REPORT ON FEBRUARY 25, 2010
LONG-TERM CARE LEADERSHIP ROUNDTABLE
Washington, DC

Participants: See attached list.

REVIEW OF MEETING OBJECTIVES

On February 25, 2010, Planetree, in partnership with The Picker Institute, brought together some of the most innovative minds in culture change today to tackle the most persistent challenges to deep, systemic change in long-term care. Funded by the Picker Institute, the Long-Term Care Leadership Roundtable was a unique opportunity for leaders from such esteemed culture change models as Eden, Wellspring, Green House and Planetree to exchange ideas, debate myths of culture change and challenge long-held conventions alongside long-term care administrators, nurses, gerontologists, researchers, funders and representatives from trade associations. Discussion ranged from the systems-level changes necessary to affect widespread culture change to opportunities to influence culture and practice on the local level in distinct environments where people live and work in the same place.

The rich dialogue that ensued at the Long-Term Care Leadership Roundtable will guide Planetree in developing a Long-Term Care Improvement Guide, as a companion to the Patient-Centered Care Improvement Guide released in October 2008 (www.patient-centeredcare.org).

Informed by the comments of short-term and long-term residents in nursing homes, assisted living communities and rehabilitation centers that were captured during Planetree focus groups over the past two years, the agenda for the day focused on barriers and facilitators to individualizing support and services for residents and the enhancement of meaningful relationships in long-term care settings. Within these broad focus themes, a number of key concepts emerged during the discussion, each of which will be reflected in the Long-Term Care Improvement Guide.

While many of the overall barriers and facilitators that surfaced in our discussions are not *new* concepts, their re-emergence at the meeting further crystallized what is important and will subsequently help to sharpen the focus of a series of best practice site visits to be made in spring of 2010. The purpose of these site visits is to identify specific tactics and practices relevant to each of the key concepts that will strengthen the case for adoption for culture change. To illustrate how the dialogue at this meeting will inform those visits, for each concept identified below we have listed specific practices to explore and questions that will be posed.

KEY DISCUSSION CONCEPTS

1. CULTURE CHANGE IS ALL ABOUT RELATIONSHIPS.

"Care is about more than treatment. It's about the relationship."

"The culture should be one where every single employee sees every interaction, whether it is a medical task or fixing the television, as an opportunity to connect with the individual."

Whether it is the relationships that develop between residents, between residents and staff, between staff and leadership or between staff and families, cultivating an environment that nurtures relationship-building will both enrich the day-to-day lives of individual residents and staff, and the community as a whole. Prioritizing relationships over tasks and efficiency, though, is a paradigmatic shift. It is a shift that requires realignment of management style and vision, human resource systems and the physical environment around the paramount importance of respectful, reciprocal and genuine relationships.

To develop relationships we must also explore the cultural divisions that exist, including differences between short-term and long-term residents, levels of care, ethnicity, class and lifestyle. Sensitivity training for all staff, residents, and families was discussed as an important aspect of building strong trusting relationships and a community of mutual respect.

Other facilitators to building relationships that surfaced during the discussion include consistent assignment, evaluating correlations between relationship and organizational size/scale, community meetings, honoring individuals regardless of limitations, establishing mentoring resident-to-resident relationships as well as resident-to-staff relationships, learning circles, communication policies around deaths and hospitalization, support for grieving and acceptance of death, welcoming processes, community rituals, dispelling fear of cognitive disability, and hiring and human resource practices.

Questions for sites relevant to this concept:

1. How do you sensitize staff to the resident experience in such a way that honors the individuality of residents and the diversity of the community?

2. How do you sensitize residents to the experiences of other residents?

3. How do you support the community through death and grieving?

4. How do you inform a resident's friend about a change in their condition (or death)?

5. What practices do you have to honor the passing of a resident?

6. How have you been able to implement and maintain consistent staffing (systems processes)?

7. Do your residents play a part in the selection and hiring of new staff?

8. What systems do you have in place to introduce new staff and residents to the community?

9. Tell me how you organize your home, e.g. length of stay, payer source, cognition, and explain why you think it works or doesn't work.

10. What mechanisms do you use to create community within your home, e.g. councils, committees, regular meetings (unit, facility etc.), learning circles?

2. THE IMPORTANCE OF AUTHENTIC EXPERIENCES.

"How do we support the rhythms of life in these places where residents are living and people are working?

"When residents know that aides have permission to provide the care they really want, they are much more likely to feel comfortable asking for things."

Lives are being lived within long-term care communities—not simulations of lives. Accordingly, efforts to *approximate* real life as part of culture change efforts simply do not suffice. A multi-purpose room, for instance, is an institutional setting where any number of planned activities may take place. A café, though, is a destination where two friends may catch up over coffee. Planned activities may provide important opportunities for relationship-building, but they should not come at the expense of a resident's personal penchant for solitude nor of more organic activities that naturally unfold throughout the day.

Living authentically not only involves choice, it also inherently involves occasional risk. For some residents, going for a walk may result in a fall, but to eliminate the opportunity for a resident to take walks out of fear of what may (or may not) result not only eliminates the risk of a fall, it also eliminates an important, authentic experience in the life of the individual. This concept of redressing the balance of risk and reward must inform culture change efforts, with communities re-considering their attitude toward risk through the lens of the primary importance of authentic experiences.

Another important topic of discussion was the difference between choice and negotiation. As an example, a community may think they are meeting individual preferences by providing residents a choice between an afternoon or morning shower. This approach, however, continues to evoke for residents a sense of coercion and lack of control. A different approach for meeting individual preferences is asking the resident the time they would like a shower and negotiating ways to meet that need. The staff in turn must feel "the permission" and control to accommodate the

resident's wishes. Ultimately, resident and staff autonomy along with a process of negotiation supports a culture of co-equals.

Some of the facilitators discussed included the importance of beginning to establish a relationship with the resident within the first 24-48 hours of admission. This would include sharing with them information about the home and those who live and work in it, but also discovering those things that are very important to the new resident (e.g. rising, sleeping times, bathing times, need for communication with family, etc.). A process then needs to be established for updating information as preferences change and having this information collected by staff closest to the resident. Other facilitators include reviewing environmental factors that contribute to authentic experiences, policies as well as education of residents/families when dealing with risk, and dispelling prevailing myths that regulations prohibit the activities or timing of activities involved.

Questions for the sites relevant to this concept:

1. Describe the first 24-48 hours when a resident moves into the community. How do you get to know them? How do they get to know the community? What are you doing to set expectations re: choice and individualized support and services?

2. What specific tools do you use to support orientation efforts for new residents and their families? How do you evaluate the effectiveness of these tools and the processes they support?

3. How does each person's plan for care and services reflect their current wishes?

4. How does each person's plan for care and services provide opportunities for personal growth?

5. How does the physical environment support the desired lifestyle of each of your residents, (for instance, access to the outdoors, spaces for conversations and intimacy), and how do staff support authentic interactions and authentic experiences?

6. How do staff learn about each resident's wishes and lifestyle preferences?

7. What things (e.g. systems, materials) are available to staff to facilitate their supporting the desired lifestyle of each of your residents? (*For instance, several people have chauffer licenses so when a group of residents wants to go to Walgreens, or out for a pizza, they can take them.)*

8. Are there regulations that staff believe (or believed) inhibit or prohibit resident choice or involvement in authentic experiences? Please provide examples.

3. QUALITY OF CARE AND QUALITY OF LIFE ARE NOT MUTUALLY EXCLUSIVE.

"Why are we still talking about quality of life and quality of care and why are we not just talking about quality? It's time to say enough already."

"We should not separate quality of care and quality of life, just like we should not separate out residents and staff because it all works out best when it is aligned…A bad experience for residents is a bad experience for staff."

While assisted living in some cases may provide an environment for enhanced quality of life, maintaining quality of care is a challenge as individuals age in place. Conversely, nursing homes have been focused on providing quality of care while often missing opportunities to support quality of life. In both settings, within the context of relationship- and community-building, there are important aspects of care and life that have to take place. One, though, need not trump the other. These are not competing aims; and in fact, a dual focus on quality of care and quality of life has the potential to ultimately enhance both. This necessitates expanding the scope of care planning beyond specific care tasks to include an understanding of the resident's lifestyle and preferences as they evolve over time.

Facilitators related to this concept include care planning processes that involve residents, family, and staff and address both lifestyle preferences and care needs, monitoring of both quality of care and life indicators, and a state survey process that focuses on both quality of care and quality of life.

Questions for the sites relevant to this concept:

1. How is quality measured in your community?
2. How do you manage residents' pain in this facility?
3. How do you establish "individualized" medication schedules which respect the needs of the resident?
4. What efforts have you made to keep the number of medications to a minimum for each of your residents?
5. Describe your palliative care (end of life) program.
6. Describe how you help all residents to maintain current advanced directives or a power of attorney for healthcare.
7. Do you have an ethics committee that deals with ethical issues when they arise (e.g. a resident who has swallowing difficulties refuses to have pureed foods)?
8. What is your dietician's approach to diet restrictions for your residents? (e.g., salt free, no sweets, etc.)?

4. INCENTIVES SHOULD BE DESIGNED TO ENGAGE LEADERSHIP IN CULTURE CHANGE PRINCIPLES.

"You can't blame the point of the needle for where it landed on the phonograph; it's the arm that places the needle there. When staff are being told to pick up the pace, it's the systems and management practices that are shaping how staff are interacting and the relationships they develop."

"People behave based on incentives – so what are the incentives that drive the system? We don't have the right metrics to create change. The default metrics are the bottom line and surveys."

"The turnover of administrators is a major problem"

"If a staff member feels vulnerable to being fired because of a deficiency, that is a real barrier to a relationship"

In many ways, culture change efforts relocate the locus of decision-making power to residents and to those closest to residents (family members and staff who work most closely with them.) This is not to minimize, however, the role of leadership in culture change. Leadership engagement and support is fundamental to any effort toward organizational transformation. Not only do leaders galvanize the community around a shared philosophical vision, but they must also ensure on a practical level that operational priorities, expectations and policies are consistent with that vision. To espouse the importance of relationships and authentic experiences as top priorities while only providing staff with metrics related to financial performance and deficiencies creates a disconnect that only leaders are in a position to address. As was pointed out on numerous occasions during the Leadership Roundtable, it is a fallacy to conclude that residents' individualized needs are not being met because it is inconvenient for staff; rather it's the pervasive culture of staff feeling pressured to conform and comply with a flawed system that is the greatest obstruction to change. Only when leaders—at both the local and the systems level—realign the definition of quality and incentives to reflect what is truly important will real change take root and flourish. Not to be overlooked is the potential for this new measuring stick for success to also assist with retention of administrators and staff alike.

Questions for the sites relevant to this concept:

1. How does leadership measure their success?

2. What are the incentives that drive administrators in culture change communities?

3. How do leaders balance operational, financial and culture change priorities?

4. What are some of the activities that you engage in to demonstrate the vision you have for culture change?

5. Do the job descriptions for staff and leaders include statements on how they are to contribute to the organization's culture change goals?

6. Do the annual evaluations for staff and leaders include how they, individually and collectively, are contributing to the leader's vision for culture change?

7. If there is a corporate structure (multi-facility), how do regional managers support facility leadership in achieving their culture change goals?

5. SENSITIVITY TRAINING MUST COINCIDE WITH A PROCESS FOR SYSTEMIC CHANGE.

"Empathetic, sensitivity experiences are very powerful, but if not linked with systems change, you are adding stress to the staff that cannot change the system."

"When we look at staff and resident relationships, I hope we don't just do more sensitivity training but look at the drivers that set the pace for how care is given."

"It is not the artifacts or the programs that need to be further discovered and exploited, rather it is the fundamental process of implementing and sustaining change."

Well-meaning leaders often focus on sensitivity training as a key strategy for affecting change. This approach, however, is short-sighted and puts the community in the difficult (if not impossible) position of trying to make changes in a deeply flawed system. In the absence of a concurrent process to gather perspectives of all stakeholders as a means to prioritize opportunities for improvement, change will remain elusive. A defined improvement process *and* sensitivity training that involves *all* stakeholders in the community is essential. When leaders engage an entire community in transformation we move away from the concept of making changes *for* a community to making changes *with* a community.

As an example, learning circles that engage all community stakeholders build sensitivity while unraveling "the system." To rebuild "the system" leaders must ensure that sacred time is set aside for the right answers to emerge. As all of the possible solutions are discovered, a process for prioritizing the opportunities for change is the next important step to not only implementing change, but sustaining it.

Some of the other facilitators discussed include work-based learning strategies, orientation for residents on working with their caregivers, conducting focus groups with all stakeholders, and creating community goals with all stakeholders.

Questions for the sites relevant to this concept:

1. How do you gather perspectives of all stakeholders?

2. Describe the process that is used to establish and prioritize goals for transformation.

3. Describe a system/process that you have changed in order to support culture change.

4. How are staff, residents and families involved in the process of change?

5. How do staff, residents and families provide you with information about what systems/processes need to be adjusted in order to meet their individual lifestyle preferences?

6. What resources and tools have you accessed to support the process of change?

7. What partnerships have been developed to support culture change goals?

6. EMBRACING CONFLICT IS ESSENTIAL TO THE MOMENTUM OF CHANGE.

"We need to be able to celebrate mistakes – looking at the problems on a daily basis is important and when there is discussion about a topic, it's out in the open."

"Traditionally, good managers are the ones who minimize conflict, not embrace it".

Embracing conflict is not only a means to building relationships but also to finding the *right* solutions for change. If conflict is not supported, staff may avoid challenging discussions, revert back to old practices and make decisions based solely on what will result in the least resistance. Leaders often misunderstand the realities of a problem when the staff is avoiding the truth to minimize conflict with co-workers. In addition, a collaborative work environment is created when leaders and staff engage in a review of the system—as opposed to a person—as the root cause to a problem. Ultimately, how problems are resolved and handled on a daily basis can greatly impact the momentum and buy-in to making changes.

Facilitators discussed related to this concept include the need for consistent coaching of staff, training on conflict resolution, and effective processes for problem-solving and decision making inclusive of all stakeholders, celebration of mistakes, and root cause analyses.

Questions for the sites relevant to this concept:

1. Describe the process for how problems and concerns are gathered in this community.

2. Describe the process for how problems and concerns are addressed in the community.

3. How are the resolutions to issues communicated?

4. Has all staff received training on conflict resolutions?

5. Describe how problems and concerns are addressed through a performance improvement process. Are they built into the performance improvement committee? How are the minutes from this meeting disseminated?

7. TEAMWORK IS NOT INNATE; IT MUST BE CULTIVATED.

"You cannot be successful as a nurse unless dietary is successful."

*"High functioning teams make a huge difference…
they can make decisions quickly and more effectively."*

"Teamwork is a guided process… communities need to determine who the team is. How is teamwork defined? And what are the markers of team behavior?"

Leaders reflected on quantitative data provided by My Inner View that indicates that teamwork has minimal correlation with staff's eagerness to recommend the facility as a place to work. The question raised was whether employees understand who their "team" is and how important teamwork is to satisfying residents, a strong correlation to staff satisfaction. Breaking down the silos between departments, shifts, and roles involves an intentional process of creating self-directed teams. Leaders must actively guide this process until markers of teamwork such as effective communication, interdependence, and accountability are realized.

Questions for the sites relevant to this concept:

1. How are teams defined in your community?
2. What types of teams have you established in this facility? What is their purpose?
3. What systems are in place for shift-shift communication?
4. What systems are in place for the results of a care/service-planning meeting to be shared with the team caring for the resident?
5. What members of the team participate with the resident in the creation of the plan for care and services?
6. What systems or processes are in place so that departmental silos are broken down in this facility? (i.e. dietary and nursing)
7. What do you look to for measures of successful teamwork?

8. THE LANGUAGE WE USE IS A REFLECTION OF CULTURE.

"'Resident-centered' suggests that the needs/desires of the individual are greater than the needs of the others in the social setting. We all live in social settings with interdependencies – we all make compromises. It requires discussion and negotiation – between residents, between staff, between residents and staff."

"Nursing homes are also serving short-term patients, who do not want to be referred to as residents."

"Maybe the answer should be relationship-centered. That is powerful because it leaves no doubt…it's all inclusive."

Language shapes our way of thinking, and as such, thoughtful use of language is essential when it comes to culture change. Beyond "institution" versus "home" and "facility" versus "community," the language we use to guide the day-to-day living that goes on in communities can either reinforce significant cultural shifts or undermine them, e.g. patients versus residents; workers versus staff, care versus support and services.

Questions for the sites relevant to this concept:

1. What language do you use to describe your vision?

2. What language changes do you feel are essential to transforming your culture?

3. How do you encourage your staff to use language that is consistent with your culture?

4. How are staff oriented to the language acceptable in your home?

9. CULTURE CHANGE WILL REMAIN THE EXCEPTION VERSUS THE EXPECTATION WITHOUT A STRENGTHENED CASE FOR ADOPTION

"Who is <u>not</u> at the table – the executives – the CEO, equity firms, wall street. They have the power to make the decisions. Who are the influencers at that level?"

"It is going to take much more than influencers. Research needs to be done!"

The case for adoption moves beyond the business case. It is not only about the return on investment but also encompasses clinical outcomes, changes in the survey and quality indicators, and the effects on resident and staff satisfaction. Establishing a case for adoption also involves continued development and evaluation of metrics that drive and sustain progress. Ultimately, the overall outcomes of transformation need to link strategies back to the business case. The questions for sites, then, become how to develop a more comprehensive message and

measurement strategy, and then how to leverage it to bring policy makers, payers, regulators, and "the executives" to the table to ensure that culture change is in fact, *the expectation.*

Question for sites relevant to this concept:

1. Why did your organization decide to embark on a journey of culture change?

2. How are you monitoring your effectiveness in reaching those aims?

3. How are you measuring the overall impact of culture change in your community? Have you monitored the financial investment?

4. How are you sustaining changes?

5. What is your succession plan to ensure your vision is carried forward?

10. RAISING CONSUMER EXPECTATIONS

"When I have a relative who needs skilled care, they don't ask where is the closest place that practices culture change. They don't know that there is anything better to ask for."

"People do not want to hear about long-term care – they don't want anything to do with it. I hate the term long-term care, it goes to long-term not CARE. We need to change the message, and change the story."

As we establish the case for adoption we must also consider the importance of raising consumer expectations for long-term care and the implications on both the local and national level. At a local level, communities engaged in culture change must be telling their story and considering how best to position themselves uniquely in the marketplace. Not only does this strategy have the potential for positive outcomes for individual communities, but also for long-term care on a broader scale. As consumer awareness of what is possible is heightened on a national level, consumer demand can become a driving force for the case for adoption.

Question for sites relevant to this concept:

1. How are you telling your story to the community and marketplace?

2. Has this work differentiated your organization from the competition?

3. Has census improved?

4. How do you utilize your families and residents to share their experiences?

5. What ways do you involve the community in the activities of your home so they can discover for themselves what culture change "looks like"?

6. What ways do you support your residents to participate in outside community activities (churches, social clubs, political action, etc.)?

7. How do you use the media to broadcast the changes you have made?

NEXT STEPS IN THE DEVELOPMENT OF THE LONG-TERM CARE IMPROVEMENT GUIDE

Beyond the conceptual discussion, Long-Term Care Leadership Roundtable participants also identified practical ways that the Long-Term Care Improvement Guide can best advance culture change at the local level by:

- Complementing the dissemination of best practices with tangible guidance and tools around the process of change.
- Demystifying common regulatory myths that continue to stymie culture change efforts.
- Highlighting nuances to culture change within different settings, e.g. nursing homes, assisted living communities and rehabilitation centers.
- Striving to avoid rampant institutional biases in language and nomenclature.

Site Visits:
As discussed, the meeting highlighted important aspects of culture change that will be explored in more depth during site visits over the coming months to communities on journeys of transformational culture change. Sites to be visited include:

- Augsburg Lutheran Home, Baltimore, MD
- Bethel Health Care, Bethel, CT
- Brewster Village, Appleton, WI
- Delnor Glen, Geneva, IL
- Evergreen Retirement Community, Oshkosh, WI
- Fairacres Manor, Greeley, CO
- Landis Home, Lititz, PA
- Piper Shores, Scarborough, ME
- Planetree Netherlands Sites (potential)
- St. Elizabeth Home, East Greenwich, RI
- St. John's Lutheran Ministries, Billings, MT
- Wesley Village, Shelton, CT

The one-day visits to sites using a variety of culture change models in both not-for-profit and for-profit settings will be focused not only on culture change innovations and best practices, but also on the *processes put in place to implement and sustain those changes*. These findings will then be documented in the Long-Term Care Improvement Guide.

The Long-Term Care Improvement Guide will be released at the Culture Change Leadership Summit on **Tuesday, October 5th** in **Denver, Colorado**. The day-long event will feature healthcare leaders imparting their experiences with culture change across the continuum of care. Speakers will address challenges and opportunities for culture change from an operational, policy and consumer awareness perspective.

The meeting is generously funded by the Picker Institute. This funding allows us to waive the registration fee for participants. To register, visit **www.regonline.com/culturechangesummit.** Participation is limited, so early registration is recommended.

2/25/10 LONG-TERM CARE LEADERSHIP ROUNDTABLE PARTICIPANT LIST

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