AN EVALUATION OF THE LIVEWELL METHOD

A final report from a study by the Institute on Aging at Portland State University indicates that LiveWell learning collaboratives and coaching reduce costs while increasing job satisfaction and employee retention. As this report also demonstrates, LiveWell helps staff improve resident care and quality of life through a bottom-up and top-enabled approach.

LIVEWELL

Portland State UNIVERSITY

EVALUATION OF THE LIVEWELL METHOD™

Final Report

Submitted to Oregon Department of Human Services
8.25.2021

Prepared by Portland State University Institute on Aging

Table of Contents

1 Executive Summary

Quality of care is important to assisted living and residential care (AL/RC) owners and operators, advocates, and state policy staff, including the licensing and oversight agency. Oregon has several mechanisms for addressing quality in these settings, including administrative rules (OAR 411-054-0025) that require AL/RC to have a quality improvement plan, legislative actions such as HB 3359 that established the quality measurement program (411-054-0320), regulatory oversight activities, and the state's Ombudsman program. Since 2015, the Oregon Department of Human Services (ODHS) has supported a novel quality approach called the LiveWell Method, the focus of this report.

The LiveWell Method uses a practice-based framework to improve the quality of life for people living and working in long-term care settings, including assisted living and memory care. It is designed to improve teamwork, communication, and morale by helping staff organize, track, measure, and improve daily operations. This evaluation is informed by the LiveWell Method's "bottom-up and top enabled" approach, which engages and empowers direct care staff and administrators to create a more democratic and transparent workplace. In addition, the evaluation included questions to assess LiveWell's core values, such as creating care innovations, nurturing dignity, creating community, and honoring elders, as well as organizational frameworks such as "lean thinking" and "human-centered design," and trauma-informed practices.

Between September 2019 and June 2021, 188 staff from 46 AL/RC communities participated in a LiveWell training or in one of three 12-week virtual Learning Collaboratives (referred to as cohorts). Of these 188, staff from at least 23 AL/RC communities attended an in-person LiveWell training held before the COVID pandemic, and staff from 23 AL/RC communities attended an online Learning Collaborative (one community participated twice). A training sessions was held in December 2019 for five for nurse consultants, as well as a "Foundations in QI" training for 26 DHS staff in January 2020. In addition, 61 staff, including administrators and direct care workers, participated in an online LiveWell Meet Up session. Below we summarize key information and findings from this evaluation.

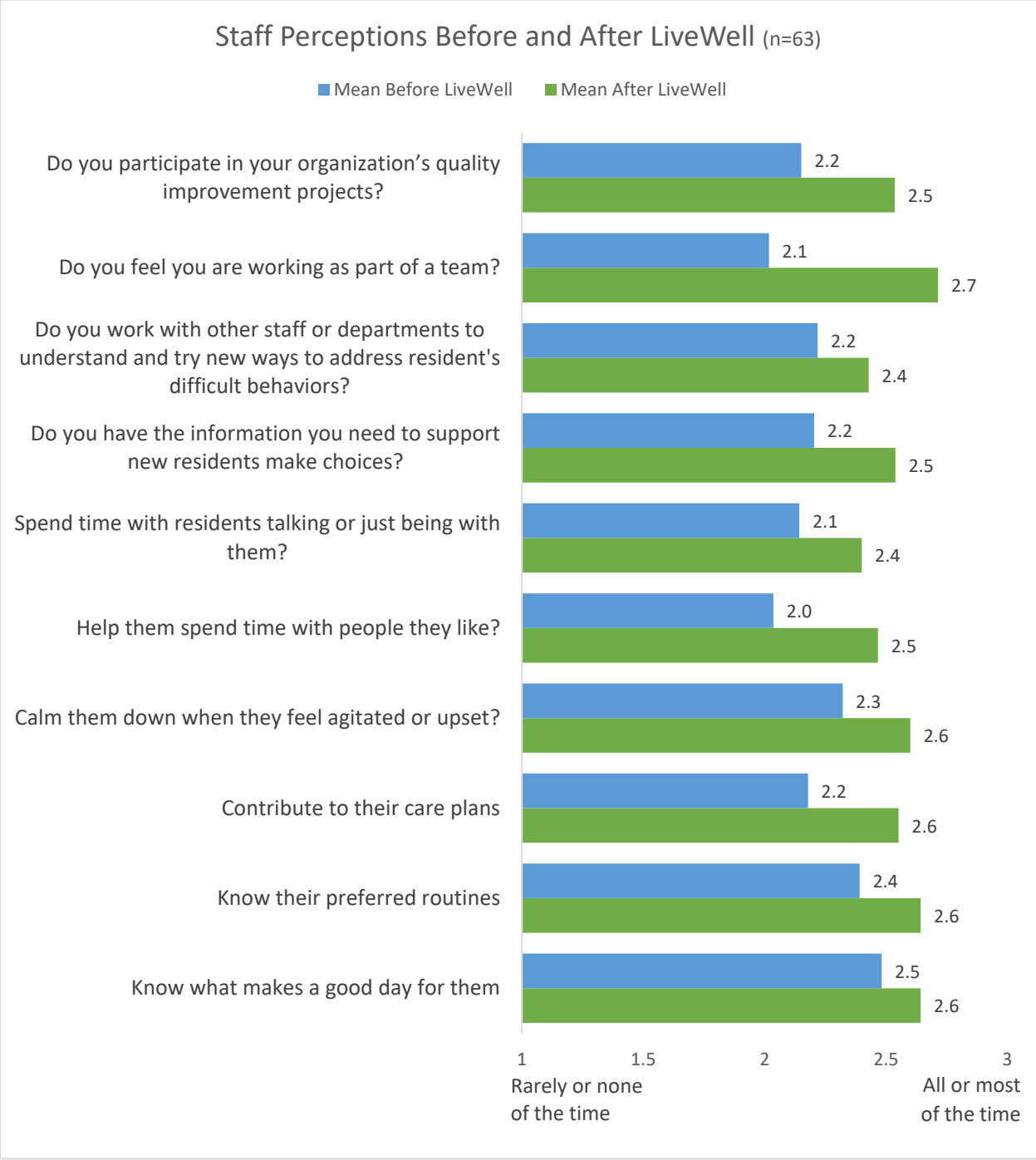
Learning Collaboratives

Of the Learning Collaborative participants (staff and administrators) surveyed, the majority rated the online format, relevance and quality of content, and discussions as "good" or "excellent." Comments from some participants include:

- "We were able to use the clock to identify a time frame when falls were happening and make adjustments to the activities of the day to reduce falls and increase safety checks."
- "I believe, and am hoping, we will be able to use these tools in the future to improve staff retention and resident care... This program is a must for looking at the long-term gains for our community."
- "Using the huddle will be a communication tool our community will enjoy. Time to get together [to] talk about what's happened throughout the shift and make sure staff is doing well during our busy day."
- "LiveWell gave our team skills and learning tools that can be used in the following years."
- "I believe, and am hoping, we will be able to use these tools in the future to improve staff retention and resident care. There are tools we can use that we did not have a chance to implement fully that I am sure will help to support staff morale and resident care. Combined, the outcome will be very positive. This program is a must for looking at the long-term gains for our community."

Learning Collaborative participants were asked to complete a survey that included 10 questions about activities related to quality and resident care. Among those who completed the survey, improvements were seen in all 10 topics, as shown below. The largest increases included feeling like part of a team, helping residents spend time with others, and contributing to resident care plans.

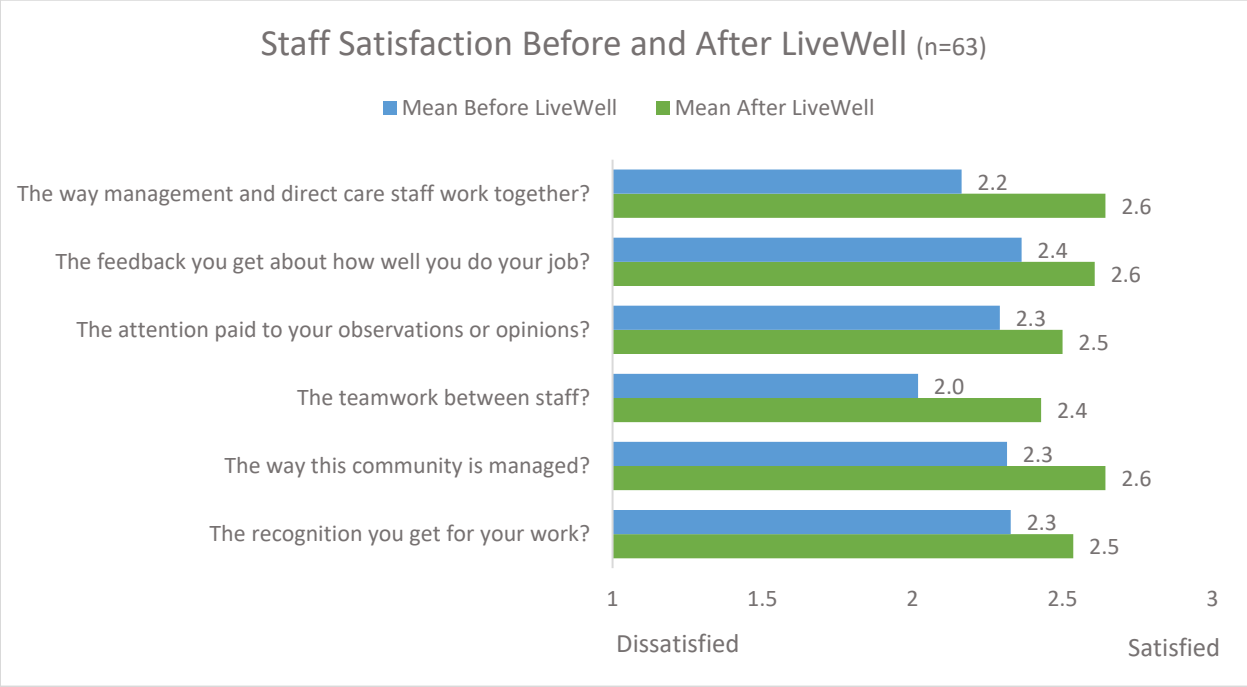
Executive Summary Figure 1. Staff Perceptions Before and After LiveWell



*Note: the number of staff who answered each question ranges from 35 – 63 due to skip patterns and some missed questions.

In addition, participants were asked to rate their satisfaction with their job experience before and after the Learning Collaborative. As shown in the below figure, all respondents showed improvements.

Executive Summary Figure 2. Staff Satisfaction Before and After LiveWell



*Note: the number of staff who answered each question ranges from 35 – 63 due to skip patterns and some missed questions.

In sum, these results indicate that during a 12-week Learning Collaborative, participants showed positive changes in all of the quality, job performance, and resident care topics assessed.

Coaching Method

Coaching is the primary way that the LiveWell Method is delivered to participants. The trained coaches described LiveWell tools, including how AL/RC staff could adapt tools to meet their communities' needs, encouraged teamwork and leadership as well as honest communication and shared responsibility, and developed relationships with AL/RC staff. The key tasks of LiveWell coaches included:

- Building the Learning Collaborative curriculum
- Fostering participant engagement with the LiveWell Method
- Teaching with modeling and collaborative problem solving
- Building relationships with and among participants
- Supporting participants and communities

Benefits of LiveWell Participation

All Oregon AL/RC must have a quality improvement program in place. Of the administrators who participated in LiveWell training, 62% believed that LiveWell helped their community create a more robust quality program.

Quality improvement programs can result in cost savings to communities. The participating administrators were asked about the financial costs of medication errors, resident falls, and staffing concerns. Those who responded rated medication errors and resident falls as the least costly and staff turnover and unplanned staff absences the costliest.

Program Adaptation and Flexibility

Between March and August 2020, the LiveWell team made significant changes in response to the pandemic. Oregon DHS staff and the IOA team consulted with the team during this period. Initially, the LiveWell team shared content with participants through email communication, video messages posted to the LiveWell website, and four scheduled online training sessions. However, after several weeks, and in consultation with ODHS, the IOA evaluation team, and AL/RC providers, the LiveWell team decided to discontinue offering these online trainings and to instead build on the success of the initial Learning Collaborative (held February 2020).

Based on the evaluation and time spent with the LiveWell team during the past two years, the IOA team has the following recommendations for scale up of this novel quality program.

1. Seek buy-in from partners within ODHS, including policy analysts, survey team members, and leadership. These partners can support recruitment and retention of AL/RC communities into the LiveWell program.

2. Advocate for state-level policy changes that support a formal quality assurance and program improvement (QAPI) process.

3. Work with AL/RC innovators and "early adopters" who have implemented LiveWell and culture change methods, because these thought leaders may encourage other AL/RC owners to participate in LiveWell.

4. Build on the success of the multiple training, coaching, and peer networking opportunities tested during the 2019-2021 LiveWell project period by continuing to offer them in a structured way. The ongoing

support provided through in person training, followed by coaching over a 12-week period, and twice monthly Meet Ups proved to be a powerful way to connect over time with many staff.

5. Continue to collaborate with the IOA team to include evidence based on current research on AL/RC administrator job stressors and supports, regulatory deficiencies, and hospice use among AL/RC residents.

6. Develop outreach materials to inform AL/RC owner/operators how LiveWell can complement and strengthen their existing policies and practices, including quality assurance program, person-centered care, and tracking and reporting quality metrics (e.g., staff training and turnover, resident falls). For example, explain how LiveWell tools like the care calendar support tracking resident falls, a metric that AL/RC communities are required to report annually to Oregon DHS.

7. Continue supporting diversity, equity, and inclusion principles, as Oregon's senior population and the long-term care workforce becomes increasingly diverse across several social and demographic characteristics.

2 INTRODUCTION

The need for quality of care among assisted living and residential care (AL/RC) communities, including those endorsed for memory care (MC), is well accepted. Oregon's administrative rules require that all AL/RC "must develop and conduct an ongoing quality improvement program that evaluates services, resident outcomes, and resident satisfaction" (Oregon Department of Human Services, 2021). The rules do not define the type of quality program that the communities should use. To encourage participation in a QAPI, Oregon Department of Human Services supported the development, implementation, and evaluation of the LiveWell Method. The LiveWell Method can complement existing quality programs that each AL/RC has in place.

This report describes the results of an evaluation of LiveWell activities between September 2019 and June 2021. The COVID-19 outbreak, which the World Health Organization declared a pandemic in March 2020, resulted in several modifications to the way that The Malden Collective (TMC) delivered quality improvement materials to AL/RC communities. The Portland State University (PSU) team worked closely with TMC leadership and staff to design an evaluation process that was rigorous and flexible.

The primary LiveWell activities described here include three cohorts of Learning Collaboratives and 12 Meet Ups. The Learning Collaboratives are 12-week sessions that included weekly meetings with a LiveWell coach and AL/RC staff and administrators who were expected to share materials with community staff who did not attend the weekly meetings. On average, 16 staff participated in the weekly sessions. The coaches, in addition to moderating the sessions, provided additional support as needed to participants, via text, telephone and email. In 2021, the LiveWell team began offering Meet Ups in response to feedback from former LiveWell participants who wanted an opportunity to reconnect and discuss how to

apply the LiveWell Method to both new and existing topics. These online sessions, scheduled for 30 minutes each, provided an opportunity for former participants to reconnect and to get information about a timely topic, such as COVID-10 vaccines.

Before the pandemic started, all training sessions were held in-person at locations throughout Oregon. These included:

- Consultant Training (12/06/19; 5 participants)
- Foundations in QI Training with DHS staff (1/21/20; 26 participants)
- Basic Training at Willamette View (2/4/20; 18 participants)
- Basic Training at ODHS building in Salem (2/7/20; 17 participants)
- Learning Collaborative pilot (2/21/20; 12 participants)

Based on the surveys completed by participants, these training events received positive scores, with the majority of topics scoring 3 out of 5. The highest scores (over 4.5 out of 5) across multiple training sessions were for deeper understanding of the methods/tools and the trainers' qualifications. The learning collaborative pilot, basic trainings held 2/04/20 and 2/07/20 received scores of at least 4.63 out of 5 on all measures. However, in written feedback, some ODHS staff, including surveyors, indicated that the LiveWell content, while interesting, was not relevant to their jobs.

The evaluation methods include several data sources, both qualitative and quantitative. The main goals were to assess the following:

- AL/RC staff and community engagement in LiveWell
- Participants' ratings of the LiveWell Method
- Leadership engagement
- Coaching effectiveness

We collected information about staff participation (engagement) in Learning Collaborative sessions, surveyed participants using an online tool, interviewed leaders (administrators and owners), interviewed all LiveWell coaches and reviewed and summarized their written notes, and observed at least one recorded session for each cohort of LiveWell communities. In addition, we collected and summarized information about the types of AL/RC communities that participated.

3 Findings

3.1 Facility Characteristics

Participants from at least 23 AL/RC communities attended the in-person LiveWell trainings, and 23 AL/RC communities attended the online Learning Collaboratives (one community participated twice). The LiveWell team compiled facility information from both the in-person and online versions of LiveWell (see Table 1). Facility type (AL or RC), memory care endorsement, Medicaid contract status, location, profit status, and ownership information were examined. It should be noted that clear information about facility ownership is not always available: the figures here are based on whatever ownership information was available online or provided by communities. Communities that participated online also provided information about their capacity, number of residents, and number of staff on their LiveWell applications; this information is also summarized for the online participants.

Overall, AL and RC communities were fairly equally represented (54% vs 43%). About a third of communities were independently owned and two-thirds were based in Oregon, according to the available ownership information. A slightly higher number of AL/RC communities accepted Medicaid (85%) compared to the state (79%) (Carder et al., 2019). Statewide, 35% of AL/RC have a MC endorsement, slightly higher than the number of MC that participated.

A notable difference between the online and in-person LiveWell communities was the location of the communities. Among the in-person attendees, nearly two thirds were from urban areas, the remaining were from rural areas, and none represented frontier communities. Among the online communities, 52% were from rural areas, 35% were from urban areas, and 13% were from frontier areas. This may indicate that the online Learning Collaboratives

were more accessible for rural and frontier communities. However, several in-person LiveWell sessions that were scheduled to be held in rural areas were cancelled due to the COVID-19 pandemic or other issues. Had these events been held, it is possible more rural and frontier communities would have been represented, although LiveWell team members noted barriers to obtaining buy-in from some rural and frontier communities. For example, some AL owners and operators indicated that because the LiveWell team was from the Portland area, they would not understand local community concerns. One in-person training session in a rural community scheduled prior to the COVID-19 pandemic was cancelled because none of the communities who signed up attended.

Table 1. Characteristics of AL/RC Communities Participating in LiveWell, 2019-2021

	In Person Sessions (n=23)	Virtual Sessions (n=23)	Total (n=46) N (%)
Facility type			
AL	11	14	25 (54)
RC	12	8	20 (43)
SNF	NA	1	1 (2)
MC endorsed			
Yes	7	4	11 (24)
No	16	19	35 (76)
Medicaid contract			
Yes	19	20	39 (85)
No	4	3	7 (15)
Location			
Rural	7	12	19 (41)
Urban	16	8	24 (52)
Frontier	0	3	3 (7)
Profit Status			
For-profit	16	18	34 (77)
Not-for profit	7	5	12 (23)
Independently owned			
Yes	9	8	17 (37)
No	14	15	29 (63)
Oregon-based			
Yes	18	14	32 (70)
No	5	9	14 (30)
Facility details*			
Capacity (mean, range)	NA	47 (16-154)	
# of residents (mean, range)	NA	33 (14-80)	
# of staff (mean, range)	NA	36 (13-112)	

*These data were taken from facility applications to LiveWell. One community was excluded because it included staff and residents in its in-home care program in its staff and resident counts.

3.2 Online Learning Collaborative Attendance

Staff attendance in the Learning Collaborative sessions is an important marker of community and staff engagement and commitment. If staff do not attend on a consistent basis, they will not be able to learn and use LiveWell concepts. The IOA evaluation team created a participation tracking form that coaches completed each week. The attendance data were compiled to describe LiveWell participants and community attendance over time. Because the data are manually entered by coaches, note that reporting errors are possible.

Weekly community attendance across all three cohorts can be seen in Figure 1. For a detailed review of the weekly attendance by cohort and community, please see Appendix A.

Overall, there are many similarities in attendance among cohorts:

- The highest levels of participation are seen at the beginning of the Learning Collaborative between weeks 2 and 4.
- Participation decreases during the middle of the Learning Collaborative between weeks 6 and 9.
- Participation increases slightly at the end of the Learning Collaborative, typically at the all-community Learning Collaborative.

The gradual decline in participation may reflect that while there are attendees who attend every week or nearly every week, there are also attendees who begin the Collaborative and drop out or who attend less consistently over time. Possibly some staff check in at the beginning to see 'what it's all about' and then again at the end to learn how the program went.

There are several notable differences among the cohorts:

- Cohort 2 skipped week 11 due to several communities operating COVID vaccine clinics.
- In Cohorts 1 and 2, the highest level of participation in the second half of the Learning Collaborative occurred during the all-community collaborative session, in which communities presented their LiveWell accomplishments. This was week 11 for Cohort 1 and week 12 for Cohort 2. For Cohort 3, however, the highest level of attendance in the second half of the collaborative was week 10. During the all-community collaborative week 12, one community (C19) who typically brought 4-5 attendees during previous weeks, was not able to attend due to unforeseen difficulties. This perhaps accounts in part for the

lower than expected attendance during the all-community collaborative.

- While Cohorts 2 and 3 saw a gradual decline in participants, Cohort 1 saw a steeper decline. Coaching notes from the time describe difficulties with attendance due to the Oregon wildfires, acute staffing shortages, and active COVID-19 outbreaks in several communities.

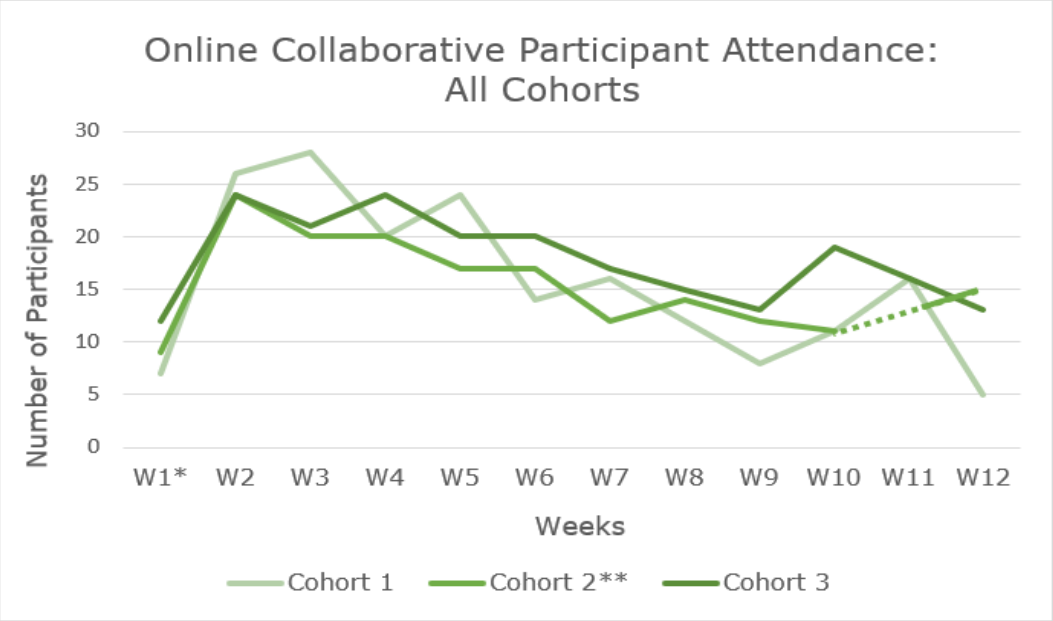


Figure 1. Online Collaborative Participant Attendance. *Week 1 was the executive briefing. **Cohort 2 skipped week 11 and resumed week 12.

3.3 Meet Ups

During the first online Learning Collaborative, several participants shared that having the opportunity to meet with other AL/RC communities was one of the most powerful parts of their LiveWell experience, and that they hoped there would be more opportunities to do so in the future. This idea aligned with two of the LiveWell team's own goals: to build supportive relationships among AL/RC communities, and to continue to engage participants with LiveWell after the Collaborative ended. Using this information, the LiveWell team designed Meet Ups: 30-minute meetings for current and former participants as well as others interested in learning more about LiveWell, quality improvement, or the topic addressed during the session.

Between November 2020 and May 2021, 12 Meet Ups were held online. These brief, 30-minute Zoom meetings included topics such as COVID-19 policies, psychosocial needs of staff during the pandemic, end of life planning, vaccines, and one open-ended session. At least 61 individuals

participated in the 12 Meet Ups, though this is possibly an underestimate given that participants sometimes had several other attendees in the room who were not indicated on the tracking sheet.

The evaluation team provided a spreadsheet for coaches to track attendees and content, as well as a survey for attendees to complete after each Meet Up. The brief survey asks participants if the information they learned was useful, if they plan to attend another Meet Up, if they have suggestions for future Meet Ups, and if they would like to present at a future Meet Up. Between November 2020 and May 2021, the survey received 23 responses.

- 87% of respondents said the information provided was useful.
- 96% of respondents said they planned to attend a future Meet Up.

Participants were also asked to share their primary job. Ten identified as administrators, three as life enrichment coordinators, three as residential care coordinators, and as seven "other" (e.g., social services director, marketing director, gerontologist, etc.).

Suggestions for future meetings included community building, leadership training, how communities develop service plans, and tools for reducing staff turnover and call-outs.

3.5 Learning Collaborative Participant Experience

Participants completed online surveys at the end of the Learning Collaborative to provide feedback on their experience and reflect upon the impact that LiveWell had in their community. The survey questions can be found in Appendix B. One hundred and twenty-three staff and administrators signed up to participate in the online Learning Collaborative. Of those, 107 attended at least one session. Across all three Learning Collaboratives, 47 participants completed a post-survey. Of note, participants could choose to skip questions on the survey, so the number of responses for each question varies.

The majority of participants throughout the three cohorts (n=45) rated the online format, relevance and quality of content, and discussions as good or excellent.

Figure 2. Participant Rating of Learning Collaboratives

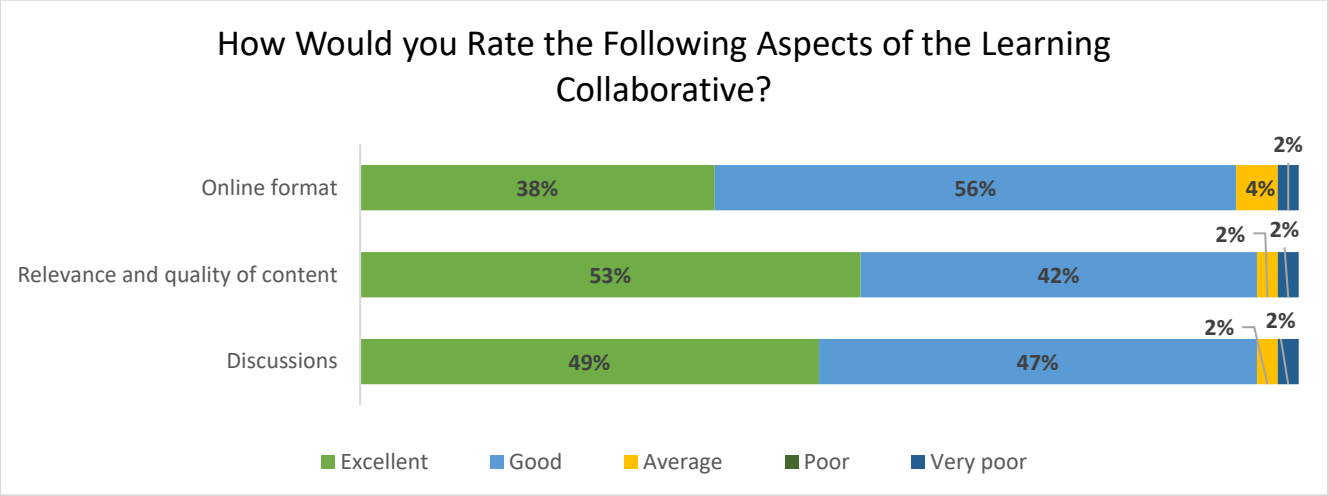
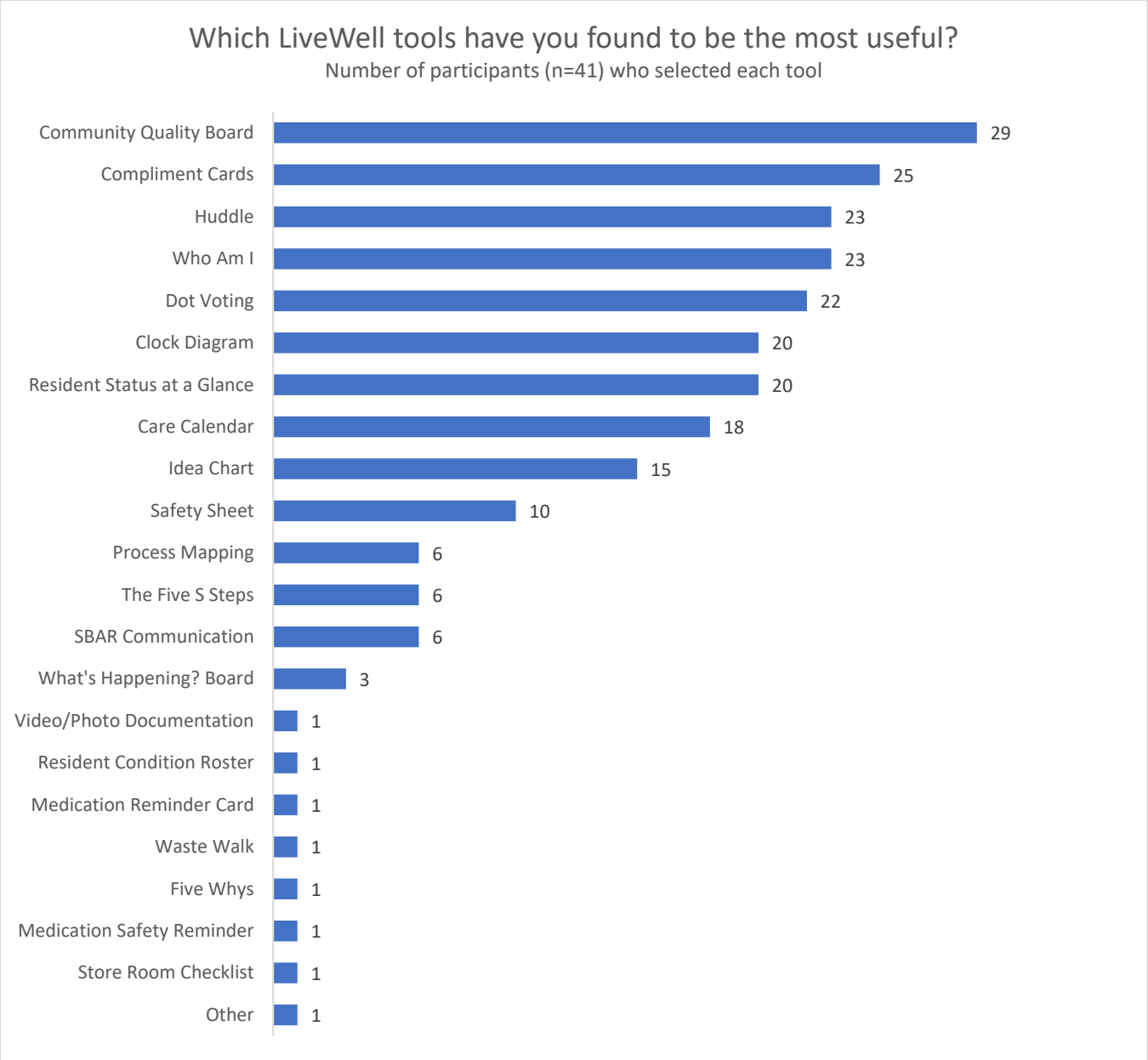


Figure 3. Example of a Community Quality Board

LiveWell coaches emphasized a few key tools in the Learning Collaboratives. The Community Quality Board was the top-rated tool by participants. This was a core focus of the Learning Collaborative, and the central hub of

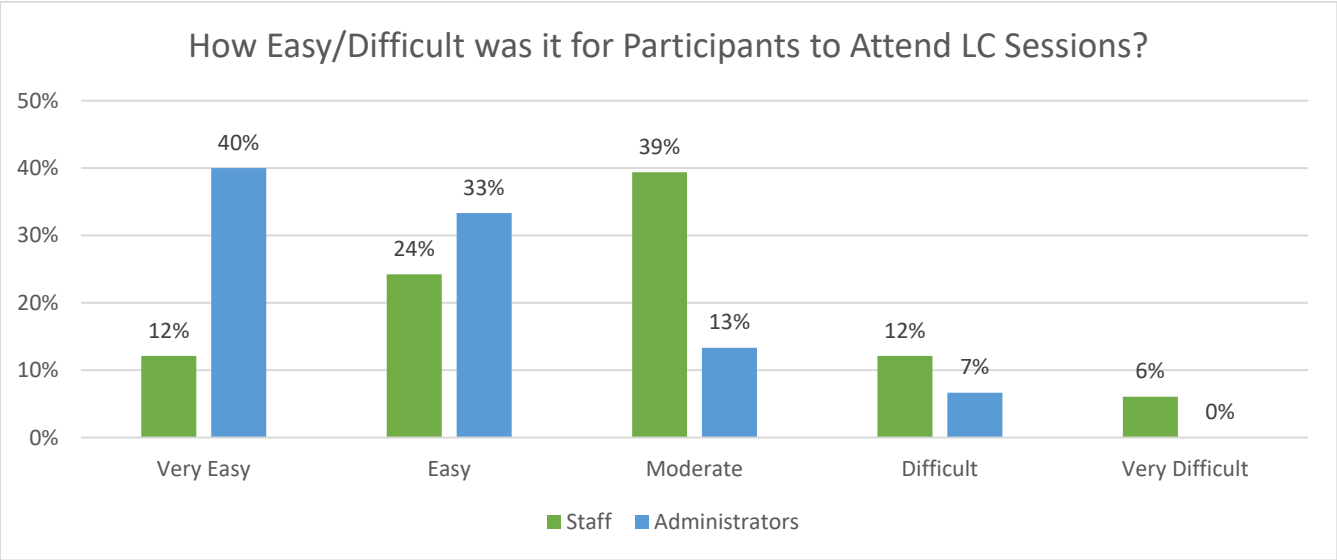
LiveWell activities in the community. These boards included LiveWell tracking tools and served as a place where staff could engage with the quality improvement activities the community implemented. Compliment Cards, the "Who Am I?" exercise, and Huddles were also highly rated, as well as the Clock Diagram, Dot Voting, and Resident Status at-a-Glance. These tools were often included as part of the Community Quality Board.

Figure 4. Participants' Ratings of the Most Useful LiveWell Tools



When asked how easy or difficult it was for participants to attend Learning Collaborative sessions, administrators perceived it to be easier than staff reported. While 73% of administrators (n=14) rated it as "easy" or "very easy" for staff to attend the weekly sessions, only 36% of staff (n=31) reported it as such. A fair share of staff felt it was moderately (39%) or difficult/very difficult (18%) to attend. This suggests that some administrators may have underestimated their staff's ability to balance their regular work duties with the additional time needed for LiveWell.

Figure 5. Administrator (n=14) and Staff (n=31) Rating Ease of Attendance



Did staff attend Learning Collaborative sessions during their assigned work shift?

Most staff attended during their assigned shift. Of those who attended outside their shift, only one stated that they were not paid for their time.

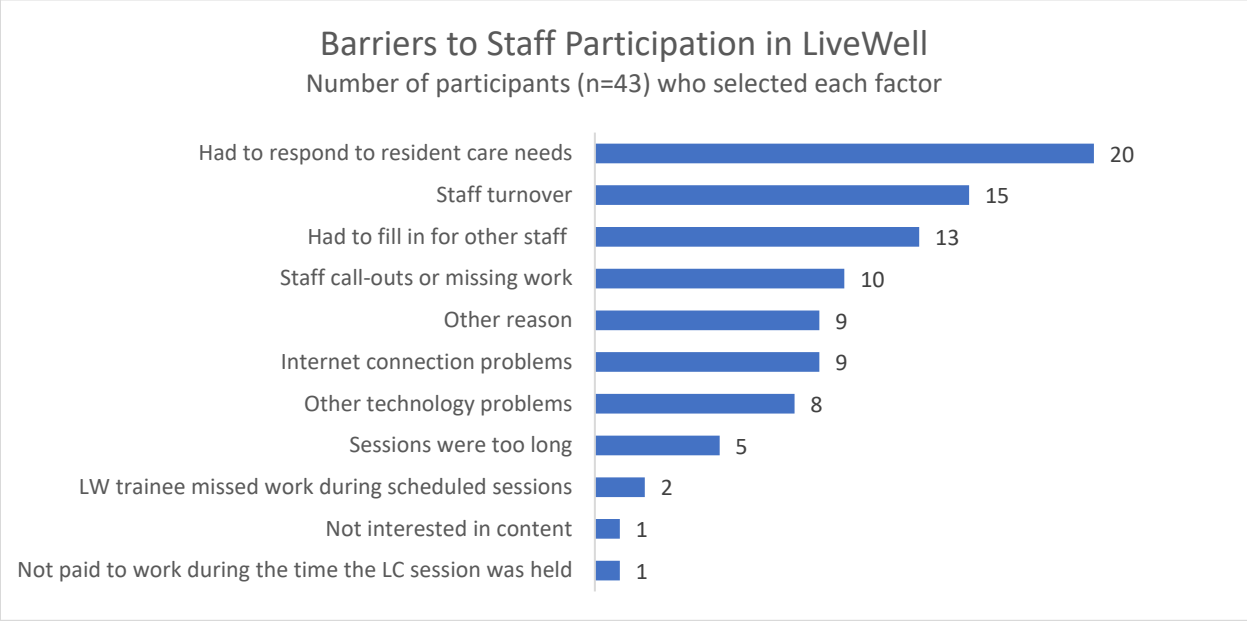
Table 2. Staff Attendance During and Outside Their Shift

	Staff		**Administrators**	
	Yes	No	Yes	No
Attended during shift	26	5	12	3
Attended outside shift	6	21	10	5
If yes, paid for shift?	5	1	9	1

3.6 Barriers and Facilitators to Participation

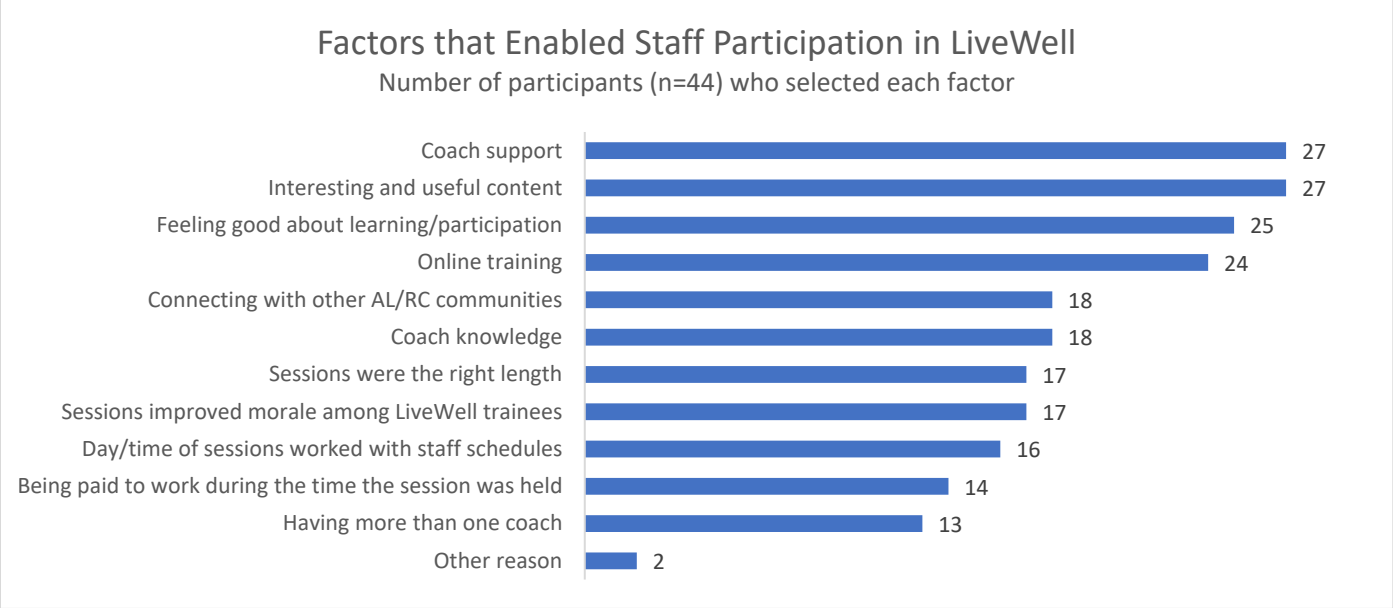
The greatest barriers to participation were related to staffing and staff work demands. Most frequently, staff reported having to respond to resident care needs, filling in for other staff, staff call-outs or missing work, and staff turnover. These issues point to the broader challenge of staffing in assisted living and residential care, highlighting the difficulty of implementing a staff-empowered quality improvement approach if there are insufficient staff to meet the needs of residents. Technology or internet connection problems were less frequently reported, but presented a challenge to some participants.

Figure 6. Barriers to Staff Participation in Learning Collaboratives



Other reasons: "Had other work that needed to be done." "Competing priorities." "Work Noc shift." "Vacation time." "Tours during sessions." "Had an emergency to take time off-Also front reception and interruptions would sometimes prevent me from attending partial session." "Just keep the machines working, laundry room." "conflicting schedules."

Figure 7. Factors that Enabled Staff Participation in LiveWell



Other reason: "Having Director be interested in program"

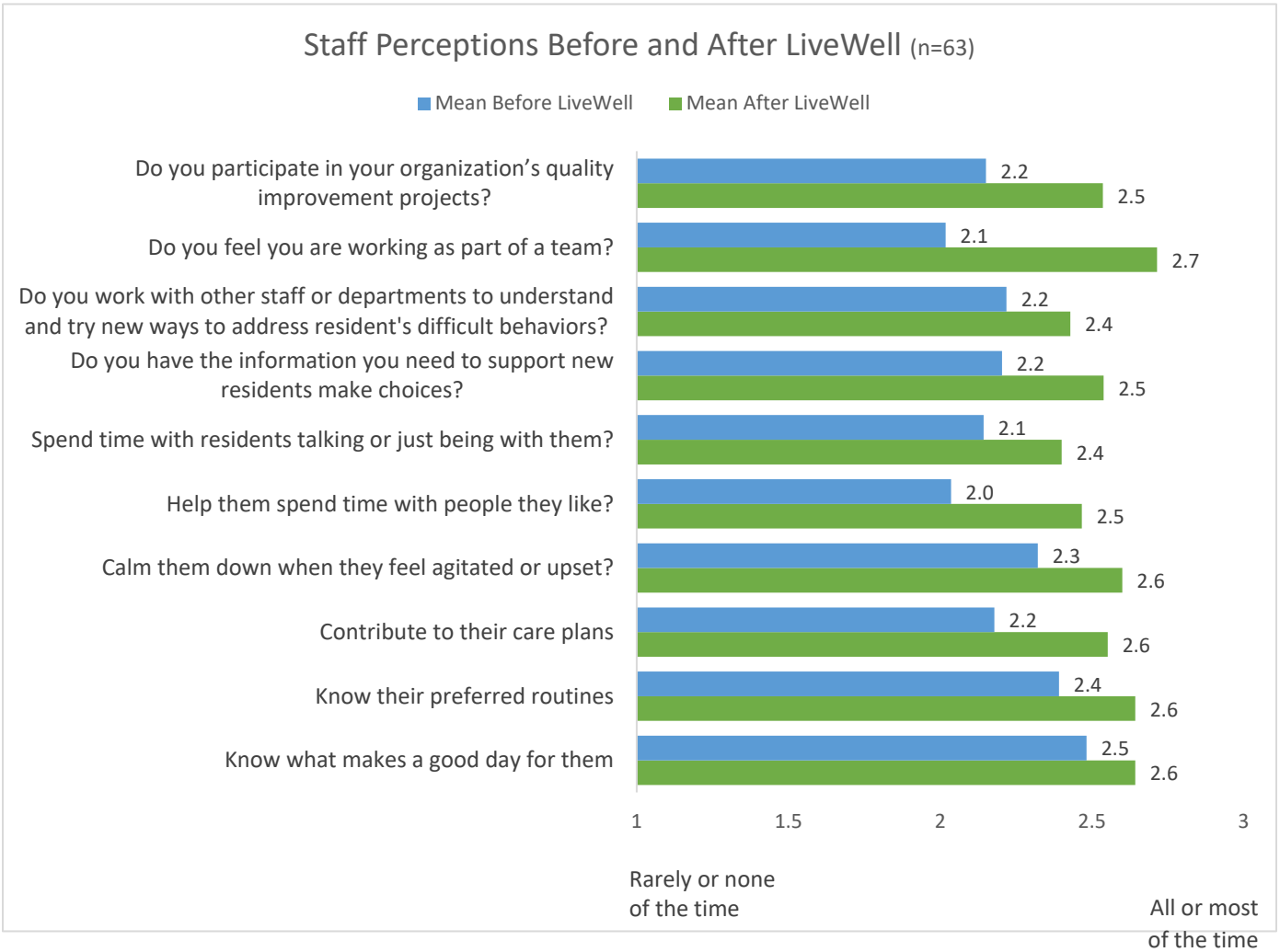
Support from coaches was the most frequently selected factor that facilitated staff participation in LiveWell, followed by interesting and useful content and feeling good about learning/participation. The shift to an online model also appeared to make it easier for staff to participate, eliminating the need for staff to take a full day off work and travel to an in-person training site. Participants also seemed to appreciate the peer-to-peer learning that was made possible through the structure of the Learning Collaborative. Staff were able to connect with other AL/RC communities, share experiences, and learn from each other in breakout rooms through Zoom. There is evidence from other training programs that peer-based training of care-related staff is effective (Finn & Sturmey, 2009).

We asked staff to rate several aspects of their work and their ability to provide person-centered care to residents before and after their participation in LiveWell (Figure 8). Of those who responded to this question across the three cohorts, the average ratings increased after their participation for all 10 aspects of quality and resident care. The greatest improvement after LiveWell was staff feeling like they were working as part of a team. There is evidence from many organizations, including healthcare settings, that effective teamwork is associated with improved outcomes, including staff retention (Salas et al., 2009).

We calculated the percent change in how often staff felt that each of the 10 activities took place before and after participating in a 12-week Learning Collaborative. The largest increases observed were for the following seven activities:

- Feeling like part of a team: 22%
- Helping residents spend time with others: 20%
- Contributing to care plans: 15%
- Participating in quality improvement: 12%
- Having information needed to support new residents: 12%
- Spending time with or talking to residents: 12%
- Calming residents who feel anxious or agitated: 12%

Figure 8. Staff Perceptions About Quality and Resident Care Before and After LiveWell

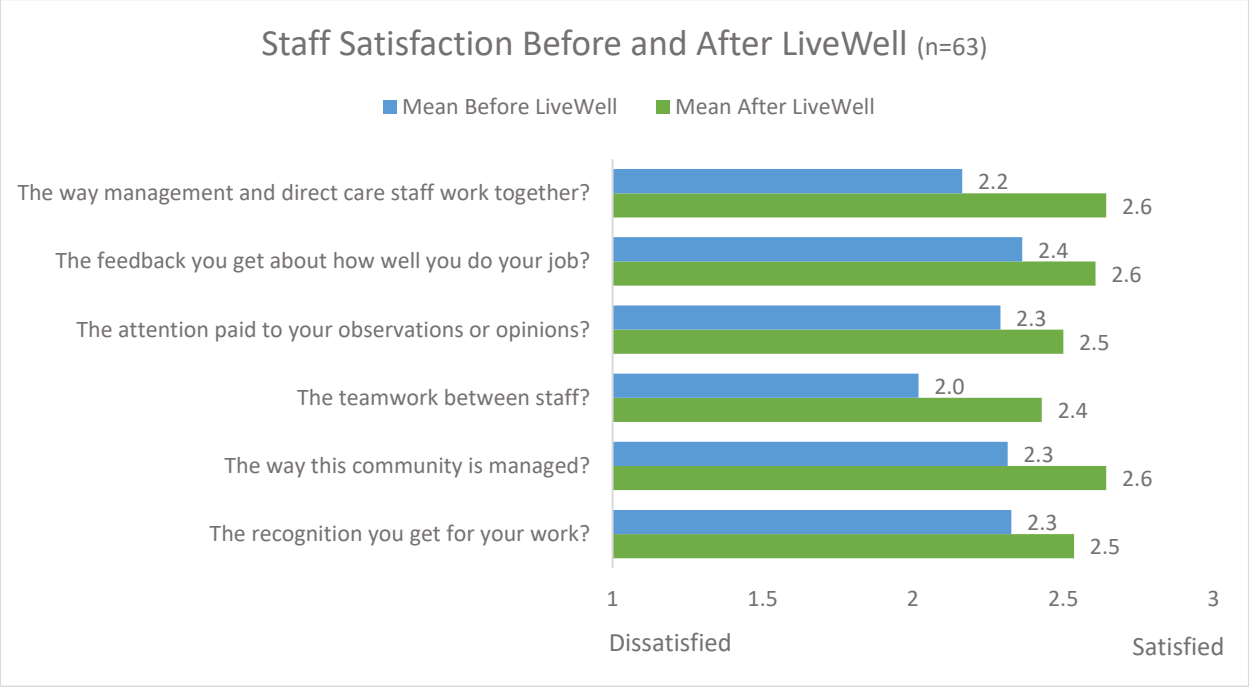


*Note: the number of staff who answered each question ranges from 35 – 63 due to skip patterns and some missed questions.

Staff also rated their satisfaction with several aspects of their work before and after participating in a LiveWell Learning Collaborative, and all respondents reported greater satisfaction after LiveWell. The greatest improvements in satisfaction were the teamwork between staff and the way that management and direct care staff work together (Figure 9). Specifically, the following score increases were observed:

- The way management and staff work together: 15%
- Teamwork: 15%
- How the community is managed: 12%
- Receiving feedback on job performance: 8%
- Attention paid to observations and opinions: 8%
- Recognition of work: 8%

Figure 9. Staff Job Satisfaction Before and After LiveWell



*Note: the number of staff who answered each question ranges from 35 – 63 due to skip patterns and some missed questions.

3.6 Open-Ended Questions

The survey included several open-ended questions so that participants could describe in their own words their experience using LiveWell tools.

What, if anything, changed after using the LiveWell tools?

Twenty-two participants answered this question. Some described how LiveWell helped their communities develop "more of a team atmosphere," with staff "taking on more as a team." Similarly, others felt that LiveWell improved their community's communication channels. As one participant explained, "our staff have been able to communicate to each other more effectively, specifically about any grievances or concerns." Another participant expressed optimism about how LiveWell Huddles would improve communication going forward:

> *Using the huddle will be a communication tool our community will enjoy. Time to get together [to] talk about what's happened throughout the shift and make sure staff is doing well during our busy day.*

Many participants described how the LiveWell Method and tools enable "more to have a voice" and staff to be more involved in quality improvement. "I think that we ignited some interest in staff that did not have interest at the start of the program," a participant explained. Others commented on measurable improvements in quality metrics, including falls, staff attendance, resident satisfaction, missed showers, and missed meals. "Charting it really makes it clear when there is an issue," a participant explained. Another shared,

> *We were able to use the clock to identify a time frame when falls were happening and make adjustments to the activities of the day to reduce falls and increase safety checks.*

Finally, a few participants expressed hope that LiveWell "gave our team skills and learning tools that can be used in the following years." A participant answered,

> *I believe, and am hoping, we will be able to use these tools in the future to improve staff retention and resident care. There are tools we can use that we did not have a chance to implement fully that I am sure will help to support staff morale and resident care. Combined, the outcome will be very positive. This program is a must for looking at the long-term gains for our community.*

Is there anything about your experience with the LiveWell Learning Collaborative that you think would be useful for other communities, the LiveWell team, or DHS to know?

Thirteen participants answered this question. Several of those responses were simply additional positive feedback about the LiveWell program. "I believe that all communit[ies] should go through the program to help better the resident care," a participant said. Another shared, "I love the tools and will continue to build off of them. I believe the tools will increase our quality."

Several comments expressed suggestions for changes to the LiveWell program. One participant described the difficulty of participating in a program like LiveWell when the community is facing other challenges:

> *For the participants- this is a program that can be overwhelming to implement if you are understaffed or have a smaller community that needs more attention during the training. But, the great part is that you can assimilate the experience, take the tools, review the videos and join the groups when finished with the program. I think this is a program that can be introduced over time and be successful. I would have liked a little more emphasis on staff retention within the team building program.*

Another participant expressed "mixed feelings about the online format," explaining that "The downside is that I don't think some folks are comfortable offering up information during the online sessions. I wonder if participants are more interactive during in person session." Similarly, another participant described how the online format made interactions difficult:

> *If there could be more incorporation of the breakout rooms. I think it'll be easier for people to speak up if they're not trying to talk over 10+ people, especially when there is lag from internet. Also, with breakout rooms, you are put into a position to speak to someone who isn't usually in your team or cohort, so the opportunity to learn different viewpoints increases.*

3.7 Coaches' Perspectives on Participant Experience

During the Learning Collaborative, coaches completed a weekly survey for the PSU evaluation team, summarizing the week's events. Here, they described the challenges participants faced as well as their progress. Across all three Learning Collaboratives, there were many similarities in the most frequently described challenges and successes.

What challenges were participants experiencing with LiveWell in their communities this past week?

By far, the greatest challenge according to coaches was participants' ability to fully participate in LiveWell due to difficulties within the community environment: "chronic understaffing," constant turnover, "toxic work environments," technical issues, "COVID-19 endurance," and more. Unexpected events—a "pipe bursting," "staff illness," evacuations during the wildfires—caused many participants to miss Learning Collaborative sessions. These challenges made it difficult for staff to attend, engage fully in the curriculum, or implement it in their communities. One coach described,

> *...burnout and exhaustion in some of the participants. So much has happened this year that they are finding it difficult to find the time and energy to do "one more thing."*

Participants "feeling overwhelmed and not supported much by Administrators and co-workers" compounded these challenges. One community missed the first week of the Learning Collaborative because they had not been told about LiveWell and "had no idea what it was about." "Limited support from executive leadership" not only deprived staff of needed direction and encouragement, but missed an opportunity to "bring new ideas and practices to staff." Without leadership and community support, implementing LiveWell tools was a daunting challenge for some participants. Another coach described how a "lack of inspiring leadership is a real barrier because good leaders participating in our sessions have more committed staff who produce better results than teams with little or misplaced leadership."

Over the weeks, communities encountered some issues implementing the LiveWell tools (e.g., "Huddles are challenging," and "not enough room for quality board."). These comments, however, were not as frequent as those about participant engagement.

What is going well for participants in terms of using LiveWell in their communities?

Coaches often described how, despite the significant challenges LiveWell participants faced in their daily work, participants began to implement and notice changes as a result of the LiveWell tools. Some improvements occurred simply because staff were aware these metrics were being tracked. This seemed especially true for metrics that focused on individuals' behavior. "Some communities expressed that just by putting up measures they are seeing activities change," a coach recorded, "for example, by tracking staff callouts visibly, the callouts have diminished." Another community that struggled with ensuring that residents received timely showers saw their compliance rate "went from 9.6% in March to 50% in April." These improvements may be because, as one participant explained,

> *It's very easy for us as managers to tell staff results, but having them actually read and see visuals on the CQB, helps them see how we are trending and take action.*

Other improvements occurred because LiveWell tools enabled participants to gain insight into problems to identify their root cause. For example, one community observed that falls were happening in the same location. The administrator observed that "residents often fall there because they reach down to pick up lint. [The administrator] bought a carpet sweeper to put nearby so that it would be easier for staff to clean up. Fewer falls!" In this way, the tools empowered staff to become "more observant about things that are happening around them in caring for their residents."

Beyond positive changes in measured outcomes, coaches described how LiveWell improved community culture. At the community level, LiveWell "brought staff together." Several participants noted that they "communicate better using LiveWell tools." Specifically, Community Quality Boards and Huddles were named as crucial tools for communication and helping "staff getting to know residents and staff better." Tools like Dot Voting (a LiveWell tool that empowers staff to anonymously voice their opinion on a subject) and others helped with "finding alternative ways to make all staff on all shifts feel involved and heard." Compliment Cards were identified as being "very uplifting for staff" and residents. One community shared that "compliment cards focus us on positivity…one of the most negative residents wrote a compliment to another resident."

Many of these changes demonstrated a shift toward a more empowered, democratic, and supportive workplace ethos. For example, one community used Dot Voting to identify that incontinence care was the issue that staff

wanted to work on. In response, they created a white board to track incontinence care between shifts. The administrator told the coaches that

> *She has listened in on some new conversations based on the white board tool that showed new accountability from staff and "has mitigated a lot of conflicts" between shifts.*

For individual participants, coaches observed how some participants were "building their confidence" each week as they became more familiar with the LiveWell tools and values; similarly, another coach noticed that their participants "recognize leadership skills in themselves and other staff more fully because of LiveWell training." One participant shared that LiveWell "helped me know my own worth in my industry." For others, meeting with other communities each week "reminded me I am not alone in the struggle."

5 Administrator and Leadership Perspectives

A common theme in the coaching summaries and coach interviews was the need for leadership support for communities to be successful in LiveWell. Leaders, including owners, regional directors, and administrators, were variously involved throughout the Learning Collaboratives, although administrators played the key role in facilitating LiveWell in their communities.

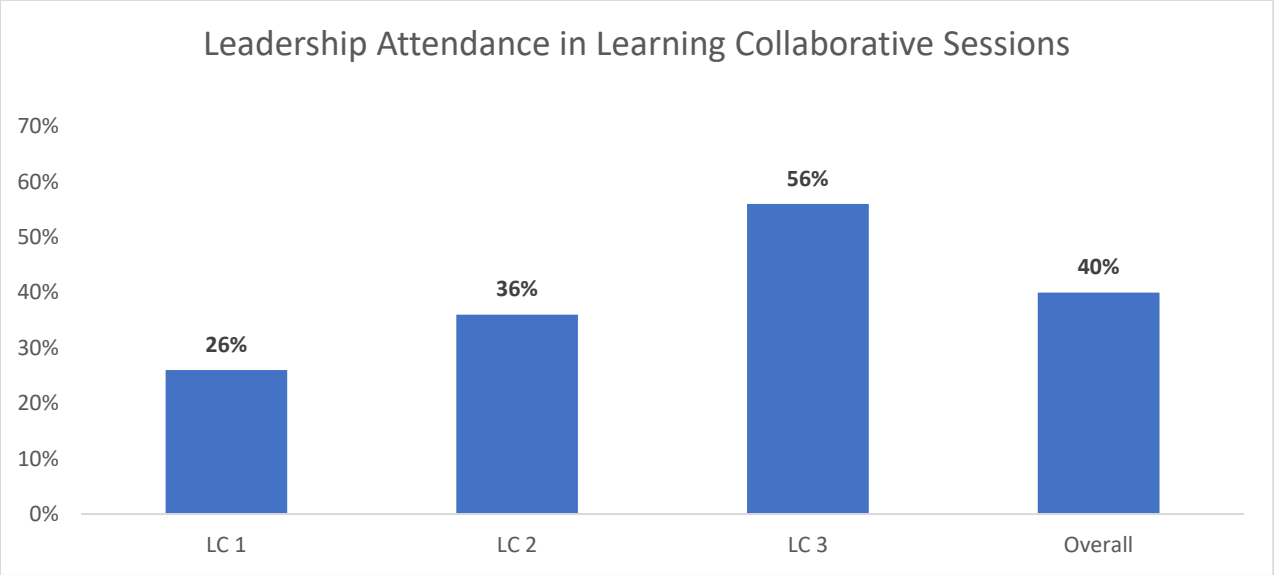
Here we examine leadership attendance at Learning Collaborative sessions, how leadership attendance compares to staff attendance, how often administrators met with their LiveWell teams outside the Learning Collaboratives, and the importance of support from owners and regional directors.

We also review administrators' responses on the post-survey provided to all Learning Collaborative participants; this explores administrators' perceptions of how their staff were impacted by LiveWell, opinions about LiveWell, and their perceptions of the costliness of various issues in AL/RC communities. Finally, we review the key themes that emerged from interviews with administrators, who described their experiences with QAPI before and after LiveWell.

5.1 Leadership Participation and Support during LiveWell

We tracked participation during each weekly session of the three 12-week Learning Collaboratives. Leadership attendance increased over time: during the first Learning Collaborative, leaders attended an average of 26% of sessions, and they completed 56% of sessions during Learning Collaborative 3. This may be due in part to the LiveWell coaches' efforts to increase administrator engagement. Overall, leadership representatives attended roughly 40% of the sessions.

Figure 10. Community Leadership Attendance in Learning Collaborative Sessions



Leaders of communities who completed LiveWell attended an average of 42% of the 12-week sessions. Among communities who dropped out, administrators attended just 19% of the sessions their communities completed prior to dropping out.

Leadership attendance at Learning Collaborative sessions may impact staff engagement and attendance. Among those who completed LiveWell, communities with above average leadership attendance had an average of 4 staff participants, while communities with below average leadership attendance had an average of 3.1 staff participants. Surprisingly, communities with above average leadership attendance had slightly lower staff attendance (53%) than communities with below average leadership attendance (59%). This may be partly explained by the fact that during Learning Collaborative 3, the administrator was the primary (sometimes the only) attendee in three communities. When these three communities are removed from the analysis, the average number of non-leadership

participants increases to 4.75 and attendance increases to 64%. There are several possible reasons why an administrator would be the primary LiveWell participant. One reason, of course, is low staffing. Other possible reasons include lack of support from corporate leadership, the need for the leadership skills to train and mobilize a team, and the impact of COVID-19. Of course, all these factors could be at play.

Administrator support between Learning Collaborative sessions could be just as vital to communities' success as attendance during Learning Collaborative sessions. All participants were asked on the post-survey how often they met as a team: administrators were asked how often they met with their staff, and staff were asked how often they met with administrators. Participants were not asked to track how often they met as a team, so the results they reported are only estimates. Overall, 47% of respondents reported meeting 4-6 days per week or daily. Thirty percent of respondents reported meeting as a team 1-3 days per week. Twenty-three percent reported meeting less than once a week or not at all.

There was some discrepancy in the frequency of meetings reported by administrators compared to staff. For example, 33% of administrators reported meeting less than once a week, while only 19% of staff said the same. Possibly staff and administrators have different definitions of "meeting," whether formal or informal.

Table 3. Frequency of Administrator and Staff Meetings Between Learning Collaborative Sessions

	Administrators (n=15)	**Staff (n=32)**	**All (n=47)**
Daily	27%	19%	24%
4-6 days per week	13%	28%	23%
1-3 days per week	27%	31%	30%
Less than once a week	33%	19%	21%
Not at all	0%	3%	2%

The importance to administrators of support from corporate leaders, such as owners and regional directors, was described by some AL/RC administrators as well as the LiveWell team. As the LiveWell team recruited new participants, it became clear that lack of communication between owners and administrators was a barrier for some, while active support promoted engagement for others.

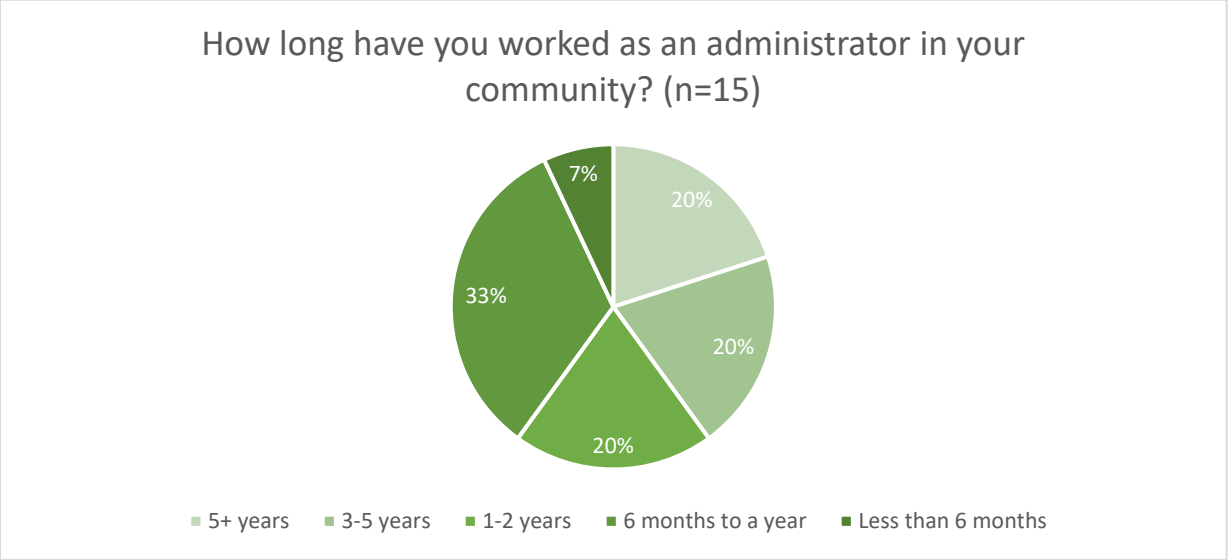
Administrator engagement with LiveWell may also be impacted by the support they receive from their corporate office or company leadership. On the Learning Collaborative post-surveys, administrators were asked to rate their level of agreement with the statement, "My corporate office or company leadership supported my community's participation in LiveWell." Across the three Learning Collaboratives, 13 administrators answered this question. Of those, 54% said "Strongly Agree," 38% answered "Agree" and 7% answered "Disagree." This indicates that, at least for those who responded, most felt supported by their corporate leadership. These results only reflect the perspectives of communities who completed the sessions. Therefore, we do not know if a lack of support from corporate leadership may have contributed to communities' ability to complete the program.

5.2 Administrator Survey Responses

Across three different Learning Collaborative cohorts, fifteen administrators completed a survey after finishing the Learning Collaborative (see Appendix B).

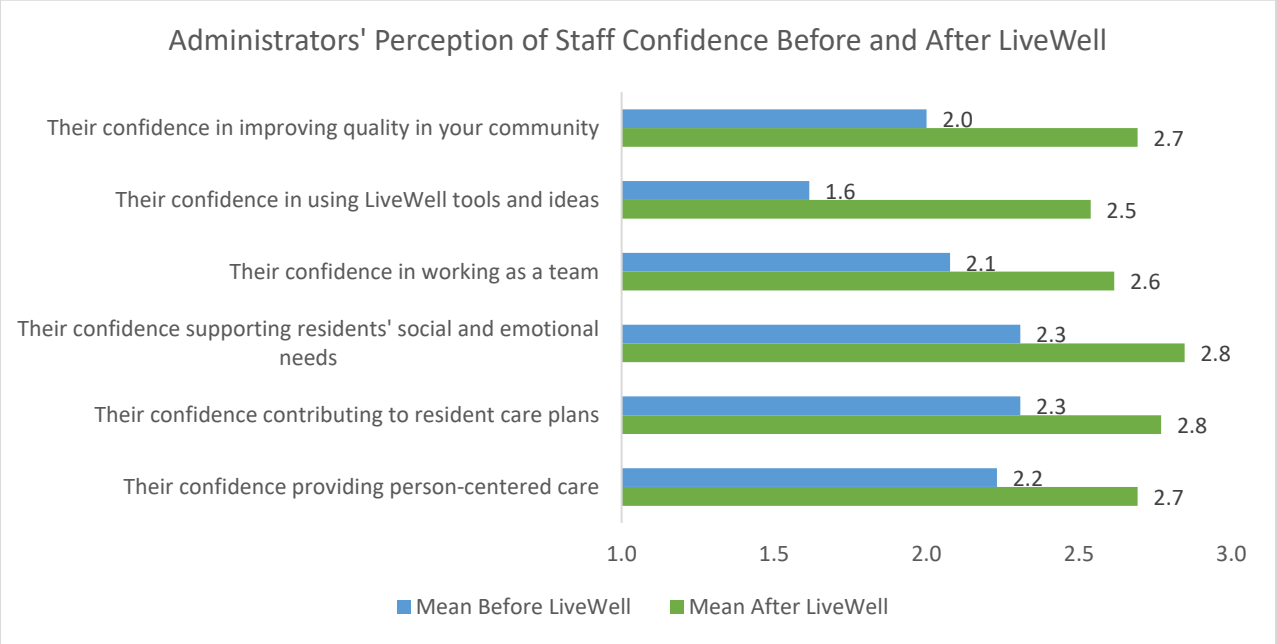
Among the 15 administrators who completed the survey, 6 (40%) had been in their role for less than a year. Six had been employed as an administrator between one and five years, and three had been in that role for more than five years. On average, they reported working 54 hours a week (answers ranged from 40 hours to 65).

Figure 11. Amount of Time Administrators who Participated in LiveWell have Worked in their Current Position



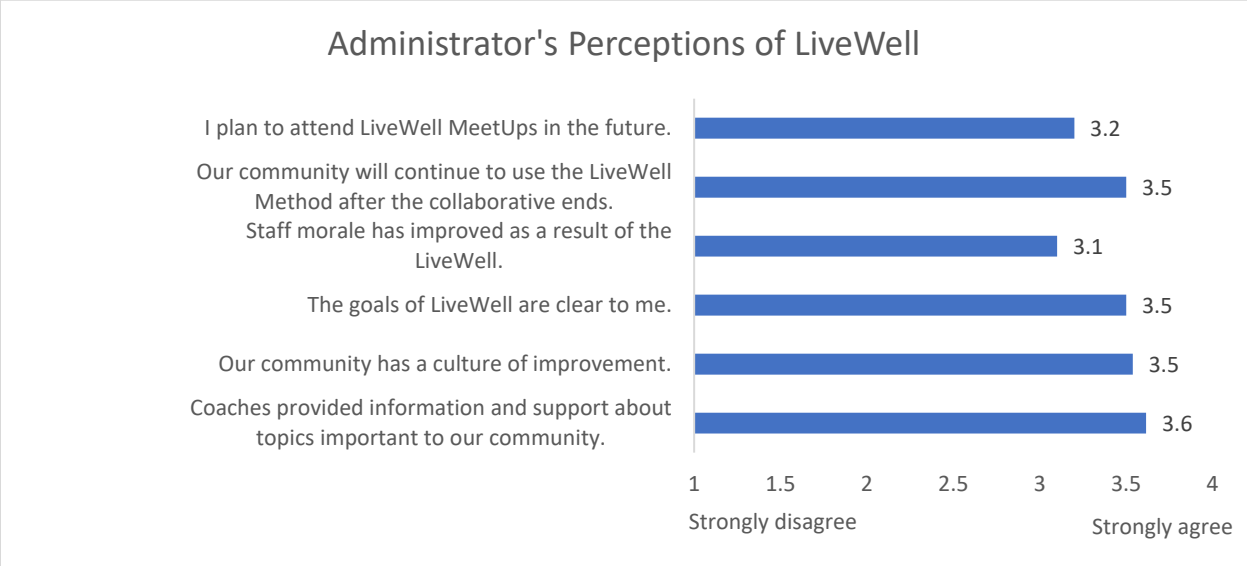
Administrators were asked to evaluate whether staff member's confidence when performing various skills changed after completing the twelve-week Learning Collaborative (see Figure 12). Specifically, the question asked administrators to compare staff confidence on several measures of quality care, both before and after the sessions, on a scale from 1 to 3. These administrators observed the greatest improvement in staff's confidence using LiveWell tools and ideas (from 1.6 to 2.5) and confidence in improving quality in their community (from 2.0 to 2.7). They noted the least amount of change in staff's confidence delivering person-centered care and improving resident care plans. Possibly these staff are not expected to participate in care plan development.

Figure 12. Administrators' Perception of Staff Confidence Before and After LiveWell



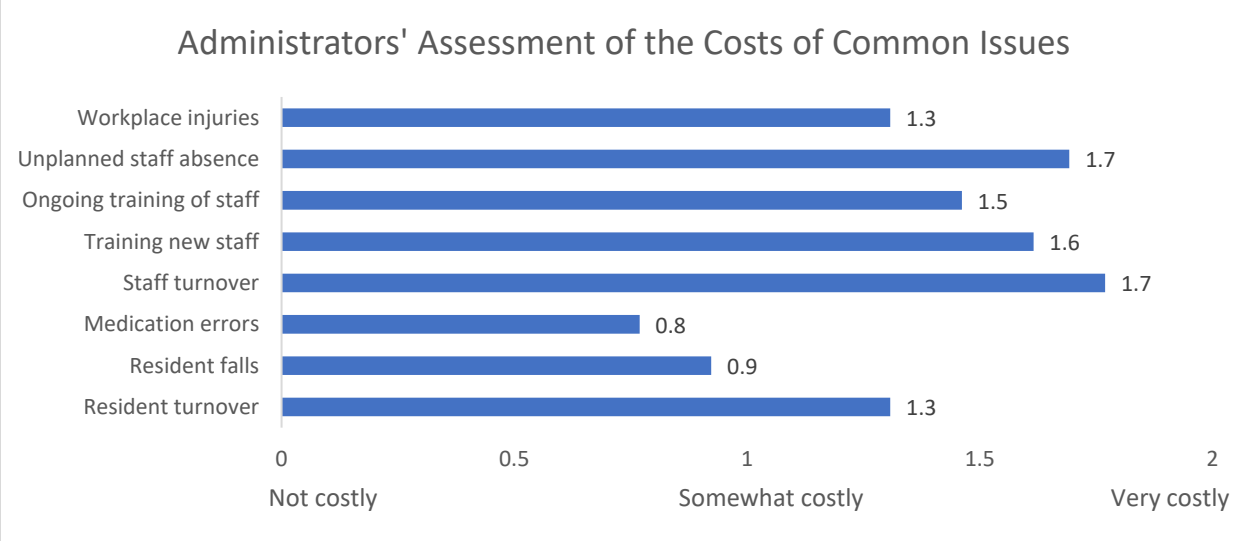
Administrators were asked whether they agreed or disagreed with various positive statements about their experience with LiveWell (Figure 13). Generally, administrators either agreed or strongly agreed with all statements. The statement "Staff morale has improved as a result of LW" had the lowest level of agreement, while "Coaches provided information and support about topics important to our community" had the highest level of agreement.

Figure 13. AL/RC Administrator Perceptions of LiveWell as a Quality Improvement Program



Administrators were asked whether eight different negative events were "Very Costly," "Somewhat costly," or "Not costly" to their community. These results can be seen in Figure 14. Administrators rated medication errors and resident falls as the least costly, and staff turnover and unplanned staff absences the costliest. Administrators were then asked if they anticipated that LiveWell practices would help reduce costs in any of these areas. Five administrators said yes, one said no, and the rest chose not to answer the question.

Figure 14. AL/RC Administrators' Assessment of the Costs of Common Issues



Administrators were asked if they believed that LiveWell helped their community create a more robust QAPI program: 62% said yes, 23% said maybe, and 15% said no. Similarly, they were also asked if LiveWell had made their community more prepared for future state surveys, and 62% said yes and 38% said maybe.

5.3 Owner/Administrator Interviews

We interviewed four executive leaders whose AL communities took part in the Cohort 2 Learning Collaborative (the interview guide can be found in Appendix C). These individuals included two owners/administrators who each owned one AL, the regional director of two AL residences, the regional director of a company that owns three ALs in Oregon as well as residences in two other states. All were located in rural communities or small towns and operated as for-profit organizations. Based on these interviews, we noted six common themes.

Theme 1. Before LiveWell, communities had QAPI systems that varied in their scope and methods.

Each community had a variety of QAPI systems in place. For example, a regional director said that they used measuring, root cause analysis, and developing new policies and procedures. Another used daily stand-up meetings, 24-hour alert charting, and resident satisfaction survey results as well as ED walk throughs in different departments. Another tracked the time between a resident call-light signal and staff response. One said that their QAPI approach consisted of the "normal stuff," like employee training, reviews, raises, and staff meetings.

Theme 2. The LiveWell approach complemented communities' QAPI systems by providing a shared language and tools that formalized and expanded existing quality programming. For example, an owner/administrator said,

> *We had goals, knew what we wanted to do, but LiveWell gives a process to achieve goals. Like map charting falls. We did our instant reports of falls, as required by the state. But the map tells us who, when and where falls take place, and lets us identify the repeat fallers. It was an enhancement of our prior process.*

Another owner/administrator had a similar experience, saying that at first, he was worried that LiveWell would significantly change his management approach, but that instead, LiveWell allowed them to "do what we have already been doing, just with these great tools." In addition, LiveWell expanded quality programming by involving staff other than managers who

had primary responsibility for quality efforts. For example, a regional director said,

> *Everyone participates and all the staff are part of the team. Not just the managers. Every team member brings something.*

LiveWell allowed them to engage staff from across departments or with different job responsibilities. "LiveWell is all about empowering employees" through education and listening to them.

Theme 3. Corporate leaders have an important role in the QAPI process.

A regional director said that corporate leaders review electronic health records and conduct audits, then share that information with staff. They can provide ongoing support and information to managers about quality improvement. It should be more than giving them audit reports, or telling them what they did "wrong."

In addition, leaders can motivate their staff to participate in QAPI. For example, an owner/administrator said,

> *At first, it was a struggle to get people to participate. I had to really drive it home at a couple of meetings that we needed people to participate. But as soon as they started, they loved it. One day I had to arrive late and missed the beginning of the session. When I got to work, they were all in their offices, plugged in, glued to the screen.*

Theme 4. Tracking quality measures can save AL/RC communities money.

Two executive leaders described how tracking had helped them save money and reduce negative outcomes. For example, by tracking resident falls, one community learned that the number of resident falls increased after dinner. By doing this, they realized that they did not need to hire additional staff, but rather to change the staff schedules (from a 6 am to 2 pm shift to a shift from 11 am to 7 pm). By doing so, they saved money and retained residents.

Theme 5. Executive leaders appreciate the LiveWell Method.

Comments from these four executives were uniformly positive. A regional director said, "I absolutely love this program" and that their communities who have not yet participated in LiveWell "have seen the visuals" and are "really impressed." An owner/administrator said,

> *The state makes things too complicated. LiveWell makes it simple—I'm overwhelmed and amazed by how they take things that are so*

complicated and make them simple. People can just walk by the board and see how we are doing. You look at them [the tools] and think, that's so simple I could have made that. But LiveWell did all that thinking for you.

Theme 6. Differences between small and large companies matter.

The two owners/administrators who each had one AL residence shared common differences compared to the regional directors of larger chains. The larger chains had standard QAPI systems and tracked numerous metrics. Not surprisingly, the larger chains had more resources available to them, both in terms of number and type of staff, but also financial resources to pay for future LiveWell sessions. The owners/administrators of single ALs were more engaged in daily operations. Rather than relying on systematic tracking and calculating costs associated with, for example, resident falls, they had a working understanding of problem areas. However, LiveWell provided tools that formalized their quality programming.

Based on these four interviews, executive leaders, including owner/administrators and regional directors, have an important role in quality improvement activities in AL communities. They provide training and support to staff, communicate with state agency staff, and make decisions about which quality metrics to track and how to respond to trends, such as staff turnover and resident falls.

In sum, leadership is a core concept for The Malden Collective and LiveWell. Future phases of the LiveWell program will include a leadership module designed to empower administrators as leaders, provide administrators with new ways to reduce their day-to-day burdens and their stress, to use practical concepts and skills for lifting a community's morale and retaining staff and residents, and to improve the likelihood of successful quality and performance outcomes. In 2020, Oregon DHS funded the Institute on Aging to conduct research on AL/RC administrator tenure and turnover. The findings from that study will be shared with The Malden Collective.

6 The Role of the LiveWell Coach

The same four coaches ran the Learning Collaboratives throughout the project period with the exception of one coach who retired near the end of Cohort 2. This continuity speaks to the ability of coaches to engage with AL/RC staff, including those who returned for Meet Ups. In addition, it indicates that The Malden Collective has a strong track record in retaining coaches over time.

6.1 Key Tasks of a LiveWell Coach

As described, the role of the LiveWell coach has changed dramatically over time. A member of the PSU evaluation team reviewed weekly coaching summaries, timing templates and slides, and several of the recorded Learning Collaborative sessions. From these observations, five key LiveWell coach tasks were identified.

- Building the Learning Collaborative curriculum
- Fostering participant engagement with LiveWell
- Teaching with modeling and collaborative problem solving
- Building relationships with and among participants
- Supporting participants and communities

Together, these coaching strategies support communities' success, as described in more detail below.

Building the curriculum. As previously described, the role of the LiveWell coach has changed significantly over time. A key responsibility of coaches during the online Learning Collaborative was building and adapting the

weekly curriculum. While a single coach drafted the materials (slide deck and timing template) all the coaches met weekly to review the materials and suggest changes. Coaches used participant feedback to continuously update the materials, observing what "works" and what doesn't.

Fostering participant engagement with LiveWell. LiveWell coaches fostered engagement from Learning Collaborative participants during and between Learning Collaborative sessions. During sessions, coaches drew out participants by asking them questions, offering affirmations, and asking them to share their work. Between Learning Collaborative sessions, coaches reached out to participants and their leaders, especially when attendance or progress with the LiveWell materials was faltering.

The primary purpose for reaching out to LiveWell participants outside of the Learning Collaborative was to foster engagement with the program. This was especially important at the beginning of the Learning Collaborative when communities occasionally struggled to get their teams organized. As the Learning Collaborative progressed, coaches continued these efforts, but also made special attempts to engage administrators at communities where lack of leadership involvement was a barrier to progress:

> *I asked [the administrator] how everything was going with the LIVEWELL tools," a coach recorded, "and she said, 'I'm not sure how it's going.' She admitted she hasn't spent any time in front of their [quality board].*

Coaches used these conversations to update administrators on their staff's important work and to find opportunities for shared goals and collaboration.

Teaching with modeling and collaborative problem solving. Naturally, a portion of the LiveWell curriculum requires didactic teaching for participants to learn about the LiveWell values, quality improvement, and how to use the LiveWell tools to improve facility culture and quality. Coaches used a slide deck and the LiveWell binder to guide participants through this material, especially at the beginning of the Learning Collaborative. However, as participants built up their knowledge and skills, coaches used modeling and mutual aid as educational tools.

Coaches modeled leadership skills, active listening, and team building through their interactions with participants. For example, a core LiveWell principle is that everyone is a leader and that it is essential to hear everyone's voice. Coaches modeled this behavior by centering participants' voices during the Learning Collaboratives and by empowering participants to choose their own quality metrics and methods. Coaches repeatedly

emphasized that they "could never tell you what is best for your community—only you could do that." Another example of modeling is "What Went Well / Even Better If": during the mid-point of every Learning Collaborative, coaches dedicate time to solicit constructive feedback from participants, a practice they encourage participants to use as well. Coaches then implement that feedback. This stands in stark contrast to traditional top-down leadership styles that participants may be more familiar with.

Another important teaching strategy coaches used was collaborative problem solving. Each week, communities "reported out" about their experience with implementing the LiveWell tools and homework. This provided opportunities for communities to describe areas where they were struggling. While the coaches offered suggestions, they also used these moments to open up discussion among all participants ("Has anyone else ever dealt with this type of issue?"). For example, one community described how they were struggling to get Huddles up and running. A participant from another community suggested starting them at shift change if that was easiest just to get things started. Another participant shared that she was grateful to hear about the other community's struggle because "I feel like we have been really behind." During this brief interaction, participants practiced giving and receiving informational and emotional support while simultaneously learning from a practical, relatable problem. This would not be possible without the guidance and structure created by the LiveWell coaches.

Building relationships. LiveWell coaches cultivate relationships not only between themselves and their participants, but among and within communities. LiveWell requires participants to work on teams within their own organizations and creates opportunities for participants to hear from other communities. During the week six session, coaches began with a team building activity in which participants from different communities were paired into dyads and asked to share something they liked about themselves. Afterwards, they debriefed with participants. A coach asked, "How was it to focus totally on listening?" A participant replied, "I actually enjoyed that…we're very rural, so we don't get to hear about other places very often, so that's kind of nice." Beyond cultivating engagement in the program, building relationships furthers LiveWell's goal of creating supportive connections within and among the communities after the Learning Collaborative ends.

Another goal of deepening relationships and building rapport was to foster a trusting environment in which participants felt comfortable sharing their thoughts and struggles. As coaches wrote in the weekly timing template for the week 7 curriculum, "The more you know about a person, the more potential for understanding, dignity and value… sharing of oneself leads to

trust." By deepening these relationships, coaches helped create a generative, open learning environment.

Supporting participants and communities. During and between the Learning Collaborative sessions, coaches provided multiple types of support to participants and their communities. From problem solving and brainstorming, to homework reminders and emotional support, coaches not only made themselves available to participants, but proactively reached out to offer encouragement. "I sent 4 texts to encourage LiveWell activity and encourage all during these difficult times with words about caring for self," a coach recorded. Another coach documented connecting with a participant outside of the Learning Collaborative sessions to help with a specific issue: the community was struggling with staff members feeling jealous of the person who had been chosen to be the LiveWell team lead, and therefore rejected the LiveWell team's efforts. "I suggested they invite all naysayers to participate as well!" the coach recorded.

The breadth of support LiveWell coaches provide can be seen when evaluated with Curtona & Suhr's social support category system, which defines five areas of support: informational (knowledge, facts, or advice), emotional (concern, empathy, and caring), esteem (messages to promote one's skills and inherent value), social network support (messages that create a sense of belonging to a group), and tangible support (physical goods and services) (Curtona & Suhr, 1992). With the exception of tangible support, LiveWell coaches are likely to provide informational, emotional, esteem, and social network support to each participant throughout the Learning Collaborative. This exemplifies the breadth of skills coaches employ throughout the regular course of their work.

6.2 Lessons Learned from Coaches

Recognizing the importance of the coaches' perspectives as LiveWell evolved, we wanted to capture their reflections throughout the evolution of the LiveWell Method. We facilitated several focus groups throughout the first year of both in-person and virtual training sessions and conducted exit interviews with all coaches in June 2021 after the final Learning Collaborative wrapped up. We asked them about their greatest lessons learned, challenges and successes, and what recommendations they had for LiveWell as the method moves forward into its next phase. The interview guide can be found in Appendix D.

Role of the coach: qualities and experiences. Everyone brought something to the team: compassion, direct experience, positivity, customer service orientation, connecting over Zoom, knowing the LiveWell Method,

trauma informed care, listening. Some felt it was important to have experience as an educator or coach, and to have relatable experience. Lived experience working in communities gives the ability to empathize and understand what communities are facing. Only one coach had lived experience working in AL/RC communities. Lack of knowledge made it difficult to support communities through the COVID-19 pandemic.

Coaches noted the need to meet trainees where they are at and use appropriate language and framing to make the content accessible. A few noted the importance of being a good listener and not being directive unless asked. This was challenging because staff were not accustomed to being consulted in key matters or QI decision-making. The LiveWell team eventually took a "both-and" approach: listening to staff and allowing them to take the lead while still providing instruction and recommendations as needed. Knowing the LiveWell content is also an essential foundation to be able to effectively coach communities in implementing the practices. One person said,

> *There are a lot of educators out there who think they know everything, or want to come across that way. Even when we built the curriculum, we simplified, simplified, simplified. You have to do that so people know what you're talking about, for them to be interested, and so they can see that you care.*

Personal characteristics included being humble, non-judgmental, positive, and believing that people are doing their best. Coaches need to have that attitude so they can celebrate the progress communities do make and see their resilience despite challenges. A good coach is a relationship builder and has the ability to build rapport with staff and leadership quickly. A foundation in trauma-informed care also emerged as an essential characteristic and became even more clear through the challenges long-term care communities faced not only with the pandemic, but through historic fires, civic unrest, and the many challenges of the past year.

Challenges in coaching. The most pressing challenge mentioned by most coaches was the shift from an in-person to a virtual model. Modifying the content, learning how to use Zoom—all of the upfront work was time consuming at first, but coaches noted the support from the LiveWell team was excellent. Some were surprised to find that powerful connections can still be made through an online platform. Moving forward, coaches expressed optimism incorporating some in-person components. Coaches also wanted to ensure that participants felt comfortable and were able to reach out to coaches for support.

Another key challenge mentioned was related to interpersonal dynamics with another coach that emerged as a result of assigning two coaches per Learning Collaborative. Some issues described were conflicting personalities between coaches, coaches not being familiar with the LiveWell tools, or a lack of fidelity or focus on the method. It was also noted that the difference between coaching and training was quite a leap, with coaching being more oriented toward listening and supporting, training focusing on educating and advising. The LiveWell training and coaching model continues to evolve as the team experiments with using the one-day training to cover LiveWell content and the coaching follow-up to integrate it into practice.

On a broader level, others noted how challenging it is trying to instill change within these corporate structures and institutions considering them inherently oppressive. The people within them are disempowered and exhausted and unacknowledged in the broader society. Participants didn't have enough time because they are stretched thin and it always felt like LiveWell was pulling them away from their work.

Recognizing that each community entered into LiveWell from a different starting point, we can consider the Theory of Organizational Readiness for Change (Weiner, 2009) in our interpretation of their ability to implement LiveWell successfully. Readiness for change refers to "organizational members' shared resolve to implement a change (change commitment) and shared belief in their collective capability to do so (change efficacy)." More effective implementation is achieved when readiness is high because members are more likely to "initiate change, exert greater effort, exhibit greater persistence, and display more cooperative behavior."

Pivot to virtual. Coaches noted pros and cons to shifting to a virtual platform. On the one hand, it gave an opportunity for greater connection statewide with no commute for participants, no travel to training sites, and minimal time off work. Peer-to-peer learning reached new heights and the Learning Collaboratives transformed into a mechanism for building relationships between different communities that wouldn't have otherwise existed. Participants enjoyed the breakout rooms, and one coach noted that the online format is perhaps more equalizing, disrupting traditional power dynamics. Designing the new curriculum went well; as the LiveWell team-built relationships, they entered a productive pattern of suggestion and feedback.

The greatest learning curve in the virtual pivot appeared to be learning how to use Zoom because most of the coaches had no experience with it. Some felt LiveWell lost something when it went online. Building a curriculum and presenting on Zoom was challenging, but it helped tremendously to have the

skills and expertise on the team to develop the content. It became more of a burden, and also made it easier for people to not show up. Different coaching styles were challenging, but also an opportunity to grow and stretch. Coaches committed to making the Zoom format work.

Facilitators and barriers to success. We asked coaches to reflect upon the aspects of communities who were able to make progress implementing LiveWell and those who were less successful. The most prominent factors of success included:

- Executive leadership support of the AL/RC administrator from the company owner, regional operations staff, and boards of directors.
- AL/RC administrator commitment to implementing LiveWell, and clear communication of goals and expectations to staff participants.
- AL/RC administrator support for staff to commit the time necessary to participate in weekly sessions.
- Administrator and staff willingness to make changes, including breaking old habits and creating new processes.
- Coaches and administrators recognize staff participant successes from the beginning.
- Involvement of one or two motivated, experienced, and enthusiastic staff participants to encourage others to get on board.
- Availability of additional staff to cover resident care so that the LiveWell team can step away from work to participate in the virtual collaborative sessions.
- Emphasize open communication channels between staff and administrators.

Even dedicated participants struggle without the support of their administrators, and a committed administrator is limited without the support of their corporate leadership or board of directors. If a community cannot staff their essential functions (e.g., resident care), they are much less likely to be successful in LiveWell. The most challenging part includes getting started and overcoming resistance to change. Coaches noted the challenge of change fatigue, where staff no longer pay attention to the new directives from management because they anticipate that management will drop new practices or goals. One coach observed that when staff see other staff not showing up, they become less likely to show up.

Another key factor in community success relates to their existing organizational health, with the foundations of good camaraderie and communication there and ready for improvement. Communities should strive to become a safe place for their staff to be and work. Success is much more probable with the foundations of a team atmosphere, rather than a toxic

culture. While LiveWell likely does not change the organizational power structure itself within 12 weeks, it facilitates opening the communication channels between decision makers and staff. Even with better communication channels, however, there are structural barriers (e.g., lack of time) and social or cognitive barriers (e.g., self-efficacy). Because of this, LiveWell provides tools that work within the limitations of the AL/RC environment, as well as an empowering value structure that empowers staff to use the available platforms. LiveWell might be too heavy a lift for communities that are not ready. Instead, focus on communities that are investing in good practices and make them stronger.

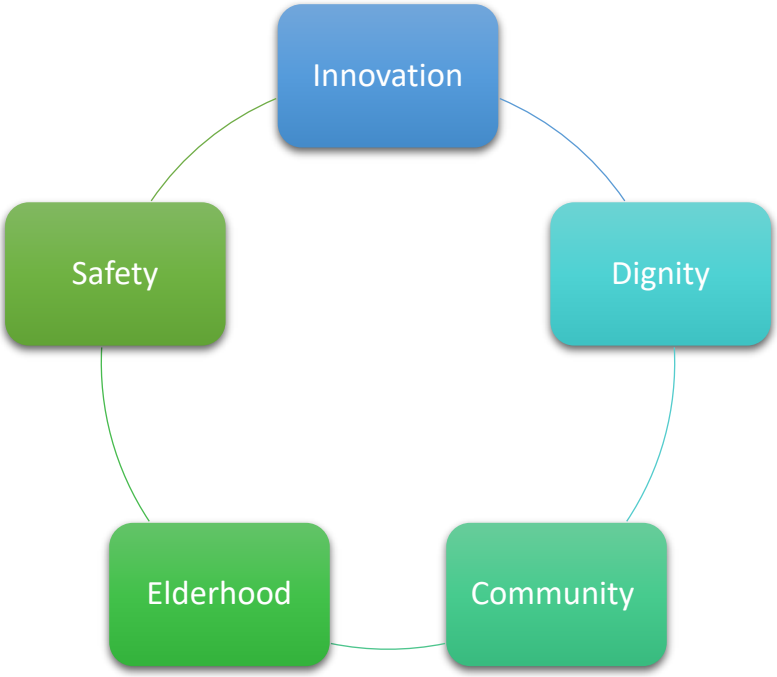
Scale-up recommendations from coaches

- More in-person support opportunities. A hybrid model—perhaps starting out in person and then moving to Zoom.
- Identifying the right number of communities per collaborative and time per session. With the Equity, Diversity, and Inclusion (EDI) component and breakout rooms, an hour can feel too brief, though this amount of time is likely reasonable given the demands on staff time.
    - Implementing EDI throughout LiveWell. Coaches noted that the additions to the weekly content didn't flow and could use revision to be sure the language was appropriate to meet staff where they are at.
- Expectations for communities and participants need to be clear. One option is that it could be mandated that staff need to have six or more hours of training. Make it more specific that staff need to do LiveWell or some other program. In other words, more direct incentives for communities to participate, like financial incentives.
- Consider adding more positions to the team, such as:
    - An effective lead coach who can advise and manage coaching. This could help free up more time for LiveWell leadership to focus on administrative and scale-up priorities. There is a need for well-thought out on-boarding/training for new coaches and clear expectations.
    - A PR professional who can dedicate themselves to LiveWell's marketing and recruiting needs.
- Support from external agencies and organizations will be key to success in the scale-up. Some recommendations include:
    - Creating coaching linkages with the ombudsman, advocates, even surveyors. Create more positive, productive relationships.
    - Obtaining formal support from the state and industry in order for LiveWell to meet its full potential.
    - Getting buy-in from corporate and management leaders, both financially and in terms of state policy. This might take the form

of providing financial incentives or bonuses to communities or staff who participate in LiveWell. Because AL professionals participate in the state policy process, obtaining their support of any future QAPI legislation addressing LiveWell will be important.

6.3 LiveWell Values in Action

The LiveWell website includes the following mission: "Innovate care. Nurture dignity. Build community. Honor elders." Examining whether and how these practices are enacted within the LiveWell Learning Collaborative is important for determining how LiveWell manifests its five core values:



A member of the PSU evaluation team reviewed the coaching summaries, Learning Collaborative templates, presentations, and observation notes to identify how these values emerged, noting common themes.

Innovation. Many innovations are evident based on coaches' descriptions of some communities' successful transformation after using LiveWell tools and practices. The value of innovation, however, is in its ongoing practice, or as one coach described in a coaching summary, developing "the habit of analyzing needed improvements and to 'reach for the [LiveWell] binder' to find solutions." LiveWell advocates for workplace cultures that view change as a continuous reflective exercise. One coach, describing the "spirit" of the LiveWell Huddle explained:

> *[Huddles] need to be obvious to the flow of community and how important it is that everyone takes a piece of the puzzle, reminding one another that quality improvement is never done.*

In addition to learning about the LiveWell tools, the practices of noticing and listening were integrated into several LiveWell exercises according to the written curriculum. During the observed sessions, coaches encouraged participants to consider themselves leaders and not simply adopt LiveWell practices, but adapt them to their environments. This ownership and creative permission potentially fostered buy-in from participants and yielded more innovative results. A participant from a community that analyzed the impacts of staff turnover and resident falls explained,

> *I'm just thinking of all the other ideas we can do. [Another team member] and I were talking yesterday about staff education gleaned from these graphs that we are seeing, so we can continue educating staff about attendance and falls.*

For this participant and others, quality improvement became a way of viewing the often taken-for-granted events throughout the day as opportunities for positive growth and change.

Dignity. Dignity can be defined as being valued and respected for who one is as an individual and is a core component of person-centered care in Oregon's administrative rules for AL/RC care. For LiveWell, a key aspect of fostering the value of dignity in participants is "valuing and being valued in your work." In a Learning Collaborative session, an owner expressed that person-centeredness must be prioritized "not just for [resident] care, but for the staff." Similarly, the coaching summaries, Learning Collaborative templates, and observations demonstrate that LiveWell believes promoting a sense of dignity not just between staff and residents, but among staff, is essential for improving the culture and outcomes in long-term care.

LiveWell approaches the concept of dignity in several ways. One way is through "exercises that build on dignity of all," meaning the team-building exercises conducted during the Learning Collaborative sessions and weekly homework. During the weekly sessions, coaches asked participants to warm up through various activities geared toward promoting a sense of self-worth in participants, such as sharing something participants appreciated about a team member, a resident, or themselves in order to "discuss and teach about appreciation of each other, valuing the contributions we all bring to our workplace."

"Exploring ways and introducing tools that help people build relationships [and] think of themselves as a team who trust and treat one another with dignity and respect" was another way dignity was grounded in the LiveWell curriculum. The Who Am I tool was named specifically in the coaching summaries as a "way to build dignity of all staff, residents, and relationships between all." By increasing shared knowledge about individuals' identities through tools like Who Am I, LiveWell hoped a natural sense of respect and appreciation would emerge in participants. Several communities described completing the Who Am I tool with one another or residents as a meaningful part of the Learning Collaborative. Compliment Cards were also highlighted as a way to nurture feelings of worth and value in participants and residents, and which every community integrated into their Quality Boards or Huddles.

Finally, the value of dignity was modeled by the coaches in their practice of affirming and recognizing the efforts of the individual team members. At the beginning of each week's coaching template, coaches reminded themselves to "welcome each person as they appear and state something positive about their contributions to date." Potentially, this practice not only built up the self-efficacy of participants, but modeled supportive leadership practices that participants could emulate.

Community. If dignity fosters a sense of worth and appreciation among individuals, LiveWell believes a sense of community can be developed from that mutual respect. During Learning Collaborative sessions and homework, LiveWell coaches encouraged participants to find creative ways of honoring and showing affection for their communities. For example, during week six of the second Learning Collaborative, one potential homework assignment for participants was to "Come up with your own idea of something that honors you or others in your community." The coaches then showed an example from a community that put a world map on the wall and encouraged staff and residents to place a pin on the locations where they were born and places that mattered to them. Such activities educate the community about one another, provide opportunities for individuals to feel known, and build a sense of collective identity.

LiveWell coaches often describe the importance of a "bottom-up, top-enabled" approach to quality improvement where "everyone has a voice," as opposed to more traditional top-down leadership approaches to quality improvement. Democratic principles are embedded in LiveWell's tools, such as Dot Voting, LiveWell Huddles, and Resident Status-at-a-Glance. The coaches repeatedly emphasized the importance of collective ownership and shared leadership in the quality improvement process, as exemplified by this quote from a Learning Collaborative template:

> *...our theme for today - involvement and empowerment of your staff, freeing them to step up with the leadership that is within them. We want to encourage you to get more and more staff involved in the LiveWell efforts so that they all can develop their leadership qualities.*

Here, quality improvement is not an isolated task done by one person or a few "team leads," but is a community norm grounded in individual respect. As described elsewhere in this report, LiveWell participants also recognized how important it was to have broad participation from staff for LiveWell to be successful, finding that without engagement across shifts, departments, and roles, innovations were nearly impossible to implement.

Co-enabling values: dignity, community, and innovation. While reviewing these materials, a key finding was that these three values are often interrelated and co-enabling. To the LiveWell coaches, promoting dignity enabled building community, and a greater sense of community enhanced the power of innovations. A LiveWell coach explained this best in a coaching template for week six:

> *...the tools are simple, lean management tools intended to reduce the time it takes for [staff] to complete specific tasks. They are effective because they support improved communication and the participation of all staff and residents...the deeper value they offer when implemented in [the] LiveWell model is that they are intended to reveal the natural leadership skills of each person. They build leaders into positive teams when slowly and incrementally implemented.*

Here, the coach explains how the success of the LiveWell tools rests upon the cohesion of the community, which rests upon the leadership of each individual. Participants expressed this interconnectedness as well. Paradoxically, for others, the time and clarity provided by LiveWell tools enabled them to be more person-centered and community-oriented in their leadership. When asked what had changed for participants on a personal level because of LiveWell, one participant shared,

> *I think I became a lot more organized. Before I felt a little scrambled. Now I think I'm more patient. I like to get everyone's input. I have learned that a lot of us need visuals instead of just telling someone to go do this or that.*

Which value sinks in first for participants ultimately may not matter. What seems apparent is that these values are mutually affirming within the LiveWell curriculum.

Elderhood. During the first two Learning Collaboratives, the value of Elderhood or the issues of ageism and ableism were not directly addressed in the LiveWell curriculum. However, with the integration of EDI curriculum during cohort 3 (see section 6.4), this value was incorporated into the Learning Collaboratives. During the weekly land acknowledgement, coaches "honored elders, past, present, and future." During another segment on the EDI principles, LiveWell coaches described how the goal of LiveWell is to help foster healthy communities "where residents with staff authentic involvement can explore elderhood as a meaningful, purposeful state of life." Most significantly, during week 9, coaches lead a discussion about the presence and impact of ageism in American culture; participants were given a homework assignment to reflect upon how they can help reduce the impact of ageism. While this value may not be as overtly emphasized in the LiveWell curriculum as the other values described here, which are perhaps more directly tied to quality improvement, the value of Elderhood could be seen as an anchoring value in LiveWell, centering the importance of improving the quality of care provided to older adults within AL/RC communities.

Safety. Improving resident and staff safety is a core aspect of any QAPI program and is likely a significant draw for communities to participate in LiveWell. Safety is a central aspect of the LiveWell curriculum. In the LiveWell binder, the section "Well Residents" provides multiple tools for tracking resident falls, improving medication safety, noticing changes in condition, and reporting safety hazards. Elsewhere, tracking and reducing staff injuries is identified as an important goal for quality improvement. An essential component that every community must create is a Community Quality Board, also called a Safety Board, which showcases the metrics that community is tracking.

However, as is stated on the first page of the binder, LiveWell is a "how program, not a what program": in other words, it is not a falls prevention program, medication administration class, or other didactic, content-focused curriculum. As coaches stated in a learning template, it is essential that communities choose quality metrics that "*are most pertinent to your community life situation*" (original emphasis). From there, LiveWell encourages communities to tailor their approach to improving safety in ways that make the most sense for their unique needs, rather than imposing specific objectives. Communities could choose different or multiple tools to track a single outcome: for example, coaches demonstrated how insight about falls could be gathered using the Care Calendar, Clock Diagram, or Measles Diagram, and the 5 Whys could help identify reasons the falls occurred. In the coaching summaries, coaches noticed different ways

communities embraced this challenge. One coach described how a LiveWell participant,

> *...stayed after a few minutes to ask how best to measure med errors. [Coach name] explained how to use the calendar tool, and now she will add it to their board.*

Other communities tracked infections, falls, and emergency room visits. One community reported that seeing they had gone 17 days without an emergency room visit "lifted morale" among the staff. Others also found that creating a visual representation of their safety goals made them seem more actionable. One coach recorded a participant as saying, "When staff see it in black and white or red and green they can work to improve things on their shift."

While not explicitly stated, the LiveWell Method draws a connection between safety and the social and cultural factors of a workplace environment. Consider, for instance, this quote from a coach's summary about the importance of mid-shift huddling:

> *Huddle is an Intentional gathering DURING the shift...Time to check in about how staff and residents are doing once everyone has a sense of what they need to do their best work for the rest of the shift...Discuss resident changes/need within HIPPA compliance...Hold at Quality Board to review measurements, daily schedule, meals, etc.*

Here, communication and cohesiveness are essential aspects of creating a culture of safety. The LiveWell approach considers that safety is not a singular outcome of performing routines correctly, but deeply connected to multiple human factors, such as whether staff feel comfortable raising concerns, have time to attend to safety, and know residents well. An excellent example of this is the Resident Status-at-a-Glance tool, which empowers any staff member to report on a safety concern for a resident, even if they are not a direct care worker.

6.4 Equity, Diversity and Inclusion Efforts

During the third Learning Collaborative, the LiveWell team began incorporating a curriculum that covered the principles of Equity, Diversity, and Inclusion (EDI). LiveWell defined these terms as follows (text copied from a LiveWell slide):

- Equity: the quality of being fair and impartial.
- Diversity: the practice of involving people from a range of social & ethnic backgrounds and of different genders, sexual orientations, etc.
- Inclusion: when all individuals are respected, feel engaged and motivated and their contributions are valued.

To quickly incorporate this new material, one coach drafted the weekly EDI content, which then was discussed and integrated into the curriculum during the weekly coaches' meeting. A member of the PSU evaluation team reviewed the final curriculum (timing templates and slides) and watched several of the recorded sessions.

The EDI material was incorporated into the weekly sessions primarily through three methods: starting the session with a land acknowledgement, a brief discussion at the beginning of the session about a specific EDI topic, and a homework assignment connected to EDI at the end. Coaches discussed the following EDI topics:

- Honoring "all voices past, present, and future," especially indigenous communities, through land acknowledgement.
- Incorporating diverse individual and cultural perspectives of quality improvement; challenging participants to connect with other staff from different cultural backgrounds.
- Acknowledging that staff inhabit an environment and culture in which they are devalued and often subjected to racist and sexist remarks; coaches facilitated a discussion about how to potentially handle these types of remarks.
- Challenging participants to advance EDI in their own communities.
- Using the Flame Model, a LiveWell Tool, to reflect upon how participants' communities do or do not embody the principles of EDI.
- Discussion of how ageism impacts older adults, and how participants might reduce the impact of ageism and become better advocates of inclusion for older adults and the value of Elderhood.

The EDI content integrated well into many of LiveWell's existing principles and materials, such as incorporating all voices and valuing the dignity of the individual, and shifting from a "consumer/worker to citizen/community

participant" perspective. As one LiveWell coach explained during a Learning Collaborative session,

> *We believe that there is a beauty in the multiculturalism we see in our care. We believe that it is the obligation of all of us to get the input of all residents and staff….to meet with our values of dignity, community, empowerment…we just thank you so much for your work in these values. We are building beautiful communities in the future.*

A member of the PSU evaluation team reviewed several of the recorded sessions and observed that levels of engagement with the EDI material varied among the participants, groups, and sessions: while some sessions did not see robust engagement, others had lively participation. For example, during week 4, the Learning Collaborative groups discussed the previous week's homework assignment to ask someone from a different cultural background about their perspectives on caregiving or just in general. One of the Learning Collaborative groups had a lively discussion in which every participant shared a reflection. One participant stated,

> *…I looked at how different cultures look at quality. I talked to our manager who is Latino about all the LiveWell stuff. He had interesting responses about how in his culture…it's more about relationships. Not about 'did we do this many things'…for him, quality is more relational, not analytical.*

Another participant shared,

> *I am Hawaiian and Japanese…in a lot of different cultures the family comes together to care for their elders. I'm finding in this job that that's not very common. It's been difficult, but it helps not just to have a single-minded view on it. In our facility, we're not all related but we act like we are.*

By contrast, the other Learning Collaborative group struggled to generate conversation. Coaches' questions and encouragers were met mostly with silence. This group was more than twice as large as the other Learning Collaborative group, and technical issues and background noise were competing distractions. The group size and interruptions perhaps made it more challenging for participants to speak up; assigning participants to breakout rooms could potentially avoid these issues in the future. During the individual interviews with LiveWell coaches (see section 6.2), some coaches commented on the incorporation of the EDI content during this most recent Learning Collaborative. Coaches agreed that a focus on EDI aligned with LiveWell's values and mission and was essential for transforming LTC. Two coaches mentioned that with the heightened attention to EDI across a

variety of organizations, it was important for LiveWell to discover how best to incorporate the materials for its target audience and ensure the content "flowed" with the existing curriculum. One coach reflected,

> *We have to be careful not to have it be a separate thing. It was a little clunky this last time when we just added things in. To me, it didn't flow very well. To me, I would like it to be more woven in so that there is a connection to EDI on every slide, rather than a section where we talk about EDI, and then suddenly we are talking about these tools. I think we will probably get there, but we didn't get there this time.*

Another coach shared that the EDI content was new material not just for LiveWell, but for the participants, and so this most recent Learning Collaborative cohort represented an opportunity for LiveWell to learn through trial and error.

> *...it will flow better as it just becomes part of, you know, where LiveWell is going…Right, because everyone's doing it. …a lot of webinars start off with a land acknowledgement, and so I think it really does have its place. But I was surprised that we had never done it before. And we saw how it went. And... when we didn't do it every time, I think it flows a little bit better.*

These comments suggest that while the integration of EDI content was not without challenges, the efforts were valuable, informative, and worth continuing with special attention to what LiveWell can effectively contribute to this complex and critical subject. Potential take-aways from these observations include:

- The EDI material may flow better if it is integrated into the LiveWell curriculum, rather than a stand-alone section.
- Land acknowledgements are a valuable practice, but they may be less impactful (and feel more like a script) when repeated to the same group of people each week. Consider using land acknowledgements during the administrator briefing, the first Learning Collaborative session, and the final session. Other methods of anchoring the Learning Collaboratives in EDI principles could be used during the intermediary sessions.
- Discussions about EDI may be new or challenging for participants. Separating large groups into breakout rooms may minimize distractions and help participants feel comfortable speaking. Having coaches break the ice by sharing their own thoughts and reflections may also encourage participation and model generative discussion.

7 Limitations

This evaluation is subject to limitations. First, much of the data is based on self-report from LiveWell participants, and not all participants completed the surveys despite repeated attempts to encourage them to do so. Second, the LiveWell coaches were responsible for tracking weekly participation in the Learning Collaborations and Meet Ups. It is possible that minor errors were made on the tracking forms. Third, due to the pandemic, The Malden Collective had to modify the training mode and materials, limiting our ability to assess program impact over time or to make statistical comparisons. For example, an early plan was to ask participants to track outcomes such as staff turnover and resident falls and to assess their success with using the forms as well as changes over time in outcomes. In consultation with ODHS staff and stakeholders, tracking outcomes was not conducted.

However, the evaluation team supplemented quantitative data such as surveys and participant engagement with a great deal of in-depth qualitative information, including coaching summaries, focus groups with coaches, and observation of audio recorded Learning Collaborative sessions. In addition, the PSU team met weekly with the LiveWell team to hear about all aspects of the program, including community recruitment, program planning and program implementation.

8 Conclusions

8.1 Summary

The LiveWell Method, operated by the Malden Collective, uses a practice-based framework for organizing, tracking, measuring, and improving daily operations. The goal includes engaging and empowering staff to create a more democratic and transparent workplace. The program seeks to establish a culture of quality based on dignity and respect for residents (elderhood) and staff, innovation, sense of community, as well as safety. The LiveWell coaches, using a peer-to-peer approach, teach practical skills such as time management, tracking and reporting, and being organized and efficient. At the same time, they teach soft skills such as supporting self-care, teamwork, and responsibility.

At least 188 AL/RC staff and administrators participated in a LiveWell training or virtual Learning Collaborative during the evaluation period. In addition, 61 individuals, including administrators and direct care staff, participated in an online LiveWell Meet Up. These numbers underscore the LiveWell team's success at recruiting and engaging staff and leadership, even during a pandemic and the 2020 wildfires. Below we summarize key information and findings from this evaluation.

Leadership attendance at Learning Collaborative sessions increased from an average of 26% of sessions during the first Learning Collaborative to 56% of sessions during Learning Collaborative 3. This may be due in part to the LiveWell coaches' efforts to increase administrator engagement. Overall, leadership representatives attended roughly 40% of LiveWell sessions.

Staff participation in Learning Collaborative sessions peaked during the first four weeks and declined, with some exceptions.

Most (73%) administrators rated participation in weekly Learning Collaborative sessions as "easy" or "very easy" for staff, while only 36% of staff reported it as such. In contrast, staff described their ability to attend weekly sessions as moderately (39%) or difficult/very difficult (18%). The top three barriers to participation described by staff included:

- Resident care needs
- Staff turnover
- Filling in for other staff

The top factors that enabled staff participation included:

- Support from LiveWell coaches
- Interesting and useful content
- Feeling good about learning and participation
- Online sessions

Of the 47 participants who completed a survey after one of the three Learning Collaborative cohorts, the majority rated the online format, relevance and quality of content, and discussions as good or excellent. Of these, 22 wrote responses to a question about whether their community changed after using the LiveWell tools. Participants described increased teamwork among staff, increased use of measurement tools, improved communication between staff, staff engagement in quality improvement, and confidence about using LiveWell tools in the future. For example:

- "We were able to use the clock to identify a time frame when falls were happening and make adjustments to the activities of the day to reduce falls and increase safety checks."
- "I believe, and am hoping, we will be able to use these tools in the future to improve staff retention and resident care... This program is a must for looking at the long-term gains for our community."
- "Using the huddle will be a communication tool our community will enjoy. Time to get together [to] talk about what's happened throughout the shift and make sure staff is doing well during our busy day."

Most (62%) AL/RC administrators believed that LiveWell helped their community create a more robust QAPI program.

AL/RC staff who participated in Learning Collaboratives and completed a survey showed improvements in all 10 aspects of quality and resident care. Before LiveWell, staff rated feeling like they were part of a team as a 2.0 out of a possible 3, and after LiveWell, the average score increased to 2.7.

Quality improvement programs can result in cost savings to communities. The participating administrators were asked whether several adverse events resulted in financial costs. Those who responded rated medication errors and resident falls as the least costly and staff turnover and unplanned staff absences the costliest.

Coaching is the primary way that LiveWell content is delivered to participants. The four original coaches continued throughout the project period, with the exception of one who retired a few months before the project ended. The coaches described LiveWell tools, including how AL/RC staff could adapt tools to meet their communities' needs. They encouraged teamwork and leadership as well as honest communication and shared responsibility among staff. Importantly, they developed relationships with AL/RC staff.

At least 61 individuals participated in the 12 Meet Ups on topics such as COVID-19 policies, psychosocial needs of staff during the pandemic, end of life planning, vaccines, and one open-ended session. Of the 23 who completed a follow-up survey, 87% said the information provided was useful and 96% said they planned to attend a future Meet Up session.

8.2 Recommendations

Based on the evaluation and time spent with the LiveWell team during the past two years, the IOA team has the following recommendations for scale up of this novel quality program.

- Seek continued support and participation from partners within ODHS, including policy analysts, survey team members, and leadership. These partners can support recruitment and retention of AL/RC communities into the LiveWell program.
- Advocate for policy changes that support a formal quality assurance and program improvement (QAPI) process.
- Work with AL/RC innovators who have implemented LiveWell and other culture change methods, as these thought leaders can influence other AL/RC owners.
- Build on the success of the Learning Collaboratives, peer-to-peer training, coaching and Meet Ups.
- Continue to expand the leadership module. The IOA team can provide evidence based on current research on AL/RC administrator job stressors and supports.
- Develop outreach materials to inform AL/RC owner/operators how LiveWell can complement and strengthen their existing policies and practices, including quality assurance program, person-centered care,

and tracking and reporting quality metrics (e.g., staff training and turnover, resident falls). For example, explain how LiveWell tools like the care calendar support tracking resident falls, which communities are required to report to Oregon DHS.

- To aid in the process of recruiting new communities to participate in LiveWell, consider developing a "readiness to change" checklist based on the PRECEDE-PROCEED model of change (Green & Kreuter, 2005).
- Continue supporting diversity, equity and inclusion principles, as Oregon's senior population and the long-term care workforce becomes increasingly diverse across several social and demographic characteristics.

Finally, AL/RC resident voices are largely absent from policy and practice discussions about quality of care and wellbeing. The voices of residents in a variety of AL/RC setting types, including memory care communities, as well as rural and urban locations, and settings that primarily serve Medicaid beneficiaries, should inform ongoing dialogue about quality and safety. Oregon DHS has supported the development and validation of an interview guide, called ResView (White et al., 2019), that collects information about person-directed care. In addition, qualitative research such as focus group interviews and direct observation could be used in future studies to learn how LiveWell practices affect residents' lived experience of community-based care.

Appendix A. Learning Collaborative Attendance

Learning Collaborative 1 08/03/2020 - 10/27/2020

LC Group	Community	Participant	Role	W1**	W2	W3	W4	W5	W6	W7	W8	W9	W10	W11	W12	Average # weekly attendees	Percentage of sessions attended
A	C1	P1*	Director	1	0	0	0	0	0	0	0	0	0	0	0		8%
A	C1	P2	RCC		1	1	1	1	1	1	1	1	1	1	1		100%
A	C1	P3	LEC		1	1	1	1	1	1	0	1	1	0	0		73%
			Total	1	2	2	2	2	2	2	1	2	2	1	1	**1.82**	
A	C2	P4*	ED	1	0	0	0	0	0	0							8%
A	C2	P5	RCC		1	1	0	0									18%
A	C2	P6	Med Tech		1	1	0	0									18%
			Total	1	2	2	0	0	0	0						**N/A**	
A	C3	P7*	Administrator	1	0	0	0	0	0	0	0	0	0	0	0		8%
A	C3	P8	Dining Svcs Director		1	1	0	1	0	0	0	0	0	0	0		27%
A	C3	P9	RCC		1	1	1	0	1	1	0	0	0	1	1		64%
A	C3	P10	Resident Program Director		1	1	0	1	1	1	0	0	0	0	0		45%
A	C3	P11	Memory Care Coorinator		1	1	0	1	1	1	1	0	0	1	1		73%
			Total	1	4	4	1	3	3	3	1	0	0	2	2	**2.18**	
A	C4	P12*	Director	1	1	0	0	0	0	1	1	0	1	1	1		58%
A	C4	P13	Lead cook		1	1	0	1	0	1	1	1	1	1	0		73%
A	C4	P14	LEC		1	1	0	1	1	1	1	1	1	1			82%
A	C4	P15	Med tech		1	1	0	1	1	1	1	1	1	1	0		82%
A	C4	P16	Med Aid/Caregiver										1	1	0		18%
			Total	1	4	3	0	3	2	4	4	3	5	5	1	**3.18**	
B	C5	P17	Housekeeper		1	0	1	1	1	1	1	0	0	0	0		55%
B	C5	P18	Maintenance tech		1	1	1	1	1	1	0	0	0	1	0		64%
B	C5	P19	Concierge		1	1	1	1	0	1	0	0	0	0	0		45%
B	C5	P20	AED		1	1	0	1	0	1							36%
B	C5	P21*	Administrator	1	1	1	0	0	0	0	0	0	0	1	0		33%
B	C5	P22	Lead med tech		1	1	1	1	1	0	1	1	0	1	1		82%
			Total	1	6	5	4	5	3	4	2	1	0	3	1	**3.18**	
B	C6	P23	Nurse		1	1	1	1	0	0							36%
B	C6	P24	Cook		1	1	1	1	0	0							36%
B	C6	P25	Caregiver		0	0	1	1	0	0							18%
B	C6	P26	Medication Tech		0	1	1	1	0	0							27%
B	C6	P27	Res. Service Coordinator		0	1	1	1	0	0							27%
B	C6	P28	Housekeeper		0	1	1	1	0	0							27%
B	C6	P29	Activities Director		1	1	1	1	0	0							36%
B	C6	P30*	Exec director	0	0	0	0	0	0	0							0%
			Total	0	3	6	7	7	0	0	0	0	0	0	0	**N/A**	
B	C7	P31*	Director	1	1	1	1	1	0	1	0	1	1	1	0		75%
B	C7	P32	RCC		1	1	1	0	1	0	1	0	1	1	0		64%
B	C7	P33	LEC		1	1	1	1	1	1	1	1	1	0	0		82%
			Total	1	3	3	3	2	2	2	2	2	3	2	0	**2.27**	
B	C8	P34	RCC		1	1	1	1	1	1	1	0	0	1	0		73%
B	C8	P35	Housekeeping		0	1	1	0	0	0							18%
B	C8	P36	Activities		1	1	1	1	1	0	1	0	1	1	0		73%
B	C8	P37*	Exec director	1	0	0	0	0	0	0	0	0	0	1	0		17%
			Total	1	2	3	3	2	2	1	2	0	1	3	0	**1.82**	
			Weekly Total A	4	12	11	3	8	7	9	6	5	7	8	4	**7.64**	
			Weekly Totals B	3	14	17	17	16	7	7	6	3	4	8	1	**9.36**	
			Weekly Totals All	**7**	**26**	**28**	**20**	**24**	**14**	**16**	**12**	**8**	**11**	**16**	**5**	**17**	

Key

LC Group A

LC Group B

Dropped

P*: Leadership

W1**: Week 1 Executive Briefing

VR: Viewed recording

Zeros = unexpected absences

Blanks = expected absences (e.g., participant dropped)

Learning Collaborative 2 09/10/2020 - 01/26/2021

LC Group	Community	Participant	Role	W1**	W2	W3	W4	W5	W6	W7	W8	W9	W10	W12	Average # weekly attendees	Percentage of sessions attended
C	C9	P38*	Owner/Administrator	1	1	1	1	1	1	1	1	1	0	1		91%
C	C9	P39	Med Aid		1	0	0	0	1	0	1	1	0	1		50%
C	C9	P40	LEC		1	1	1	1	0							40%
C	C9	P41	Assistant Director		0	1	1	1	1	1	1	1	1	1		90%
C	C9	P42	PSA		0											0%
C	C9	P43	RCM		1	1	1	1	1	1	1	1	1	1		100%
			Total	1	4	4	4	4	4	3	4	4	2	4	**3.8**	
C	C10	P44*	ED	1	0	0										9%
			Total	1	0	0									**N/A**	
C	C11	P45*	Owner	1	1	1	1	0	1	0	0	1	0	1		64%
C	C11	P46	MA, RCC, Adm Asst		1	1	1	1	1	0	0	0	0	0		50%
C	C11	P47	RCC		1	0	0	0	0	1	1	0	1	1		50%
C	C11	P48	RN		1	1	1	0	1	0	0	0	1	1		60%
C	C11	P49*	Administrator		1	1	1	1	1	1	1	1	1	1		91%
C	C11	P50	Activities Assistant		1	1	0	1	1	1	1	0	1	1		80%
C	C11	P51	NOC shift lead		0	0	1	0	0	0	1	0	0	0		20%
C	C11	P52*	Reg. Dir. of Clinical Servi	1	1	1	1	1	1	0	0	1	0	0		64%
C	C11	P53	Cook - dietary		0	0	0	0	0	0	0	0	0	0		0%
C	C11	P54	Lead Med Aid		1	0	0	0	0	0	0	0	0	0		10%
C	C11	P55	RN		1	1	1	0	0	0	0	0	1	1		50%
C	C11	P56	Office Manager								1	1	0	0		20%
			Total	2	9	7	7	4	6	3	5	4	5	6	**5.8**	
C	C12	P57*	ED	1	0	1	0	0								18%
C	C12	P58	RCC / Lead med tech		0	0	1	0								10%
C	C12	P59	Med Tech		0	0	0	1								10%
			Total	1	0	1	1	1							**N/A**	
D	C13	P60*	Owner/Admin	1	0	0	0	0	0	0	0	0		1		18%
D	C13	P61	Caregiver/med aid		1	0	0	0	0	1	0	1	1	1		50%
D	C13	P62*	Owner/Admin	1	1	0	0	0	0	0	0	0	1	1		36%
D	C13	P63	Caregiver/med aid					1	0	0	0	0	0	0		10%
D	C13	P64	Caregiver/med aid		1	1	1	1	1	1	1	1	VR	VR		80%
			Total	2	3	1	1	2	1	2	1	2	2	3	**2**	
D	C14	P65	LPN		1	1	0	0	0	0						20%
D	C14	P66	RCC/ Training manager		1	1	0	0	0	0						20%
D	C14	P67*	Managing partner	0	0	0	0	0	0	0						0%
D	C14	P68	Lead med tech		1	0	1	0	0	0						20%
D	C14	P69*	Administrator	0	1	1	0	0	0	0						18%
			Total	0	4	3	1	0	0	0					**N/A**	
D	C15	P70	RCD		0	0	0	0	0	0						0%
D	C15	P71*	Exec Director	1	0	0	0	0	0	0	0	0	0	0		9%
D	C15	P72	Resident Care Director		VR	1	1	1	1	VR	1	1	1	0		70%
D	C15	P73	Office Manager		1	1	1	1	1	1	1	1	1	1		100%
D	C15	P74	Culinary Director		0	0	0	0	0	0	0	0	0	0		0%
D	C15	P75	DHW/Staff RN		0	1	1	1	1	1						50%
			Total	1	1	3	3	3	3	2	2	2	2	1	**2.3**	
D	C16	P76	Med tech		1	0	1	1	1	0	1	0	0	0		50%
D	C16	P77*	Exec Director	1	1	0	1	1	1	1	1	0	0	1		73%
D	C16	P78	Med tech		0	0	0	0	0	0	0	0	0	0		0%
D	C16	P79	Med tech		1	1	1	1	1	1	VR	VR	VR	VR		60%
			Total	1	3	1	3	3	3	2	2	0	0	1	**1.9**	
			Weekly Totals C	5	13	12	12	9	10	6	9	8	7	10	**10.1**	
			Weekly Totals D	4	11	8	8	8	7	6	5	4	4	5	**7**	
			Weekly Totals All	9	24	20	20	17	17	12	14	12	11	15	**17.1**	

Key

LC Group A

LC Group B

Dropped

P*: Leadership

W1**: Week 1 Executive Briefing

VR: Viewed recording

Zeros = unexpected absences

Blanks = expected absences (e.g., participant dropped)

Learning Collaborative 3 03/02/2021 - 05/25/2021

LC Group	Community	Participant	Role	W1**	W2	W3	W4	W5	W6	W7	W8	W9	W10	W11	W12	Average # weekly attendees	Percentage of sessions attended
E	C17	P80*	Administrator	1	1	1	1	VR	1	1	1	1	1	1	1		92%
E	C17	P81	Com. Relations Director	1	1	1	1	1									45%
E	C17	P82	Life Enr. Coordinator	1	1	1	1	1	1	1	1	1	1	1	1		100%
E	C17	P83	Res. Care Coordinator	1	1	1	1	1	VR	1	1	1	1	1	1		92%
E	C17	P84	Caregiver		1	1	0	0	0	0	0	0	0	0	0		18%
E	C17	P85	Med tech		1	0	1	1	1	0	0	1	1	0	1		64%
E	C17	P86	Caregiver		0	0	0	0	0	0	0	0	0	0			0%
E	C17	P87	Caregiver		0	0											0%
E	C17	P88	Med tech		0	0	0	0	0	0	0	0	0	0	0		0%
E	C17	P89	Med tech		1	1	0										18%
E	C17	P90	Housekeeper		1	1	1	1	1	1	1	0	0	1	1		82%
E	C17	P91	Food Services		0	1	1	1	1	1	0	0	0	0	0		45%
E	C17	P92	Maintenance		1	1	1	1	1	1	1	1	1	1	1		100%
			Total	4	9	9	8	7	6	6	5	5	5	5	6	**6.82**	
E	C18	P93*	CEO	1	0	0	0	0	0	0	0	0	0	0	0		8%
E	C18	P94*	Administrator	1	0	1	1	1	0	1	1	1	0	1	1		75%
E	C18	P95	Memory Care Admin.	1	1	0	0	0	0	0	0						18%
E	C18	P96	Caregiver		0	0	1	1	1	0	0	0	1	1	0		45%
E	C18	P97	Caregiver		0	0	0	0	0	0	0	0	0	0	0		0%
			Total	3	1	1	2	2	1	1	1	1	1	2	1	**1.55**	
E	C19	P98*	Administrator	0	1	1	1	0	1	1	1	1	1	1	0		75%
E	C19	P99	Bus. Office & Com. Rel.		1	1	1	1	1	1	1	1	1	0	0		82%
E	C19	P100	Memory Care Director		1	1	1	1	1	1	0	0	1	1	0		73%
E	C19	P101	Res. Services Coordinator		1	0	1	1	0	1	0	0	1	1	0		55%
E	C19	P102	Maintenance Director		0	1	1	1	1	1	1	1	1	1	0		82%
E	C19	P103	Dining Services Director		0	1	1	1	1	1	0	1	1	1	1		82%
E	C19	P104	Activities Director		0	0	0	0	0	0	0	0	0	0	0		0%
			Total	0	4	5	6	5	5	6	3	4	6	5	1	**4.55**	
E	C20	P105*	Administrator	1	VR	1	1	1	1	0	1	0	1	1	1		75%
E	C20	P106	Resident Care Manager		1	0	0	0	0	0	0	0	0	0	0		9%
E	C20	P107	RCC		1	1	1	0	1	0	1	0	1	0	0		55%
			Total	1	2	2	2	1	2	0	2	0	2	1	1	**1.45**	
F	C21	P108*	Administrator	1	0	0	0	0	0	0	0	0	0	0	0		8%
F	C21	P109*	Regional Director	1	0	0	0	0	0	0	0	0	0	0	0		9%
F	C21	P110	Activities Director		1	0	1	1	1	0	1	0	1	1	1		73%
F	C21	P111	RCM		0	0	0	0	0	0	0	0	0	0	0		0%
			Total	2	1	0	1	1	1	0	1	0	1	1	1	**0.91**	
F	C22	P112*	Administrator	1	1	1	1	1	1	1	1	0	1	1	1		92%
F	C22	P113	Nurse Manager		1	0	1	1	1	1	1	0	1	0	0		64%
F	C22	P114	Activities Coordinator		1	1	0	1	1	1	1	1					64%
F	C22	P115	Admin. Coordinator		1	0	1	1	1	0	0	1	1	1	1		73%
			Total	1	4	2	3	4	4	3	3	2	3	2	2	**3**	
F	C23	P116*	Administrator		1	1	1	0	1	1	0	1	1	0	1		67%
F	C23	P117	Dir. of Integrated Care		0	1	0	0	0	0	0	0	0	0	0		9%
F	C23	P118	Director of Operations		0	0	0	0	0	0	0	0	0	0	0		0%
F	C23	P119	RN Manager		0	0	1	0	0	0	0	0	0	0	0		9%
			Total	0	1	2	2	0	1	1	0	1	1	0	1	**0.91**	
F	C24	P120*	Administrator	1	1	0	0	0	0	0	0	0					17%
F	C24	P121	RN		0	0	0	0	0	0	0	0					0%
F	C24	P122	CNA		1	0	0	0	0	0	0	0					9%
F	C24	P123	CNA		0	0	0	0	0	0	0	0					0%
			Total	1	2	0	0	0	0	0	0	0	0	0	0	**N/A**	
			Weekly Total E	8	16	17	18	15	14	13	11	10	14	13	9	**14.4**	
			Weekly Total F	4	8	4	6	5	6	4	4	3	5	3	4	**5.09**	
			Weekly Total All	12	24	21	24	20	20	17	15	13	19	16	13	**19.5**	

Key

LC Group A

LC Group B

Dropped

P*: Leadership

W1**: Week 1 Executive Briefing

VR: Viewed recording

Zeros = unexpected absences

Blanks = expected absences (e.g., participant dropped)

Appendix B. LiveWell Learning Collaborative Post-Survey

The PSU evaluation team changed the structure and some of the questions in the Learning Collaborative survey after the first Learning Collaborative. Our initial intention was to have all participants complete a pre-survey at the beginning of the learning collaborative and a post-survey at the end. However, we observed a significant drop off in survey completion from the pre-survey to the post (43 respondents completed the pre-survey; 19 completed the post-survey). Given this result and the feedback we received about how AL/RC staff busyness, we adopted a simplified survey strategy for the second and third learning collaboratives, consisting only of a post-survey with some retrospective questions. This is the version of the survey that is shared below.

LiveWell LC Post-Survey - May 2021

Start of Block: Default Question Block

Intro Thank you for taking the time to complete this survey. It should take about **10** minutes to answer these questions. Confidentiality is very important to us. Your answers will be added to all the other LiveWell Learning Collaborative team members and will be reported without identifying you or your community. There are no right or wrong answers. We just want to hear **your opinion**. If you have questions or would like to complete this survey by phone, please contact Serena Hasworth at 503-725-5208 or email the evaluation team at LiveWellEvaluation@pdx.edu. Thank you!

Text 1 The following information is for tracking purposes only. Your responses are confidential and we will never share them directly with DHS or the LiveWell team.

Q1 Your name

_____

Q2 Your community

▼ Emerson House ... Mirabella South Waterfront AL

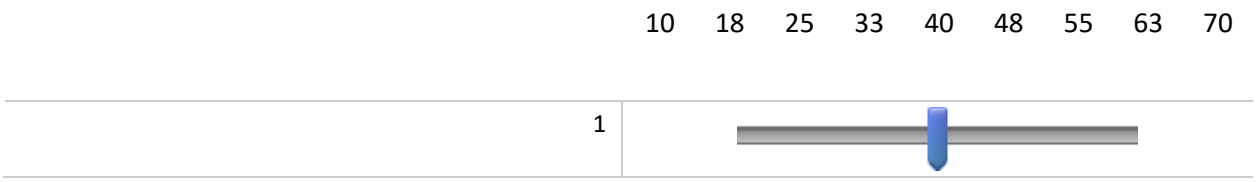
Q3 Your primary job

- ○ Administrator/Director
- ○ Caregiver
- ○ Dining/kitchen
- ○ Housekeeping/laundry
- ○ Life enrichment coordinator/activities director
- ○ Maintenance
- ○ Medication aide
- ○ Resident care coordinator/manager
- ○ Other (describe) _____

Q4 How long have you worked in this position at your community?

▼ Less than 6 months ... 5+ years

Q5 How many hours do you usually work per week?



Page Break

Text 2 The following questions are about your experience with the online Learning Collaborative.

Q6 How many LiveWell Learning Collaborative sessions did you attend? (Note: if you viewed the recording of the session, please consider that "attending" for this question.)

- ○ All or almost all of the 12 sessions
- ○ About half of the sessions
- ○ Less than half of the sessions
- ○ I attended the Executive Briefing, but did not participate in the weekly sessions.

Display This Question:

If How many LiveWell Learning Collaborative sessions did you attend? (Note: if you viewed the record... != I attended the Executive Briefing, but did not participate in the weekly sessions.

Q7 Overall, how would you rate the following aspects of the Learning Collaborative?

	Very poor	Poor	Average	Good	Excellent
Online format	○	○	○	○	○
Relevance and quality of content	○	○	○	○	○
Discussions (e.g., group sharing, reporting out, breakout rooms)	○	○	○	○	○

Display This Question:

If Your primary job = Administrator/Director

Q8A Overall, how easy/difficult was it for the LiveWell trainees to attend the Learning Collaborative?

- ○ Very difficult
- ○ Difficult
- ○ Moderate
- ○ Easy
- ○ Very easy

Display This Question:

If Your primary job = Administrator/Director

X→

Q9A Did staff attend Learning Collaborative sessions during their assigned work shift?

- ○ Yes
- ○ No

Display This Question:

If Your primary job = Administrator/Director

X→

Q10A Did staff attend Learning Collaborative sessions outside of their assigned work shift?

- ○ Yes
- ○ No

Display This Question:

If Did staff attend Learning Collaborative sessions outside of their assigned work shift? = Yes

X→

Q11A If yes, did they receive payment for their time?

- ○ Yes
- ○ No

Display This Question:

If How many LiveWell Learning Collaborative sessions did you attend? (Note: if you viewed the record... != I attended the Executive Briefing, but did not participate in the weekly sessions.

And Your primary job != Administrator/Director

Q12S Overall, how easy/difficult was it for you to attend the Learning Collaborative?

- ○ Very difficult
- ○ Difficult
- ○ Moderate
- ○ Easy
- ○ Very easy

Display This Question:

If How many LiveWell Learning Collaborative sessions did you attend? (Note: if you viewed the record... != I attended the Executive Briefing, but did not participate in the weekly sessions.

And Your primary job != Administrator/Director

X→

Q13S Did you attend Learning Collaborative sessions during your assigned work shift?

- ○ Yes
- ○ No

Display This Question:

If How many LiveWell Learning Collaborative sessions did you attend? (Note: if you viewed the record... != I attended the Executive Briefing, but did not participate in the weekly sessions.

And Your primary job != Administrator/Director

X→

Q14S Did you attend Learning Collaborative sessions outside of your assigned work shift?

- ○ Yes, and I was paid for my time
- ○ Yes, and I was not paid for my time
- ○ No, I only attended during my work shift

Page Break

Display This Question:

If Your primary job = Administrator/Director

Q15A How often did you meet with your staff to discuss LiveWell in your community?

- ○ Daily
- ○ 4-6 days per week
- ○ 1-3 days per week
- ○ Less than once a week
- ○ Not at all

Display This Question:

If Your primary job != Administrator/Director

Q16S How often did you meet with your administrator to discuss LiveWell in your community?

- ○ Daily
- ○ 4-6 days per week
- ○ 1-3 days per week
- ○ Less than once a week
- ○ Not at all

X→

Q17 Below is a list of potential barriers to participation in the weekly LiveWell sessions. Please check all that applied to your community's experience.

- [ ] Internet connection problems
- [ ] Other technology problems
- [ ] Staff didn’t know the date/time of the session
- [ ] Sessions were too long
- [ ] Staff call-outs or missing work
- [ ] Had to respond to resident care needs
- [ ] Staff turnover
- [ ] Had to fill in for other staff
- [ ] Not interested in content
- [ ] Not paid to work during the time the Learning Collaborative session was held
- [ ] Coaches did not provide useful information
- [ ] Other reason _____

Q18 Below is a list of potential factors that might encourage participation in the weekly LiveWell sessions. Please check all that applied to your community's experience.

- ☐ Online training
- ☐ Coach support
- ☐ Coach knowledge
- ☐ Having more than one coach
- ☐ Day/time of sessions worked with staff schedules
- ☐ Sessions were the right length
- ☐ Connecting with other AL/RC communities
- ☐ Interesting and useful content
- ☐ Being paid to work during the time the Learning Collaborative session was held
- ☐ Feeling good about learning/participation
- ☐ Sessions improved morale among LiveWell trainees
- ☐ Other reason _____

Q19 The length of the Learning Collaborative (12 weeks) was

- ○ Too short
- ○ About right
- ○ Too long

Page Break

Display This Question:

If Your primary job != Administrator/Director

Q20S
The following questions ask about your experience working and supporting residents in your community. Please be sure to check a box that describes how things were before you began the Learning Collaborative, and one in a box that describes how things are now.

Thinking about the people in your care, for how many did/do you...

	Before LiveWell			After LiveWell		
	Few or none	About half	All or nearly all	Few or none	About half	All or nearly all
Know what makes a good day for them?	○	○	○	○	○	○
Know their preferred routines (for example morning, evening, mealtime)?	○	○	○	○	○	○

Display This Question:

If Your primary job != Administrator/Director

Q21S Thinking about the people in your care, for how often were/are you able to...

	Before LiveWell			After LiveWell		
	Rarely or none of the time	About half of the time	All or most of the time	Rarely or none of the time	About half of the time	All or most of the time

Contribute to their care plans (or service plans, task lists)?	○	○	○	○	○	○
Calm them down when they feel agitated or upset?	○	○	○	○	○	○
Help them spend time with people they like?	○	○	○	○	○	○
Spend time with residents talking or just being with them?	○	○	○	○	○	○

Page Break

Display This Question:

If Your primary job != Administrator/Director

Q22S Thinking about your work, how often did/do you...

	Before LiveWell			After LiveWell		
	Rarely or none of the time	About half the time	All or almost all of the time	Rarely or none of the time	About half the time	All or almost all of the time
Have the information you need to support new residents make choices?	○	○	○	○	○	○
Work with other staff or departments to understand and try new ways to address resident's difficult behaviors?	○	○	○	○	○	○
Feel you are working as part of a team?	○	○	○	○	○	○
Participate in your organization's quality improvement projects?	○	○	○	○	○	○

Display This Question:

If Your primary job != Administrator/Director

Q23S How satisfied were/are you with...

	Before LiveWell			After LiveWell		
	Dissatisfied	Neutral	Satisfied	Dissatisfied	Neutral	Satisfied
The recognition you get for your work?	○	○	○	○	○	○
The way this community is managed?	○	○	○	○	○	○
The teamwork between staff?	○	○	○	○	○	○
The attention paid to your observations or opinions?	○	○	○	○	○	○
The feedback you get about how well you do your job?	○	○	○	○	○	○
The way management and direct care staff work together?	○	○	○	○	○	○

Display This Question:

If Your primary job = Administrator/Director

Text 3 This section asks you to rate several aspects of resident care and quality before your staff started the LiveWell Learning Collaborative compared to now. These questions are based on your own experience and observations of your staff who participated.

Display This Question:

If Your primary job = Administrator/Director

Q24A Please be sure to check a box that describes how things were before your LiveWell Trainees began the Learning Collaborative, and one in a box that describes how things are now.

	Before LiveWell			After LiveWell		
	High	Moderate	Low	High	Moderate	Low
Their confidence in providing person-centered care	○	○	○	○	○	○
Their confidence in contributing to resident care plans	○	○	○	○	○	○
Their confidence in supporting residents' social and emotional needs	○	○	○	○	○	○
Their confidence in working as a team	○	○	○	○	○	○
Their confidence in using LiveWell ideas and tools	○	○	○	○	○	○
Their confidence in improving quality in your community	○	○	○	○	○	○

Display This Question:

If Your primary job = Administrator/Director

Q25A Please indicate your level of agreement with the following statements:

	Strongly disagree	Disagree	Neutral	Agree	Strongly Agree
My community had specific goals for improving quality before starting the LiveWell Virtual Learning Collaborative.	○	○	○	○	○
Staff morale has improved as a result of the LiveWell Learning Collaborative.	○	○	○	○	○
My corporate office or company leadership supported my community's participation in LiveWell.	○	○	○	○	○
My corporate office and/or company leadership knows the goals and the practices that my team is implementing through LiveWell.	○	○	○	○	○
The LiveWell coaches provided information and support about topics important to our community.	○	○	○	○	○
Our community has a culture of improvement.	○	○	○	○	○

The goals of LiveWell are clear to me.	○	○	○	○	○
Our community will continue to use the LiveWell Method after the collaborative ends.	○	○	○	○	○
I plan to attend LiveWell MeetUps in the future.	○	○	○	○	○

Page Break

Text 4 This section asks about your community's use of LiveWell tools.

Q26 Which LiveWell tools have you found to be the **most** useful? (Check all that apply)

- ☐ Care Calendar
- ☐ Clock Diagram
- ☐ Compliment Cards
- ☐ Dot Voting
- ☐ Huddle
- ☐ Idea Chart
- ☐ Process Mapping
- ☐ Community Quality Board
- ☐ Resident Status at a Glance
- ☐ Safety Sheet
- ☐ SBAR Communication
- ☐ 5S
- ☐ Who Am I
- ☐ Other _____
- ☐ None

Q27 What, if anything, changed as a result of using the LiveWell tools?

_____

_____

_____

_____

_____

Q28 Which of the following are you tracking or displaying on your Community Quality Board?

- ☐ Compliment cards
- ☐ Care calendar(s)
- ☐ Clock diagram(s)
- ☐ Trend chart(s)
- ☐ Other (describe) _____

Q29 Please describe your community's experience implementing huddles. Tell us when and how often they occur (e.g., shift change, after meals), who participates, and what is covered. Please also describe what impact, if any, the huddle has had in your community.

_____

_____

_____

_____

_____

Q30 Which of the following issues are you tracking using LiveWell tools?

- ☐ Resident turnover
- ☐ Resident falls
- ☐ Medication errors
- ☐ Staff turnover
- ☐ Training new staff
- ☐ Ongoing training of staff
- ☐ Unplanned staff absence
- ☐ Workplace injuries
- ☐ Other (describe) _____

Page Break

Display This Question:

If Your primary job = Administrator/Director

Q31A Do you anticipate that LiveWell tools/practices will help reduce costs in any of these areas?

- ○ Yes (describe) _____
- ○ No
- ○ Don't know

Display This Question:

If Your primary job = Administrator/Director

Q32A How would you rate the financial costs to your community of the following:

	Not costly	Somewhat costly	Very costly
Resident turnover	○	○	○
Resident falls	○	○	○
Medication errors	○	○	○
Staff turnover	○	○	○
Training new staff	○	○	○
Ongoing training of staff	○	○	○
Unplanned staff absence	○	○	○
Workplace injuries	○	○	○

Page Break

Display This Question:

If Your primary job = Administrator/Director

Q33A As a result of your LiveWell participation, do you feel that your community has a more robust quality assurance program (QAPI)?

- ○ No
- ○ Maybe
- ○ Yes

Display This Question:

If Your primary job = Administrator/Director

Q34A Do you believe that this QAPI has prepared your community for future state surveys?

- ○ No
- ○ Maybe
- ○ Yes

Q35 Is there anything about your experience with the LiveWell Learning Collaborative that you think would be useful for the LiveWell team, DHS, or future LiveWell participants to know? (e.g., content or information that you would have wanted the Learning Collaborative to address that was not addressed)

_____

_____

_____

_____

_____

End Thank you for completing this survey! We appreciate your time to provide your opinion. Please click the button below to submit your response.

End of Block: Default Question Block

Appendix C. Leadership Interview Guide

Name:
Organization:
Job position:

We are asking these questions of corporate leaders whose communities are taking part in the LiveWell Quality Program. You are not required to answer the questions, but your responses will help us improve the program. Your name and the name of your organization will not be shared with the LiveWell team or with Oregon DHS. We will be summarizing responses from all participants and will make general suggestions for future QI programs and training.

1. What are some reasons that your company decided to take part in LiveWell training and coaching?
    a. Looking back, what were you hoping [your company] would gain by participating in LiveWell?

2. As you might know, LiveWell's current approach is an online learning collaborative that includes coaches who provide support and information. In addition, they encourage peer-to-peer learning and team building. How do you feel this method has worked for the administrator, staff, and residents in your communities?

    a. What have you heard about the coaches, online format, peer-to-peer learning, and/or the content?

3. What type of quality assurance program did you have prior to LiveWell?
    a. What are the financial costs of your QA program
    b. Based on your experience, what are some challenges to using any quality assurance program?

4. How would you rate the financial costs to your communities of the following: (very costly, somewhat, not costly)
    a. Resident turnover
    b. Resident falls
    c. Consumer dissatisfaction
    d. Medication errors
    e. Staff turnover
    f. Training new staff
    g. Ongoing training of staff
    h. Unplanned staff absence
    i. Workplace injuries
    j. Regulatory deficiencies
    k. Other metrics?

5. In your experience, is it possible to save money by investing in a quality assurance program?
    a. Do underwriters expect companies to have a QA program? [Describe]

6. In your opinion, what is the role of corporate leaders in supporting quality improvement at the community level?
    a. How do you help communities address problems and challenges that may be above the decision-making authority of the administrator?

7. What, if anything, does LIVEWELL add to your current QA program?
    a. How likely are you to expand the LIVEWELL program to your other communities?
    b. Currently LIVEWELL is a free service, subsidized by Oregon DHS quality care funds. How likely are you to pay for this service in the future?

8. Is there anything else about your experience with quality assurance programs in assisted living that you'd like to share with us today?

Appendix D. Final Interview with LiveWell Coaches

Confidentiality statement and permission to record. Any questions for me before we begin?

1. Looking back on these past two years, what are some of the greatest lessons learned during your time as a coach?
    a. Is there anything you felt unprepared for in your role?
    b. What qualities and professional experiences make for a good coach?

2. What were some of the greatest challenges you faced as a coach?

3. We cannot understate the impact of COVID on long-term care communities this past year. Looking back to the time when LiveWell pivoted from an in-person to a virtual model, there were many unknowns. Your role as a coach evolved to expand to trainer, content creator, among other things. Let's do a "What Went Well, Even Better If" with the restructuring of the LiveWell model to meet the needs of communities during the pandemic.
    a. What went well?
    b. Even better if? (What didn't go so well?)

4. Some communities had more success than others. From your perspective, what aspects set those who were are able to make progress implementing LiveWell and those who were less successful?
    a. Several communities dropped off a few weeks into the Learning Collaborative. From your view, what factors contributed to this the most?
    b. What barriers remain the most persistent to successful quality improvement using the LiveWell method?

5. How would you describe the "secret sauce" of LiveWell? If you were to capture the impact that LiveWell has had in assisted living communities these past two years, what would you highlight?
    a. Can you think of an example from one of the communities you coached where LiveWell had a significant impact on company culture?

    b. How about resident care or quality outcomes? (e.g., fall reduction)
6. Do you have suggestions for improvement as LiveWell moves forward with its scale-up?
    a. Staffing structure?
    b. Recruiting and retaining communities?
    c. Coaching process?
    d. Learning Collaborative approach?

7. What's next for you?
    a. [If continuing as a coach] What do you look forward to in this next phase of LiveWell?
    b. [If not continuing] Can you speak to the pushes and pulls that have led you to the decision to step away from coaching?

8. Wrapping up, is there anything else you'd like to add? Anything we didn't talk about that you think is important for DHS, the LiveWell team, or us to know?

Appendix E. References

Carder, P.C., Tunalilar, O., Elliott S., & Dys, S., (2019). 2019 Resident and Community Characteristics Report: Portland, OR: Portland State University. Institute on Aging. https://www.pdx.edu/ioa/oregon-community-based-care-project

Cutrona, C. E., & Suhr, J. A. (1992). Controllability of stressful events and satisfaction with spouse support behaviors. *Communication research*, *19*(2), 154-174.

Finn, L. L., & Sturmey, P. (2009). The effect of peer-to-peer training on staff interactions with adults with dual diagnoses. *Research in Developmental Disabilities*, *30*(1), 96-106.

Green LW, Kreuter MW. Health Program Planning: An Educational and Ecological Approach. 4th Edition. New York: McGraw-Hill, 2005.

Oregon Department of Human Services, Aging and People With Disabilities, Oregon Administrative Rules. (2021). *Chapter 411, Division 54, Residential Care and Assisted Living Facilities.* https://www.oregon.gov/dhs/SENIORS-DISABILITIES/SPPD/APDRules/411-054.pdf

Salas, E., Rosen, M. A., Burke, C. S., & Goodwin, G. F. (2009). The wisdom of collectives in organizations: an update of the teamwork competencies.

Weiner, B. J. (2009). A theory of organizational readiness for change. *Implementation science*, *4*(1), 1-9.White, D. L., Tunalilar, O., Hasworth, S., & Winfree, J. (2019). The resident VIEW in nursing homes. *Gerontology and Geriatric Medicine*, *5*, 2333721419877975.