Implementing Culture Change

Measuring Outcomes for Quality Improvement

PRESENTED BY WENDY BOREN, BS, RN
SINCLAIR SCHOOL OF NURSING, UNIVERSITY OF MISSOURI
QUALITY IMPROVEMENT PROGRAM FOR MISSOURI

QIPMO

Sinclair School of Nursing

Introduction

If you ask residents of nursing homes what makes them happy, it is in large measure a few simple things. They want more control over their lives. They want to be able to have positive relationships with those around them- residents and staff. They want to be treated with dignity and respect. They want to be able to engage in meaningful activities that make a difference. These are not unreasonable requests. In fact they are very much the same things people who do not live in nursing homes want.

So why, then is it so difficult to provide this? It is a combination of factors that have evolved over time, reflecting both cultural and regulatory biases. (1)

QIPMO

Sinclair School of Nursing

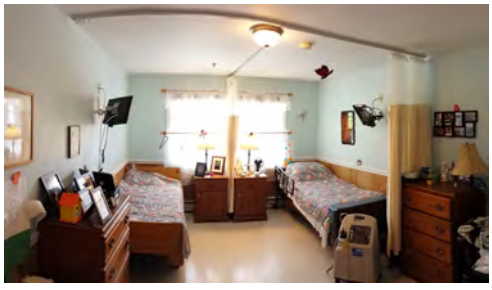
There are several pieces to figuring out how to give that control and make that harmony happen, while at the same time making money, improving quality measures, and creating a home that includes dignity, autonomy, and privacy.

- Making the Case for Adoption of Culture Change
- Understanding the Regulations
- Studying the Impact on Staffing
- Making a Home
- Realizing the Privacy Joke
- Using Artifacts of Culture Change

QIPMO

Sinclair School of Nursing

MAKING A CASE: *Adopting* CULTURE CHANGE



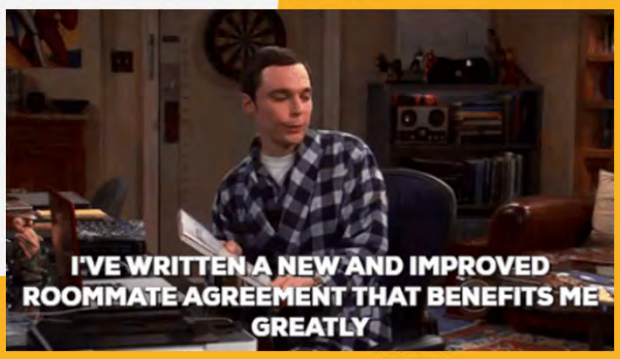
Before Culture Change...

... after starting Culture Change

QIPMO

Sinclair School of Nursing

Welcome to Your Roomie!



QIPMO

Self-Examination Activity

Ask yourself these questions. Be honest - no one will know the answers but you.!

1. If you were to suddenly become wheelchair-bound or an amputee, would you mind your life being severely restricted in unnecessary ways just because of the wheelchair?
2. If your spouse had a car accident causing some kind of brain trauma, are you all right with them being served with sippy cups and an aid that uses baby talk?
3. If are currently someone who loves fresh air, quiet, natural lighting, and Saturday Night Live, are you okay with not being allowed to open the windows, call lights or loud TV's, fluorescent overhead lights, and an "encouraged" bed time?

Because this isn't OUR home, or OUR life, we tend to overlook how much we restrict and regulate that 's completely unnecessary. Last question…

4. If you realized that it cost the same amount of money to go to home A, where they encourage resident independence or home B where it frequently smells like pee and you get ketchup packets if you're lucky on a luke-warm hotdog, where would you go? EXACTLY! And so will all your friends. In the end, culture change pays… in QMs and $$.

QIPMO

Sinclair School of Nursing

Short-Stay Quality Measures

- Residents who self-report moderate/severe pain
- Residents with pressure ulcers that are new or worsened
- Residents who were offered/received the flu vaccine
- Residents who were offered/received the pneumonia vaccine
- Residents who newly received an antipsychotic medication
- Residents who made improvement in function

QIPMO

Sinclair School of Nursing

Long-Stay Quality Measures

- Residents experiencing one or more falls with major injury
- Residents who self-report moderate to severe pain
- High-risk residents with pressure ulcers
- Residents who were offered/received flu & pneumonia vaccines
- Residents with UTIs
- Low-risk residents who lose control of their bowel and bladder
- Residents who have/had a catheter inserted and left in
- Residents who were physically restrained
- Residents who need more help with ADLs

QIPMO

Sinclair School of Nursing

Long-Stay Quality Measures

- Residents who lose too much weight
- Residents who have depressive symptoms
- Residents who received an antipsychotic medication
- Prevalence of falls
- Residents who used antianxiety or hypnotic medication
- Prevalence of behaviors affecting others
- Residents whose ability to move independently worsened

QIPMO

Sinclair School of Nursing

So... How Does THIS Go TO THAT?

YOU'VE GOT TO KNOW THE *PERSON!*

1. Ask questions that actually count towards helping the person AND those QMs…

(EXAMPLE FOR PAIN)

- What kind of pain meds have helped you in the past? Tylenol vs Advil…?
- Don't forget the comorbidities. They are a big source of chronic pain and affect both short-stay and long-stay #s. Chronic arthritis? Bike accident as a kid? Baseball injury?

2. Get serious about the non-pharmaceutical options (behaviors, psychotropic medications, pain control, falls)

- Quiet space
- Kids
- Intellectual stimulation
- Music
- Movement - dancing, exercising, walking, waving… just not sitting or lying for 24h/day!

QIPMO

Sinclair School of Nursing

THINK *outside* THE BOX

• Be committed as an organization to REAL change. Life is not a one-size-fits-all!

3. Don't dump them in a wheelchair!! Keep them moving - don't treat them like they're in a nursing home. (PU's, improvement in function, continence, ADL help.)
4. Be on your game with pressure ulcers…
   - Know the history (not just how it was acquired but if there was one there before)
   - Get the doc on board sooner rather than later
   - Don't wait to change something that's not working

Sinclair School of Nursing

Understanding the Regulations: Tags Pertinent to Person-Centered Care and Culture Change

QIPMO

Sinclair School of Nursing

Nail Holes and Refrigerator Rights

Trivia: what are these F-tags??

- F557, F584
- F912
- F561, F809

QIPMO

Sinclair School of Nursing

16

F557 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(2) The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents

F584 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.

The facility must provide— §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

F912 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.90(e)(1)(ii) Measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms;

GUIDANCE: §483.90(e)(1)(ii) See §483.90(e)(3) regarding variations.

The measurement of the square footage should be based upon the useable living space of the room. Therefore, the minimum square footage in resident rooms should be measured based upon the floor's measurements exclusive of toilets and bath areas, closets, lockers, wardrobes, alcoves, or vestibules. However, if the height of the alcoves or vestibules reasonably provides useful living area, then the corresponding floor area may be included in the calculation.

The space occupied by movable wardrobes should be excluded from the useable square footage in a room unless it is an item of the resident's own choice and it is in addition to the individual closet space in the resident's room. Non-permanent items of the resident's own choice should have no effect in the calculation of useable living space.

Protrusions such as columns, radiators, ventilation systems for heating and/or cooling should be ignored in computing the useable square footage of the room if the area involved is minimal (e.g., a baseboard heating or air conditioning system or ductwork that does not protrude more than 6 to 8 inches from the wall, or a column that is not more than 6 to 8 inches on each side) and does not have an adverse effect on the resident's health and safety or does not impede the ability of any resident in that room to attain his or her highest practicable well-being. If these protrusions are not minimal they would be deducted from useable square footage computed in determining compliance with this requirement.

The swing or arc of any door which opens directly into the resident's room should not be excluded from the calculations of useable square footage in a room.

F561 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.10(f) Self-determination.

The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section.

§483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

F809 (Rev. 173, Issued: 11-22-17, Effective: 11-28-17, Implementation: 11-28-17)

§483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care.

§483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

§483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. DON'T FORGET TO CARE PLAN IT if it's a frequent thing!

REGULATIONS AND CULTURE CHANGE

It is a *myth* that regulation is a barrier to person-directed transformations in long-term care. In fact, investigations by the *Pioneer Network* suggest that these homes do achieve equivalent or better regulatory outcomes when compared to non-adopter homes.(4)

QIPMO

Sinclair School of Nursing

Studying the Impact on Staffing

Four Foundational Practices to Staffing and Culture Change as created by Brady & Frank… (1) consistent assignment; (2) huddles; (3) involving CNAs in care planning; and (4) QI closest to the resident.

Forty-nine nursing homes incubated these practices through fifteen month learning collaboratives convened and facilitated by five Culture Change Coalitions and four nursing home corporations. The incubating homes strengthened these practices by applying them to high priority clinical areas, and found that with huddles and consistent assignment they were able to improve outcomes by adapting to residents' customary routines. As they saw the benefits in clinical outcomes and honed their foundational practices, the incubators were able to build on small scale adjustments to expand their flexibility in dining, morning routines, and night time care. The homes found that the practices together – engaging staff in individualizing care – accelerated improvement in clinical, human resource, and organizational outcomes.[5]

Results = improved quality measures, fewer citations, higher quality of life for residents, happier staff (less turnover!)

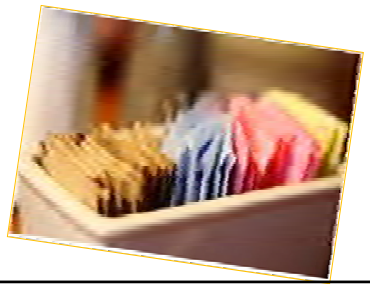
Free Starter Tool-kit for Engaging Staff in Individualized Care from the Pioneer Network

NOTE - **David Farrell will be coming April 30 in Kansas City and May 1 in St. Charles… brought to you by MC5! Stay tuned for details.**

Making a Home

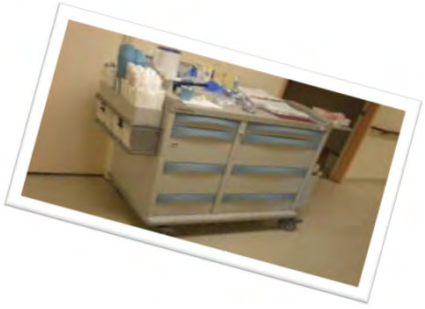
During meals, residents are brought into the dining room, often an hour or more before the meal, to sit and wait for the cart to come up from the kitchen so they can have a tray of moderately warm food, served on plastic plate warmers with plastic mugs, plastic-wrapped bread, and sugar from little paper packets. Staff set up one resident, then leave to get another tray and serve another. Residents are seated next to other residents with similar assistance needs, to make it easy for one staff to walk around a table and help 3 or 4 residents efficiently.[6]

So are you going for low-scale fast-food joint or upscale restaurant?



HOME KILLERS

SECRET… you don't *have* to have a nurse's station ***or*** a med cart



- Fluorescent lights
- Plastic cups
- Plastic furniture
- Plastic glove boxes everywhere
- Two beds separated by a curtain and set up the same way

QIPMO

Sinclair School of Nursing

DESIGN ON A $DOLLAR$

- *Front Entrance*
- *Corridors*
- *Shared bathrooms - typical signage vs "mom" signage*

http://designonadollar.org/

Low Cost Practical Strategies to Transform Nursing Home Environments: Towards Better Quality of Life Prepared for Quality Partners Nursing Home QIO Support Center by Lois J. Cutler Rosalie A. Kane September, 2006 ****See pages 2-3, page 7 Staff Amenities, 10-11.**

QIPMO

Sinclair School of Nursing

Realizing the Privacy Joke

- HIPPA ha!
- Back to those F tags… barely room for a single chair, much less *two* to have a conversation with a visitor
- Higher risk/spread of infections
- Harder to market: The impact of this can be seen in the construction cost analysis conducted by Calkins and Cassella (2007). After analyzing 189 bedroom plans and developing a detailed cost analysis, the average cost of construction plus capital costs (debt) of a traditional, side-by-side shared room was found to be $41,012 or $20,506 per person, while the average cost of a private room was $36,515 (2005 dollars). Thus, it costs $16,009 more per person to build private versus traditional shared rooms. Stated another way, it costs $32,018 more to build two private rooms than one shared room. This would seem to support those who say that private rooms are too expensive to build. But taking a life-cycle costing approach, it can be demonstrated that this difference in construction cost is not as great as it might appear. Based on a large national study, the average daily cost of a private room in a nursing home is $23 more than a shared room. If the beds are all occupied, assuming a $23 dollar a day difference, it would take 1.9 years to recoup the cost differential of building 2 private rooms versus 1 shared room. However, if the facility cannot fill a bed in a shared room, the lost revenue is not $23, but $167 per day - the average daily cost of a shared bedroom. At $167 a day it takes only 6.4 months to recoup the construction and debt differential (Calkins & Cassella, 2007)

Back to the *Roomies*

Sharing a room means…

- adjusting to the day-to-day routines, behaviors and activities of another person
- hearing someone moaning constantly
- seeing them use their bedside commode
- listening to their TV shows
- not being able to set the temperature the way you want
- not be able to keep the door open (or closed) as is your preference
- keeping people out of their room, if the roommate wants to let them in[8]

And if they're incontinent, too… the fun *just begins*!

QIPMO

Sinclair School of Nursing

26

USING THE ARTIFACTS OF CULTURE CHANGE

- The *Artifacts of Culture Change* tool fills the purpose of collecting the major concrete changes homes have made to care and workplace practices, policies and schedules, increased resident autonomy, and improved environment. It results from study of what providers and researchers have deemed significant things that are changed and are different in culture changing homes compared to other homes.
- Dining - dining has traditionally been one of the most institutional practices of nursing home life and work - telling people when and what they will eat. And it is the one event that happens the most every day. Offering more common dining practices such as restaurant, family and buffet styles and opening up dining times has had many positive outcomes such as weight gain, savings in unwasted food, and increased resident choice as experienced by Providence Mt. St. Vincent (Ronch and Weiner, 2003) and Crestview (Rantz and Flesner, 2004). Many homes have also transitioned to having the kitchen open and/or pantries and snack bars where food is available 24 hours a day, often pointing out we all have "refrigerator rights" at home. Another source documents that as residents are able to eat food they desire, weight loss declines (Rantz and Flesner, 2004). Additionally, homes have realized the value of baking in resident living areas. Aromas increase appetite, and residents eat better, as already experienced by The Green Houses (*The Green House Project* DVD, 2005).

USING THE ARTIFACTS OF CULTURE CHANGE

- Routine - just as people did prior to living in a nursing home, they should have the opportunity to follow their personal routine. The *QIO* 2004-2005 culture change pilot report summarized this as follows, "People now wake up, spend their days, and go to bed according to their own routines, and as they are restored to their own rhythms, they are thriving. So are those who care for them. As work is reorganized to follow the pace of each resident, instead of a rigid institutional routine, workers are able to fulfill their intrinsic motivation to care for others, and to experience respect and care from their organizations" (Quality Partners of Rhode Island, 2005).
- Animals, aromatherapy, the internet
- Structural changes - nursing stations, living rooms, no long halls, carpet, private rooms, kitchenette, café, KIDS, consistent staffing

Main Points Regarding the Artifacts of Culture Change Tool

1. The tool is not connected to enforcement, is not punitive, and no surveyors will be collecting data using this tool.
2. This is a government product that homes and provider organizations can freely use to showcase positive changes they are making.
3. The tool is a concrete set of changes homes make to practice and policies in the process of transforming an institutional culture into one that resembles home and that takes seriously the residents' direction of their own lives.
4. The tool affords the opportunity for an individual home to gauge its progress and do its own benchmarking of where they are on a culture change journey.
5. The tool is a data collection instrument meant to reflect progress by a simple points structure of total change, partial change or no change to specific items.
6. The tool may change in the future if a sufficient number of homes complete it and the information from each home is captured in an online data base that could generate more information about averages and prevalence.
7. This tool is a CMS-developed product. As such it is to remain in its final form but to be given away freely.

**New Dining Standards and New Artifacts of Culture Change being developed right now. Please contact borenw@missouri.edu if you have any suggestions for these. *The Pioneer Network* is looking for input to pass on to developers.

QIPMO

Sinclair School of Nursing

Positive Outcomes of Culture Change

Pioneer Network is committed to studying how adopter outcomes translate into more quantifiable metrics and to benchmark those metrics with national data. The goal of this work is to accelerate adoption and support implementation and sustainability by articulating the operational linkages between person-centered care, quality of care, and financing —

The Case for Adoption

Find the Pioneer Network handout here:

https://www.pioneernetwork.net/wp-content/uploads/2016/10/Positive-Outcomes-of-Culture-Change-The-Case-for-Adoption.pdf

QIPMO

Sinclair School of Nursing

Conclusion

If nothing else…

- See the Light!
  - Lighting: The aging eyes of a 60 year old person require up to three times more light for tasks than they did as a healthy 20 year old, and by the time they reach age 85 they may require as much as five times more light. Glare also becomes a particularly debilitating factor. Solving the problems effectively requires providing the necessary light for older eyes to see, by 1) raising light levels substantially, 2) balancing natural light and electric light to achieve even light levels and 3) eliminating glare. LIGHTING: PARTNER IN QUALITY CARE ENVIRONMENTS, Brawley and Waggoner.

Sleep/wake cycle, multiple forms of lighting in an area, taller ceilings, allow more natural light inside ***including in resident rooms - don't forget the guy on the other side of the curtain!!***

- Control the Noise!
- Practice Customer Service! (Yes! It can be a "hotel")
- Give Autonomy a Try!

QIPMO

Resources

(1)Creating Home in a Nursing Home: Fantasy or Reality? Margaret P. Calkins, PhD President, IDEAS Inc, Board Chair, IDEAS Institute

(2)Making the Case for Adoption https://www.pioneernetwork.net/wp-content/uploads/2016/10/Positive-Outcomes-of-Culture-Change-The-Case-for-Adoption.pdf

(3)Appendix PP https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

(4)Transformative Nursing Homes Experience Positive Regulatory, Quality and Financial Outcomes https://www.pioneernetwork.net/wp-content/uploads/2016/10/Transformative-Nursing-Homes-Experience-Positive-Regulatory-Quality-and-Financial-Outcomes..pdf

(5)A Free Starter Toolkit for Engaging Staff in Individualizing Care https://www.pioneernetwork.net/resource-library/resource-libraryengaging-staff-individualizing-care/

(6)Design on a Dollar http://designonadollar.org/

(7)Low Cost Practical Strategies to Transform Nursing Home Environments: Towards Better Quality of Life Prepared for Quality Partners Nursing Home QIO Support Center by Lois J. Cutler Rosalie A. Kane September, 2006

(8)Envisioning your future in a nursing home Margaret P. Calkins, Ph.D.

(9)Development of the Artifacts of Culture Change Tool, April 2006, Carmen Bowman

TOOLS for Change

VOL. 1 NO. 2
APRIL 2011

Positive Outcomes of Culture Change — The Case for Adoption

Pioneer Network is committed to studying how adopter outcomes translate into more quantifiable metrics and to benchmark those metrics with national data. The goal of this work is to accelerate adoption and support implementation and sustainability by articulating the operational linkages between person-centered care, quality of care, and financing — ***The Case for Adoption***.

Recent evidence demonstrates the positive outcomes of culture change. In general, this evidence can be categorized into four broad impact areas: organizational, quality of care, staffing and life engagement.

Examples of Organizational Impact: Increased levels of occupancy; Increased percentage of private pay census; Reduction in the use of agency staff; Increases to operating margins; Improved market position; Waitlists for residents; Strengthening of outside community support (donations) and volunteers.

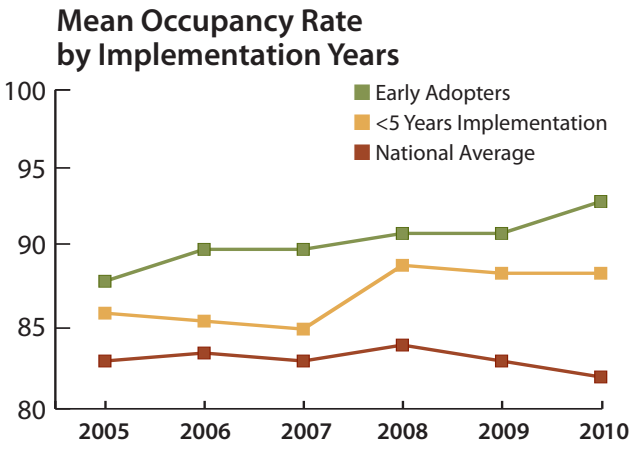
Examples Quality of Care Impact: Improvements in quality indicators most correlated with person-centered principles including use of restraints, weight loss, falls, agitation, pressure ulcers, medication use, time in a bed or chair and re-hospitalizations.

Examples of Staffing Impact: Reductions in turnover (leadership team, clinical, front-line staff); Low or no use of agency staff; Fewer "call-offs" or sick days; Increased levels of staff satisfaction formally (surveys) and informally (verbally to peers and leadership); Active understanding of culture change and person-centered principles by the majority of staff; Formal recognition of employees for excellence in person-centered care; Self-motivation, critical analysis, and problem-solving by front-line staff to incorporate person-centered principles.

Life Engagement: Increased levels of resident satisfaction formally (surveys) and informally (verbally to peers and staff); Resident choice in daily activities and routines (measured by care plans); Increased levels of engagement especially in residents with chronic health conditions or dementia (measured by MDS 3.0); Emphasis by residents and staff on relationships and community; descriptions of the organization as "home" or "family."

Examples of Pioneer Network's findings to demonstrate these outcomes are highlighted below.

OCCUPANCY

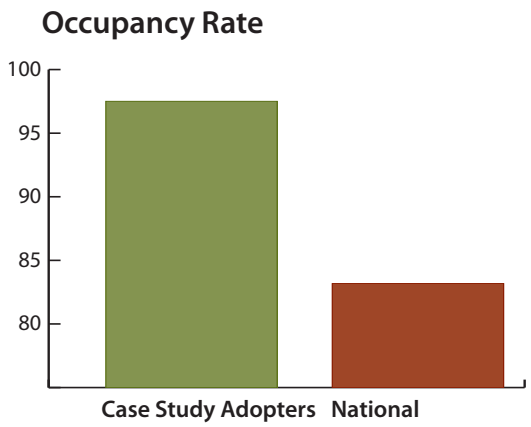


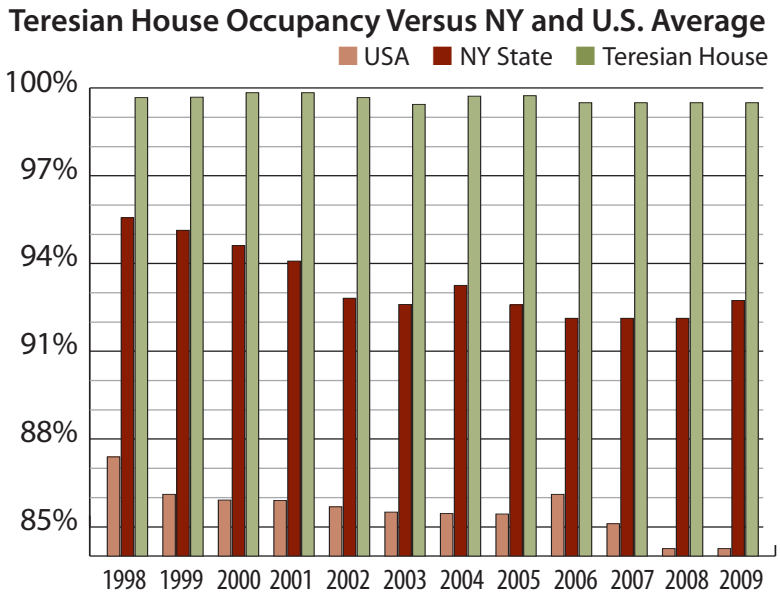
Adopter homes have a statistically significant higher occupancy rate (longitudinally — suggesting consistency) than the national average.

- The green line represents that early adopters (sustained for nine years or more) maintain, on average, occupancy rates 9 points higher than the national average. With a 100 bed assumption and private pay rates, 9 occupancy points equates to $719,415 in potential additional revenue (based on the 2009 MetLife Nursing Home Survey equating private pay rates to $79,935 a year).

- The yellow line represents mid stage adopters implementing for 5 years or less. Occupancy has consistently been rising for this group post-implementation. An increase of occupancy by 3 points (with the 100 bed private pay assumption) equates to an additional $239,805 in potential yearly revenue for this group of homes.

Case studies confirm these findings:





REVENUE

A recent study entitled "Occupancy and Revenue Gains from Culture Change in Nursing Homes: A Win-Win Innovation for a New Age of Long-Term Care," found positive outcomes and revenue gains from culture change adoption[1]. Experts in culture change were asked to identify facilities that "best exemplified homes engaged in sustained culture change innovation." This was defined as homes engaged in change for two years or more in key areas of care practice, environment, and workplace. Adopters were compared with a control group of similar homes on two variables: percentage of beds occupied, and revenue per bed per day. Data are from 2004, pre-culture change, and 2008, after adopters had been engaged in culture change for at least two years.

1 A. E. Elliot, "Occupancy and Revenue Gains from Culture Change in Nursing Homes: A Win-Win Innovation for a New Age of Long-Term Care," *Seniors Housing & Care Journal*, 2010 18(1):61–76 : http://www.nic.org/NicStore/p-352-2010-seniors-housing-care-journal.aspx

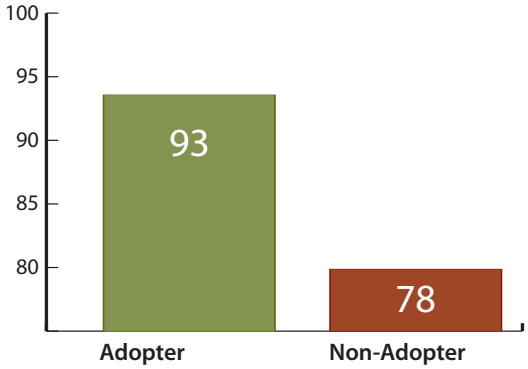
Key Findings

- From 2004 to 2008, nursing homes in the adopting group experienced a modest but significant improvement in occupancy compared with the control group. Both groups had occupancy rates of 86 percent before culture change was implemented in 2004, but by 2008, the occupancy rates of adopter homes increased to 89 percent, while those in the control group remained at 86 percent.
- Revenue increased significantly for adopter homes when compared with control-group homes. Implementing culture change resulted in an additional $11.43 per bed per day for a 140-bed nursing home. This translates to an additional $584,073 in revenue per year for the adopter home.

MARKET POSITION

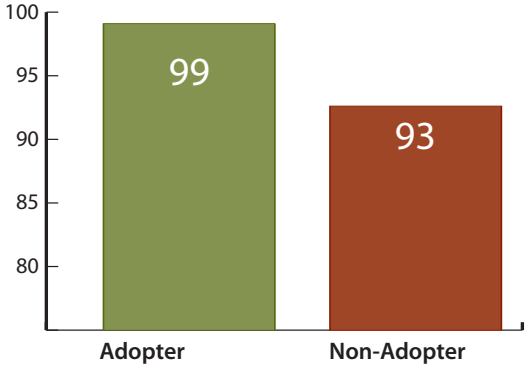
Below are examples of statistically significant competitive advantage (as measured by occupancy) for adopter homes in four major cities. Data are from Nursing Home Compare 2010 and represent Medicare certified SNF's and CCRC's located within the city limits. Cities chosen are those markets where adopter homes represent 15% or more of beds in the Nursing Home Compare database (to establish a relevant comparison).

Denver Occupancy Percentage



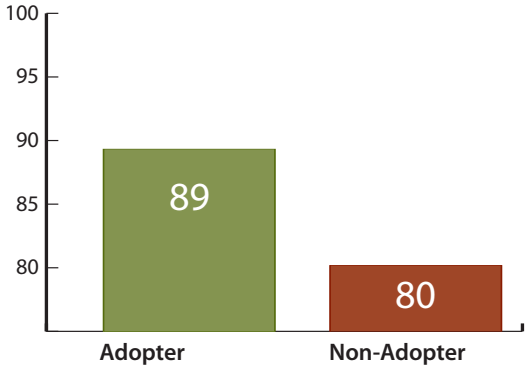
Denver adopter beds = 20% (487 out of 2477 total)
Denver adopter organizations = 25% (6 out of 24 total)

New York Occupancy Percentage



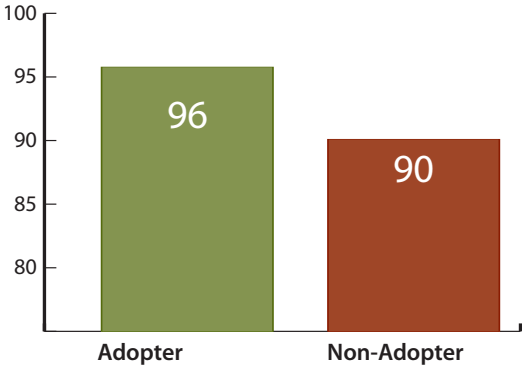
New York adopter beds = 24% (1,355 out of 5,662 total)
New York adopter organizations = 15% (3 out of 20 total)

Omaha Occupancy Percentage



Omaha adopter beds = 17% (455 out of 2665 total)
Omaha adopter organizations = 14% (3 out of 21 total)

Providence Occupancy Percentage

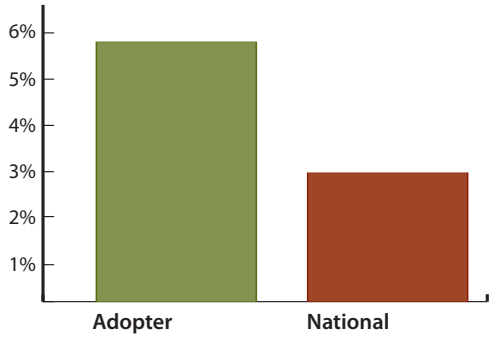


Providence adopter beds = 30% (356 out of 1199 total)
Providence adopter organizations = 25% (3 out of 12 total)

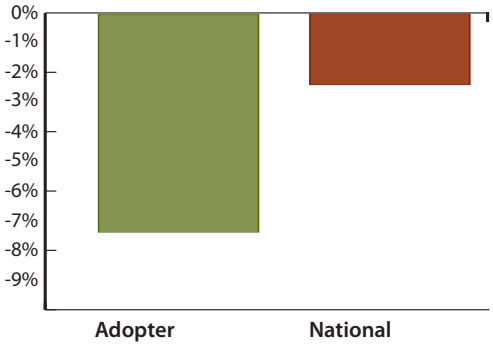
PRIVATE PAY CENSUS

Data supports that adopters experience an almost 1-to1 correlation between increases in private pay and decreases in Medicaid occupancy.

% Change Private Pay Occupancy from 2004 to 2008



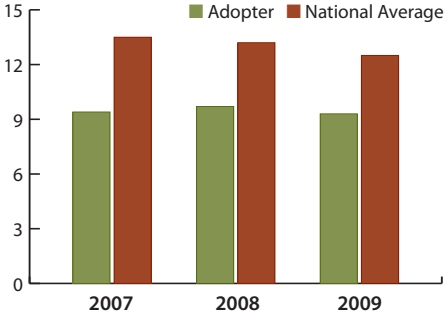
% Change Medicaid Occupancy from 2004 to 2008



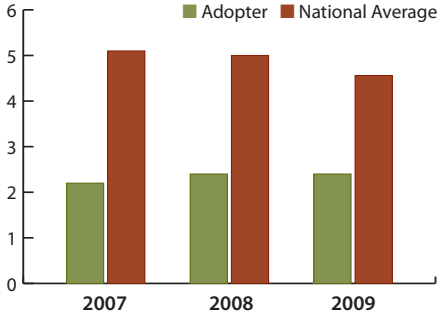
CLINICAL OUTCOMES

Pioneer Network continually tracks clinical outcomes of adopters and finds consistent, positive results. Below are longitudinal examples.

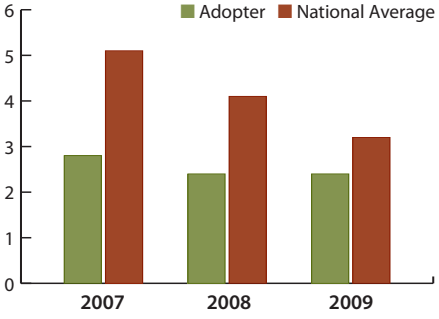
Percent of High-Risk Residents with Pressure Sores



Percent Who Spent Most of Time in Bed or Chair



Percent of Residents Physically Restrained



Aside from the substantial benefits to residents from these reductions, there are obvious cost implications as well. AHRQ estimates that the average pressure ulcer-related hospital stay extends to between 13 and 14 days and costs between $16,755 and $20,430, depending on medical circumstances.

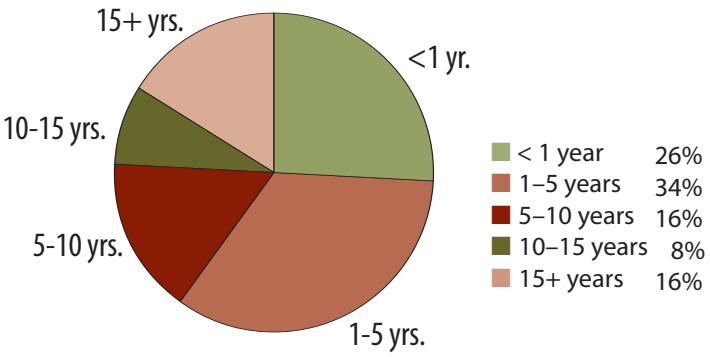
Culture change is a process not a program. Quality of life, a decreased % of time spent in a bed or chair and fewer restraints are inherent in this person-centered process. Although quality programs such as Advancing Excellence are making great strides in reducing these outcomes nationally, adopter homes have achieved these outcomes for over 10 years.

STAFFING

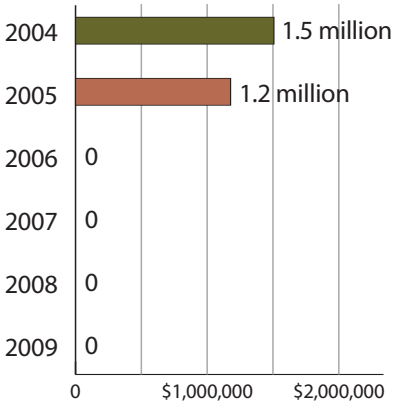
Examples of staffing impact from case studies are below (view full case studies at www.pioneernetwork.net/Providers/CaseStudies/).

Teresian House

Teresian House Staff Longevity

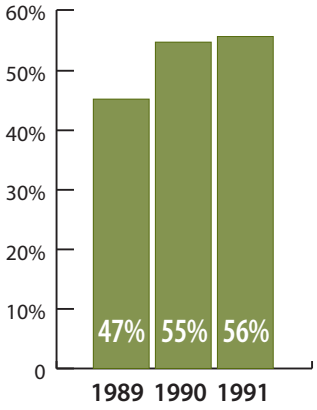


Dollars Spent on Agency Staff

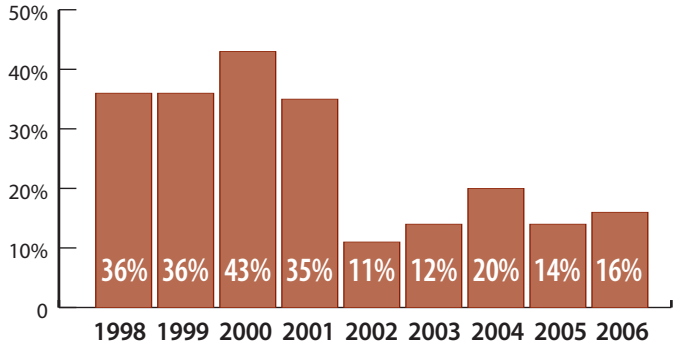


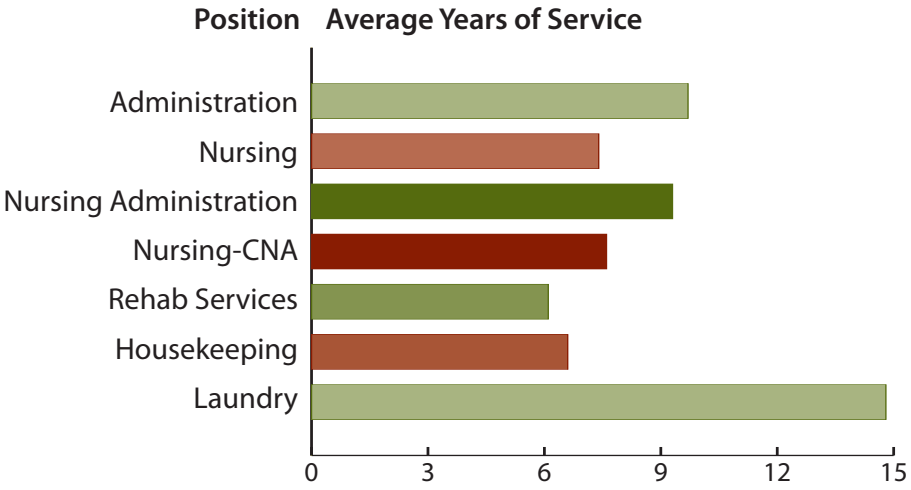
Providence Mount St. Vincent

Percentage of Staff Turnover Before Culture Change



Percentage of Staff Turnover After Culture Change

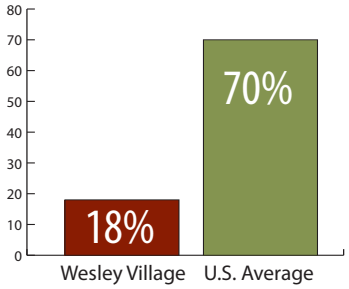




Wesley Village

Visit
www.pioneernetwork.net/Providers/CaseStudies/Wesley/
to view the Wesley Village case study

Wesley Village CNA Turnover

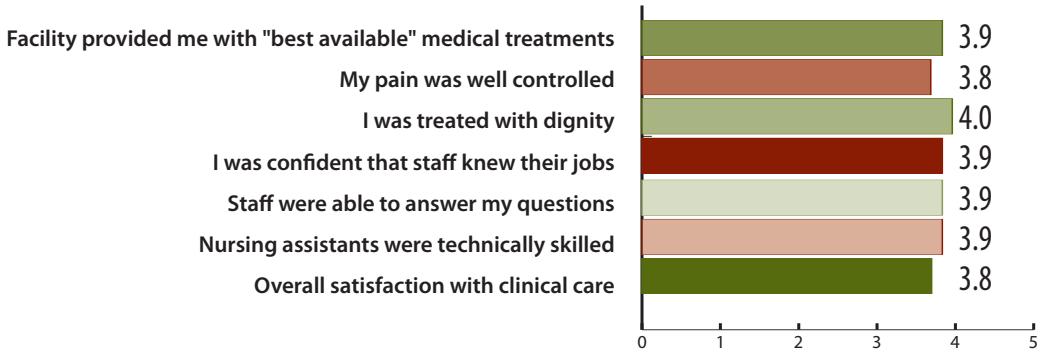


Resident Satisfaction

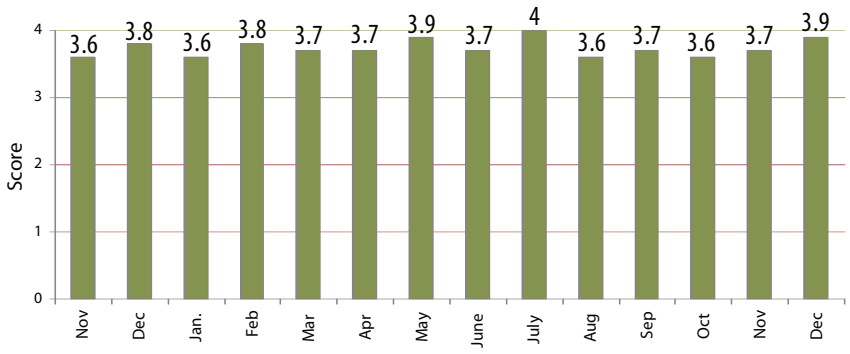
While quality of life is the most important outcome of culture change and person-centered care, resident satisfaction is one proxy for this measurement in nursing homes. Below are examples from case studies(view full case studies at http://www.pioneernetwork.net/Providers/CaseStudies/).

Providence Mount St. Vincent

Satisfaction with Clinical Care (Short-Stay Rehab)



Recommendation of the Mount



Additional Resources are available at http://www.pioneernetwork.net/Providers/Case/

THE COMMONWEALTH FUND

Made Possible with Support from The Commonwealth Fund

Pioneer Network

Pioneer Network in Culture Change
230 E. Ohio Street
Suite 400
Chicago, IL 60611
Phone: 312-224-2574
Fax: 312-644-8557
info@PioneerNetwork.net
www.PioneerNetwork.net