Building a Culture of Improvement:

How CareHomes Wellbeing™

Created the Foundation for Change

in Ten Long-Term Care Facilities in Oregon

Final Report to the Oregon Department of Human Services
on the Results of a Six-Month Pilot
Grant #146757 between DHS and CareOregon, Inc.
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Report author: Barbara Kohnen Adriance, MPP
CareOregon, Inc.

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Please note that this report names the 10 facilities participating in the CareHomes Wellbeing™ Pilot but de-identifies them in data summaries and in the narrative. Each facility will receive this report together with customized summary information from the data submitted.

This report contains video links. We recommend that you watch them because they offer additional insights that are better conveyed “live” than on paper.

I. Executive Summary

1.1 Background

CareOregon received a grant from the Department of Human Services' Quality Care Fund to pilot a project introducing a Lean-based methodology called CareHomes Wellbeing™ in 10 assisted living and residential care facilities in Oregon. The goal of the Pilot was to improve the safety, experience and efficiency of services delivered in assisted living and residential care settings. Funds were used to provide licenses, training, site support, networking, shared learning, and project management. Despite the reduction in the originally planned pilot activity period from 50 weeks to 24 weeks, staff had enough time to learn the methodology, apply it, show results, and most importantly, generate significant momentum to change. All 10 facilities that were initially selected continued their active participation throughout the duration of the Pilot.

1.2 Critical findings based upon Pilot objectives

- Reducing medication errors, falls, unplanned staff absences and above all staff turnover can free up significant resources to reinvest in staff and residents. In six months, the Pilot achieved the following:

  - 35% reduction in medication errors
  - 40% reduction in unplanned staff absence
  - 30% average spread and adoption of methodology with rates varying from 13% to 74% among facilities
  - 13% increase in staff feeling happy that their suggestions for improvement are acted upon
  - 11% increase in staff feeling that they can show progress and success during state compliance survey process

- Staff turnover in long-term care facilities is extremely high, and associated administration costs are much higher than most staff and administrators realize. There was a 20% average staff turnover in the Pilot facilities during the pilot period, costing facilities between $562,000 and $773,000 in six months alone. Reducing staff turnover, thus enhancing staff retention, can improve the quality and continuity of care, resident experience, and compliance.
- Sustaining a culture of improvement requires excellent teamwork, clear and effective communication, and strong relationships among staff.
- Flexibility of staff roles is needed in order to respond to specific care needs that are often short-term in nature.
- Moving from a compliance culture to an improvement culture requires a clear vision of the desired future state. It also takes time and effort. The methodology and tools in CareHomes Well Being™ provided a quick, accessible and easy way to begin this journey.
- To build and sustain a culture of improvement, leaders need to shift their approach to leadership from a traditional delegation/hierarchical model to a coaching/team-centered one.

- Based on the results of the first six months, we estimate that every $1 invested in a quality improvement methodology such as CareHomes Wellbeing™ will generate $12.50 in benefit over a five-year period.

1.3 Recommendations

We recommend a four-part sustainability plan:

a. *Create an Oregon-specific quality improvement program for long-term care based on the experience of the 10 pilot facilities.* An Oregon-focused, person-centered methodology would integrate other successful quality improvement tools, such as those developed to track changes of condition documentation and geriatric medications management. The new Oregon methodology and set of competencies would have applicability for all types of facilities/ communities along the continuum of care including adult foster care, residential care facilities, assisted living facilities, nursing homes, and post-acute care nursing facilities.

b. *Scale the program by using leaders within the pilot facilities as trainers and mentors* for new participating facilities, especially multi-facility organizations.

c. *Continue strengthening the program in the 10 pilot facilities principally by continuing and growing the Learning Collaborative*. The collaborative of Pilot facilities and future cohorts of participating facilities would meet quarterly to exchange best practices and develop networks.

d. *Continued consultation support for sustainability, but at a reduced level*.

2. Background on CareHomes Wellbeing™

2.1 Origin of CareHomes Wellbeing™

Created by England's National Health Service Institute for Innovation and Improvement (NHSI), CareHomes Wellbeing™ is the most recent Lean-based methodology in the Productive Series, a set of improvement programs for health care settings. CareHomes Wellbeing™ was designed specifically for caregivers in long-term care settings. It was introduced in Northamptonshire, England in 2013 and was provided to CareOregon under license from The Social Care Improvement Group in England.

CareOregon first became interested in NHSI's Productive Series when NHSI's flagship program, The Productive Ward: Releasing Time to Care™ was developed in 2007. Releasing Time to Care™ (RT2C), as it has been branded in the US, is also a Lean-based methodology. It focuses on nurse caregivers in acute care settings. In 2009, CareOregon began testing Releasing Time to Care™ in Oregon, and its early success in four hospitals -- Oregon Health & Science University (OHSU), Providence Portland Medical Center (PPMC), Tuality Hospital, and St. Charles Medical Center -- led CareOregon to adapt the program to a US setting. Between 2009 and 2013, 14 hospitals in the US and Canada received training at CareOregon from nurses who had completed the program and had become RT2C facilitators within their hospitals.

In 2012, CareOregon introduced a companion program to be used in hospital surgical settings called the Productive Operating Theater™ (TPOT). It is currently used in operating rooms at Legacy Good Samaritan Medical Center in Portland.

2.2 CareOregon's record of accomplishment with similar programs

Our track record of adapting and delivering RT2C and TPOT gave us the confidence that CareHomes Wellbeing™ would work equally well in Oregon. Some of the strengths of the NHSI suite of programs include the following:

- Programs focus on achieving quality, cost reduction and satisfaction by focusing on the workers, their values as a team and their unique cultures.
- Programs are developed, led and implemented by the frontline workers with support from management. For this reason, the programs build upon and reinforce the learning that is best understood by the team, as opposed to learning that comes from outsiders who are unfamiliar with the culture. This "bottom-up, top-enabled" approach leads to very high levels of engagement, knowledge and skills development, and leadership.
- The programs are cost effective because they do not depend on outside consultants.
- Programs focus on the how, not the what. They are the foundation that enables delivery of any type of quality improvement initiative.
- The benefits of the programs grow over time, and the benefits grow in sync with the commitment to the approach. According to OHSU and PPMC, RT2C has contributed to reduced cost, improved quality of care, more teamwork, better morale, and a better understanding of whole systems. It has helped develop leaders and build a culture of improvement. Each hospital directly correlated RT2C to its receipt of Magnet designation, the highest award of excellence in nursing care offered to just 7% of the nation's hospitals.

2.3 Testing CareHomes Wellbeing™ was a natural next step for CareOregon

We were experienced with the methodology of the other programs in the Productive Series and with the trainers in England who have taken a lead in their delivery. We were also convinced that the methodology provided a unique approach to quality improvement that we had not seen anywhere else, a blend of quality improvement competencies, teamwork and leadership strategies, and easy to use tools.

As a Medicaid managed care organization that includes a focus on members who are eligible for both Medicaid and Medicare, we at CareOregon know when our members are in a hospital or skilled nursing facility. However, we know little about our members' residential environments and the types of challenges they face on a daily basis.

3. The Pilot Project

3.1 Overview

Funding for the Pilot was provided by the Quality Care Fund under the direction of the Long-term Care Quality Steering Committee. Grant funding of $89,700 was used to implement the CareHomes Wellbeing™ methodology in 10 assisted living and residential care facilities in Oregon. Funds were used to provide licenses, training, support, networking, shared learning, and project management during a six-month period.

CareOregon provided additional support in the form of project management, support to facilities, data collection and analysis of social return on investment (SROI). This additional funding was provided to meet the pilot objectives and maximize organizational learning for the facilities.

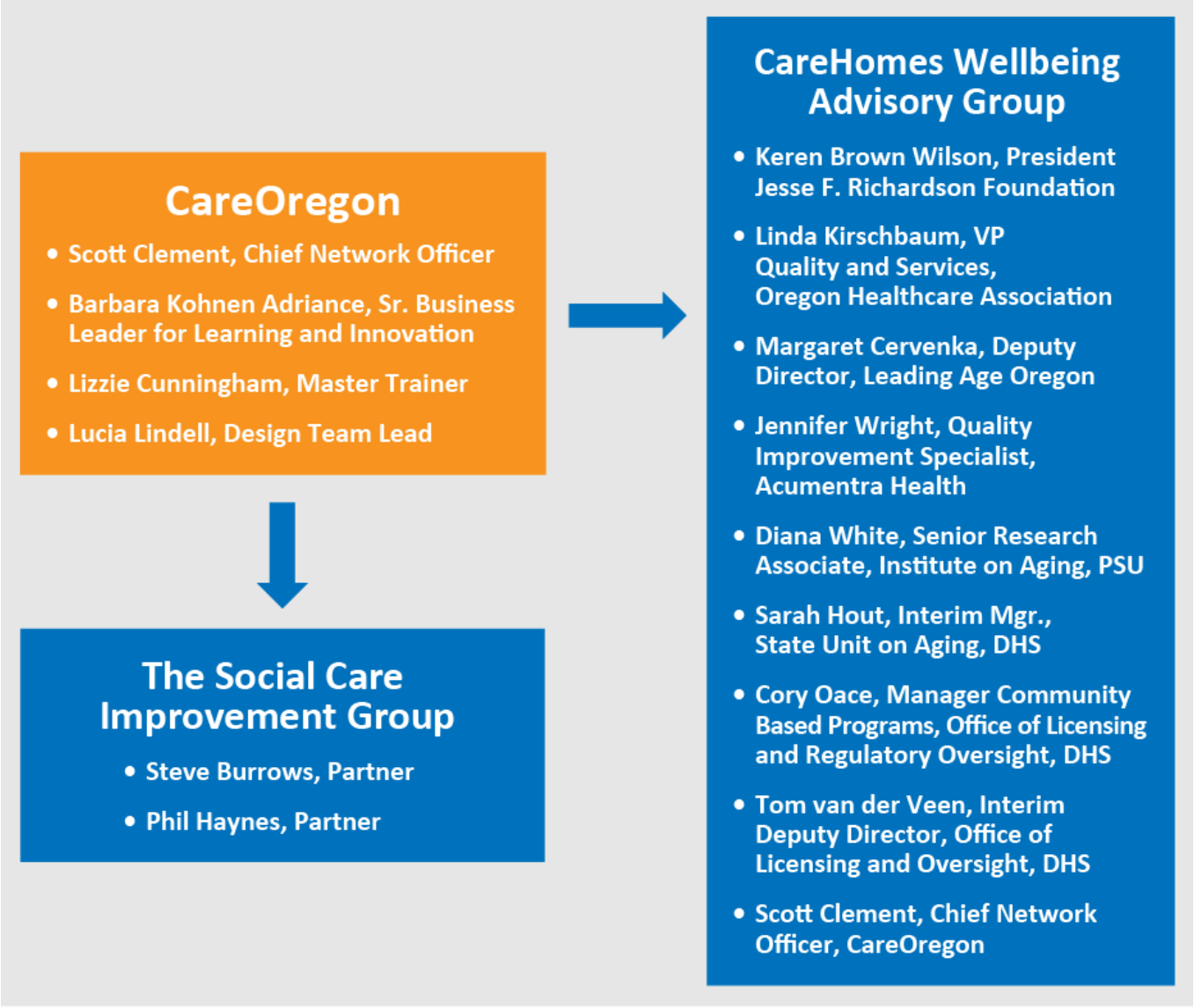
The initial proposal was for a 50-week pilot to take effect after selection of the facilities. Due to contracting procedures and the grant requirement to complete the project by June 30, 2015, the pilot period was shortened to six months. Even with this condensed timeframe, staff learned the methodology, applied it, improvements began to emerge and, most importantly, significant momentum was generated to move from a compliance culture to an improvement one. The six-month condensed timeframe was sufficient to show real change, but we believe more time is needed to achieve and demonstrate the full benefits of the methodology.

The Pilot rolled out as planned, with no changes to implementation. This report and appendices complete the requirements of the grant.

3.2 Management and implementation of the Pilot

3.2.1 Organizational structure

Figure 1: Organizational chart



CareOregon provided oversight, project management and site support for the Pilot. Please see Appendix A for biographies of CareOregon staff. In addition, CareOregon conducted a separate but related analysis to determine a social return on investment.

For training and initial site support, CareOregon subcontracted with the individuals who first developed and piloted CareHomes Wellbeing™ in England, Steve Burrows and Phil Haynes. They are now partners in the consulting firm The Social Care Improvement Group (TSCIG) based in England. Appendix B describes TSCIG. CareOregon licensed CareHomes Wellbeing™ from TSCIG, which in turn had a license agreement with the NHS. CareOregon then provided licenses to participating facilities.

Although CareOregon has had substantial experience and success implementing the RT2C and TPOT programs, we did not have the context of the long-term care perspective and environment. To add this perspective to our expertise, we convened an advisory group composed of leaders of long-term care in Oregon. They included an entrepreneur, several state officials, representatives of the two major long-term care associations, an academic and a practitioner. The advisory group met three times, first to assist in identifying a broad range of facilities, then to review progress of the Pilot, and finally to recommend next steps. The meetings took place Nov. 13, 2014, April 24, 2014 and July 14, 2015.

3.2.2 Success factors

The grant agreement was executed Nov. 17, 2014 with a planned start date of Jan. 16, 2015. With only eight weeks over the holidays to recruit facilities and launch the Pilot, CareOregon took a comprehensive and disciplined approach to managing it. Interested facilities had to complete an application with a letter of support from the CEO of their organization. Facilities also had to identify a project lead, review the timeline and deliverables and sign a participation and sublicense agreement committing to the requirements and expectations of participation in the Pilot. Administrators of the facilities had to attend the first event, an executive briefing. Up to five staff were given the opportunity to attend two mandatory training sessions, three sharing events and five site visits during the pilot period. Staff were required to collect data on a monthly basis to meet the State's reporting requirements. The information sheet, application, and participation agreement can be found in Appendices C, D and E.

To ensure that data were collected easily by the facilities and submitted on time every month, CareOregon created a data capture template for the facilities to use. See Appendix F. These data were consolidated into a single spreadsheet for ease of review.

Given that facilities signed up just two to six weeks prior to the program's start, we anticipated some non-participation. However, **not a single facility dropped out, and participation remained high throughout.**

A crucial success factor was the relationship between TSCIG and CareOregon. Partners Steve Burrows and Phil Haynes have worked with CareOregon staff for many years. Their ability to organize, work quickly and identify areas of concern were invaluable in successfully completing this fast moving project. A final success factor was the value of expertise and perspective provided by a committed, passionate and focused professional. Lizzie Cunningham is a charismatic nurse from NHSI in England who provided the principal support for facilities. She played the role of neutral observer, asking the obvious questions and redirecting teams when needed. Early on, she advocated spending additional time supporting sites that needed more help in implementation. Although this time was not budgeted, CareOregon approved the extra support and it greatly helped the facilities that received it.

3.3 Methodology for Pilot implementation

3.3.1 Selection of facilities

Ten facilities were selected based on the criteria recommended by CareOregon and the Advisory Group. These criteria were developed to provide a broad representation of assisted living and residential care facilities. The goal was to test the CareHomes Wellbeing™ methodology in diverse settings to determine its applicability in Oregon and to generate the strongest possible learning opportunity.

Table 1: Criteria for Selection of Facilities

1	Size
2	Location (urban or rural)
3	Presence of CareOregon members
4	Payer mix
5	Tax Status
6	Independent or part of a chain
7	Membership in Oregon Healthcare Association or Leading Age
8	Specialty

Three facilities considered applying but were unable to participate at the time the Pilot began.

3.3.2 Pilot elements

The Pilot consisted of five major activities: training, site visits, sharing events, data collection, and analysis of social return on investment. Appendix C contains a summary and timeline of these activities.

Three training sessions were held at CareOregon's offices. The first was a half-day Executive Briefing for administrators that focused on the program and how to support their teams. Next, participants learned the methodology of CareHomes Wellbeing™ during a two-day master class followed a month later by a one-day master class. The master classes consisted primarily of small group work, large group discussion, information delivered via PowerPoint, worksheets, and video. Each facility was given a boxed set of materials to use as a guide.

Five site visits were conducted at each facility over the course of the pilot. These consisted of visits primarily by Lizzie Cunningham, with the support of Phil Haynes, Lucia Lindell, or Barbara Kohnen Adriance. The visits lasted approximately 90 minutes. Trainers talked with staff engaged in the work, viewed progress, and provided support and troubleshooting.

In between the site visits, three sharing events were held at CareOregon. These 5 to 7-hour events brought teams together to share experiences, network and learn from one another. The final sharing event was also the celebration of the completion of the pilot, and teams were given certificates of achievement to mark their progress.

The fourth component of the pilot was monthly data collection. Each facility collected data on staff turnover, staff absence, medication errors and the adoption of CareHomes Wellbeing™ methodology. These data were compiled by Lizzie Cunningham and reviewed by CareOregon staff.

Lastly, although not part of the Grant activities, CareOregon utilized a forecasting/evaluation tool called social return on investment to determine the likely costs and benefits of implementing an improvement methodology such as CareHomes Wellbeing™ over a five-year period. This type of analysis is designed to quantify and forecast the impact of various interventions. We thought it would provide an additional and useful perspective.

4. Findings

This section corresponds to the requirements of Exhibit A, Part 1 Program Description, Section 3E of Grant #146757 made to CareOregon.

4.1 Identification of the 10 assisted living/residential care facilities trained.

Table 2 below shows the facilities that participated in the Pilot.

Table 2: List of Participating Facilities

	Facility	License	Location	# Beds	Management
1	Avamere at Bethany	ALF	Bethany	65 plus 26 dementia care	Avamere Corporate
2	Macdonald Residence	ALF: Specialty high needs	Downtown	54	Macdonald Center
3	Marquis Forest Grove	ALF	Forest Grove	70	Marquis Corporate
4	Mary's Woods at Marylhurst	ALF and RCF	Lake Oswego	~50 ALF beds, ~25 dementia care beds	Sisters of the Holy Names of Jesus and Mary
5	Maryville Memory Care	RCF: Specialty dementia care	Beaverton	16	Sisters of St. Mary of Oregon
6	Our House	RCF: Specialty HIV	SE Portland	14	Independent
7	Prestige Summerplace	ALF	E. Portland	102 ALF; 16 dementia care	Prestige Corporate
8	Rose Schnitzer Manor	ALF	Hillsdale, PDX	155	Cedar Sinai
9	Spring Meadows	ALF	St. Helens, OR	32	Concepts in Community Living
10	Willow Place	ALF	Newberg, OR	26	Concepts in Community Living

4.2 Evidence that the facilities are fully equipped with the skills, knowledge and ability to implement the following.

4.2.1 Implement all four key aspects of the CareHomes Wellbeing™ improvement methodology - measure, capture, understand and improve

Each facility designated up to five staff members to participate in the training, site visits, and sharing events to learn and apply the methodology to their facility. A total of 49 staff representing a variety of roles from each facility participated. See Table 3 below.

Table 3: Attendance at Training and Sharing Events

Role	Facility	Jan 16 Exec Breifing	Jan 29 Master Class	Jan 30 Master Class	March 11 sharing event	April 24 sharing event	July 14 Sharing event
Memory Care Supervisor	Avamere Bethany	n/a	√	√	√	x	x
Administrator	Avamere Bethany	n/a	√	√	√	√	√
Resident Aide	Avamere Bethany	n/a	√	√	x	x	x
Regional Operations	CCL	√	√	√	√	√	√
Waitstaff	Summerplace	n/a					
RN Manager	MacDonald Home	n/a	√	√	√	√	√
Resident Aide	MacDonald Home	n/a	√	√	√	√	√
Program Director	MacDonald Home	√	√	√	√	√	√
RN Manager	Marquis Forest Grove	n/a	√	√	√	√	√
Resident Services Co-ordinator	Marquis Forest Grove	n/a	√	√	√	√	√
Dietary Aide	Marquis Forest Grove	n/a	√	x	x	x	x
Administrator	Marquis Forest Grove	√	√	√	√	√	√
Med aide/caregiver	Marquis Forest Grove	n/a	√	√	x	x	x
Staffing co-ordinator	Mary's Woods	n/a	√	√	√	√	√
Director	Mary's Woods	√	Ÿ	n/a	n/a	n/a	Substitute
Director of Nursing Services	Mary's Woods	√	√	√	√	√	√
Resident Aide	Mary's Woods	n/a	√	√	√	x	Ÿ
RN	Mary's Woods	n/a	√	√	√	√	√
RN Manager	Maryville	n/a	√	√	√	√	√
Caregiver	Maryville	n/a	√	√	x	x	x
Director	Maryville	√	n/a	n/a	n/a	n/a	√
Lead Caregiver/Med aide	Maryville	n/a	√	√	√	√	√
Caregiver/med aide	Maryville	n/a	√	√	√	x	x
RN Manager	Our House	n/a	√	√	√	√	√
Director of Nursing	Our House	n/a	√	√	√	√	√
RN	Our House	n/a	x	x	√	x	x
Director Social Services	Our House	√	n/a	√	n/a	n/a	n/a
CMA	Our House	n/a	√	√	√	√	√
Executive Director/Chairman	Our House	√	n/a	n/a	n/a	n/a	√
Health Services Director	Rose Schnitzer	n/a	√	√	√	√	√
Director	Rose Schnitzer	√	n/a	n/a	n/a	n/a	√
Lead Maintenance	Rose Schnitzer	n/a	√	√	√	√	√
Resident Assistant	Rose Schnitzer	n/a	√	√	√	√	x
Dietary Manager	Rose Schnitzer	n/a	√	√	√	√	√
Health Services Co-ordinator	Rose Schnitzer	n/a	√	√	√	√	√
Director	Spring Meadows	√	√	√	√	√	√
RN Health Services Director	Spring Meadows	√	√	√	√	√	√
Lead Med Aide & Trainer	Spring Meadows	n/a	√	√	√	√	√

Table 3: Attendance at Training and Sharing Events (continued)

Role	Facility	Jan 16 Exec Breifing	Jan 29 Master Class	Jan 30 Master Class	March 11 sharing event	April 24 sharing event	July 14 Sharing event
Director of Implementation	Summerplace	√	n/a	n/a	n/a	n/a	x
Administrator	Summerplace	n/a			√	√	√
Activities Co-ordinator	Summerplace	n/a	√	√	√	√	x
Dietary Assistant	Summerplace	n/a	x	x	√	√	√
Interim Administrator	Summerplace	√	n/a	n/a	n/a	n/a	n/a
Lead RN	Summerplace	√	n/a	n/a	n/a	n/a	x
Exp co-ordinator	Summerplace	n/a	√	√	√	x	x
PCA	Summerplace	n/a	√	√	x	x	x
Director	Willow Place	√	√	√	√	√	x
Activities Director	Willow Place	n/a	√	√	√	√	√
RN Heath Services Director	Willow Place	n/a	√	x	x	x	x

In addition, trainers visited each site five times during the course of the Pilot. Table 4 lists the dates of each site visit.

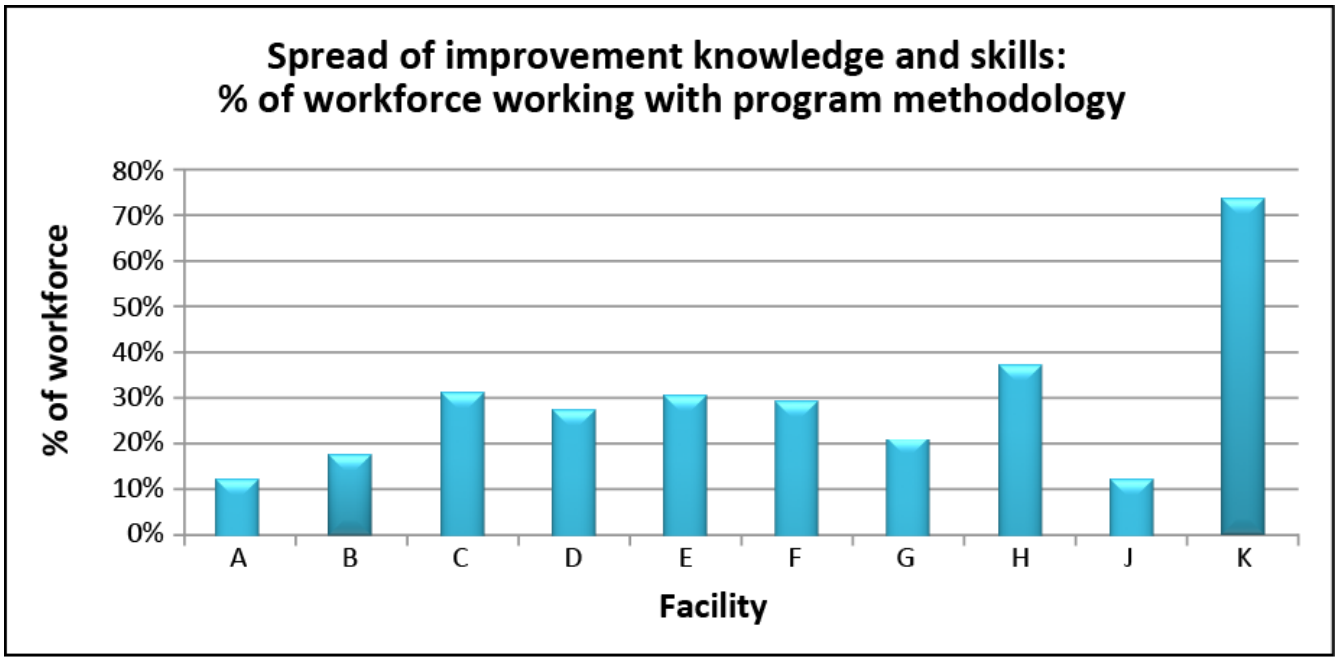
Table 4: Site Visit Schedule

Facility	Feb Visit 1	Mar Visit 2	Apr Visit 3	May Visit 4	June Visit 5	Extra Visits
A	18-Feb-15	12-Mar-15	6-Apr-15	18-May-15	9-Jul-15	
B	16-Feb-15	13-Mar-15	6-Apr-15	canceled	22-Jun-15	27-Mar-15
C	16-Feb-15	12-Mar-15	10-Apr-15	14-May-15	25-Jun-15	
D	19-Feb-15	12-Mar-15	8-Apr-15	12-May-15	29-Jun-15	1-Apr-15
E	18-Feb-15	12-Mar-15	8-Apr-15	12-May-15	23-Jun-15	27-Feb-15
F	18-Feb-15	13-Mar-15	9-Apr-15	13-May-15	22-Jun-15	
G	20-Feb-15	13-Mar-15	14-Apr-15	15-May-15	26-Jun-15	20-Apr, 21-Apr, 1-Jun 2015
H	19-Feb-15	13-Mar-15	10-Apr-15	13-May-15	24-Jun-15	31-Mar-15
J	20-Feb-15	13-Mar-15	7-Apr-15	15-May-15	24-Jun-15	
K	19-Feb-15	12-Mar-15	9-Apr-15	14-May-15	23-Jun-15	13-May-15

4.2.2 Ensuring the spread and adoption of the Care Homes Wellbeing™ improvement process throughout each facility

To measure spread and adoption of the CareHomes Wellbeing™ methodology, we created a matrix for each facility to record how familiar staff at each facility were with each of the tools. An example of this can be found in Appendix H. Individuals were given either 1 or 2 points for each tool, depending on whether their mastery of the tools was at the level of “aware” or “involved.” The adoption rate at each facility was calculated according to the number of employees at the “involved” level.

Graph 1: Spread and Adoption of CareHomes Wellbeing™



The results show that spread and adoption within each organization range from 13% to 74%, with an average adoption rate of 30%. *These results are considerably higher than we expected for such a short pilot period.* We expect spread and adoption to continue to grow measurably over the next several months and years to come.

4.2.3 Focus on outcomes and benefits derived from changes made

The best way to understand the impact of CareHomes Wellbeing™ is to listen to participants in their own words. This seven-minute video captures staff and administrators' reflections at the end of the six-month pilot period. They speak to the value of the program in transforming their facilities as well as to the value of learning together with other staff. https://youtu.be/wEbx0z5Xz3I. Appendix I includes two additional video links composed of interviews taken at the beginning and midpoint of the Pilot.

In addition to the changes described elsewhere in Section 4, trainees reported significantly higher levels of teamwork, team morale and engagement of residents. These changes contributed to greater awareness by staff of the safety issues affecting residents. In addition, staff reported greater efficiency as a result of organizing their workplaces to improve previously frustrating processes.

Creating a vision. During the Pilot, nine of 10 facilities implemented the *Our Home Now and In the Future* tool. This tool created a baseline for the current experience of the staff and started their visioning process for the future. It was also the first step in staff engagement. Project leads had to try different ways to get staff to participate in the exercise. The resulting insights were discussed and shared collectively.

Developing teamwork and morale. Team morale at Facility E was low at the start of the project, due in part to staff not having a dedicated space away from high-need residents in which to take breaks. After locating a suitable space for a break room and getting approvals to ensure its use for staff, morale

increased. Staff in this facility went on to create an informal system to manage unplanned absences among themselves rather than working directly with the administrator. These changes generated trust and created a climate of openness to learn other key tools such as *SBAR (Situation Background Assessment Recommendation)*, from the project leads.

At Facility D, staff verbalized that they frequently went without taking breaks from their work. They tracked staff lunch breaks and created a buddy system that enabled workflows to continue uninterrupted while staff were on break.

In Facility J, the project lead quickly learned that the cost of food was an issue for many staff. With the full support of the chef, the facility started "Soup Fridays" – one day a week when every person could have a free bowl of soup. Staff morale increased greatly. When the test was temporarily halted, morale decreased.

Facility F used the *Community* tool to get to know one another. It started as an effort in one department but quickly grew in scope as enthusiasm among staff grew. It turned into a special party honoring staff in which they created a scrapbook illustrating their identity and spirit.

Facilities G and J enjoyed success with the *Three Things About Me* tool in which staff write down three things that others might not know about them. The book created by one facility was copied and put in several locations within the facility. Residents liked learning more about the staff, and staff got to know one another better, thereby enhancing the team culture. This tool was particularly important to a new administrator seeking to connect with staff.

Greater focus on residents. At the start of the pilot, Facility C created a *Residents Summary Board* to show key resident information visually. This board allowed staff to quickly and easily track changes in the care residents required. Facility E created a similar board to track changes of condition.

Facilities B and H used the *My Story* tool for residents to describe their life stories, experiences and opinions in their own words. One facility created "Resident of the Month," located at the reception desk to highlight the life of one person at a time. Another facility created a "Mystery Resident of the Month" competition in which residents got the opportunity to guess who was featured. This focus greatly improved both the morale of residents and staff as they got to know one another.

Greater efficiency. Several organizations reported significant gains in morale and time by using the *Organizing Our Workplace* tool. Facility A discovered it had duplicate food in several different areas. Their over-ordering resulted in being consistently over budget. The team used the tool *Organizing Our Workplace* to track the areas where food supplies were located and then to consolidate stocking. They also centralized supplies within the health care team. The facility was able to save money by minimizing overstocking and consolidating supplies. It also saved time spent by staff "hunting and gathering." The facility is now reporting greater confidence that they have the right amount of supplies.

Facility F used the same tool to reorganize and streamline their nurses station, which has resulted in reduced time spent looking for forms and a calmer feeling when working in that environment.

Facility K initially used *Organizing our Workplace* in the library designated for resident activities, then spread it to the staff offices that were also being used for storage of old equipment and supplies. The facility is planning a garage sale to raise funds that can be used to purchase other needed items.

4.2.4 Create internal cultures of sustainable continuous improvement

Usually, changing culture is a long-term endeavor. The CareHomes Wellbeing™ Pilot was in effect only six months, so one would not expect major changes in culture in such a short time. And yet, *we have seen significant movement toward establishing cultures of continuous improvement in every facility*. We have seen the use and integration of many of the tools in the facilities, with greater impact coming from each subsequent application of them. This suggests a powerful morale boost created by self-improvement, and a highly positive impact on day-to-day work activities.

Some of the changes reported by staff include:

Improved internal communication. Facilities reported greater openness, communication, and sharing of information among staff and management. This has been accomplished by staff building relationships, understanding more about one another and developing their teams. Attendance at staff meetings improved 100% in one facility due to increased employee engagement, and there were reports from another facility that some staff came in on their own time just to attend staff meetings. *Crucially, staff from at least two facilities reported that the empathy of administrators toward staff had increased.*

Taking initiative and sharing responsibility. Facilities reported that staff are now more likely to take the initiative to improve. The more follow-through and action that staff see, the more engagement and trust there is. And the more trust, the more likely staff are to take initiative to make the changes that they know are needed. After tracking staff absence with the *Safety Cross* tool, Facility K decided that staff members would call other employees directly when they needed someone to fill in for them. In another facility, the activities director became concerned about the number of falls experienced by residents. She adapted the *Clock* tool to track the time of day and corresponding shift when resident falls happened. Using both the *Clock* and the *Safety Cross* made the problem of falls more visible to all staff, not just senior staff.

Focus on residents. Caregivers are communicating more with one another about residents, and residents say that they have more confidence that things that are promised will happen. One facility created a board in the catering department to track residents' food preferences, gaining much support from the residents.

This focus on residents has improved safety awareness. One facility struggling with slow call buzzer answer times identified the need for a shower aide. Call buzzer answer times decreased as a result of a dedicated staff person's attention to helping residents shower. When the shower aide role was discontinued, call buzzer answer times increased – but falls did not. The facility learned that the root issue was falls. Once staff became aware of the falls problem, they took steps to minimize them and falls decreased as a result.

Increased transparency and accountability. Every facility used the *Idea Cards* tool to generate suggestions and engage staff. They shared the ideas, voted on them, and turned them into action. The

process created transparency. It also provided a voice to staff who felt that they had none previously. This change of inclusion was very significant in some organizations.

4.2.5 Collaborate with other individuals and facilities to improve together

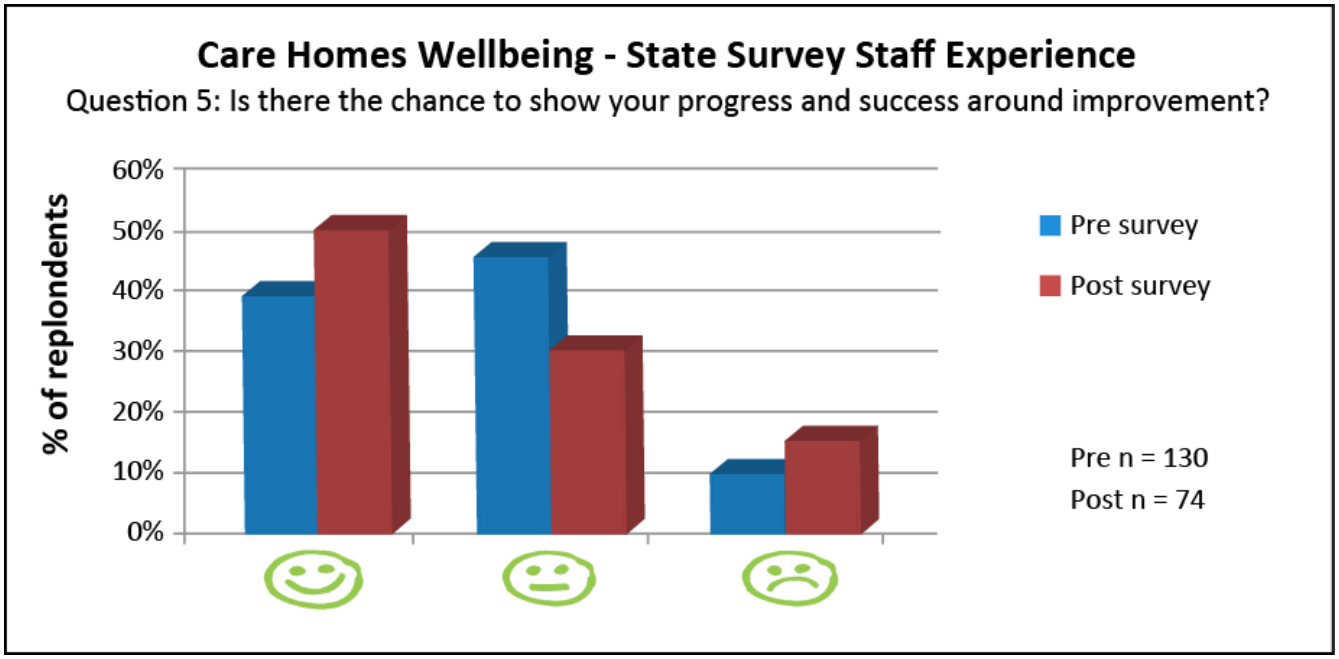
For most participants, mixing with staff from other facilities during the sharing events was a new experience. Project leads developed relationships with staff from other organizations within the learning collaborative, and some even engaged outside of the collaborative to get information, support and new ideas. Staff reported exchanging information about staffing levels and internal communication systems. One project lead said that she would not have had the confidence to ask for help outside her organization prior to this Pilot, and an administrator reported that she would not have reached out to another administrator even in her own network had it not been for the Pilot.

4.3 Pre and post facilities' compliance survey scores for each facility in clinical and non-clinical areas

We measured staff attitudes toward compliance at the beginning of the Pilot and again at the end. We chose staff attitudes rather than changes in state survey compliance scores because those surveys are administered every two years and the pilot period lasted just six months. Appendix J lists the five questions comprising the survey, combined responses, and responses as a percentage of the whole. Note that there was a 43% decline in the number of respondents pre- and post-survey, from a total of 130 at the beginning of the Pilot to 74 at the end. The link between the CareHomes Wellbeing™ intervention and this measure is weak.

Graph 2 shows that there was an 11% increase in respondents feeling that there is the chance to show progress and success around improvement during the State's compliance survey process. There was a also a marked decrease in respondents feeling ok about the State survey process and a slight increase in the number of respondents feeling worse about their understanding of the process. It is difficult to gauge whether these results are meaningful.

Graph 2: Staff Attitudes Toward Compliance



4.4 Pre and post staff and resident experience scores for each facility

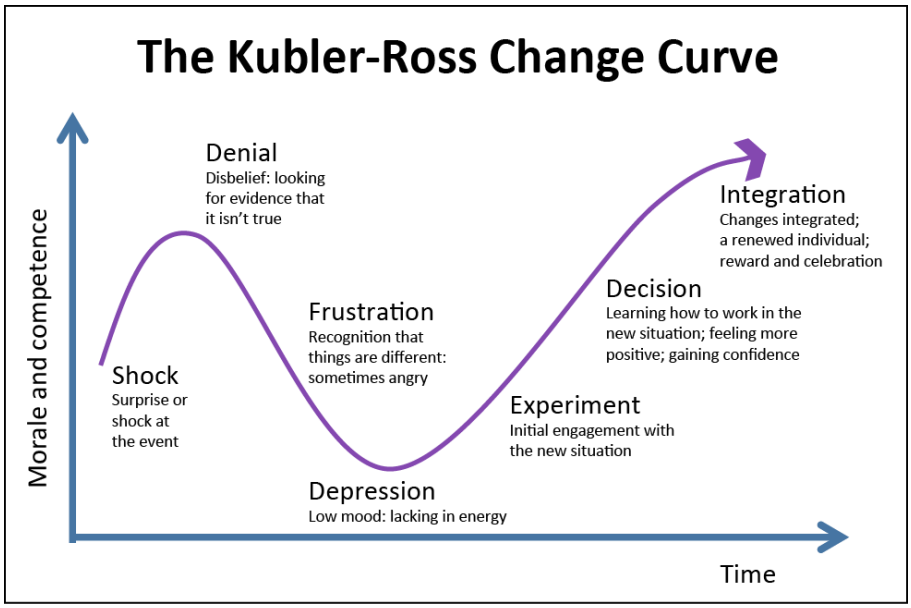
At the beginning of the Pilot, project leads helped to design short surveys to gauge the *experience* of fellow staff and residents. We chose to measure experience as opposed to satisfaction because experience is measured in the moment and is not dependent on expectation.

Note that the number of respondents declined from the pre to the post period in both surveys, and the respondents themselves were not necessarily the same people from the first survey to the second. Many of the respondents were not working at the facilities when the first survey was given.

Staff were asked the following questions:

1. Do you feel your suggestions for improvement are acted upon?
2. Do you feel supported by your organization?
3. Are things organized to help you do your job?
4. Do you get all the information you need to do your job effectively?
5. Are new staff given the support to quickly become part of the team?

Of note, there was a 13% increase in the number of people feeling happy that their suggestions for improvement were acted upon and a 7% increase in respondents feeling happy about being supported by their organization. There was also a 6% increase in the number of respondents feeling unhappy about the support given to new staff to quickly become part of the team. The Kubler-Ross change curve below shows how staff typically react to change. Some will be in denial that there are issues, others will be frustrated or angry, and others will suffer low morale before they learn to work in a new environment. We would expect more positive results in staff experience after a longer period of implementation.



The full results can be found in Appendix K.

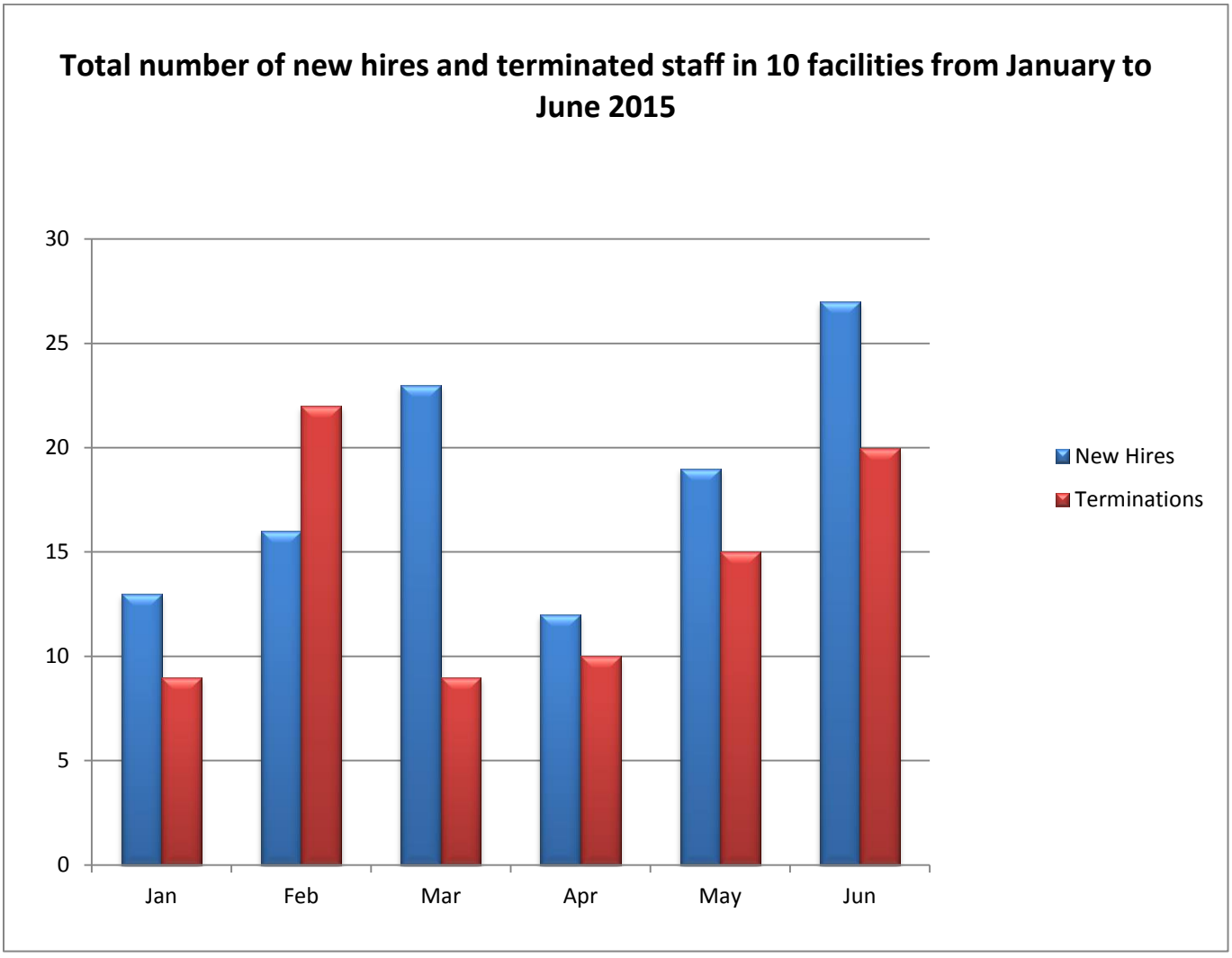
With respect to resident experience, pre and post survey results showed little change in response to the following questions:

1. How do you feel about your physical environment?
2. Do you feel the staff here work as a team?
3. How do you feel about mealtimes?
4. Do you get the support you need from the staff?
5. Are you kept informed about the things that matter to you?

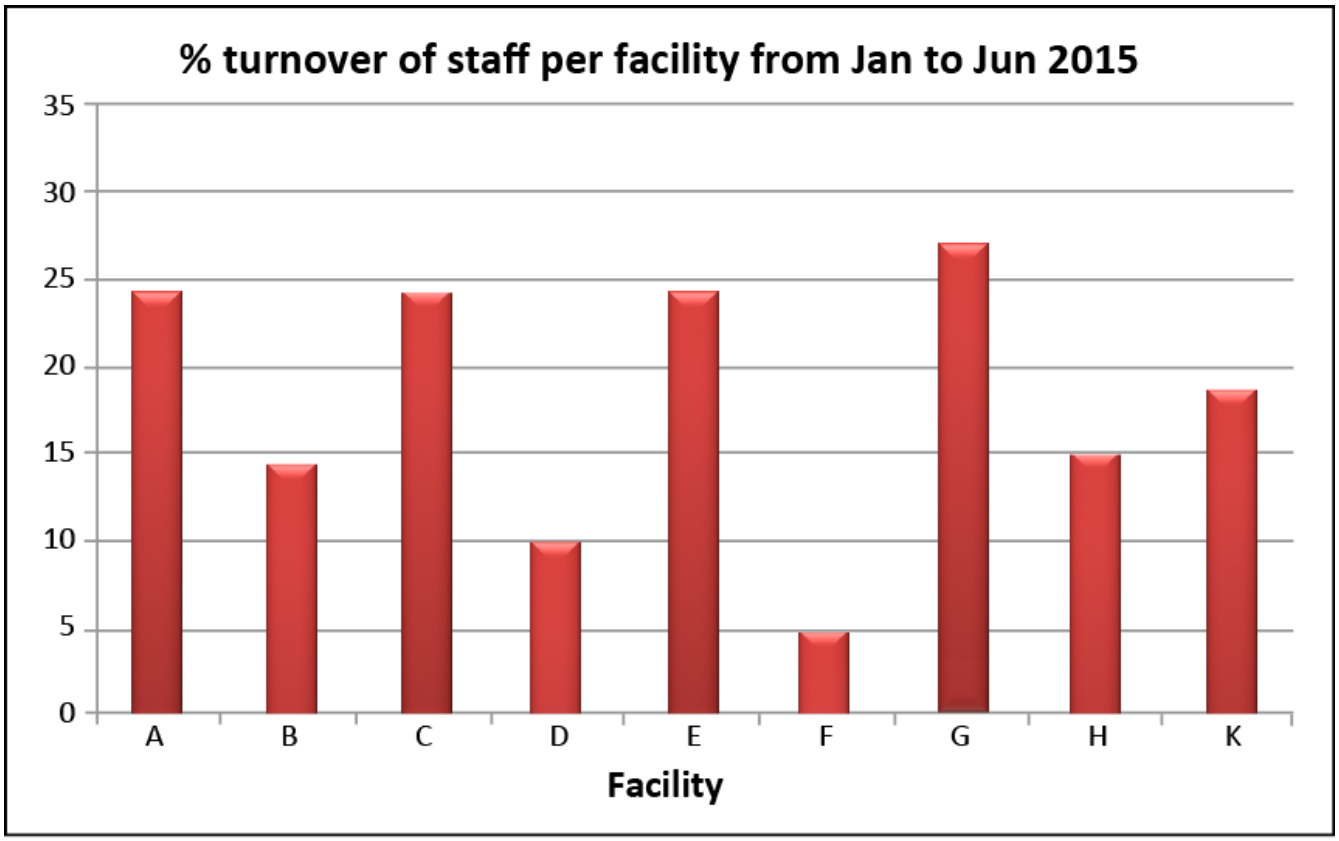
The full responses are located in Appendix L. We think the main factor influencing the lack of change in resident experience was the disruption that occurs with organizational change and staff turnover.

4.5 Pre and post staffing numbers at each facility to demonstrate staff turnover for each facility

Graph 3: Staff Turnover per Month per Facility



Graph 4: Percent Turnover by Month



Graphs 3 and 4 show the combined results of staff turnover as reported by each facility at the beginning of the Pilot and again after six months. On average, staff turnover was 20%, with some facilities experiencing much higher percentages. We cannot yet determine whether staff turnover rates are declining due to the Pilot, but we received anecdotal information from staff and administrators indicating that staff turnover causes very high levels of disruption. For this reason, we quantified the administrative aspect of its cost.

The reasons for staff turnover include:

- Low pay
- Other work options in the same geographical area
- Feeling overwhelmed because of a high census or acuity level
- New administrator or another change in leadership
- Medical leave
- Change in family circumstance
- Mistreatment of staff by challenging residents
- Wanting new opportunities after gaining skills or a degree

To quantify the administrative cost of staff turnover, we developed a generic process map. This map was based on discussions with each facility to understand the workflows involved in hiring new employees. We estimated the amount of time needed to complete each of the process steps and then assigned a dollar value to the process based on hourly wages. We looked at three forms of

recruitment: one with no backfill, one with backfill using overtime, and one with backfill using temporary agency hires. Appendix M shows the recruitment process and its cost.

We then used this information to quantify the administrative cost of staff turnover. Table 5 shows an estimated cost to facilities of staff turnover during the six-month Pilot to be between $562,000 and $773,000.

Table 5: Estimated Cost of Recruiting New Hires

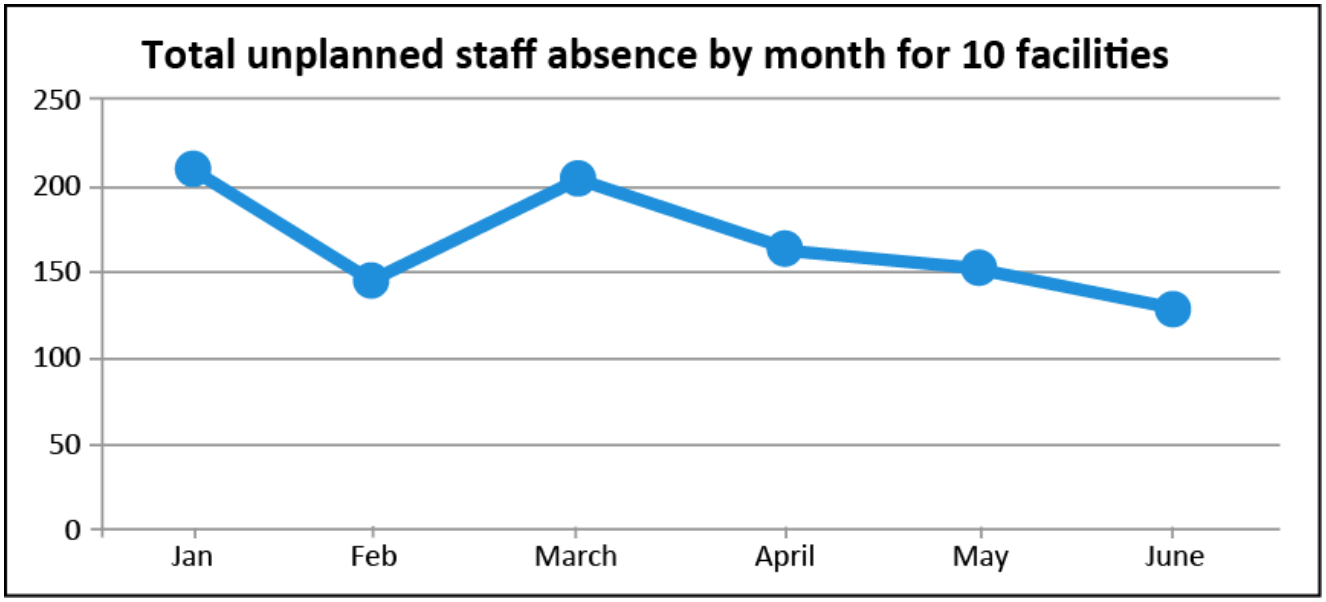
Facility	# New hires over 6 mo. period	Cost with backfill, overtime	Cost with backfill, agency
A	21	$107,310	$147,630
G	39	$199,290	$274,170
H	9	$45,990	$63,270
D	9	$45,990	$63,270
B	5	$25,550	$35,150
F	6	$30,660	$42,180
E	6	$30,660	$42,180
K	6	$30,660	$42,180
C	9	$45,990	$63,270
Totals	**110**	**$562,100**	**$773,300**

NB: Estimated cost of recruitment using backfill and overtime is $5,110/person. Estimated cost of backfill using agency support is $7,030/person

4.6 Pre- and post- unplanned staff absences for each facility

Unplanned staff absences declined during the Pilot, with seven of the 10 facilities experiencing a decrease. Graph 5 shows the total number of absences per month.

Graph 5: Unplanned Staff Absence

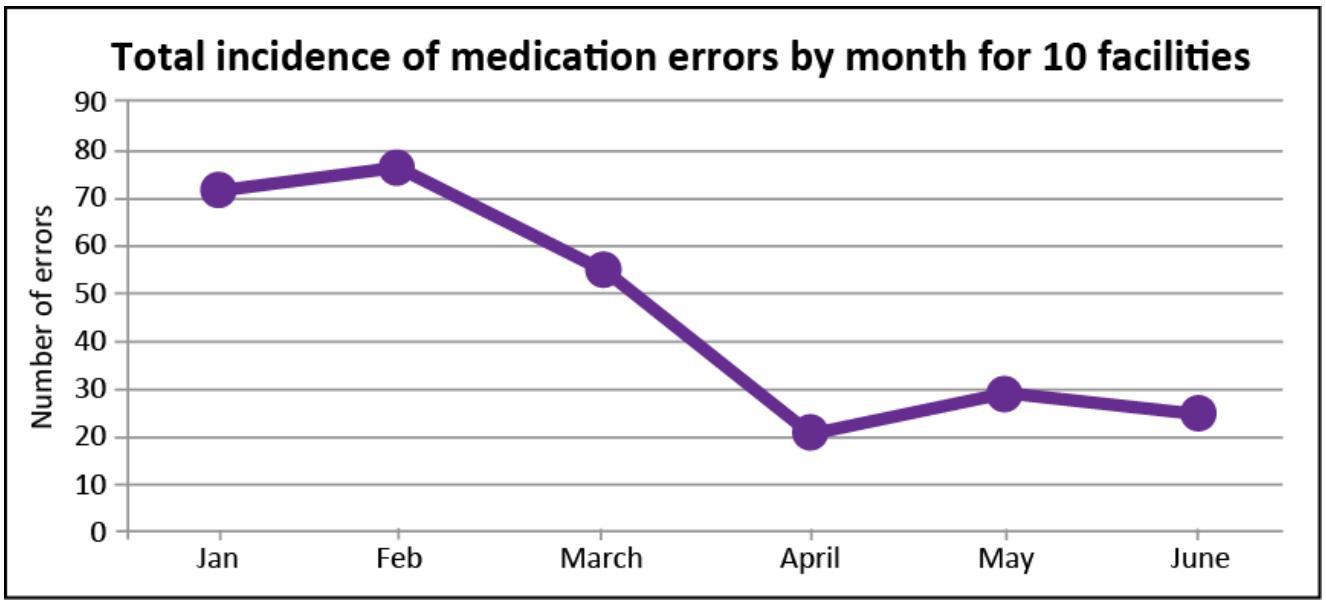


Part of the decrease can be attributed to the impact of CareHomes Wellbeing™. Tracking unplanned staff absence through safety crosses made the issue visible to all. It led to more empathy among staff for one another. It also led to a variety of solutions, such as providing more flexibility in shifts and allowing staff to make arrangements among themselves to cover for one another's absence. (We found that it was seven times more expensive for administrators to make arrangements for staff absence than for staff to arrange it themselves.) The reasons for staff absence did not change during the Pilot -- life events, sickness, childcare and issues with family members remained the top drivers.

4.7 Pre- and post-medication error rates for each facility

There was a **35% decline** in medication errors over the course of the Pilot, from 72 total errors in all of the facilities in January to just 25 in June. See Graph 6 below.

Graph 6: Reduction in Medication Errors



Facility B focused on reducing its medication errors during the Pilot. Previously, residents had to wait in line for medications and many became confrontational during the waiting process. After involving residents in the identification of the problem and ways to address it, the facility decided to create a waiting area for residents with a separate area for diabetics. Medication errors decreased significantly as a result. Facility B attributes half of their reduction in medication errors to CareHomes Wellbeing™ tools and half to the introduction of an electronic medical record (EMR). Another facility reported that focusing on medication errors before the introduction of an EMR eased the transition to the EMR because staff had become familiar with measuring the incidence of medication errors.

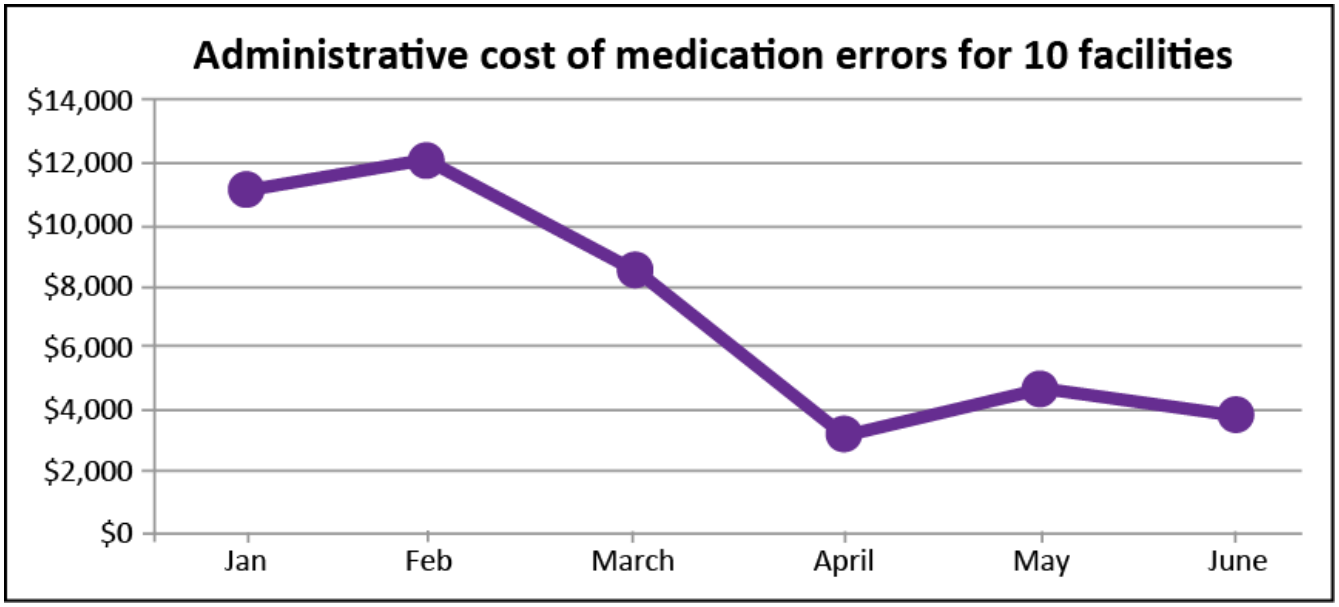
One issue that made measurement difficult was the different interpretations of what constitutes a medication error. Although staff at all the facilities agreed that a medication error includes wrong site, wrong dose, wrong resident, wrong drug or wrong time of medication administration, there are some gray areas. Some facilities have a wider definition, such as lack of follow-up on PRN medication and documentation, lack of medication stock or residents bringing in medications from outside. This additional reporting has helped to highlight issues that staff can address to make medication administration processes safer.

Two facilities participating in the Pilot broadened their definition of medication errors to reduce these and other types of errors. One facility discovered that medications were frequently administered late because they were prescribed to be administered during shift handover. After consulting with their doctors, the facility changed the scheduled times medications were to be administered, and errors subsequently decreased.

Because of the cost of medication errors and the corresponding benefits of preventing them, we analyzed one aspect of their cost: their administrative cost. We looked at the administrative cost of reporting two types of errors, those that did not result in harm and those that did result in harm. We developed process maps to understand the workflows involved in reporting medication errors, then queried facilities on average times for each part of the process and calculated the cost of the process using average hourly wages. See Appendix N, Process Maps for Medication Errors. We calculated an estimated average administrative cost for a medication error with harm would be approximately $473,

and without harm $156. (Note that no facility experienced a medication error with harm event during the course of the Pilot, and administrators reported that such errors are extremely rare.)

Graph 7: Administrative Cost of Medication Errors During Pilot Period



Graph 7 summarizes our findings. The total administrative cost of reporting the 278 medication errors experienced by the facilities over six months was $43,368. Compared to January's baseline month, the reduction in medication errors totaled 154 over six months, a savings of $24,024.

4.8 Falls

Although we were not required to report on falls, we collected anecdotal information from eight facilities to estimate the administrative cost to facilities of managing falls and the corresponding benefit we could expect from reducing them. This information formed part of our social return on investment analysis.

As with staff turnover and medication errors, we created a process map detailing the estimated administrative cost to the facility due to falls resulting in no harm, falls requiring a 911 call, and falls resulting in hospital admission. See Appendix O. Facilities were asked to estimate the average number of falls per month, and then we calculated the likely cost over a one-year period. Table 6 shows an estimated annual administrative cost of falls to be $272,000 for the eight facilities or about $34,000 per facility.

Table 6: Estimated Cost of Managing Falls in 8 Facilities

Type of fall	Estimated Cost	Estimated # Falls/mo.	Cost per year
No harm	$155	109	$202,740
911 call	$313	14	$52,584
Hospital admission	$713	2	$17,112
Total			**$272,436**

Note that while falls are costly to facilities and to residents, staff reported that residents are more likely to be admitted to the hospital for pneumonia or urinary tract infections than for falls. We estimate that the administrative cost of managing infections would be similar to the cost of falls, with less reporting time but more patient care.

4.9 Recommendations for and/or identification of barriers to replicating the program on a statewide basis

After the six-month Pilot, we recommend expansion on a statewide basis. The appeal of this methodology became apparent early on, with staff and administrators overwhelmingly supportive. Several multi-facility organizations have expressed strong interest in integrating the methodology into their other facilities, including skilled nursing facilities and nursing homes. The video link below provides a sense of the enthusiasm and momentum that has been created among staff and administrators. https://youtu.be/wEbx0z5Xz3I

In the interim summary to the State, we indicated our interest in exploring a Phase 2. (Appendix G.)

Quality improvement methodologies take time to reach their full potential. With continued application of the improvement tools, spread to departments beyond the initial ones, and deepening knowledge and experience within and across organizations, we believe that the results of implementing quality improvement methodology and universal tools such as CareHomes Wellbeing™ will become more positive over time. We would expect to see further reductions in medication errors, staff absence and, most importantly, staff turnover. We would expect to see a greater satisfaction and focus on safety, greater teamwork among staff, more bonds between staff and residents and ultimately greater levels of engaged leadership throughout the participating facilities.

Over the course of this Pilot, we noticed the challenges that facilities encountered. For greater success, future rollouts of this or a similar methodology need to consider:

- *Dedicating sufficient time for staff to learn and implement the methodology.* The amount of time required depends on the facility, its current challenges and leadership. At the beginning of implementing a new methodology, staff typically feel that the time allotted is inadequate no matter how much time they actually have; nevertheless there is a need to have enough time to learn and use the tools.
- *Ensuring that facilities are ready.* Facility readiness means that the administrator understands the methodology, its benefits, is able to communicate the "why we are doing this" to staff at all levels in the facility and has co-created with lead staff a plan for implementation. Administrators should understand that everyone is a stakeholder and has an important role to play in achieving the facility's vision.
- *Building a more structured approach.* There are many tools in CareHomes Wellbeing™. We found that facilities struggled with selection of which tools to use and in what order. They would have benefited from more direction.
- *Starting small.* Starting within one department and building gradually makes it easier to identify and resolve issues before they become too big or uncontrollable. It also allows for the organic creation of a common language and approach to improvement within the entire facility.

- *Having a kickoff celebration.* Every facility struggled with engagement at the beginning of the Pilot, and some staff felt left out. We believe that staff would have benefited from a more celebratory atmosphere at the outset, possibly by including additional visits by trainers. Such visits early in the Pilot may have provided more credibility.
- *Informing administrators that staff will make small budget requests.* Staff will likely come to administrators requesting small additional resources, and will need the authority to manage those funds. The requests during the Pilot were contained within existing budgets.

5. Key Learnings

This Pilot created many opportunities for questions and reflection among CareOregon staff as we learned about the long-term care sector. Below are some of our key learnings that we wanted to share, beyond the measures reported above.

5.1 The best leaders enable and empower their staff and co-workers

We learned a lot about leadership during the sharing events, site visits and training. We found that the most engaging leaders, whether or not in traditional positions of power, saw themselves as coaches who lead by example. They have a relational style, are open to learning from other staff and influence others. We heard from several administrators that they saw themselves as "strong leaders" and "control freaks". When they stepped back and gave leadership opportunities to staff, they were perceived as less remote, more visible and team-oriented. Staff also became more accountable for their own actions as a result. When administrators "let the staff surprise them," they were able to see the leadership qualities of staff whose positions were less visible. In at least one instance, a newly visible staff lead left the organization to further develop her learning and leadership capabilities.

We also noticed that as difficult as it was for some project leads and administrators to receive critical feedback, those who were not defensive or reactive found that staff were much more engaged than they had expected. These leaders came to realize that their staff's positive commitment to change was driving some of their complaints.

Other observations:

- The best leaders can develop a plan, identify the key players, "get the right people on the bus and in the right seats" and then support them.
- They are not afraid to fail, or to let their staff fail, because they frame failure as learning. They create a way to talk about the things that do not work.
- They are good communicators. They talk frequently about what matters. They explain the reason for regulations, for example.
- And most importantly, they understand the cultural, economic and social context lived by their staff. That includes language, ethnicity, family life and barriers. We noticed, for example, that transportation to work was a major barrier for staff, with some staff traveling to work up to an hour and a half each way.

5.2 Wages are the biggest driver of staff turnover, but they are not the only driver of staff satisfaction

Caregiving is a second job for many staff we met, and many people are faced with the difficult life challenges that arise from this situation. In the first visioning sessions, staff at almost every facility brought up the issue of wages as their number one concern. It created an opportunity for administrators to acknowledge the issue and address measures that were being taken. In at least one case, the administrator was able to redirect staff to existing internal training and education opportunities for higher-level jobs, thereby boosting morale.

We know that improved staff morale, communication, and leadership – all aspects of high-performing organizations – play a major role in reducing staff turnover, medication errors, and falls. If a portion of the savings realized by improving these measures was re-directed to staff salaries or incentives, then this top need by caregivers could be addressed.

5.3 Flexibility in staff roles is needed

When addressing a problem within a facility, it is critical for leaders to have the flexibility to reassign staff on a temporary basis to address and understand problems. The creation of a shower aide role on a temporary basis helped staff at one facility see that their real issue was not answering call buzzers quickly, but rather preventing falls (see p. 17.) Without the ability to shift staff resources temporarily, the facility would not have gotten to the root cause of the problem.

5.4 The more diverse the staff, the more communication challenges there will be

There are wide differences in language, culture and ethnic backgrounds among caregivers, even within a single facility. That makes communication difficult and places an extra burden on administrators to know their workers well and to learn how to communicate in culturally appropriate ways. We were especially pleased to hear from several staff that both administrators and staff had more empathy for one another as a result of this Pilot.

5.5 The existing compliance framework creates a negative environment for improvement

We were surprised at the punitive language used in the industry when problems are identified. In reports regarding medication errors, for example, caregivers are considered “perpetrators” and residents “victims.” This creates an environment that negatively affects transparency. Staff said that they felt less willing to report errors because they were afraid of the consequences. One administrator spoke of having to counsel an extremely stressed and tearful caregiver who was anxious about having a formal interview regarding an error that was made. This kind of fear-based culture runs counter to the characteristics of an improvement culture, and stands in stark contrast to the efforts undertaken in acute care facilities to develop a blame-free culture.

5.6 Compliance language is too hard to understand

Caregivers struggled to understand, let alone master the regulations governing their caregiving. We think that simplifying compliance language and focusing on what each person’s role is in achieving compliance would be a positive step toward achieving the State’s compliance goals.

5.7 Learning together in a collaborative manner is invaluable

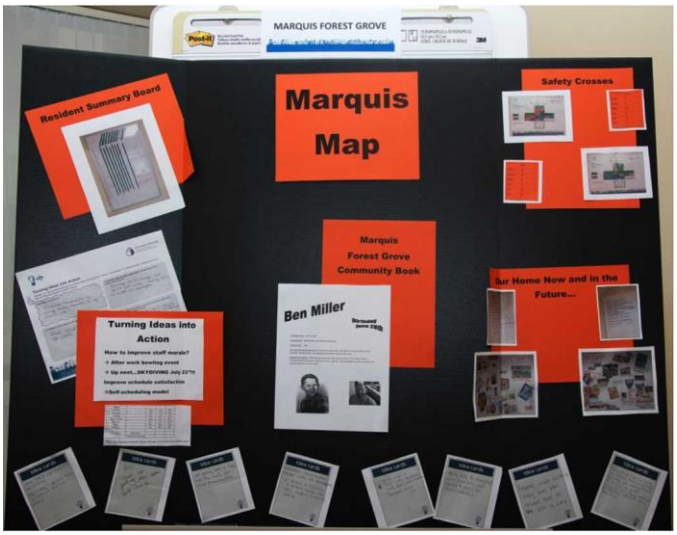
Although CareOregon has had much experience in convening caregivers to learn from one another, we were reminded that the peer-to-peer aspect of learning is invaluable. Few people were eager to participate in sharing events initially, but they all quickly realized that their problems were similar. And in the sharing events, they borrowed ideas and practices freely from each other. This aspect of learning is central to a scaling model. We intend to continue convening the initial group on a regular basis for as long as the group finds it useful.

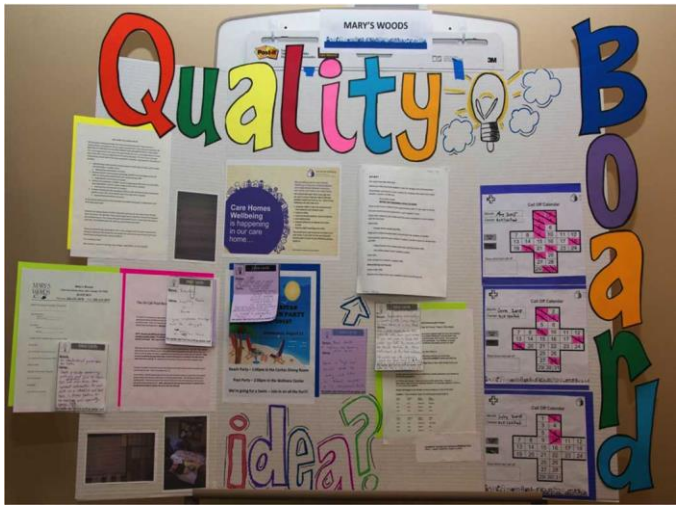
6. Learning Collaborative in Action

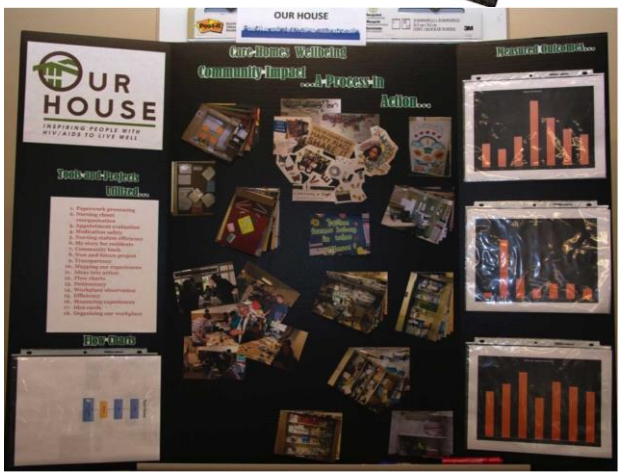
The photographs below bring to life the journey of the CareHomes Wellbeing™ trainees and the tools they used and shared.

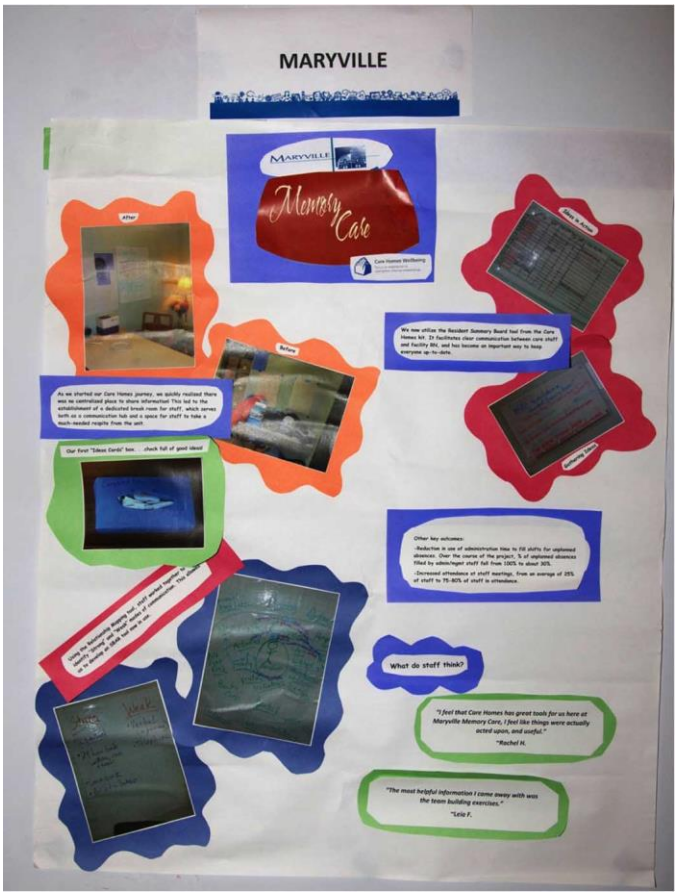
Celebration Event July 2015 - Presentations and Posters from participating facilities

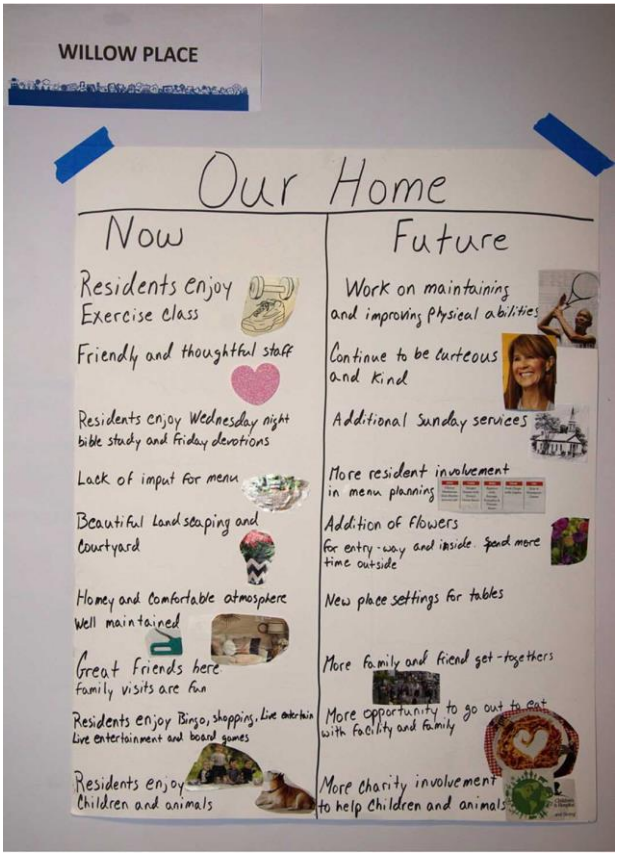
Sharing Event — sharing experiences of using CareHomes Wellbeing™ **tools**





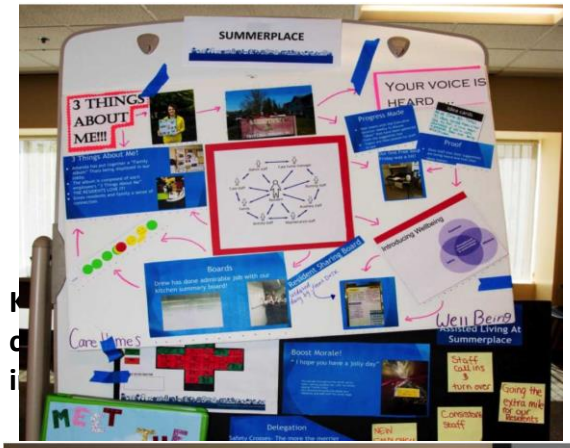



MARYVILLE
Memory Cafe
What do staff think?

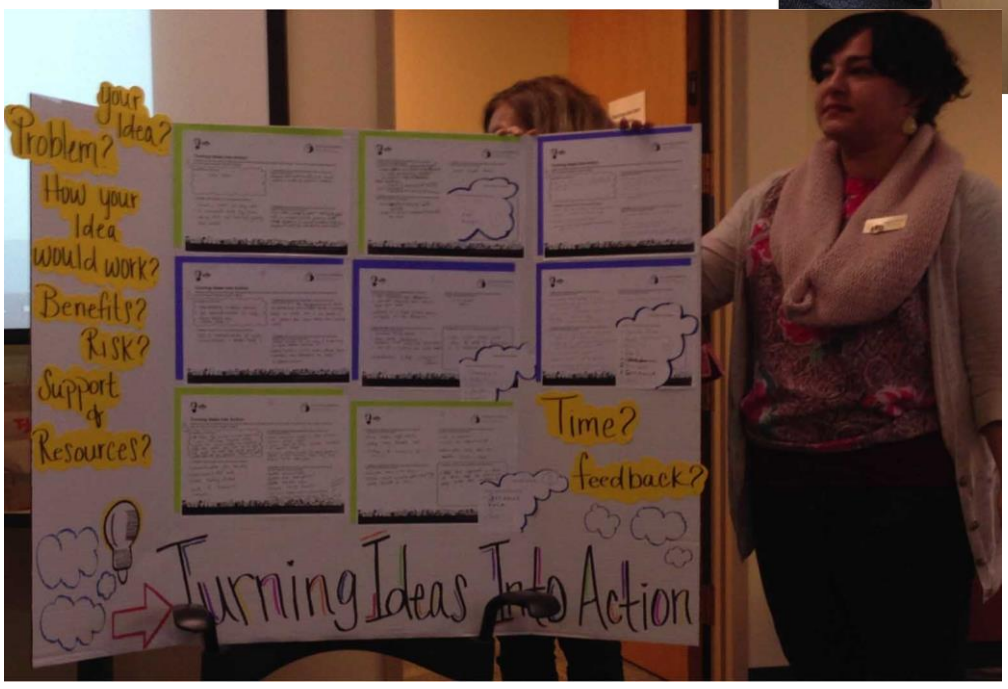

WILLOW PLACE
Our Home
Now
Future
Residents enjoy Exercise class
Friendly and thoughtful staff
Residents enjoy Wednesday night bible study and Friday devotions
Lack of imput for menu
Beautiful Landscaping and courtyard
Homey and Comfortable atmosphere Well maintained
Great Friends here family visits are fun
Residents enjoy Bingo, shopping, Live entertain Live entertainment and board games
Residents enjoy Children and animals
Work on maintaining and improving physical abilities
Continue to be curteous and kind
Additional Sunday services
More resident involvement in menu planning
Addition of flowers for entry-way and inside. Spend more time outside
New place settings for tables
More family and friend get-togethers
More opportunity to go out to eat with facility and family
More charity involvement to help children and animals


OUR HOUSE
Care Homes Wellbeing
Community Impact
A Process in Action
OUR HOUSE

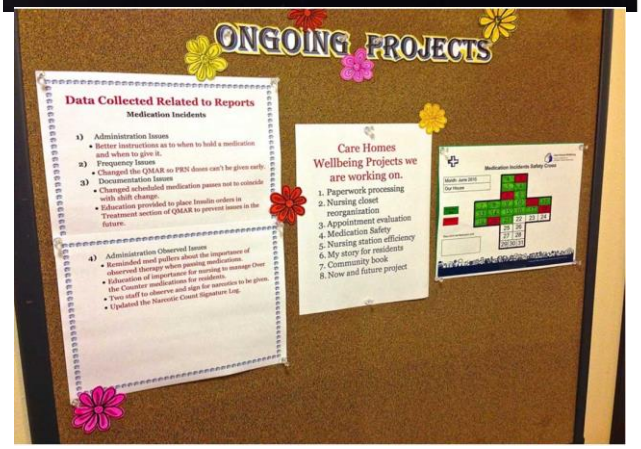

MacDONALD HOME
Macdonald Residence
Care Homes Wellbeing
Focus on experience to strengthen internal relationships


SUMMERPLACE
3 THINGS ABOUT ME!!!
YOUR VOICE IS HEARD
Boards
Care Times
Boost Morale!
Staff Call ins & turn over
Going the extra mile for our Residents
Delegation
Assisted Living At Summerplace


OUR QUALITY BOARD


your Idea?
Problem?
How your Idea would work?
Benefits?
Risk?
Support & Resources?
Time?
feedback?
Turning Ideas Into Action

Photographs from site visits to facilities



CareHomes Wellbeing™ Training January 2015

7. Social Return on Investment (SROI)

To better understand the quantifiable benefits of reducing medication errors, staff turnover, unplanned staff absence, and falls, we used a social return on investment framework.

The table below shows an estimated social return on investment over the next five years of $12.50 for every $1 invested by the State and by CareOregon.

Below we have listed the outcomes that we expected from the Pilot, how we would measure them, a financial proxy that we could use for each indicator and their combined value. The information that we used to build the financial proxies was based on interviews and self-reporting by facilities as well as process maps showing times and salary costs for each aspect of the administration processes. (See appendices.)

We calculated the benefits over a six-year period (five years plus the current year), applying a standard discount rate. We divided that by the amount of the initial grant plus CareOregon's investment. Please contact the report authors to see the full SROI report.

Outcomes	Indicators	Financial Proxy	Value
Reduced staff turnover and shift in staff satisfaction	Percentage of staff turnover	Administrative cost to backfill the vacant position	$255,500
Reduced number of call-ins for unplanned absences	Number of call-ins for unplanned absences	Administrative cost to cover unplanned absences	$25,300
Identification of risks for resident falls and reduction of falls	Number of falls without harm to the resident	Administrative cost to report the incident	$40,900
	Number of falls with call to 911		$11,200
	Number of falls with a 5-day hospital admission		$3,600
Identification of risks for medication incidents	Number of medication incidents without harm to the resident	Administrative cost to report the incident	$63,800
	Number of medication incidents with harm to the resident causing a 1-day hospital stay		$4,700
Total Value for one year			**$405,000**
Present Value over Six-year Period (discount rate 3.5%)			**$2,200,000**
Total Investment			**$163,000**
Social Return on Investment			**$12.50**

8. A Word on the Collaborative Nature of this Pilot

We want to note the collaboration and supportive tone of all the participants in this Pilot from the earliest stages of proposal submission, through contracting and implementation. It is very much appreciated.

Very special thanks go to Keren Brown Wilson and Linda Kirschbaum for spending many extra hours guiding CareOregon staff through the history, issues and needs facing today's older adults.

Another special thanks goes to the advisory group for guiding the selection of facilities representing a diverse cross section that greatly enhanced the Pilot learnings.

And finally, a special thanks to TSCIG for contributing additional resources to strengthen the work and for being both a thought and implementation partner.

9. Appendices

APPENDIX A: CareOregon Biographies

CareHomes Wellbeing™ - Lead Staff from CareOregon

Scott Clement, Chief Network Officer, CareOregon and Project Sponsor for CareHomes Wellbeing™. Scott has over 25 years of experience in the healthcare industry. He rejoined CareOregon in April 2012, having worked as a finance analyst from 2001 to late 2005. Prior to rejoining CareOregon, he served as the Vice President for Provider Services for Regence BlueShield of Idaho. Scott began his career in healthcare with what was then the Health Division of the Multnomah County Human Services Department. In addition to his experience in public health and work with CareOregon and Regence, Scott has had extensive managed care contracting experience, including work with a large physician practice and with Legacy Health System in Portland.

Barbara Kohnen Adriance, Senior Business Leader for Learning and Innovation and Program Manager for CareHomes Wellbeing™. Barbara has responsibility for developing CareOregon's emerging Discovery, Design, and Development (3D) team. Using human-centered design methodology, the team develops promising ideas into prototypes and pilots. It also adapts innovative improvement methodologies from England's National Health Service, such as Releasing Time to Care™, now in 17 hospitals, and CareHomes Wellbeing™, now in 10 long-term care facilities in Oregon.

Barbara's professional background and experience are in international development and international economic policy. Before coming to CareOregon six years ago, she lived in Guatemala City and built a social enterprise at the Centro de Investigaciones Regionales de Mesoamerica, a national NGO engaged in preserving historical memory and addressing that nation's racial and ethnic conflicts. Previously, she lived and worked in Washington DC, heading the Center of Concern's Rethinking Bretton Woods Project, serving as policy advisor on international economic and human rights issues for the US Catholic Bishops Conference, and helping to start a social justice advocacy network for Jesuit colleges and universities. Her regional expertise is Latin America and she has spent significant time in Central and South America with a number of organizations, including the Ford Foundation and the Inter-American Foundation. She has a master's degree in public policy from Duke University and an undergraduate degree in international policy from Georgetown University's School of Foreign Service.

Lizzie Cunningham, Master Trainer for CareHomes Wellbeing™. Lizzie has over 30 years of experience working within the healthcare sector in roles ranging from clinical nursing, specialist nurse advisory and operational management as well as in regional and national improvement roles.

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Lizzie has a passion for leading innovation and improvement work for the NHS (National Health Service in the United Kingdom) and health systems in the United Kingdom and worldwide. She has significant practical knowledge and expertise in improving the quality, safety and experience of patient care. She has also co-developed and led a new approach in quality improvement programmes, The Productive Series: Releasing Time to Care™ (RT2C) that have been implemented worldwide. In addition, she has been responsible for developing associated training for these programmes as well as mentoring, coaching and supporting front line staff and leaders in a number of improvement techniques.

Lizzie is now living and working in the US playing a key role in the expansion of the RT2C programs to hospitals and systems across the country, in particular supporting the RT2C collaborative that has been developed in the Pacific Northwest. Her personal NHS experience enables her to bring insight as well as compassion and understanding to the work she does. She uses her relationship-building and communication skills to be effective, working in a supportive and engaging way with staff, leaders and other stakeholders, helping to provide the new perspectives that are required in supporting and encouraging people to think and work differently.

Lucia Duque Lindell, Project Analyst for CareHomes Wellbeing™, is a life-long learner and a natural-born leader. Lucia joined CareOregon almost six years ago and has excelled in different roles within the organization. After working closely with consultants from IDEO, a Palo Alto based company known for the impact they create through design, Lucia took on the role of Design Team Lead and currently leads teams to develop ideas into prototypes and pilots using Human-Centered Design methodology.

Lucia is passionate about working with people, learning from them and understanding their behaviors. She has the ability to quickly identify and develop empathy with individuals from different cultural backgrounds and languages. This is in part due to her Colombian heritage and her fluency in Spanish, her first language. Last year, Lucia was the recipient of the SPIRITED award, a recognition that CareOregon gives to employees who exemplify one of the values of the organization. Her award was in the category of of Diversity, for embracing difference with an open mind.

She brings years of experience from her previous work in public relations and as press liaison in the music and entertainment industry with production companies in Colombia and Los Angeles. Lucia has a bachelor's degree in Social Communication with an emphasis in Organizational communication from the Pontifica Universidad Javeriana in Bogota, Colombia.

APPENDIX B: The Social Care Improvement Group Information and Bios

The Social Care Improvement Group (TSCIG) is a not-for-profit Social Enterprise Company that enables positive change in the care home sector and the wider Health and Social Care system. The TSCIG approach is to support care homes with improvement methodologies, utilising many years of successful implementation of change at local and system levels.

TSCIG was formed to manage the delivery of Care Homes Wellbeing™ and Care Homes Connect™ methodologies in the care home sector. The methodologies were initially developed by the NHS with TSCIG's Directors. By bringing experts in development and delivery of improvement programmes, TSCIG ensures the successful spread and adoption into the social care sector, improving outcomes for the people who really matter, the residents, their relatives and employees. As a social enterprise organisation, we are a not-for-profit company. In line with our company mission and constitution, TSCIG develops new and enhanced services to meet demands in health and social care. As a learning organisation, we use experiences to shape new innovative solutions. The TSCIG Directors have worked with CareOregon for over five years, forging an incredibly strong and fruitful relationship, gaining vast experience and a solid reputation in the Oregon health care sector.

TSCIG's Vision, Mission and Value

Vision
Integrated and sustainable continuous improvements to the quality of care provided in all areas of social care.
Mission
To support social care providers to truly put the resident at the centre of all aspects of the care they receive.
Values
The Social Care Improvement Group is a not-for-profit organisation dedicated to enhancing the quality of care in the social care sector. We help create cultures of continuous improvement and are energised when we see tangible improvements in the quality of care, especially when it is received by those who need it most.

As a not-for-profit social enterprise, we care about improving things for everyone. We use what we know to influence public debate, re-shape public policy and support the transformation of services, leading to improvements from which everyone can learn.

Core Drivers
The TSCIG Directors see improvement methodologies and innovation as the means to improve the quality of care delivered to residents in the social care sector.

We work with individual Care Home organisations, commissioners, local administrators, regulators and other interested parties involved in the provision of services for care home residents.

Steve Burrows

Steve is director of a number of companies specializing in organizational transformation. These companies work with health and social care clients to enable cultures of sustainable continuous improvement, built on foundations of operational excellence - from boardroom to bedside.

Steve has specialized in health and social care for the last eight years, in the UK and the United States, mostly for the NHS Institute for Improvement and Innovation. He led commercial product development, successful market launch and spread of improvement methodologies supporting the care home sector in the UK. Multiple organizations have implemented the methodology successfully.

His other work with the NHS is developing international relationships (for example, with CareOregon) utilizing similar methodologies, including Releasing Time to Care™.

More recently, he has been delivering front-line organizational transformation across the infrastructure support at Guy's and St. Thomas' hospitals in London.

Prior to his time in healthcare, Steve enjoyed 20 years as a forensic scientist. After time as an expert witness, he ended up with responsibility for the UK's National DNA Database and provided consultancy to non-UK forensic organizations requiring large-scale restructuring and organizational change programs. In the US he led full R&D and international commercialization of forensic technologies in partnership with the US Department of Defense and Massachusetts Institute of Technology. Steve has implemented lean methodologies in many forensic science organizations. In the UK, he implemented a national consistency model that reduced forensic turnaround times by over 600%.

Steve is a founding director of the Social Care Improvement Group. His passion is to create as much value as possible providing maximum benefit. Having worked in public services for his whole career, he enjoys seeing the "back office" working well to enable positive contributions on the front-line. As an optimist and lifelong learner, Steve has a positive view on change and always seeks opportunities to improve. He loves problem-solving and working with ranges of opinions to seek out the best solutions and then make sure they are implemented well.

Phil Haynes

Phil is a director of two companies specializing in organizational transformation. These companies work with a range of clients across health and social care, delivering lasting change by engaging senior leaders to support the change and transition processes before working with front line staff to equip and empower them to make a difference in their daily work. Phil has specialized in health and social care for the last ten years, in the UK and internationally in locations including the Middle East, Europe and the United States. He has delivered training, facilitation and direct implementation support for structured improvement program such as Releasing Time to Care™. In addition, he has designed, developed and co-produced bespoke approaches to delivering measurable and sustainable

change that is locally-owned.

His work in the Republic of Ireland over the last four years includes delivering training and facilitation on the national rollout of the Releasing Time to Care™ program, as well as tailor-made interventions and support to enable successful implementation in local hospitals. In Oregon, Phil has directly supported the implementation of Releasing Time to Care™ and has provided training and facilitation for the initial cohort implementing Care Homes Wellbeing™.

More recently, Phil has been working at two flagship London hospitals delivering transformational change to services directly supporting the provision of clinical care. This has been delivered through a structured program using appreciative enquiry to support process changes and also developing people using emotional intelligence tools and techniques.

Prior to his time in health and social care, Phil spent ten years utilizing Lean Thinking principles, tools and techniques in an automotive manufacturing environment, supplying directly to global car manufacturers such as Ford, General Motors and Nissan. Operating with a consistent focus on quality, cost and delivery in a highly competitive environment, Phil honed his knowledge and skill in empowering front-line staff to identify and reduce waste, allowing more time to be spent on value-adding activities. He successfully integrated several satellite manufacturing units into the main factory, working with staff to develop understanding and ownership of the activities and then co-producing robust processes to deliver consistent outcomes.

Phil is a founding director of The Social Care Improvement Group. He is passionate about working with people, sharing not just theory and techniques, but practical application in a way that empowers people to ask questions, helping them to develop their own sustainable solutions to the challenges they face. His engaging and collaborative approach helps to build a strong platform for success.

APPENDIX C: Information Provided to Facilities for the Pilot (CareHomes Wellbeing™ is no longer available to license)

CareHomes Wellbeing™: An Opportunity for Assisted Living and Residential Care Facilities in Oregon

For additional information contact Barbara Kohnen Adriance, CareOregon, kohnenb@careoregon.org; tel. 503-416-3675

What it is	A methodology to improve the safety, experience and efficiency of long-term care services delivered in assisted living and residential care settings in Oregon. • CareHomes Wellbeing™ was developed by the National Health Service in the UK to assist long-term care facilities with quality, compliance, and the satisfaction of their residents. The program has been made available to assisted living and residential facilities in Oregon through an agreement between CareOregon and The Social Care Improvement Group based in the UK. The program builds on the successful implementation in Oregon of Releasing Time to Care™, an improvement methodology geared toward nurses in acute care settings. • The State of Oregon has granted CareOregon funding to support ten facilities to implement CareHomes Wellbeing™ in 2015.
How it can help you	CareHomes Wellbeing™ will help your facility to: • Improve safety • Improve internal systems and working relationships • Improve efficiency to release more time to care for residents • Empower staff to make the improvements that residents and their relatives want • Meet Oregon compliance standards In addition, the teams from the first ten facilities will have the opportunity to learn from one another during four in-person events to be held during the year.
How it works	Each facility selects a team of ~5 people. The team will include senior manager, nurse, caregiver(s), and others. Phil Haynes and Lizzie Cunningham will deliver training at Oregon Health Care Association or CareOregon and will follow up in person on a regular basis. The teams will focus on four phases of improvement with an emphasis on the following measures: • Staff and resident satisfaction scores • Staff turnover • Unplanned staff absences • Medication errors Each facility will receive a set of training materials and a permanent license to continue the program.

Why CareOregon is involved	CareOregon is a Medicaid managed care organization that manages physical, mental and dental care for Medicaid and dually eligible Medicaid and Medicare members but is just learning about member experience in ALFs and RCFs. CareOregon is bringing CareHomes Wellbeing™ to Oregon in order to learn more about our members and the facilities where they live, to improve quality, and ultimately to lower cost. CareHomes Wellbeing™ advances CareOregon's mission to improve wellbeing through shared learning and innovation.
CareHomes Wellbeing™ in England	CareHomes Wellbeing™ is in its first year of testing in three sites in England and more than fifteen facilities. • Early findings show that it has reduced staff absentee rate, increased resident and family satisfaction and improved communication. The University of Leicester is evaluating its implementation. • CareHomes Wellbeing™ was developed with an investment of $1.5 million.

Date	Schedule for Training and Implementation in the Pilot
Jan. 16 **Preparation**	**Executive Briefing**: Discuss how the methodology works with senior stakeholders including owners, managers, and facility representatives. Discuss their role in generating success. Explain key aspects of methodology: 
Jan. 29-30	**Master Class, 2 days at CareOregon**: Raise awareness and understanding of the theory and practical application of the toolkit, discuss the problems currently faced by participating facilities, and discuss and agree appropriate tools to address the problems. Create plans.
Week of Feb. 16	**First Site Visits to Pilot Facilities:** See how the plans are progressing and how the tools are been used.
March	**Master Class, Day 3; First Sharing Event; Second Site Visits**: Follow up training and presentations by facilities to discuss what has been done, what has gone well and what

11-13	challenges have been faced. Review plans, expected deliverables and outcomes on site.
Week of April 5	**Third Site Visits**: Assessment of plans, data gathering and translation into outcomes.
April 24	**Second Sharing Event at CareOregon:** First shared assessment of deliverables and outcomes.
Week of May 10	**Fourth Site Visits**: Assessment of data gathered and translation into outcomes.
Week of June 21	**Fifth Site Visits**: Realization of wider benefits, sustainability, sharing of best practice and evidence that a continuous improvement culture can be sustained.
July 13 2015	**Final Sharing and Celebration Event at CareOregon**: Celebration and showcase of achievements to senior stakeholders and internal sharing of deliverables and outcomes.

End August 2015	**Delivery of Final Report**: Final collection of data and surveys from participating sites. Report will address the following:
	• Identification of the Ten (10) Assisted Living/Residential Care facilities trained.
	• Evidence that the facilities are fully equipped with the skills, knowledge and ability to:
	  ○ Implement all four key aspects of the CareHomes improvement methodology- measure/capture/understand/improve;
	  ○ Ensure the spread and adoption of the Care Homes Wellbeing improvement process throughout each facility;
	  ○ Focus on outcomes and benefits derived from changes made;
	  ○ Create internal cultures of sustainable continuous improvement;
	  ○ Collaborate with other individuals and facilities to improve together
	• Pre and post facilities' compliance survey scores for each facility across clinical and non-clinical areas
	• Pre and post staff and resident satisfaction scores for each facility
	• Pre and post staffing numbers at each facility to demonstrate staff turnover for each facility
	• Pre and post staff absences that are unplanned for each facility
	• Pre and post medication error rates for each facility
	• Recommendations for and/or identification of barriers to replicating the project on a statewide basis.

APPENDIX D: CareHomes Wellbeing™ Application used in the Pilot for the Participating Facilities

CareOregon 315 SW Fifth, Suite 900, Portland, Oregon 97204

CareHomes Wellbeing™ Improvement Program Pilot - January to June 2015 – Application Form

Please complete all sections of this form. Click inside the gray shaded area to enter information. For further information, contact: Barbara Kohnen Tel: 503-416-3675, Email: kohnenb@careoregon.org

Date	**Tax ID number:**	**For profit/nonprofit:**

Funds requested:	Each facility will receive a set of copyrighted materials plus training and support to implement the program. License fees for your facility to use materials is also included within the grant.					
		Address/PO Box	**City and Zip Code**	**Phone**	**Fax**	**Email**
Legal name of organization				[redacted]	[redacted]	[redacted]
Payment address (if different than above)	[redacted]			[redacted]	[redacted]	[redacted]
Contact person for letter of agreement and other administrative oversight						
Project leader (if different than above)						

Please note the following requirements to participate within the Pilot:

- It is essential that staff attending the first master class training also attend the subsequent trainings and sharing events over the length of the Pilot.
- Leaders in each of the participating organizations must commit to freeing staff from clinical duties to complete the activities within the length of the pilot. As a guide, a minimum of 8 hours a week will be required depending upon the number of beds to be included in the Pilot.
- Each organization must identify one person who will be the main contact for the program for the duration of the Pilot.
- Each organization must agree and identify one person to be responsible for providing data from their organization to the facilitator and for inclusion in the report required by the State.

Please complete the following:

1. **Please provide within 2-3 sentences why you wish to be involved in this program.**

2. **Are you in a position to free up staff resource to work on CareHomes Wellbeing™ activities? (Approximately a minimum of 8 hours will be needed for each organization – see table).**

Minimum number of Hours required	Size of Facility	Number of beds to include in Pilot
8	Small – up to 15-20 beds	15-20 beds
8	Medium – up to 40-60 beds	½ to 1/3 of beds (or one team)
8	Large 80 beds +	One team (or floor/wing/unit)

3. **Do you have the ability to release up to 5 staff for two initial Master classes? (See attached schedule)**

4. **Are you running at full staffing or do you have vacancies?**

5. **What is your existing experience with improvement work? Do you have any improvement work currently happening?**

6. **What is your average occupancy rate?**

7. **What reporting mechanisms are currently in place for safety and quality?**

8. **Who will be the senior lead for this program and what is their position in the organization?**

9. **Please provide a letter of support from your CEO and/or Operational Service Lead**

APPENDIX E: Facility Participation Agreement

Participation and Sub-license Agreement
Pilot Study of Care Homes Wellbeing Program

On this _____day of _____, 2014 ("Effective Date"),Care Oregon, Inc. ("CareOregon") and _____ ("Facility") have entered into this Participation and Sub-license Agreement ("Agreement") to collaborate on the Care Homes Wellbeing™ Program (inclusive of Care Homes Connect) pilot ("Pilot"), sponsored by the State of Oregon. The goal of this collaboration is to improve the quality and delivery of care in long-term care facilities, specifically assisted living facilities and residential care facilities in Oregon.

Program. The Social Care Improvement Group's ("TSCIG") Care Homes Wellbeing™ Program is an improvement program to help assisted living and residential care facilities build and strengthen a culture of improvement by adopting new operating processes and/or improving existing practices to promote safety, improve efficiency, increase staff knowledge and build strong communication and relationships between caregivers and residents.

Sponsor. The State of Oregon is sponsoring Pilot through a grant to CareOregon to conduct the implementation of the Care Homes Wellbeing Program in ten selected Oregon long-term care facilities. CareOregon with TSCIG will assist the participating facilities to implement it.

Training. TSCIG will train Facility employees in the Care Homes Wellbeing™ Program methodology.

Term. The term of this Agreement shall commence on the Effective Date, and shall continue until all the components of the timeline in Exhibit A are complete, unless terminated sooner pursuant to the terms of this Agreement.

Termination. This Agreement may be terminated with or without cause by either party upon thirty (30) days' prior written notice to the other party. In addition, either party shall have the right to immediately terminate this Agreement at any time for cause upon written notice to the other party. For purposes hereof, cause is defined as: (1) breach of any provision of this Agreement; (2) inability to perform said obligations or incompetence demonstrated in performance of obligations under this Agreement; (3) reasonable belief that any employee(s) of either party performing obligations under this Agreement has violated any applicable or relevant laws or regulations; (4) the bona fide appearance of a conflict of interest; and (5) fraud, dishonesty, substance abuse, or personal conduct which may harm the business and/or reputation of the other party.

Ownership of Materials. TSCIG has the sole copyright and title to any and all Care Homes Wellbeing™ Materials (including Care Homes Connect™) including the Care Homes Wellbeing™ name, trademarks, symbols, copyrights and service marks (collectively, "Intellectual Property"). Facility agrees not to copy, distribute, sell or license Intellectual Property. TSCIG has granted a license to CareOregon for use of the Materials including the right to sub-license Materials to facilities participating in Pilot.

Sub-license. CareOregon grants to Facility a non-exclusive, perpetual (unless terminated in accordance with the provisions of this Agreement), non-transferrable (except as provided in this Agreement) and royalty-free license to use the Materials in the Facility in accordance with this Agreement, provided that the Facility agrees to only use the Materials in the Facility location specified. If Pilot (all components outlined in Exhibit A) is not completed for any reason, including early termination within the provisions of this Agreement, sub-license is terminated effective the date of termination. In cases of termination, Facility agrees to return all Materials upon termination.

Obligations

Facility Obligations. Facility agrees to complete all components of the Pilot within the timeline as in Exhibit A, including but not limited to, the performance of the following.

- Allocate agreed-upon appropriate staff time to work on program outcomes and process measures, one-on-one conference calls, webinars and teleconferences.
- Ensure agreed-upon number of appropriate staff attend training and sharing events.
- Participate in the Pilot in accordance with the timeline in Exhibit A.
- Host site visits for the CareOregon and TSCIG facilitation team.
- Engage the governing board, leaders, clinicians and front line staff and, where applicable, facilitate residents and /or their family members in quality improvement efforts aimed at improving their experience of care.
- Collect and report process and outcome data for agreed-upon measures as determined by the program and the State of Oregon.
- Allocate a key member of the Facility team to act as liaison with the CareOregon project team.
- Complete all components of the Pilot within the timeline in Exhibit A.
- Serve as a reference for other facilities considering the implementation of the Care Homes Wellbeing Program.

CareOregon Obligations. CareOregon agrees to perform the following.

- Provide quality improvement technical assistance and consultation to maximize achievements within the 24 weeks of the pilot study.
- Designate key CareOregon personnel to be the liaison for data collection.
- Provide license to implement Care Homes Wellbeing (through granting Facility a sub-license).
- Engage and pay for TSCIG to provide Executive and Masterclass training
- Provide hard copy boxed set materials with CD for Care Homes Wellbeing and Resource packs for Care Homes Connect.

Public Release of Information. Facility grants permission to CareOregon, its subcontractors and agents to disclose Facility's participation in the Pilot and to publish information and outcomes from Pilot including but not limited to Facility's quality improvement efforts, including successes and improvement stories and interventions. Facility agrees to release of the aforementioned information in documents, photographs, images, graphs or other materials, for the purpose of promoting healthcare quality improvement. Information will be released only after providing key individuals of Facility an opportunity to review and comment. Distribution of information may include print, electronic, visual, verbal communication, Web and/or various media for an indefinite period of time. Facility agrees this release and consent are made without compensation and no compensation is required or anticipated.

Release of Data and Outcomes. Facility acknowledges that Pilot is sponsored through a grant from the State of Oregon. Facility agrees to the release of Facility data and outcomes from the Pilot to be reported by CareOregon to the State of Oregon to the meet requirements of the grant.

Confidential Information. CareOregon acknowledges that in the course of fulfilling its obligations of this Agreement, CareOregon may be given access to confidential and proprietary business information of or about Facility, including without limitation, trade secrets, payor lists, databases, strategic and financial information and other business information, the unauthorized disclosure or use of which will be highly injurious to Facility and its business and its customer relationships in amounts not readily ascertainable. Accordingly, CareOregon shall: (i) hold all such information in the strictest confidence; (ii) return all such information to Facility upon completion of Pilot; and (iii) not disclose such information to any third party or make use of it for any purpose other than to complete the Pilot.

Protected Health Information (PHI) and Compliance with Regulations. The Pilot does not anticipate access to resident PHI, however should CareOregon, its employees, subcontractors or agents be in receipt of resident PHI, CareOregon, a Covered Entity, as defined by 45 CFR 160.103, shall be responsible for compliance with all HIPAA requirements. CareOregon and Facility will each be responsible for compliance with Federal, State and local laws and regulations in performance of obligations of this Agreement.

Assignment; Subcontracting. Neither party may assign any rights or obligations under this Agreement without the other party's written consent, which shall not be unreasonably withheld, except that either party may assign its rights under this Agreement to any person or entity in the event of a merger, acquisition, or consolidation. This Agreement will be binding upon and inure to the benefit of the parties' respective successors and permitted assigns. Facility understands that portions of the services provided under this Agreement will be performed by TSCIG, a subcontractor of CareOregon in relation to the implementation of Materials.

Relationship of the Parties. CareOregon and Facility are independent contractors. No provision of this Agreement is intended to create nor shall be construed to create any relationship between CareOregon and Facility other than that of independent entities contracting with each other solely for the purpose of effecting the provisions of this Agreement. Facility does not, by this Agreement, reserve control over the methods or procedures to be utilized by CareOregon or any of CareOregon's employees, subcontractors or vendors hereunder. Neither CareOregon nor Facility, nor any of their

respective officers, directors, employees or independent contractors, shall be construed to be the partner, employee, agent or representative of the other.
Governing Laws. The validity, interpretation and performance of this Agreement shall be governed by and construed in accordance with the laws of the State of Oregon.

Dispute Resolution. Upon written demand by either party, any dispute arising out of or in connection with this Agreement, including any question regarding its existence, interpretation, validity or termination, shall be referred to and definitively resolved by mandatory binding arbitration administered by the American Arbitration and Association. The place of arbitration shall be Oregon. The arbitrator shall comply with the laws of Oregon. The judgment of the arbitrator shall be accompanied by a written statement of the basis for such judgment and may be entered and enforced by any court having proper jurisdiction. The award of the arbitrator shall be final and binding and shall not be subject to de novo judicial review. It is the express intent and understanding of the parties that each shall be entitled to enforce its respective rights under any provision hereof through specific performance, in addition to recovering damages caused by a breach of any provision hereof, and to obtain any and all other equitable remedies as may be awarded by the arbitrator. Notwithstanding the above, each party shall have the right to seek provisional remedies from a court of competent jurisdiction. The provisions of this Section shall survive the termination of this Agreement.

Limitation of Liability. To the maximum extent permitted by applicable law, in no event shall either party, nor their respective officers, affiliates, contractors and employees, be responsible or liable under any theory of liability, including contract, negligence, tort or strict liability for any indirect, incidental, special, exemplary, punitive or consequential damages, lost profits, loss or interruption of use, lost or damaged data, security, reports or documentation or revenues or other economic losses. This limitation of liability will apply regardless of the form of action, and shall apply whether or not a party has been apprised of the possibility of such damages, except for claims arising out of misuse or misappropriation of the Care Homes Wellbeing™ Materials.

Notice. Whenever notice or consent is required to be given by the terms of this Agreement, it shall be in writing and in email. Notices shall be deemed to have been duly given when emailed or postmarked, whichever is later, as follows; or to such other address as either party shall have specified by notice in writing to the other party.

If to CareOregon:
Barbara Kohnen-Adriance
CareOregon, Inc.
315 SW Fifth Avenue
Portland, OR 97204

If to Facility:
Facility Representative Name
Title
Facility Name
Facility Address
City, State, Zip

Entire Agreement. The Agreement and the exhibits and attachments hereto contain a full and complete expression of the rights and obligations of the parties and it shall supersede all other agreements, representations, and offers, written or oral, heretofore made by the parties regarding any of the subject matter contained herein. The Agreement may be modified only in writing, signed by the parties hereto.

Counterparts. This Agreement may be executed simultaneously in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

IN WITNESS WHEREOF, the parties have caused this Agreement to be executed and do each hereby warrant and represent that their respective signatory whose signature appears below has been and is on the date of this Agreement duly authorized by all necessary and appropriate corporate action to execute this Agreement.

_____	_____
Facility Name	CMS Certification Number (CCN)
_____	_____
Facility Representative Signature	Date
_____	_____
Printed Name of Representative	Title of Representative
_____	_____
Primary Contact – Printed Name	Primary Contact – Title
_____	_____
Primary Contact - Email	Primary Contact – Phone
_____	_____
CareOregon Representative Signature Name and Title	Date

Please return signed Agreement by mail or email to

Barbara Kohnen-Adriance
CareOregon, Inc.
315 SW Fifth Avenue
Portland, OR 97204

Email: kohnenb@careoregon.org

APPENDIX F: Data Collection Template

Care Homes Wellbeing™ - Data Collection Template

Date: _____ Facility: _____

	State Topic	Guidance	Frequency	Data	Comments
1	Create internal cultures of sustainable continuous improvement	Number of staff involved and empowered, examples of improvement stories. Please enter data as appropriate (Not applicable for January 2015)	Ongoing		
2	Collaborate with other individuals and facilities to improve together	Attendance at master classes and sharing events. Networking stories outside of CHWB arranged events i.e. Visits/interactions with other facilities. (Not applicable for January 2015)	Ongoing		
3	Facilities' compliance survey scores for each facility across clinical/non-clinical areas	State survey findings together with date of last survey. Please either insert findings into data column or attach a separate sheet	Information collected once prior to Master Class 1		
4	State Survey Staff Experience survey	To be completed by a minimum of 10 people or 20% of staff (whichever is the greater number). Post completed surveys to CareOregon	Collected at start and end of pilot		
5	Pre and post staff satisfaction scores for each facility	To be completed by a minimum of 10 people or 20% of staff (whichever is the greater number). Post completed surveys to CareOregon	Collected at start and end of pilot		

6	Pre and post resident satisfaction scores for each facility	To be completed by a minimum of 10 people or 20% of staff (whichever is the greater number). Post completed surveys to CareOregon	Collected at start and end of pilot		
7	Pre and post staffing numbers at each facility to demonstrate staff turnover for each facility	Enter the number of staff in post, number of departures and number of new staff per month	End of each month		
8	Pre and post staff absences that are unplanned for each facility	Enter the number of shifts lost and expressed as a % of total shifts per month	End of each month		
9	Pre and post medication error rates for each facility	Enter the number of recorded errors per month	End of each month		
10	Recommendations for and/or identification of barriers to replicating on a statewide basis	As they occur, list barriers and any recommendations for smooth spread and adoption	Ongoing		

APPENDIX G: CareHomes Wellbeing™ Interim Summary to the State

To: Jeannette Hulse, Long Term Care Quality Steering Committee

From: Barbara Kohnen Adriance, CareOregon

Date: April 15, 2015

RE: CareHomes Wellbeing™ Interim Progress Report

Thank you for the opportunity to update you and the LTC Quality Steering Committee about the progress of CareHomes Wellbeing™, approved Nov. 12, 2014. Please see my responses below to your questions.

1) Where are you in meeting the projected timeline/deliverables/outcomes for your project?
We have implemented all deliverables on time to date. See chart below and page 2 for additional detail.

CareHomes Wellbeing™ Implementation

Activity	Date Planned	Completed (Y/N)
Executive Briefing	Jan. 16	Y
Master Class, Days 1-2	Jan. 29-30	Y
1st Site Visits	Week of Feb. 16	Y
Master Class, Day 3	March 11	Y
1st Sharing Event	March 11	Y
2nd Site Visits	March 12-13	Y
3rd Site Visits	Week of April 5	Y
2nd Sharing Event	April 24	
4th Site Visits	Week of May 10	
5th Site Visits	Week of June 21	
3rd/Final Sharing Event	July 13	

2) Do you anticipate needing additional time beyond the currently contracted end date to complete your project?

No, we do not anticipate needing additional time to complete the work planned for this grant; however, the project is intended to be long term and ongoing with the strongest results evident after the project's official conclusion.

2a) If yes, do you anticipate needing additional funding above your original awarded amount?

We do not need any extra funding to implement CareHomes Wellbeing™, but we would be interested in discussing a Phase 2 to expand CareHomes Wellbeing™ to more facilities.

2b) If yes, please include the additional amount you would request and a simple line item budget.

N/A.

Additional Information from Program Description

1. *Identification of the facilities trained*

	Facility	#Trainees
1	Avamere Bethany	3
2	Macdonald Home	3
3	Marquis Forest Grove	4
4	Mary's Woods	5
5	Maryville	5
6	Our House	6
7	Rose Schnitzer	6
8	Spring Meadows	4
9	Prestige Summerplace	9
10	Willow Place	3
	TOTAL	**48**

2. *Evidence that the facilities are fully equipped with the skills, knowledge and ability to:*
   a. *Implement measure/capture/understand/improve.*
   The teams are at various stages of understanding and using the CareHomes Wellbeing framework, and they are focusing on a variety of improvements.

   b. *Ensure spread and adoption of Wellbeing throughout each facility.*
   Each facility is spreading the adoption of the framework, but given how early it is in their implementation, facilities are currently focusing on mastering the content and building the structures to carry out long-term change.

   c. *Focus on outcomes and benefits derived from changes made.*
   We set up an agreement with the facilities before beginning CareHomes Wellbeing™ to share outcomes and data on a monthly basis. These match the outcomes requested in the grant. So far, facilities have complied fully. We will use this data in the final report and are also using it as a starting point to generate a Social Return on Investment analysis.

   d. *Create internal cultures of sustainable continuous improvement.*
   All organizations are working on creating the culture that supports continuous improvement. This is the heart of the program.

e. *Collaborate with other individuals and facilities to improve together.*
All organizations participated in the first sharing event at CareOregon, in which each facility did a 10-minute presentation on their implementation, challenges, and outcomes to date. In addition, some individuals are sharing with one another outside of CareHomes Wellbeing™ events. We see this as evidence of an incipient learning community, and we will continue to support peer mentoring through the course of this project. In addition, Concepts in Community Living has invited master trainer Lizzie Cunningham to present to all their Administrators at an event April 16, 2015.

3. *Pre and post facilities' compliance survey scores for each facility across clinical/non-clinical areas.*
Pre-data have been gathered.

4. *Pre and post resident satisfaction scores for each facility*
Pre-data have been gathered. Facilities developed a short experiential-focused survey to capture satisfaction scores from residents and staff.

5. *Pre and post staff satisfaction scores for each facility.*
Pre-data have been gathered. (See above.)

6. *Pre and post staffing numbers at each facility to demonstrate staff turnover for each facility.* All facilities are up to date with data. We are learning about the implications of staff turnover, specifically the positive aspect to a certain percentage of turnover and the negative aspect when that percentage gets too high. We will share our findings in the final report.

7. *Pre and post staff absences that are unplanned for each facility.*
All facilities are up to date with reporting on this factor.

8. *Pre and post medication error rates for each facility.*
All facilities are up to date with data on this issue, and we are digging into the cost implications of various types of errors.

9. *Recommendations for and/or identification of barriers to replicating on a statewide basis*
We are currently collecting information from the facilities about the barriers they face, and for those facilities connected to larger management companies, their interest in expanding. We are looking forward to the CareHomes Wellbeing™ Advisory Group meeting on April 24 for ideas on how to scale this promising program. We expect the Social Return on Investment analysis to generate additional insights.

APPENDIX H: Spread and Adoption Matrix

	Measure						Capture			
Key: 1=Aware, 2=Involved Max score per person = 24 tools x 2 = 48 Max score per facility = # staff x 48	Planning How to Measure Our Impact	Wellbeing Measures	Measuring Experience	Measures Board	Turning Measures into Bar Charts	Turning Measures into Line charts	Relationship Mapping	Mapping Our Experience	Through Fresh Eyes	My Story
Role										
Caregiver							2			
Caregiver							2			
Caregiver										
Activities Coordinator			2				2			
Lead Caregiver	1	1	1	1	1	1	2	1	1	1
Caregiver			2	2						
Caregiver			2				2			
Lead Caregiver	1	1	2	1	1	1	2	1	1	1
Caregiver			2		2		2			
Caregiver			1							
Caregiver			2							
Lead Caregiver			2				2			
Lead Caregiver			1							
Caregiver			1							
RN Manager										
Caregiver			1							
Activities Assistant			2							
Total	**2**	**2**	**21**	**4**	**4**	**2**	**16**	**2**	**2**	**2**

	Understand			Improve											
	Deciding Where to Start	What Can We Learn	Our Home - Now and in the Future	Idea Cards	Turning Ideas into Actions	Sharing Board	Three Things About Me	Safety Crosses	SBAR	Safety Awareness	Organizing Our Workplace	Residents Summary Board	Community Book	Relatives and Staff Get Togethers	***Score (out of 48)***
Role															
Caregiver			2	2	2			1	2			1	2		14
Caregiver			2	2	2			1	2			2	1		14
Caregiver			2	2	2			1				1	1		9
Activities Coordinator			2	2	2		2	1	2			1	2		18
Lead Caregiver	1	1	2	2	2	1	2	2	2	1	1	2	2	1	33
Caregiver			2	2	2				1			1	2		14
Caregiver			2	2	2			1	2			2	1		16
Lead Caregiver	1	1	2	2	2	1	2	1	2	1	1	2	2	1	33
Caregiver	1		2	2	2		2	2	2			2	2		23
Caregiver			2	2	2			2	1			1	1		12
Caregiver			2	2	2			1	1			1	1		12
Lead Caregiver			2	2	2		2	1	2			2	2		19
Lead Caregiver			1	2	1			1	1			2	1		10
Caregiver			1	1	1			1	1			1	1		8
RN Manager															
Caregiver			1	1	1			1	1			1	1		8
Activities Assistant			1	1	1			1	1			1	1		9
Total	**3**	**2**	**28**	**29**	**28**	**2**	**10**	**18**	**23**	**2**	**2**	**23**	**23**	**2**	**252**

APPENDIX I: Video Links

Final video with trainees, administrators, guests, CareOregon, July 14, 2015

Part 3: https://youtu.be/wEbx0z5Xz3I

Midpoint video with trainee interviews, CareOregon, April 24, 2015

Part 2: https://youtu.be/p760lHwAyUI

Initial video for program launch with trainees, CareOregon, January 30, 2015

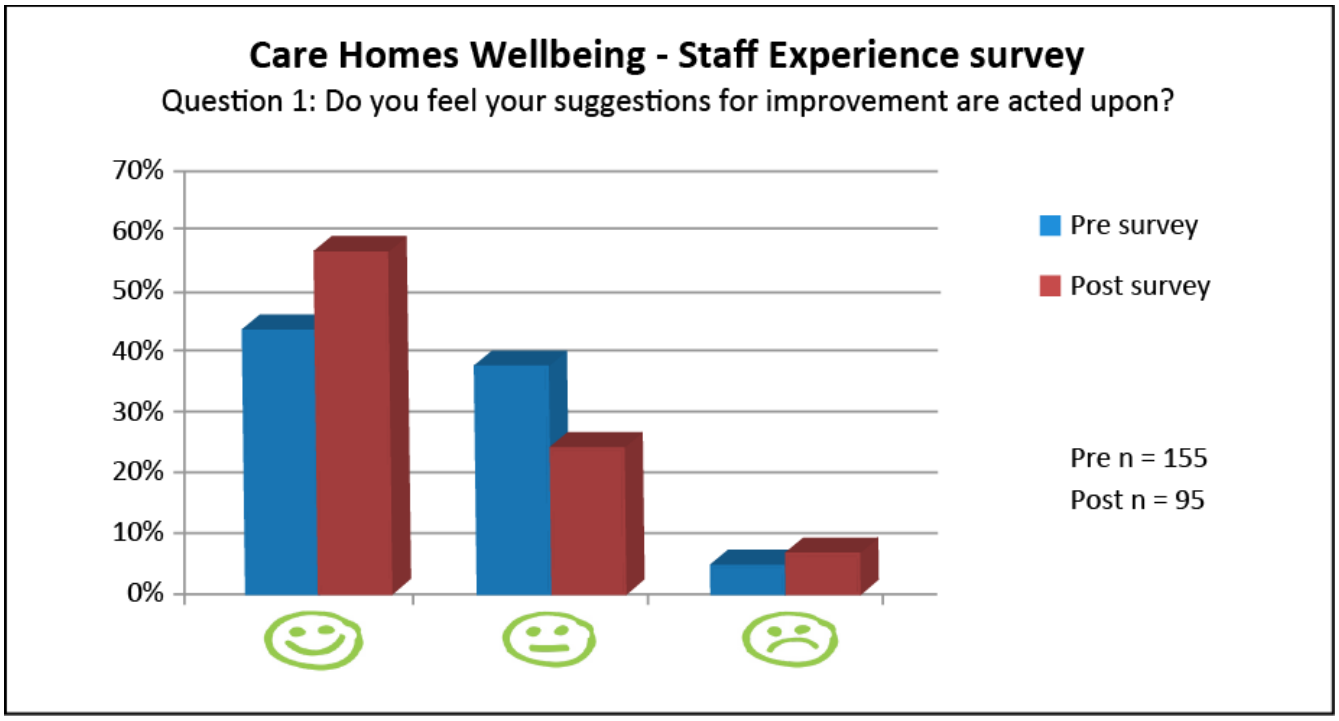
Part 1: https://youtu.be/P6yWdVE-PPI

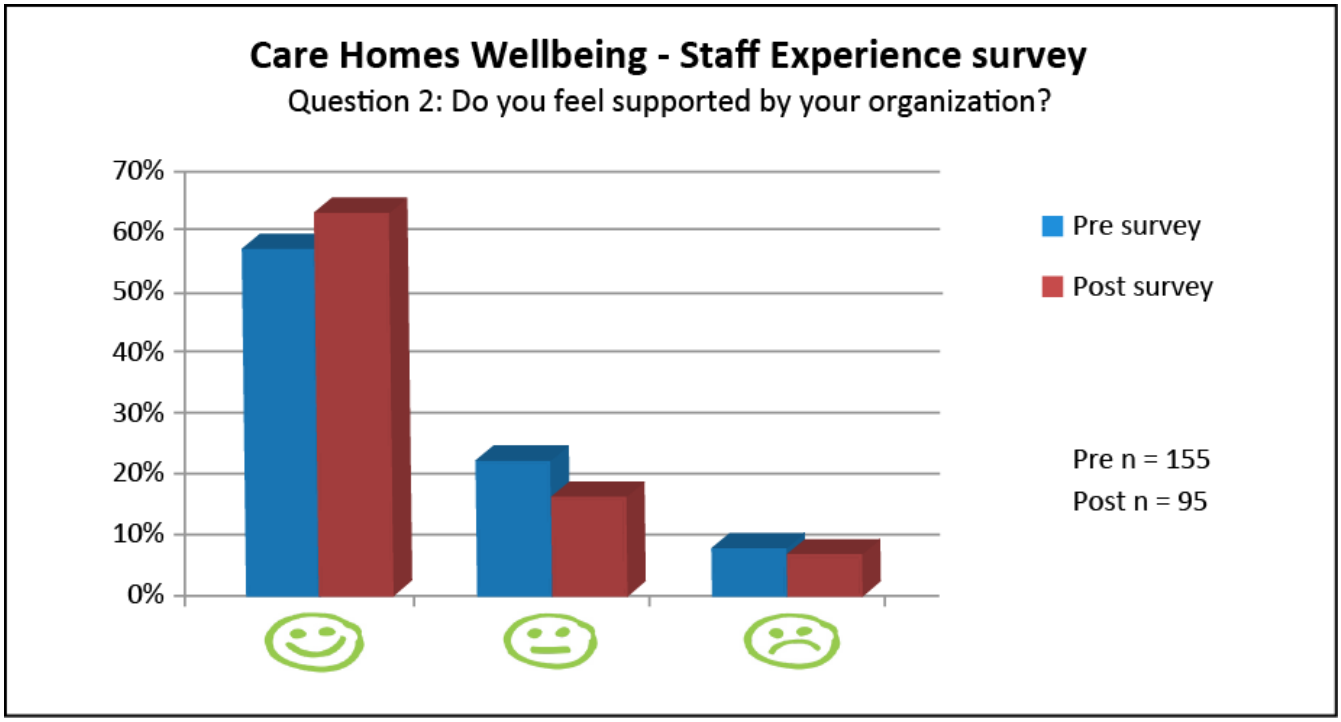
APPENDIX J: Attitudes Toward State Compliance Survey Process

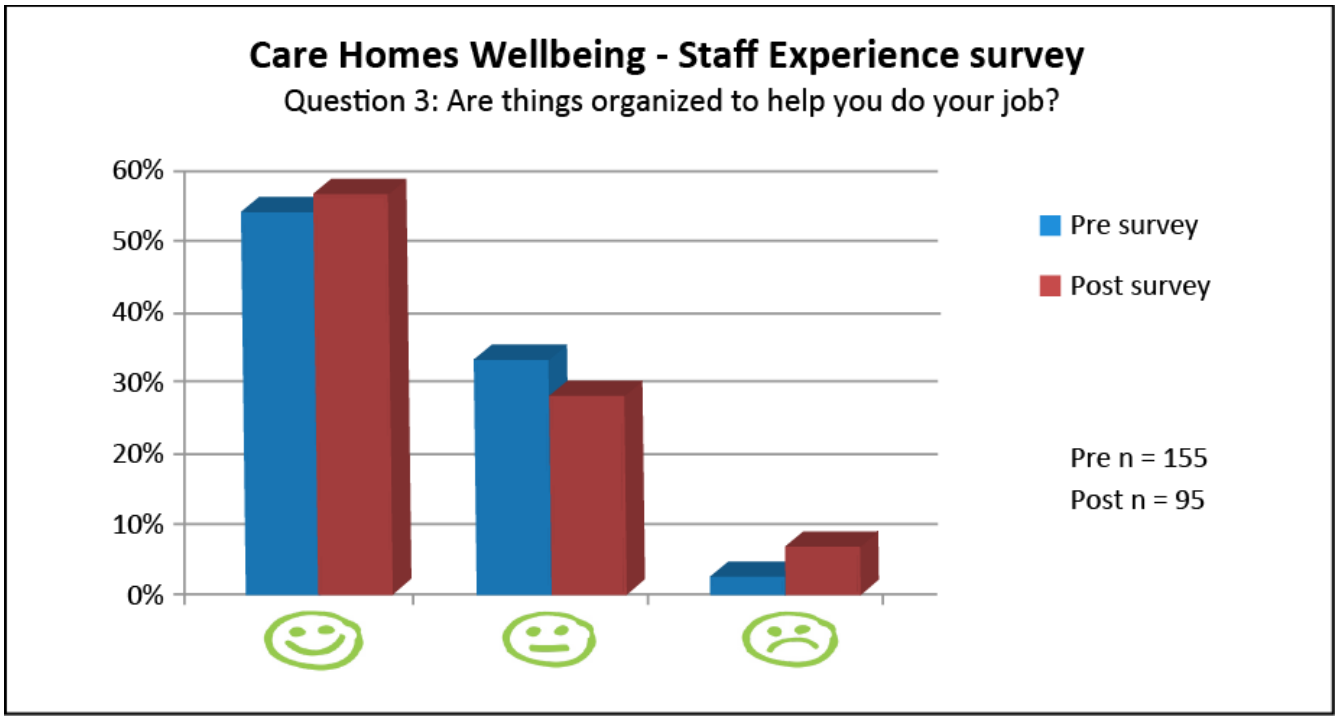
					# Respondents
Question 1 Do you know enough about the state survey?	Pre survey	46%	41%	13%	130
	Post survey	50%	32%	18%	74
Question 2 What is the atmosphere in the facility like during the survey?	Pre survey	28%	54%	18%	130
	Post survey	26%	53%	22%	74
Question 3 Do you feel involved in the State survey?	Pre survey	45%	42%	12%	130
	Post survey	42%	42%	16%	74
Question 4 Is feedback from the survey timely and useful?	Pre survey	46%	45%	8%	130
	Post survey	46%	45%	9%	74
Question 5 Is there the chance to show your progress and success around improvement?	Pre survey	44%	50%	6%	130
	Post survey	55%	35%	9%	74

APPENDIX K: Staff Experience Survey

					# Respondents
Question 1 Do you feel your suggestions for improvement are acted upon?	Pre survey	48%	43%	9%	155
	Post survey	61%	28%	11%	95
Question 2 Do you feel supported by your organization?	Pre survey	61%	27%	12%	155
	Post survey	68%	21%	11%	95
Question 3 Are things organized to help you do your job?	Pre survey	59%	37%	5%	155
	Post survey	60%	31%	9%	95
Question 4 Do you get all the information you need to do your job effectively?	Pre survey	63%	31%	6%	155
	Post survey	59%	32%	9%	95
Question 5 Are new staff given the support to quickly become part of the team?	Pre survey	62%	32%	6%	155
	Post survey	64%	24%	12%	95


Care Homes Wellbeing - Staff Experience survey
Question 1: Do you feel your suggestions for improvement are acted upon?
70%
60%
50%
40%
30%
20%
10%
0%
Pre survey
Post survey
Pre n = 155
Post n = 95


Care Homes Wellbeing - Staff Experience survey
Question 2: Do you feel supported by your organization?
70%
60%
50%
40%
30%
20%
10%
0%
Pre survey
Post survey
Pre n = 155
Post n = 95

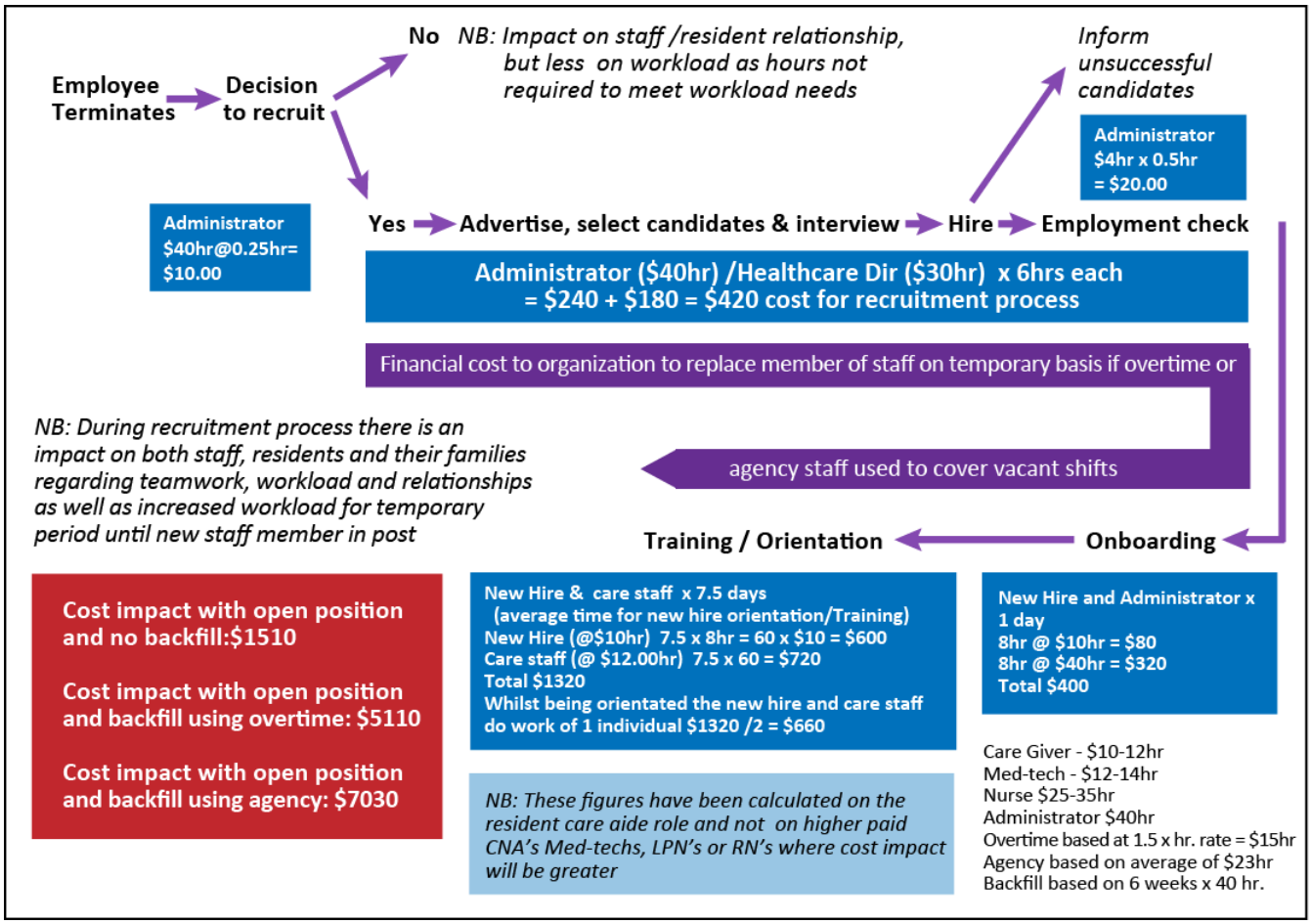

Care Homes Wellbeing - Staff Experience survey
Question 3: Are things organized to help you do your job?
60%
50%
40%
30%
20%
10%
0%
Pre survey
Post survey
Pre n = 155
Post n = 95

APPENDIX L: Resident Experience Survey

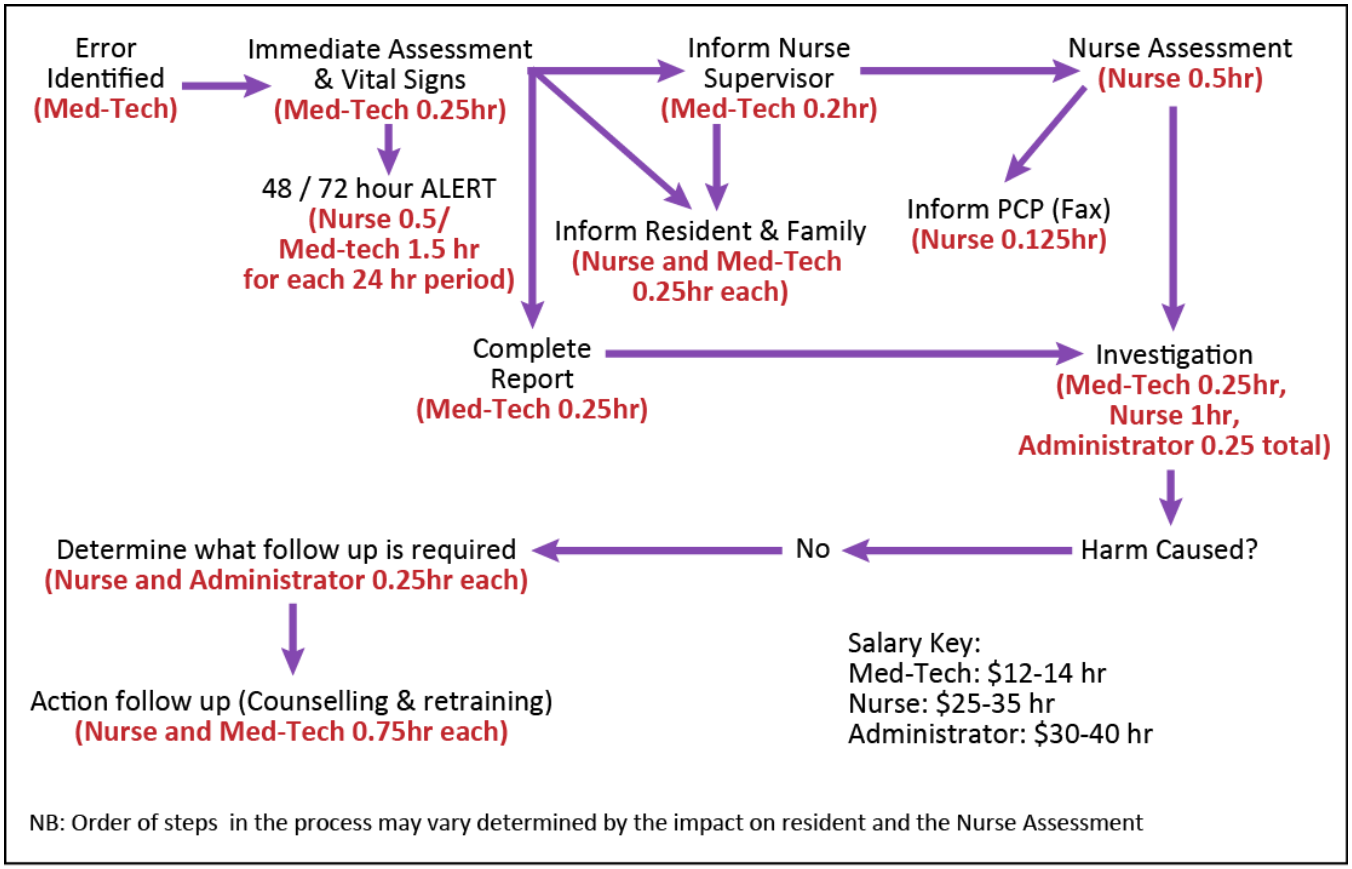
					# Respondents
Question 1 How do you feel about your physical environment?	Pre survey	79%	18%	3%	208
	Post survey	76%	21%	3%	182
Question 2 Do you feel the staff here work as a team?	Pre survey	69%	27%	3%	208
	Post survey	70%	25%	5%	182
Question 3 How do you feel about mealtimes?	Pre survey	53%	36%	11%	208
	Post survey	42%	45%	14%	182
Question 4 Do you get the support you need from the staff?	Pre survey	82%	14%	3%	208
	Post survey	73%	24%	4%	182
Question 5 Are you kept informed about the things that matter to you?	Pre survey	66%	29%	5%	208
	Post survey	59%	31%	10%	182

NB: 12.5% reduction in post survey response rate

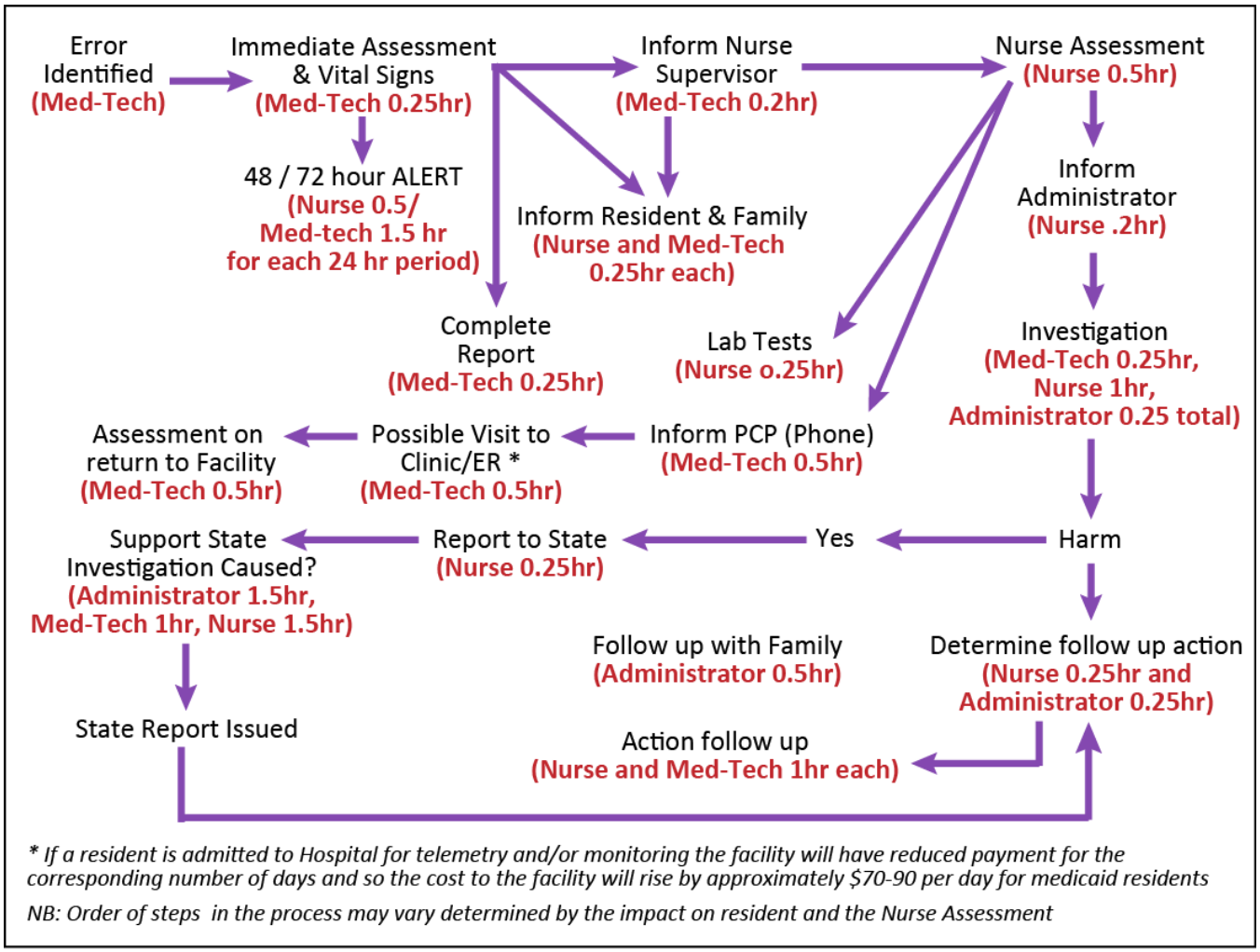
APPENDIX M: Process Map and Costings for Recruitment of New Staff



APPENDIX N: I - Process Map for Medication Errors – No Harm



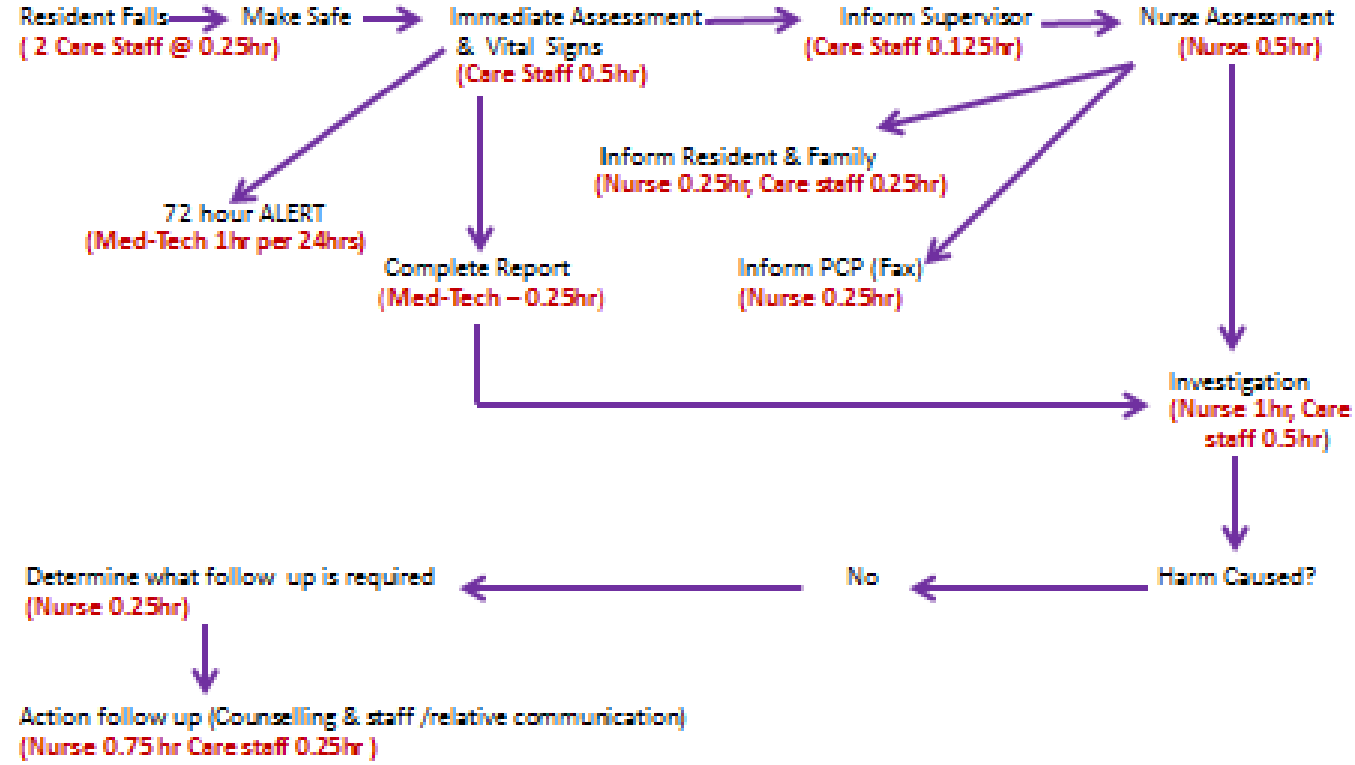
II - Process Map for Medication Errors – With Harm



** If a resident is admitted to Hospital for telemetry and/or monitoring the facility will have reduced payment for the corresponding number of days and so the cost to the facility will rise by approximately $70-90 per day for medicaid residents*

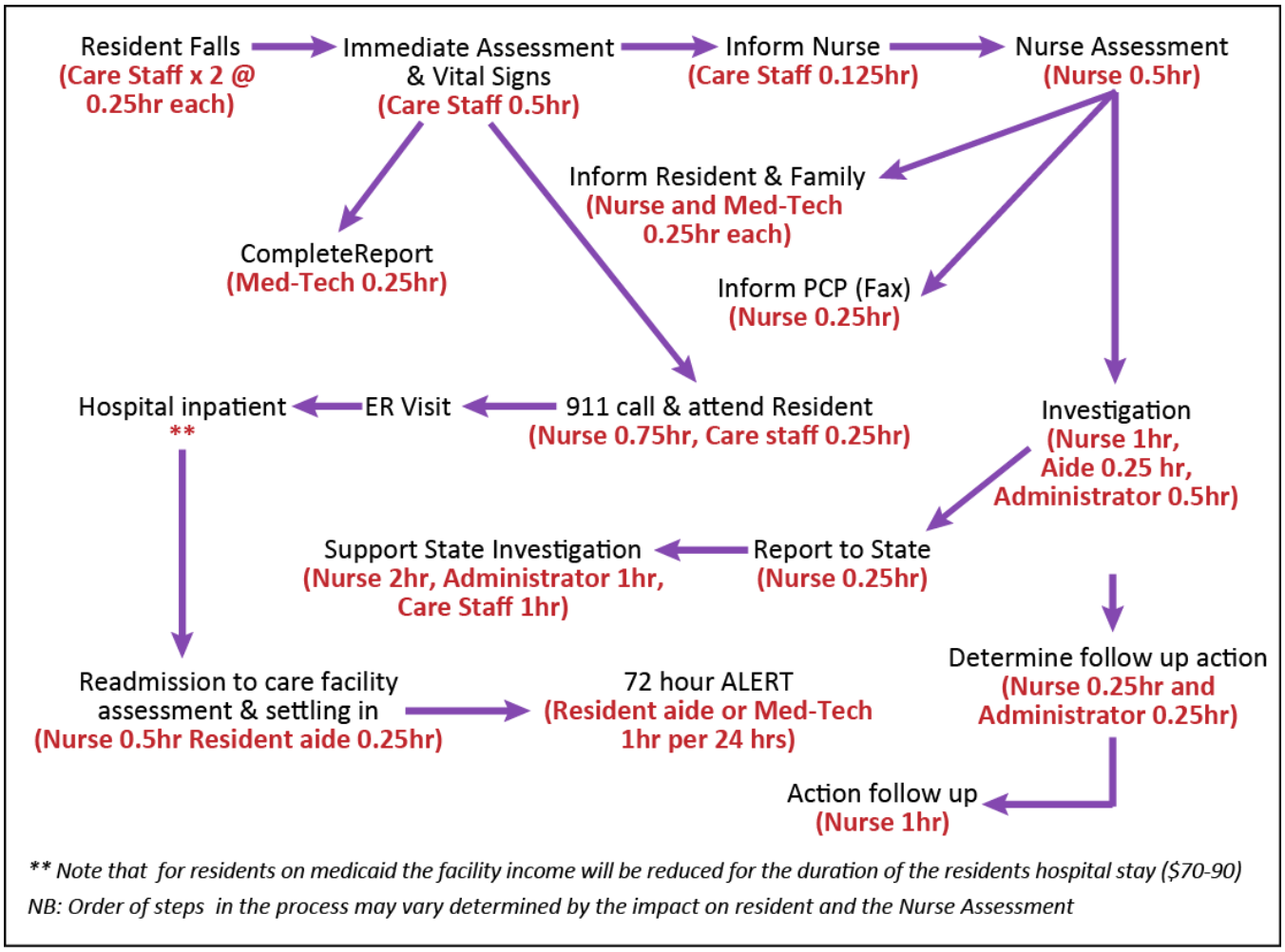
NB: Order of steps in the process may vary determined by the impact on resident and the Nurse Assessment

Appendix O: Process Map for Falls– No Harm



NB: Order of steps in the process may vary determined by the impact on resident and the Nurse Assessment

II - Process Map for Falls – With Harm



*** Note that for residents on medicaid the facility income will be reduced for the duration of the residents hospital stay ($70-90)*

NB: Order of steps in the process may vary determined by the impact on resident and the Nurse Assessment