Wesley Village. Pioneer Network gratefully acknowledges their contribution of this case study.

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Organization



Owned by the non-profit United Methodist Homes, Wesley Village provides independent, assisted living, and skilled nursing care to more than 600 residents annually. In 2002, each of the three communities on campus (as well as the individual departments within those communities) had high satisfaction scores, strong reputations, and longevity in staffing, but they were all operating in isolation. Resident-directed efforts did occur at the behest of the caring staff, but without the benefit of any deep-rooted systems change, they lacked focus and the ability to sustain those improvements.

Wesley Village noted the transformational change occurring at nearby Griffin Hospital in Derby, Connecticut and realized that Planetree concepts were very applicable to long-term care. They also noted the vast potential for improving the patient transition experience by connecting the Planetree philosophy across the continuum of care. To this end, Wesley Village began implementing and testing a set of components based on the Planetree acute care components. Some remained the same, while others were modified to meet the needs of individuals served in continuing care environments.



Taking Action



One of the most important first steps in implementation was educating staff on culture change and engaging them in the vision of community-building and relationship-centered care. At a farmhouse in the country, all staff participated in two days of experiential exercises on the aging process, teamwork, relationship-building, as well as their role in the process of implementation. Residents, families, staff, and volunteers became an integral part of the process by setting goals and identifying improvements in each of the ten continuing care components. The goals were then prioritized by a committee comprised of managers, line staff from all departments, residents and family. The goals were posted along with quality improvement indicators to raise awareness and promote transparency of an environment that strives to exceed quality standards.

The community began implementing programs to achieve these goals. In many situations, the results far exceeded expectations and were fueled by the impetus of the line staff. At the nursing home on campus, for example, they began implementing consistent staff assignment and explored other ways to ensure that resident routines and preferences were honored and that those residents determined the pace of care and services. As changes were made to improve flexibility of meal times, for example, a domino effect took place, affecting the rhythms and routines of all departments. At first, it was simply a breakfast buffet for short-term rehabilitation residents to enhance flexibility for waking and rehabilitation times and to provide a separate dining experience from our long-term residents. Staff and residents responded so positively to the changes (the smell and aroma of food, hot toast, expanded choices, fewer call-downs to the kitchen, the bonding of residents with each other and with dietary staff, increased

resident consumption of food, and an atmosphere of normalcy), that within 9 months, every resident benefited from a trayless buffet system during all meals. The administrator notes that, for one pavilion of the nursing home, the shift occurred on a day that she was out of the building, a testament to the decentralization of leadership in the community.

For many staff members, it involved a new way of looking at their jobs, and at excellence in providing services. In the activities department, employees have long been evaluated by how many residents attend a program rather than the active engagement of the residents attending. Through Planetree, the focus has now changed from the quantity of programs and the numbers served to the quality of programs and resident-directed programs that support teaching, mentoring, sharing, and the building of skills and talents. For maintenance and housekeeping departments, an Earth-friendly cleaning program has been implemented with the use of all non-toxic cleaning supplies.

Implementation Example - Journey of Dreams



As a Planetree Continuing Care community, Wesley Village recognizes that, regardless of age or physical limitations, residents still have wishes and dreams. For the last four years, the Journey of Dreams program has brought that community together to turn those dreams into reality.

In every situation, it starts with a wish and sometimes a seemingly impossible dream. It comes together with the help of connections, creativity, some good luck, and a generous dose of teamwork. The program began in 2006 when a resident told her Life Story and

shared her extensive background in drama and radio, and reflected, “those days are probably behind me.” The Activities Director responded, “Why does it have to be behind you?” – spurring the creation of a resident-led and directed Drama Club that still entertains the campus.

After that dream was realized, residents were invited to write down their personal wishes, goals, or desires and place them in a wishing well in the lobby of the assisted living community. In the skilled nursing community, recreation staff found a variety of ways of eliciting dreams, including asking residents to list what they’d like to do on a week’s vacation. The dreams began to filter in.

Currently, over 45 residents have had their wishes fulfilled. It starts with one resident’s dream, but everyone’s unique talents and passions support that dream and bring it to fruition in a community-wide celebration. Individuals who only knew one another superficially find that they share common bonds – like a love of Disney World, skiing, and, of course, developing richer and more fulfilling relationships.

Residents have ridden in a hot air balloon, a helicopter, and on a monster truck. For some residents, most of whom are in their 80s and 90s, they may not be physically able to fulfill their exact dream. In that case, the community works to enact the dream for them. A resident who hoped to visit the Hawaii and the South Seas traveled with staff to the next state to enjoy Polynesian dining and dancers surrounded by banyan trees, tropical hand-painted murals and flowing waterfalls. For a resident who was cheered up by NASCAR, the community became “Alice’s Raceway,” complete with a giant track for car races and checkered flags. And for the resident who wished to go to Disney World, the lobby became Disney’s Main Street, USA, complete with students from the local high school dressed as Cinderella, Prince Charming, and Mickey Mouse and 3-D roller coaster rides.

The program has expanded beyond anyone’s expectations, and receives funding from donations and a 5K Road Race established in 2009. Not only is this an opportunity for residents to continue to dream, regardless of where they are on life’s journey, it is also a way that family, friends, other residents, and staff members can be more engaged and fully committed to the possibilities that exist when implementing Planetree in a continuing care environment.

Spotlight on Transitional Experiences



In 2009, Wesley Village set a goal of enhancing communication and logistics among intra-campus community settings. In the spirit of creating successful transitional experiences for campus residents who are moving from one level of care to another, staff dismantled internal silos by opening up communication and sharing information, and transitional experiences began improving.

As this process evolved, it soon became clear that hospitals, home care agencies, primary care providers, and other groups needed to join the conversation. To facilitate comprehensive care planning and give practitioners the most current information about a resident's or patient's clinical status, goals and preferences, Wesley Village implemented several initiatives as part of this Transitions of Care program, including assembling a task force consisting of representatives from its own organization and local hospitals. Bishop Wicke Health Center partnered with Planetree affiliate and neighbor Griffin Hospital to improve the care and outcomes for patients with congestive heart failure. As Wicke and Griffin met success, they expanded their partnership to include the Connecticut Hospital Association and Qualidigm, the peer review organization for Medicare. This innovative and successful pilot program has now expanded to additional settings, including home health agencies and physician offices.

Implementation Example - Director of Life's Journey



When a staff member of 40 years began talking about her retirement and next steps last year, the administration at Bishop Wicke Health Center saw this as a perfect opportunity to expand its vision of relationship-centered care.

Our social worker, Irene Scheld, has been with our organization since it opened its doors in 1969,” notes Ron Bucci, Bishop Wicke Administrator. “We saw that we could enhance her life’s journey by creating a position where she could help others who are also transitioning to a new phase in their lives.”

They created a new part-time position, Director of Life’s Journey, which works primarily with individuals who are moving from short-term rehabilitation to long-term care, or for those admitted to Bishop Wicke as long-term residents. The flexible hours allow Irene to chair a series of small weekly discussion groups on each pavilion geared toward easing the transitions of these residents.

For a short-term patient who moves to long-term care, there can definitely be some culture shock, because things are run differently on the subacute area. Irene is the person who starts that dialogue about the differences. She guides patients and their families through the process, opening lines of communication, getting residents and families to open up about their fears, proactively addressing concerns, and helping to navigate the transition.

Residents who have been reluctant to participate in larger activities have warmed to the

intimate conversation groups that have become a staple on the activities schedule. All residents receive a personal invitation with a small daisy on the front. “After dinner seems to be such a logical time to sit down and have a catch-up chat,” Irene states. When asked what they talk about, she states, “Whatever you would talk about at the day’s end . . . LIFE!”

Of course, group members often share their feelings about the changes in their lives. But more often than not, it’s a smorgasbord of topics, with everyone chiming as they feel comfortable. Topics range from extended families to the best way to can fruit. A discussion of one-room schoolhouses recently revealed that 2 residents had attended the same grammar school. A Christmas dinner party with food provided by a restaurateur family member brought an unprecedented crowd, primarily because of the bonds that have been formed among the group’s participants.

The health center has seen other important outcomes. Residents participating in this program who had previously plateaued in rehabilitation have become more independent and are now seeing better results in rehab. They have seen improvement in ADLs (Activities of Daily Living) as well as improvements in behavior. The program has helped create community and optimize the culture on each pavilion, giving residents the opportunity to mingle and support one another in this time of transition. And it ultimately has further transformed the culture of the organization, continuing to enhance relationship-centered care for residents, employees, and families.

Quality Impact



At Bishop Wicke Health Center, which has received a 5-star rating from the Medicare Quality Rating System, outcomes include:

- ∞ A 42 percent increase in admissions since 2005;

- ∞ Because of the trayless dining and improvements to the dietary system, weekly supplement use has decreased by 70 percent, resulting in a savings of \$26,000 annually;
- ∞ A 90 percent reduction in restraints;
- ∞ A reduction of safety alarms by 50 percent, and the installation of a wanderguard system to allow walking throughout the facility as opposed to a locked pavilion all without an increase in falls.

Leaders attribute this improvement to Planetree initiatives including consistent assignment, information and empowerment of residents, the implementation of an incontinence program that minimizes late night wake-ups, and the redesign of an ambulation program to involve the primary caregiver (family member).

Staffing and Organizational Impact



Since implementing Planetree at Wesley Village, staff turnover has remained 40 percent below the industry average. In addition, just two years after implementing the model, the nursing home reported that no certified nursing aides had left due to dissatisfaction with their jobs. Compared to a national average of 70 percent, all turnover was involuntary at a rate of 18 percent. Since 2003, a 42 percent decrease in the amount of CNA turnover has resulted in a savings of more than \$40,000.

There has been a 36 percent increase in volunteers since 2003, with the hours volunteers

logging at Wesley Village in 2009 valued at \$250,249 (Independent Sector). One quarter of the volunteer corps is comprised of residents (13%) and staff (11%). An aggressive recycling program has also manifested savings in decreased garbage and dumpster services.

In addition, overtime costs and agency use decreased dramatically with the implementation of flexible employee scheduling and proactive hiring standards based on the Planetree philosophy.

Wesley Village CNA Turnover



Summary

Outcomes of Planetree Continuing Care Implementation
Admissions have increased by 42%
90% reduction in restraints
Weekly supplement use decreased by 70%
\$26,000 annual savings from reduction in supplements
50% reduction in safety alarms (without an increase to falls)
Turnover 40% below the industry average
18% CNA turnover (compared to 70% U.S. average)
Savings of > \$40,000 from a 42% decrease in CNA turnover
36% increase in volunteers valued at \$250,249
Decreased garbage and dumpster services costs from recycling program
Decrease in overtime and agency costs

Ultimately, the implementation of Planetree Continuing Care led to enhanced clinical, financial, and operational outcomes as well as increased resident and staff satisfaction.

In the end, Wesley Village realized that transformation is not about implementing a laundry list of programs; instead it is about awakening passion, creating a strong sense of purpose, and engaging everyone in the process of improvement. Through the interactive and supportive environment, caregivers have reawakened their inner passion and remembered what brought them to healthcare in the first place.



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Eliza Jennings

A Journey to Universal Workers Through Collective Bargaining with the SEIU



Please visit
www.elizajennings.org
to learn more about
Eliza Jennings.

Organization and Culture Change History



Mission Statement: We affirm the dignity and individual worth of older adults and their right to attain the highest possible quality of life. We strive to nurture and sustain their physical, emotional, intellectual, social and spiritual health. We are committed to having a community in which every member is equally respected, valued and empowered.

The Eliza Jennings legacy began in 1887 with the philanthropy of Eliza Wallace Jennings who donated the land and funds necessary to create a haven for needy women with health concerns. The Home opened in 1888, intending to care for women of all ages. Soon, however, the Board of Trustees recognized the special needs created by aging and thus determined to provide care specifically to older women. In 1975, the organization expanded its mission and began admitting men as well. Since the founding of the original Eliza Jennings Home in 1888, Eliza Jennings Senior Care Network has blossomed and now oversees a range of communities that cover the complete continuum of residential and community-based services for today's older adults. Eliza Jennings is accredited by CARF and offers a variety of services, including: Rehabilitation, Respite care, Adult Day, Memory Support, Skilled Nursing and Hospice care.

Beginning the process of culture change

Although the organization has always demonstrated a commitment to the quality of life of residents, the culture change journey for Eliza Jennings began in 1998, when the organization adopted a transformational strategic plan called Eliza Beyond 2000, one of the main strategies of which was the empowerment of both residents and employees. In 2002, Eliza Jennings' own transformational efforts were taken to a new level when a former Executive Director of Eliza Jennings Home attended an Action Pact culture change training in Columbus. The team was enthusiastic to create a person-centered culture at Eliza Jennings Home, and as a first step, the staff decided to videotape a typical day at the home to examine the living environment from a more objective perspective. As they watched the video, they became increasingly aware of residents lined up against a wall with lap buddies and the noise of alarms and overhead pagers. As one member of the team noted, "We realized that we wouldn't want to live here."

To progress towards a changed culture, the staff asked "What makes a home and why?" The process resulted in a list of core elements of individualized choice and resulting supportive practices. As an example, staff engaged in the following type of dialogue to support choice in wake/sleep schedule.

Core concept: "When I am home, I go to sleep and wake up when I choose."

Transformational Question: “Why don’t our residents have an individualized sleep schedule?”

Answers: “We get them up for med pass” and “One shift is responsible to put residents to bed before the next shift arrives,” and “We have to get them to breakfast at the same time.” Each answer revealed a system of institutionalized processes that required key system changes to support the core philosophy.

Culture Change Implementation

To achieve deep system transformations, Eliza Jennings first examined the philosophy of resident choice. **“Actions are not a change in culture. The philosophy to support individual choice is the change. Everything else is a manifestation of that change - the fundamental belief that you don’t know better than the resident.”** - Eliza Jennings CEO. Thus, to achieve a core transformation such as undisturbed sleep, Eliza Jennings adopted the philosophy that resident choice was the most important factor in caregiving. With that philosophy in place, every interaction in the home had to be examined (and often times adjusted) to support that choice.

For example, the figure below illustrates that, to achieve undisturbed sleep and individualized wake-up times, many systems were affected, including medication administration, dining, staffing, activities, therapy, and housekeeping. Each of those systems, in turn, required further examination. Medication pass times became more flexible and natural to how residents would take their medications at home. In the culture change environment, they are given upon rising, after dinner, and at bedtime. Breakfast became served “to order,” and food is now available 24-hours a day to accommodate varying wake times and resident preference in food choice. Therapies are conveniently scheduled around each resident’s normal routine. Consistent assignment allows caregivers to know and respect resident preferences. Activities are meaningful. Cross-training of responsibilities provides flexibility in accommodating resident needs and choices.



Example of Addressing Potential Barriers - Clinical Concerns

At first, placing resident choice at the core of operations was a challenge for many medical staff whose training focused on clinical outcomes. For example, dietary clinicians worried, “What if a diabetic resident eats seven pieces of pie or does something that we wouldn’t advise?” The answer according to an innovative Medical Director and clinical team at Eliza Jennings was, **“Individualized choice means that sometimes they will make bad choices, but we want people to have the right to make choices in their own lifetime. That is the essence of true choice.”** The staff realized that its role was to provide a resident with the benefit of its expertise though educating the resident about the possible implications of his actions, but it was up to the resident to choose what to do. Eager to include all staff and address any concerns, the suggestion was made to increase Accu-Cheks and other diagnostic tests to be sure that resident health did not decline as a result of a person-centered culture. The result of the increased testing was verification that resident health did not decline as result of having choice. Clinicians were comforted that the new systems were not having an adverse effect, and residents were happier with the ability to choose.

Household Environment



In 2003, after beginning the culture change process and engaging in many system changes, Eliza Jennings completed a seven million dollar renovation that facilitated the creation of households that support a resident-centered culture and inter-disciplinary team concept. According to the team at Eliza Jennings, **“We believe that our residents should direct their care and that Eliza Jennings is their home.”** The new households included a variety of environmental and system changes exemplified by the following:

- ∞ The elimination of paging and overhead alarms. Nurses now carry hand-held pagers to receive calls. According to one staff person, **“Once you are used to not hearing alarms or overhead pagers, you really notice how obtrusive it is when you visit other facilities.”**
- ∞ Eliza Jennings has developed the unique position of “Household Coordinator,” who is responsible for cultivating and maintaining a homelike atmosphere. They are also available to answer questions, address concerns and tailor an experience to exceed expectations. One Household Coordinator says that an important part of her role is to **“Make sure that residents and family members are happy. That means open communication, bending over backwards, and doing anything to make them happy.”**
- ∞ Households are permanently staffed, so residents and families build relationships with those that care for them. According to one staff member, **“Residents seem**

happier and more at home. The staff are close to residents and families and work well with each other. Permanent assignments really build those relationships.”

- ∞ Residents get up and go to bed when they choose. Eliza Jennings is also a restraint free community, where people are encouraged to be independent.
- ∞ Eliza Jennings has a nurse practitioner onsite to address any acute medical concerns, and to answer any medical questions.
- ∞ Bathing and shower rooms were remodeled to create a homelike environment. Shower curtains, wall decorations, music and aromatherapy all enhance the experience.
- ∞ To assist in individualized schedules, the medication pass times are at rising, after dinner and at bedtime. Medication carts do not go up and down halls.
- ∞ STNA’s do not have to wear uniforms (although some choose to do so).
- ∞ Staff bring their children and pets to visit with residents.
- ∞ Residents and staff help to choose decorations in each household.
- ∞ Households have carpet and flat screen TV’s. **“We tested different carpet options and decided on a plastic version that looks and feels like real carpet. We will never go back.”**
- ∞ Each household has a kitchen and steam tables. Food is available to residents 24 hours a day (even omelettes in the middle of the night) and is served restaurant style. The dining experience has become an opportunity for residents and staff to bond and interact. One staff member, Willie, is so well-known for his omelettes that residents come from other households to enjoy his breakfasts.
- ∞ Activities in neighborhoods are focused on life enrichment for the residents. **“Before the neighborhoods, we had more traditional activities. Then as households rolled out, we realized that we still needed the structure of communal activities, but we also needed spontaneous and one-on-one familial type activities in the households.”**

Shared Leadership and Learning



A critical component of culture change for Eliza Jennings was the move to shared leadership and learning. According to the CEO, **“It’s about moving from an all powerful position to being willing to try new things with lots of staff input and interventions in place to monitor progress.”** Shared leadership was identified as vital, because the process was so exploratory for the organization that those traditionally making decisions couldn’t predict all the steps necessary for a successful outcome. **“If you aren’t embracing that some things you try will fail, you aren’t trying anything new”** admits the team, but the result of some trial and error ultimately achieved a person-centered home for residents and staff. Below are a few of the recommendations identified by Eliza Jennings:

- ∞ **The Inter-Disciplinary Team** - A key aspect of the process was the inter-disciplinary team including residents, families, caregivers, dietary, maintenance, the Household Coordinator, the Administrator and clinical staff. **“Leadership can’t come with all of the solutions or go racing ahead of the process. There is a building of trust and engagement that is more than just knowing steps. That’s how to cement relationships. The group has to discover it themselves.”**
- ∞ **Team Communication** - With an individualized schedule, team communication becomes critical. This requires education. Instead of a set regimen by shift, teams must adapt to resident preferences. For example, staff may need to communicate that “Mrs Smith got up early, so I already gave her meds and she had breakfast at

7AM.” According to one Household Coordinator, “Working in households requires time, patience and really loving the residents. I don’t think that anyone is just here for a job, so we try to nurture that through an open door policy. Staff can just come and talk about issues.”

- ∞ **Redefining a Good Job** - According to the Administrator, “We taught our staff to do things as an institution for so long. We literally had to redefine what a good job was for both residents and staff. We had to educate staff that resident-centered care is 24 hours - not just to the end of your shift. It used to be that a good job was having everyone in bed before the end of a shift. Now, if a resident wants to go to bed late or get up at 2AM to have a sandwich, that is ok. Or, we used to teach staff to ‘check-in-change’ but, now a good job is letting the resident sleep through the night with additional education on noting skin breakdown and keeping residents dry through a disposable product.”
- ∞ **Systems to support change** - Systems include education, staff support and technology. The Life Enrichment Coordinator shared that, “We created a Wellness Category in our CareTracker system. We have communicated to the staff that everyday life leisure choice is important to quality of life and wellness. A meaningful conversation, making a root beer float, putting on a resident’s favorite program are all noted in CareTracker. It helps to show surveyors. More importantly, it really helps us to understand spontaneous relationship building in the households.”
- ∞ **Educating Residents and Families** - Residents and families also are used to an institutionalized role and often need education to fully embrace a resident-centered philosophy. Understanding that they can ask for things or direct their schedule is a new concept but one that often decreases anxiety and increases resident and family satisfaction.

Universal Worker Agreement with SEIU 1199



As the household model progressed at Eliza Jennings, direct caregivers were increasingly cross-trained to help with responsibilities outside of traditional caregiving such as preparing meals for residents, assisting with housekeeping and leading activities. By 2009, the need for a Universal Worker job description was evident to both Eliza Jennings and the SEIU District 1199 Health Care and Social Services Union. Negotiations ensued and lasted for 3-4 months, resulting in an agreement between Eliza Jennings and the SEIU in October of 2009. The **MEMORANDUM OF AGREEMENT** states:

Eliza Jennings will introduce the Universal Worker concept in Household A, pursuant to the Roll-Out Plan previously presented to the Union. Prior to the introduction of the Universal Worker concept in the initial Household, a committee will meet to review the implementation plan in that Household. The committee will consist of up to five (5) bargaining unit employees of Eliza Jennings elected by the Union and such members of management as Eliza Jennings may deem appropriate. In order to address any issues which may arise during this implementation, the committee will meet monthly for a period of six (6) months to discuss, consider, and make recommendations relative to the concept and its further implementation. In the course of those meetings, the committee will also assess the implementation of the Universal Worker concept in the Households, in accordance with a set of appropriate criteria developed by the committee, and provide suggestions and recommendations for implementation in future Households and will continue meeting quarterly thereafter to work on the Specific Joint Goals of the program:

- ∞ *Improved resident care outcomes*
- ∞ *Improved working conditions*
- ∞ *Develop a way to measure Team concept*

Several components were critical to establishing the agreement.

According to the Union representative, **“As a Union, we want to improve care and are very happy to work with providers.....This is new for both them and us.....Eliza Jennings’ heart is in the right place and I would like to see them be successful because the concept is a good one.”** Primary concerns of the Union included: 1) How to determine who will get the jobs 2) Controlling job loss and 3) Assuring seniority in choice for workers. The Union also wanted to assure a communication mechanism to follow how the program would move forward.

Eliza Jennings responded to these concerns by 1) Creating job descriptions for Universal I and Universal II workers 2) Documenting a roll-out plan 3) Detailing a selection process for workers 4) Outlining specifics for training/working conditions and 5) Agreeing to a pilot program and monthly meetings for 6 months.

Eliza Jennings Recommendations from the Collective Bargaining Process:

1) Be prepared to address the Union’s questions and to have questions answered as an organization prior to negotiations to outline:

- ∞ Job description(s) - A primary concern for the Union will likely be layoffs. Job descriptions and discussions of hiring and seniority will be instrumental in negotiations. Note: Eliza Jennings has not experienced layoffs in the transition process.
- ∞ A roll-out plan and timeline - This is difficult for the Union to conceptualize. Details are key to assisting in visualization and allaying concerns.
- ∞ Specifics for training and working conditions

2) Timing is important. Eliza Jennings was able to negotiate the Universal Worker concept in a scheduled three year collective bargaining cycle. Thus, the concept was not the only issue to negotiate. In addition, if an organization is anticipating layoffs for some other purpose, the timing might not be the best for the Universal Worker negotiations.

3) Be prepared to have something to offer in the bargaining process. Eliza Jennings was

ready to offer wage increases. They also agreed to meet with the union quarterly during the rollout process which has been beneficial in addressing issues before they become formal grievances.

4) Stay the course. The process was long and methodical but Eliza Jennings was committed to the Universal Worker concept.

The Role of the Universal Worker



Roll-out Plan

Eliza Jennings is divided into six households. In the Universal Worker Roll-Out Plan, employees are given the opportunity to select households that they wish to be assigned to. Roll-out is in the process of occurring one household at a time to allow for employee choice, training and adjustments. In each household, aides are cross-trained in dietary and housekeeping skills (training takes up to two weeks). Aides are then deemed Universal Workers (UW) at the completion of training. Dietary aides and housekeepers are offered STNA training following the completion of the aides' cross-training. They must accept or decline the offered STNA training within five calendar days. If they decide to accept the training, EJ pays for it (training takes up to 4 weeks), and the employee is

then officially a UW in the household. If the dietary aide and/or housekeeper elects not to receive STNA training they can become a Universal Worker 2 (UW2) by agreeing to cross-train. If an employee declines to become a UW or a UW2, the employee is reassigned to a traditional household, and other employees (based on seniority outside of that household) would be allowed to bid for the vacant UW position.

Universal Worker Position

According to the Universal Worker Job Description, The primary purpose of this position is to work collaboratively as part of a household team to create an environment that encourages resident involvement and personal growth. Primary responsibilities include delivery of exceptional nursing care in a household environment, assistance with the delivery of an overall dining experience and the collaborative evaluation, assessment and implementation of programming that will mirror normal life activities of residents (to include the upkeep and management of personal living space) mental and emotionally engage their interest and assist them in recapturing the value of normal community life.

As part of the Human Resources evaluation process, Universal Workers are expected to “[c]reate and maintain an atmosphere of warmth, personal interest and positive emphasis” as well as “a calm environment throughout the household and the entire Eliza Jennings community,” including “honoring and supporting residents individual routines” and an expectation that the Universal Worker “creates opportunities for and honors resident choices.”

Transition Observations

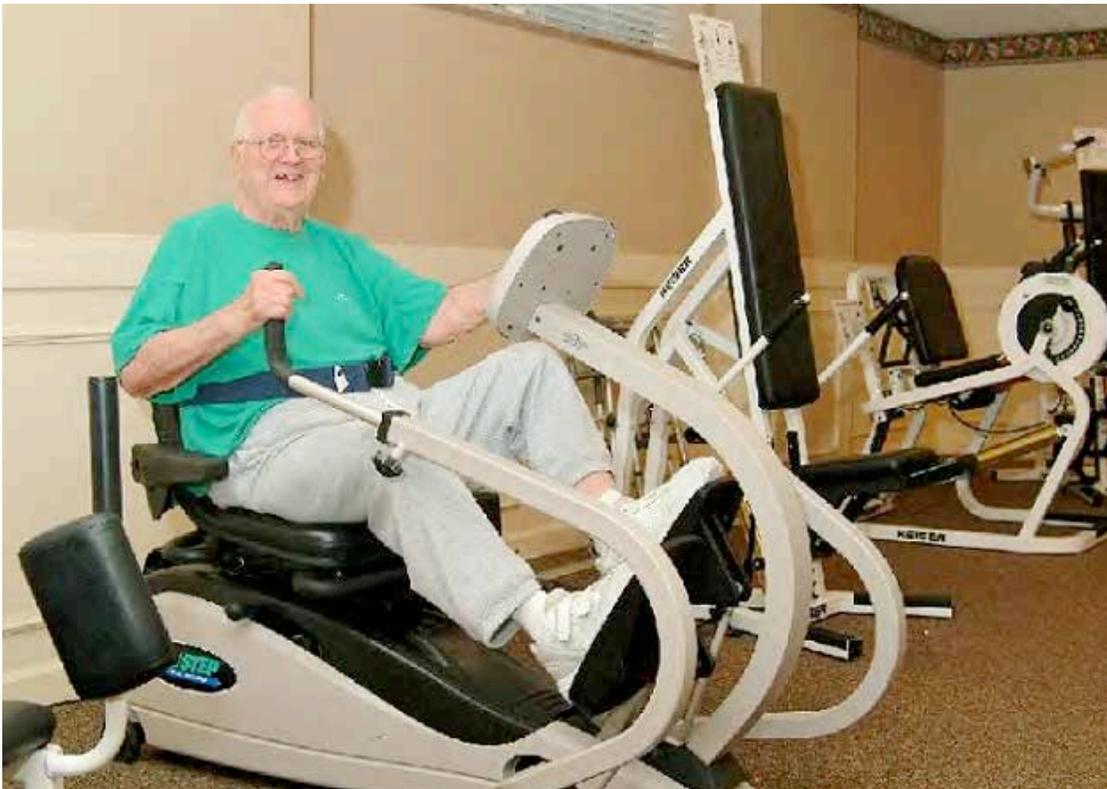
According to Universal Workers in the first household transition, **“We were already doing all of those things. As long as you have teamwork, everything will pan out.”** Part of the teamwork process is time management. **“We figure out what each of us is good at and likes to do and manage things that way.”** Some Universal Workers may be excellent cooks while others enjoy housekeeping. The team concept allows them to divide work in a way to accomplish these tasks efficiently. According to one Household Coordinator, **“You have to find each other’s high points and strengths.”** Overall, staff were very supportive stating that, **“We are able to do more for our residents.”**

A few challenges were noted by the team. Universal Workers reported that one-on-one time with residents was more challenging as they first began establishing new routines.

The concept also requires every worker to be very involved and not take advantage of colleagues. Finally, while the STNA's were already doing many of the household activities required by the UW position, there is potential for housekeeping and maintenance workers to not be comfortable with the more personal aspect of care. These workers will likely opt for the Universal Worker 2 position.

Residents reported that the transition was seamless. None of the residents interviewed had noticed any interruption or change in care. **“They just help you in everything you want to do. I can wake-up and go to sleep happy. The people are so nice and friendly.”**

Summary



Eliza Jennings has experienced numerous positive outcomes since implementing culture change and incorporating households in 2004. Annualized turnover decreased by over 50% from 2004 to 2009 (from 35.05% to 17.09%). Eliza Jennings was also recognized as one of Northeast Ohio's best places to work by NorthCoast 99 in 2005, 2006, 2008 and 2009. In addition, Eliza Jennings Home consistently performs above average on annual inspections conducted by the Ohio Department of Health and achieves superior results on resident and family satisfaction surveys. According to Eliza Jennings, this success can be attributed to number of factors:

- ∞ Eliza Jennings prides itself on the retention of a large percentage of our employees; annual turnover rates remain well below national benchmarks.
- ∞ Strong, stable and visionary organizational leadership, at all levels, generates significant strides in person-centered care initiatives.
- ∞ Superior staff retention, cross-training and consistency of assignments benefit both residents and staff by facilitating cohesive neighborhoods, improved interrelationship, above average staff and client satisfaction and, consequently, better outcomes.

The process of creating the universal worker job description and cross-training household staff has not detracted from these positive outcomes for residents, families or staff.

According to one family member, **“We value the personal care the most....We received notification of the universal workers and it’s been a seamless process because the care was already good.”**

All staff members interviewed discussed teamwork and all around resident care as positives of the experience but caution that it is a **“day by day learning experience. We are still learning as we go.”**

According to one resident (a sentiment echoed throughout the interviews), **“It’s like home. Family. Friends. We all get along wonderfully. I’m happy.”**

Restatement of Eliza Jennings Recommendations from the Collective Bargaining Process:

1) Be prepared to address the Union’s questions and to have questions answered as an organization prior to negotiations to outline:

- ∞ Job description(s) - A primary concern for the Union will likely be layoffs. Job descriptions and discussions of hiring and seniority will be instrumental in negotiations. Note: Eliza Jennings has not experienced layoffs in the transition process.
- ∞ A roll-out plan and timeline - This is difficult for the Union to conceptualize. Details are key to assisting in visualization and allaying concerns.
- ∞ Specifics for training and working conditions

2) Timing is important. Eliza Jennings was able to negotiate the Universal Worker concept in a normal three year collective bargaining process. Thus, the concept was not the only

issue to negotiate. In addition, if an organization is anticipating layoffs for some other purpose, the timing might not be the best for the Universal Worker negotiations.

3) Be prepared to have something to offer in the bargaining process. Eliza Jennings was ready to offer wage increases. They also agreed to meet with the union quarterly during the rollout process which has been beneficial in addressing issues before they become formal grievances.

4) Stay the course. The process was long and methodical but Eliza Jennings was committed to the Universal Worker concept.



Partners in Care

How the nation's largest home health agency is transforming its culture

By Matthew Ozga

January 2012

In 2006, Marki Flannery, the president of the New York City-based home care agency Partners in Care, was considering whether her organization should undergo some drastic changes—changes that would, if successful, result in a more efficient and effective staff of home care workers. While doing some research, Flannery and her colleagues stumbled over a statistic that instantly resonated with them.

“We were [reading] a white paper,” she recalls, “and this pretty thick document had information in there about an experience that a nursing home had. ...[T]he supervisors of the nurses’ aides in this particular nursing home were spending somewhere in the neighborhood of 70 percent of their time on disciplinary conversations.”

To an outside observer, 70 percent may seem like an unbelievable amount of time to spend on discipline-related issues. To Flannery, however, the statistic rang true, because she saw the same sort of thing happening at Partners in Care. Supervisors constantly had to call home health aides into their office to reprimand them, and, sometimes, to write

them up. Aides who were written up too many times were fired.

“That was a cycle,” Flannery says. “It was, you know, a lot of screaming at the aides, verbal yelling back and forth between the staff and the aides, bring them in, write them up—and it just felt like there had to be a better way.”

This cycle created a great deal of frustration among both aide supervisors and the aides themselves. Though overall, Partners in Care was considered a good place to work, with above average wages and benefits for home health aides, turnover was high and morale was low. From a business point of view, this was also expensive. It cost the agency over \$1,000 to recruit and train each new aide; plus, there were costs associated with supervisors spending so much time in discipline, and feeling stress and dissatisfaction with their jobs as a result.

With all that in mind, Flannery and the Partners in Care leadership sought to completely alter the culture of their organization.

This case study chronicles a multi-year journey that started with an invitation from PHI to participate in their Center for Coaching Supervision



Marki Flannery, President

About this publication:

This is a joint publication of the Pioneer Network (www.pioneernetwork.org) and PHI (www.PHInational.org). The author, Matthew Ozga, is a staff writer at PHI. Ellen Murphey and Christopher Cornog, freelance writers, also contributed to the research and writing of this publication.

and Leadership, and eventually progressed to training all 280 management/supervisory staff and all 9,500 home health aides in the core communication skills that are the foundation of the PHI Coaching ApproachSM (see page 3).

The results have been impressive.

The Challenge and the Opportunity

Founded in 1983, Partners in Care serves the entire New York metropolitan area: the five boroughs of New York City, Nassau and Suffolk counties on Long Island, and Westchester and Rockland counties upstate. Its staff includes physical therapists, nurses, social workers and home health aides—who provide home health services to elders as well as others in need of short-term rehabilitation or long-term support—and office staff who manage the client cases, finances, and human resources, especially the recruitment, supervision, and training of frontline staff.

At its founding, Partners in Care was a relatively small agency, with 62 home health aides and an in-house management staff of 14. Today, Partners in Care is an industry leader. With over 9,500 home health aides, and an in-house management staff of 280, it is the largest single employer of home health aides in the country. The home health aides are members of New York's largest and most powerful health care union, SEIU 1199. Partners in Care is also an affiliate of the Visiting Nurse Service of New York (VNSNY), the largest certified home care agency in the country. Thus, changes in workforce practices at Partners in Care ripple through the entire New York home care sector.

“Because of its size, its corporate relationship with the VNSNY, and its effective working relationship with SEIU 1199, Partners in Care's efforts to rethink its workforce practices have the potential to stimulate broader change in the sector,” said David Gould, senior vice president at the United Hospital Fund.

A licensed agency, Partners in Care provides services annually to over 20,000 home health clients. Each client has distinct needs, with services provided by multiple staff at different hours of the day and week. Managing these cases efficiently—including assigning and supervising the 9,500 home health aides who provide the vast majority of services—is crucial to Partners in Care's reputation for providing quality services and its success as a business.

In 2006, Flannery, who had been with Partners in Care from the beginning—advancing from manager to director to vice president to president—recognized that the organization's staggering growth had outpaced its internal capacity to manage such a large frontline staff. Time spent on disciplinary measures was far too high; retention of frontline workers, meanwhile, was unacceptably low. With more growth planned—including increased focus on growing its private pay business—it seemed the right time to focus on creating a culture that rewarded home health aides for being responsible, quality caregivers and more clearly communicated that management valued and appreciated their contributions to the agency.

“Partners in Care's efforts to rethink its workforce practices have the potential to stimulate broader change in the sector.”

—David Gould,
United Hospital Fund

Time spent on disciplinary measures was far too high; retention of frontline workers, meanwhile, was unacceptably low.

CCSL provided Partners in Care with an opportunity to build leadership, communication, and problem-solving skills throughout their organization.

Getting Started

The invitation to change

Flannery recognized the fact that the culture of her organization needed a drastic overhaul, but she says that she wasn't exactly sure how to do it. Then, in 2006, the agency agreed to participate in the PHI Center for Coaching Supervision and Leadership (CCSL), a four-year program funded by the John A. Hartford Foundation and The Atlantic Philanthropies. CCSL provided Partners in Care with an opportunity to build leadership, communication, and problem-solving skills throughout their organization.

Flannery, along with three other Partners in Care executives, first attended a PHI Executive Leadership Development seminar. The goal of the seminar was to encourage leaders of the long-term care organizations participating in

CCSL to support culture change by learning participative leadership skills and actively modeling the values they wanted their organizations to embrace.

Making a commitment

Flannery was impressed by the seminar and decided to make a serious commitment to the PHI Coaching Approach, beginning with sending several managers to the nine-day PHI Coaching SupervisionSM training. The training teaches supervisors four key skills—active listening, self-reflection and self-management, communicating expectations and concerns clearly and without judgment, and collaborative problem-solving (see sidebar). These skills help managers to support staff members while still holding them accountable when they do not meet expectations.

After attending the CCSL “train-the-trainer” seminar, the Partners in Care managers returned to work ready to conduct two-day Coaching Supervision seminars for their colleagues. The training took place on

weekends, and Partners in Care paid (and fed) participating staff, at a cost of approximately \$125,000 a year. “We did this because we wanted them to be fully present ... and we wanted to not make this a burden to them,” Flannery says. By the end of 2010, approximately 260 of Partners in Care’s home health aide supervisors and office staff had learned the core coaching skills that would change the way they approached their responsibilities as supervisors.

Reinforcing the training

Of course, one-time training sessions are not necessarily sufficient to ensure that supervisors will use and retain the coaching skills they learn. Partners in

PHI Coaching Supervision: Core Skills

The PHI Coaching Approach helps organizations—and the individuals in those organizations—build core communication skills that are essential to strengthening organizational relationships and managing change:

- ▶ **Active Listening:** Using body language, paraphrasing, and asking clarifying questions to listen attentively and ensure understanding.
- ▶ **Self-Management and Self-Reflection:** Being conscious of assumptions and biases, and setting aside emotional reactions that can get in the way of hearing someone else’s perspective.
- ▶ **Clear, Nonjudgmental Communication:** Communicating clearly and directly about expectations or concerns while using language free of blame and judgment.
- ▶ **Collaborative Problem Solving:** Using critical thinking and communication skills to build effective teams, ensure accountability, and resolve problems.

Partners in Care has developed strategies to reinforce skills after the training ends.

Care, thus, has developed strategies to reinforce the skills after the two-day Coaching Supervision training ends. For example, two weeks after training, trainees begin to receive weekly “gifts” from their former trainers—cheap, dollar-store trinkets that are intended to provide a reminder of Coaching Supervision lessons, such as the importance of active listening or asking open-ended questions. Partners in Care also posts signs throughout their offices with reminders of the skills learned.

To further ensure that Coaching Supervision truly takes hold with employees for the long term, Partners in Care in-house staff participate in monthly booster sessions, which allow supervisors and other office staff to practice and review coaching skills. “We hold each of the areas accountable to make sure that they hold these [booster sessions], because we want to sustain this,” Flannery says. The boosters last from 30 minutes to an hour, and there are up to 12 sessions held each month, giving employees flexibility in deciding which booster session to attend.

Cross-Functional Teams

Building “bridges” across the organization

In spring 2007, shortly after Partners in Care embarked on its journey to incorporate Coaching Supervision into its culture, the Partners in Care leadership established a new cross-functional team (CFT) to help guide the change process. The team was comprised of roughly a dozen Partners in Care employees, coming from all levels of the organization—trainers, home health aides, department managers, nurses, other office staff—providing a forum “where everyone has an equal voice,” Flannery says. CFT members can “test ideas, provide support [and] provide new ideas during the monthly meetings.” The team meets every month for approximately an hour and a half, and provides a way for members to work on further embedding the PHI Coaching Approach into the organizational culture.

Indeed, the CFT has become one of the driving engines of Partners in Care. “This is where all the decisions get made” regarding PHI Coaching Supervision and communications skills training for the home health aides, says Lorraine Earle, a CFT member since its inception. Earle says that Partners in Care could not have organized trainings for all of its employees without the CFT. The CFT has also been instrumental in monitoring the monthly Coaching Supervision booster sessions for their effectiveness and appropriateness, she adds.

Expanding the CFT concept

Many great ideas have emerged during CFT meetings, Flannery says. For example, she recalls an instance where trainers in the CFT gave other CFT members a “homework” assignment of devising new role-play scenarios that they could incorporate into their training. The CFT came through—“there were quite a large number of role plays that this CFT...came up with [and]

The CFT has become one of the driving engines of Partners in Care.



Lorraine Earle, Assistant Director of Certified Services and CFT member

The CFT meetings are critical to ensuring the sustainability of the whole Coaching Approach.

Partners in Care responded by undertaking the extremely ambitious project of training all of its home health aides in the PHI Coaching Approach to Communication.

brought back to the trainers,” Flannery explains. “They were fresh ideas that... [helped] make the training more interesting for the trainers as well as for the participants.”

The CFT meetings are critical to ensuring the sustainability of the whole PHI Coaching Approach, Flannery says. To that end, Partners in Care executive leadership has never once skipped or cancelled a monthly CFT meeting. “The fact that they continue with it tells us they don’t want to just give it up; they want to continue doing it,” says Maria Guzman, a trainer and a supervisor in the Partners in Care Bronx unit. “[It] helps the trainers because we know that what we’re doing counts.”

What happens in Vegas...

Flannery says that another reason it is important for the CFT to meet regularly is that it provides an opportunity for home health aides to express their opinions in front of Partners in Care executives.

“Everyone who participates [in the CFT] is an equal,” Flannery says. Flannery adds that the home health aide participants also don’t have to worry about risking their jobs by offending management: “We make it very clear that what happens in Vegas, stays in Vegas, in that room.”

“They listen to our stories,” says CFT member Delvena St. Prix Tomlinson, a home health aide, “and at the end of a [CFT meeting], they ask for our opinion and to give our experiences. We are given a chance to speak.” Laughing, she adds, “Being among the executives, it makes me feel like I’m on the number one team!”

Including HHAs in Training

The PHI Coaching Approach to communication

Coaching Supervision training was already well underway at Partners in Care when some of the organization’s home health aides began wondering when it would be their turn.

“It was the HHAs that participated in the CFT who asked, What about us? When are we going to get this training?” says Flannery. “So, we talked about it and they felt that it would be helpful to them to learn some of the same communication techniques, be they active listening or ‘pulling back,’ or learning how to interact with someone who may be angry with them, so that they themselves could be better equipped—not only in interacting with their clients, but also interacting with their supervisors and their nurses.”

In July 2009, Partners in Care responded to the desires of the home health aides by undertaking the extremely ambitious project of training all of its home health aides—8,500 at the time—in the PHI Coaching Approach to Communication. To roll out the program, the trainers who taught coaching skills to supervisors provided a train-the-trainer for the regular in-service training staff, so that they could incorporate the communications training into the ongoing in-service program.

Aides are more conscious of the messages they are sending to supervisors or clients through their facial expressions, body language, tone of voice, and the content of their speech.



Gale Storm, Education Manager

“Supervisors now listen to you more.”



Pauline Smith, Home Health Aide

Meeting this lofty goal...

Each half-day communication training session teaches home health aides the basic tools of developing their active listening and problem-solving skills, including pulling back (managing one’s emotional response) and paraphrasing. By design, the training sessions feature a very low student-to-instructor ratio, which allows for a greater level of in-class participation.

The drawback is that training such a large number of home health aides will likely take a while; as of late 2011, nearly half—4,430 of 9,500—had been trained. Those who have been trained so far, however, view the training “very, very favorably,” Flannery says.

Partners in Care managers say that they will eventually meet their lofty goal. They’ve already seen results, says Gale Storm, an education manager at Partners in Care. Aides are more conscious of the messages they are sending to supervisors or clients through their facial expressions, body language, tone of voice, and the content of their speech.

Following the training, aides are encouraged to keep in touch with their supervisors regularly, especially if they find themselves struggling with the communication skills they have learned.

“We encourage them to call if they need help in the field,” Storm says. “When you’re in the house with the client, it’s usually just you and the client... so you need to know that you have support waiting for you—you’ve just got to pick up the phone.”

Experiencing Tangible Results

A transformative change

The changes made at Partners in Care over the past several years have done far more than simply improve communications skills. According to Flannery, “Coaching Supervision has transformed the culture of this organization. Relationships between office-based supervisors and home health aides are much more positive.” Commenting on the change, Flannery notes that work in the office, which relies heavily on phone conversations with HHAs in the field, used to be loud and acrimonious, and is now noticeably quieter.

Coaching Supervision has made supervisors more aware of the tone they take when communicating with home health aides. It has encouraged supervisors to be more patient, especially during a delicate or contentious conversation. Maria Guzman, the manager of the Partners in Care Bronx unit, says that, prior to Coaching Supervision, some supervisors struggled with listening attentively and keeping their emotions in check while having difficult conversations with aides—but after undergoing Coaching Supervision training, those same supervisors exhibit remarkable levels of composure and empathy.

Home health aides also say they notice a difference in the way supervisors speak to them. “Supervisors now listen to you more,” says Pauline Smith, a home health aide who has been at Partners in Care for 12 years. “You’ll have a complaint, and the supervisors are more attentive to you and what you have to say. That way, we get better results: When the person is more

Supervisors and home health aides alike speak of the common vocabulary that the PHI Coaching Approach has taught them.



Maria Guzman, Manager, Bronx Unit

attentive to what you have to say, we have things going smoother.”

That attentiveness is built into the Coaching Supervision training. Supervisors are trained to encourage open, back-and-forth communication with home health aides—to ask home health aides their opinions, not just tell them what they should do. This approach causes home health aides to “become even more committed to what they are going to be doing,” says Lorraine Earle, the assistant director of certified services at Partners in Care. “Many times when you tell people [what to do], it’s the way you want it to be done.... A mix of what you intend to do and how I would do it is always better. And people feel committed when they’re part of a plan.”

This new approach to problem-solving has been reinforced by having home health aides participate in the PHI Coaching Approach to Communication training. Supervisors and home health aides alike speak of the common vocabulary that the PHI Coaching Approach has taught them—the entire organization is learning what phrases such as “pull back” and “paraphrase” mean, and staff remind each other of their importance regularly. “Whenever you tell someone, ‘Did you pull back?’ or ‘Are you paraphrasing?’, they immediately know what you’re talking about,” Guzman says. “Because of the training, everybody’s on the same page.”

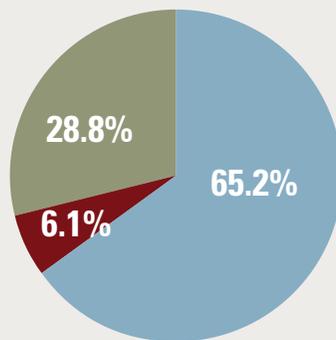
Survey Results

In 2010, three years following the first PHI Coaching Supervision trainings at Partners in Care, evaluators surveyed supervisors trained in the approach. Survey results showed that the majority of supervisors felt the training improved relationships, teamwork, and the ability to solve problems.

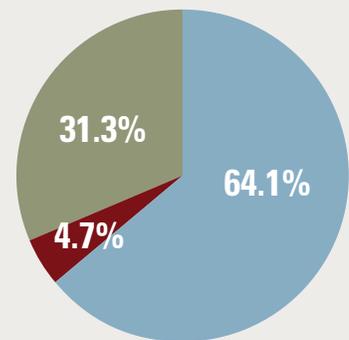
- Improved
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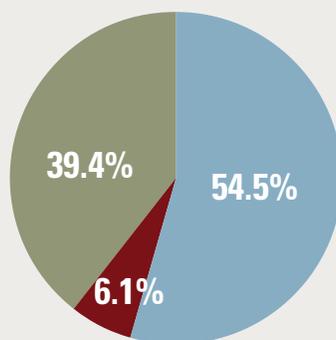
Since Coaching Supervision training, the staff’s ability to resolve conflicts at the workplace has...



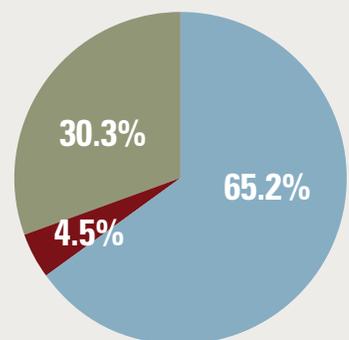
Since Coaching Supervision training, the overall relationship between staff and clients has...



Since Coaching Supervision training, the overall relationship between staff has...



Since Coaching Supervision training, the quality of teamwork within my organization has...



“I think the culture has really changed a whole lot” due to the coaching training, adds Earle. It’s become so ingrained in the day-to-day activity of Partners in Care, in fact, that supervisors and other office staff can remind each other to practice good communication skills “just with an eye, or a tap,” she says.

Less time spent on discipline

One of the most positive outcomes that has resulted from the culture change effort at Partners in Care, and the Coaching Supervision training in particular, is the fact that supervisors spend far less time disciplining home health aides. And when it is necessary to discipline them, supervisors do so in a far more productive way than before, actually taking the time to ask the aides to come up with their own solutions to problems that interfere with their work performance. “In the past, people tried to problem-solve for [the] home health aides,” Earle said.

For example, if an aide showed up to her assignment late, the supervisor would threaten her, telling her to be on time no matter what. Now, Earle says, “We allow the home health aides to be very much a part of their own problem-solving process... [We don’t] just tell them to get an early train or to get a back-up plan for a baby sitter.” Instead, supervisors work with the home health aides to devise a better solution to the ongoing problem, even if that means being more flexible than they would in the past. “Maybe they have to start at a later time: 10 o’clock rather than 9 o’clock,” Earle says.

“In the past,” Earle continues, “people would have just gotten very upset that they had to place a case at the last moment” to replace a tardy aide. Today, however, supervisors are “very, very careful about what they say to an aide, knowing that the same situation can happen to them—people really stop and think before they make any adverse comment to the home health aides.” Earle’s comments point to the culture of respect that has evolved with the implementation of the PHI Coaching Approach.

Today supervisors are “very, very careful about what they say to an aide, knowing that the same situation can happen to them...”

—Lorraine Earle, Assistant Director of Certified Services

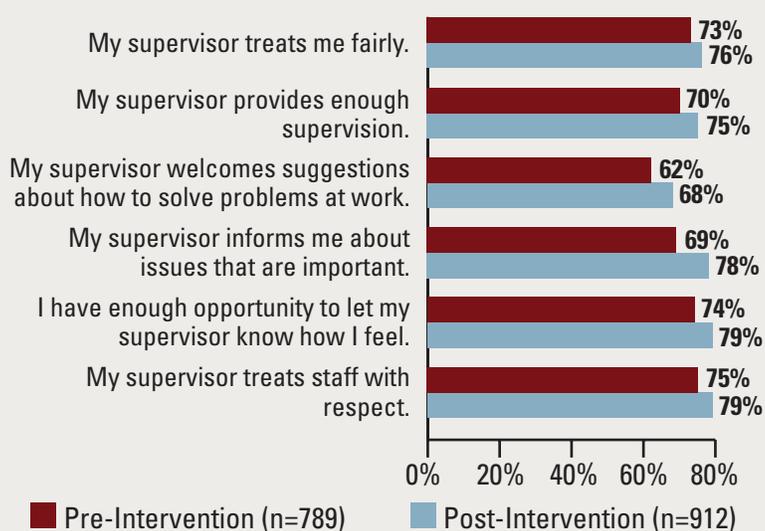
Figure 1. Supervisory Staff Turnover Before and After Implementation



Improved job satisfaction and reduced turnover

There is additional, more tangible evidence that Partners in Care has made a worthwhile investment in changing its culture. Staff surveys administered before and 18 months after the coaching training show improvement in job satisfaction for all staff as well as reduced turnover for supervisors (see Figure 1). In addition, home health aides feel strongly that supervisors are treating them fairly and respectfully (see Figure 2). In fact, taken together the shifts seen in the six survey items related to supervision were statistically significant—an indication that these changes were not due to chance but rather to a change within the organization or environment.

Figure 2. **Supervisory Support: Percentage of HHAs Agreeing/Strongly Agreeing**



The culture of respect and support has helped to bring stability to a growing staff.

Not only have supervisory relationships improved, so has the delivery of services.

Importantly, over 80 percent of surveyed aides indicated that they would recommend Partners in Care as a good place to work.

Retention of home health aides in an organization as large as Partners in Care is influenced by many factors. According to employees at all levels, from home health aides to executives, the culture of respect and support that has developed throughout Partners in Care as a result of their participation in CCSL has helped to bring stability to a growing staff. Turnover rates for home health aides remain steady at about 25 percent—considerably lower than the industry average of 40 percent. “I do think that the work that we’ve done as a result of our training with PHI... has had an impact on our retention of our staff, because what we hear consistently is staff feel that we care about them, and that we

respect them, and that we want to make sure that we are doing everything we can to support them and show them that we appreciate them,” Flannery says. “I think that makes a big difference.”

Improved communication with clients

As a result of creating a coaching culture, managers at Partners in Care say that not only have supervisory relationships improved, so has the delivery of services. Supervisors, who often are called on to help home health aides resolve issues with clients, have developed better communication and problem-solving skills, which allow them to provide better support to both clients and aides.

Nancy Ramirez, one of the Partners in Care supervisors trained in PHI Coaching Supervision, says the PHI Coaching Approach helped her resolve a problem client case that had been a thorn in her side—and a big drain on her time and energy—for over a year.

The scenario: The client, who we’ll call Mrs. X, had been sent several different aides, one after the other, for almost 18 months. At first Mrs. X always said she liked the new aide, but after three or four months she would call Partners in Care to complain.

“This aide doesn’t do anything,” she’d say. “She’s not right for the job.” Each time, she demanded a new aide. A new aide would be sent, and after another three or four months, the same scenario invariably unfolded.

Ramirez respected the aides and believed that they were doing their jobs well. She decided that, in this case, it would be appropriate for her to visit the client herself and assess the situation.

The visit: With some trepidation, Ramirez—along with a VNSNY nurse—went to see Mrs. X.

Ramirez, who was used to Mrs. X's booming, angry voice on the phone, was expecting a fight. She was preparing to pull back. But after knocking on the door, she was surprised to be greeted by a small, stooped, white-haired, fragile-looking, and very elderly woman.

"Mrs. X?" asked Ramirez doubtfully. Mrs. X then opened her mouth—and in an incongruously booming voice regaled Ramirez with a list of her numerous medical ailments. Mrs. X's current aide was there as well, and in an exchange of glances with the aide, Ramirez understood that this was Mrs. X's routine.

Using the PHI Coaching Approach: Over the next hour, Mrs. X recounted the story of her ailments several times, very loudly. It was daunting for Ramirez and required all of her recently learned "pull back" skills to maintain her composure. But as a result of her coaching training, Ramirez was able to see that more than anything else, Mrs. X mostly wanted the attention of someone who would listen to her, and did not know a better way to get it.

Drawing on the active listening and paraphrasing skills she had learned, Ramirez gave her full attention to Mrs. X. The complaining slowly wound down, and eventually stopped. Mrs. X began to talk about other things, and a real conversation began to develop.

New Information: Shortly thereafter, a new piece of the puzzle emerged when Mrs. X's grown son came in, said hello, and went off to his room. The PHI Coaching Approach training that Ramirez had experienced emphasizes reading body language as well as verbal cues, and Ramirez noticed at once that Mrs. X went stiff and quiet when her son entered the room. Mrs. X seemed scared of her son.

Ramirez later confirmed this suspicion with the aide, who explained that Mrs. X was terrified of her son's temper and that once her son came home, she became silent and required complete silence of the aide as well. She sometimes required her aide to just sit and do nothing. Later, however, Mrs. X would call the agency to complain that the aide was not helpful.

The outcome: In one brief home visit, Ramirez used virtually all of the skills she had learned in the coaching training to gain a much fuller understanding of the situation, both from Mrs. X's and the aide's point of view. Her view of Mrs. X had shifted radically—from a ferocious "battle axe" to a fearful old woman who was desperate for real attention.

With this understanding, Ramirez was finally in a position to give Mrs. X the help she needed. She worked with others at Partners in Care to come up with a long-term solution for Mrs. X's care, and arranged for a social worker to intervene with Mrs. X's son.

"I had moved from the mindset of 'this client is a problem' to 'this client has a problem,'" Ramirez said. "And we can help her with it."

Home health aides deliver better care

All of the internal changes at Partners in Care, Flannery says, are also contributing to higher-quality level of care provided by home health aides because "if the aides feel more valued...their whole approach with their clients is going

"Aides are using these skills to listen to their clients differently, and to focus on what the real issue is."

—Maria Guzman

Foundation for New Business Opportunities

The organizational culture change that Partners in Care has made, according to Flannery, has positioned the agency for new business opportunities. Partners in Care is expanding its private pay business. That market, more so than its traditional business—which is paid for through Medicaid and Medicare—is going to be sensitive to quality issues. And as Flannery is quick to point out, clients of home health agencies typically value the relationship with their aides more than any other aspect of their care. Clients who don't have good relationships with their aides are far more likely to break their connection with Partners in Care and look elsewhere for care.

"In trying to grow the private pay business, we've been doing focus groups and meeting with former customers, potential customers, to try to get at the attributes that they are looking for," says Flannery. "We know that clients want aides they can talk to easily, who will listen and understand, and whose company they can enjoy. They want to look forward to seeing their aides."

From their focus groups, Partners in Care developed a positioning statement, what they call their "brand promise":

We will listen, understand, and go the extra mile to accommodate your needs.

Flannery notes, "We looked at our brand promise and realized what we're doing with the PHI Coaching Approach absolutely ties in and supports what we are hoping to accomplish in our brand promise. This change in our culture—which is really all about strengthening relationships between staff and between staff and clients—is most definitely going to help support the growth of our private pay business."

Changing the culture in an organization with nearly 10,000 employees takes strong leadership and participation at all levels.

to be [changed], and the clients are probably having a better experience."

The positive effects have become even more evident as home health aides have joined their supervisors in learning the core communication skills of the PHI Coaching Approach.

According to Maria Guzman, manager of Partners in Care's Bronx unit and one of the Partners in Care trainers, "Since home health aide training began in July [2009], we are really seeing the effect. Now the aides are on the same page as the supervisors, and they are able to communicate better. We're getting good feedback from aides and clients. Aides are using these skills to listen to their clients differently, and to focus on what the real issue is. They're really listening and asking the right questions."

Aides are finding the communication training inspiring and useful. "They're all thankful that they had the training," says Guzman. At monthly booster sessions—or when Guzman is just walking down the hall at the agency—aides run up to her, eager to tell how they have implemented their training on the job.

"Maria! I used the skill! I used the skill!" they say. Guzman is thrilled. "There's no better satisfaction for a teacher than a student who has put her learning to use and been changed by it," Guzman concludes.

Lessons Learned

Changing the culture in an organization with nearly 10,000 employees is a massive task

that takes strong leadership and widespread participation at all levels. The Partners in Care journey provides lessons for other long-term care organizations invested in creating workplace cultures that are supportive, respectful environments in which staff at all levels thrive—and as a result provide the very best care and support to those they serve. Some of the key factors in Partners in Care's success have been:

Including everyone in training: Over the last several years, Partners in Care's leadership has learned that the changes they have made to the organization cannot fully take hold unless all staff, from top to bottom, are fully invested in them. To that end, the organization has been extremely diligent in making sure that everyone receives training in the PHI Coaching Approach:

Leaders at Partners in Care not only embraced the concept of coaching, they embraced the practices.

The signs of that commitment are literally hanging on the walls of Partners in Care's office in midtown Manhattan.

Coaching Supervision for managers and supervisors, the Coaching Approach to Communication for frontline staff. Flannery says that the total commitment to the training initiative—"from myself straight through to every single person in this organization"—has been the principal reason for its success.

Modeling change: Leaders at Partners in Care not only embraced the concept of coaching, they embraced the practices. Everyone, including Flannery and her top leadership staff, models the skills and behaviors learned in the coaching training. This has been critical to achieving the culture of respect that now permeates the organization.

Ongoing training: The organization also hasn't wavered from its goal of maintaining regular booster sessions for supervisors and office staff, and it constantly monitors and reviews the effectiveness of the training.

"I would say this organization is totally committed" to supporting its trainers, says Lorraine Earle. "We are constantly looking for ways for improving, and how we can better serve," she adds. "We didn't just start and stop—we didn't [train] just one set of people and say, Okay, it stops here."

Integrating the change into daily practice: The signs of that commitment are literally hanging on the walls of Partners in Care's office in midtown Manhattan. "If you look around the office," Flannery says, "there are signs everywhere: coaching tips, things people need to keep in mind." Partners in Care has incorporated the coaching lessons in countless other subtle ways, from inspirational messages printed on employees' pay stubs to buttons and t-shirts worn around the office that say "Coaching Supervision Makes a Difference—Ask Me About It." Supervisors disseminate "mini-boosters" through email, reinforcing the skills learned through the initial trainings.

When asked, "Is coaching working?" Pauline Smith, a home health aide at Partners in Care for 12 years, says, all the aides are talking about the coaching experience. "So I can say, yes, it's working. It has become a part of us now."



Pioneer
Network

Pioneer Network (www.pioneernetwork.net) is a center for all stakeholders in the field of aging and long-term care whose focus is on providing home and community for elders. We believe that the quality of life and living for America's elders is rooted in a supportive community and cemented by relationships that respect each of us as individuals regardless of age, medical condition or limitations.

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PHI (www.PHInational.org) works to improve the lives of people who need home and residential care—and the lives of the workers who provide that care. Using our workplace and policy expertise, we help consumers, workers, employers, and policymakers improve eldercare/disability services by creating quality direct-care jobs. Our goal is to ensure caring, stable relationships between consumers and workers, so that both may live with dignity, respect, and independence.

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