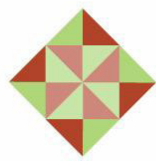

PIONEER NETWORK CASE STUDIES

Providence Mount St. Vincent- A Case for Sustainability

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I. EXECUTIVE SUMMARY

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

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

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

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

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

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

Impact on Business: Turnover decrease from 50 to 15%; Average length of tenure for a CNA at The Mount is 7.6 years; The Mount scores consistently high on staffing surveys; Very modest estimates put cost savings of lower turnover and increased retention at $270,000 per year. Even at an extremely conservative scenario of $50,000 total yearly revenue per resident, The Mount still generates $1,200,000 in additional revenue over the national average (200 bed assumption).

"You don't feel old. You just fit in." - Resident of Independent Living

II. Organization

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

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

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

Providence Mount St. Vincent is West Seattle's largest employer with 476 staff members from 32 countries, and also has more than 200 volunteers. Medicare, Medicaid, Third Party and Private Pay are all accepted payment types. Medicaid (48%) and Private Pay (41%) are the primary payment sources for residential care neighborhoods.

III. History

Photo of Sisters of Providence

Founded as the St. Vincent Home for the Aged in 1924 by Sr. Mary Conrad Kratz, The Mount has a long and rich history of compassionate care administered by the Sisters of Providence. Prior to the person-directed innovation of the 1990's, The Mount operated for 30 years as a more traditional, institutional model. Although known for clinical excellence, The Sisters' tradition of providing compassionate care, spiritual ministry and

quality of life existed within an environment driven by regulators and medical charts that ultimately resulted in loneliness and isolation for residents.

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

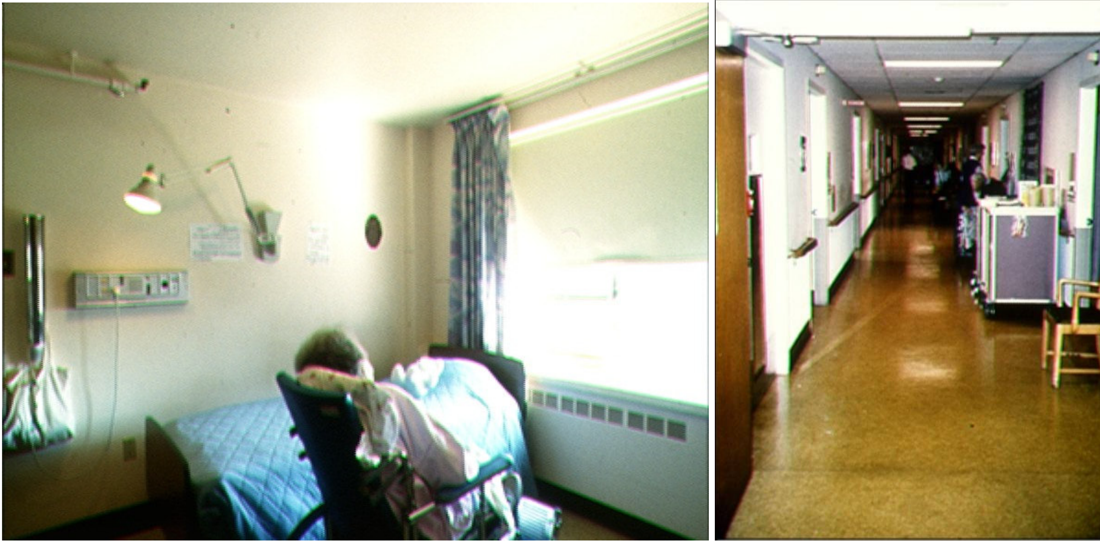
In 1991, a leadership team identified this problem as a "culture of dependence" that was ultimately misaligned with the organization's values and mission. They opted for an organizational transformation, but they first reflected on common themes creating a culture of dependence in the systems and environment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

IV. Common System Themes Prior to Implementation

Table 1 - Common Themes in The Mount's Processes and Systems Prior to Implementation
Centralized departments; **Lack of autonomy for residents in dining or choice of meals;** **Lack of autonomy for residents in activities;** **Lack of autonomy for residents in bathing schedules;** **Language supported a culture of dependence (e.g. "patient," "ward," "floor" and "unit");** **Residents identified by medical conditions or level of care;** **Staff-resident interaction was not a priority;** **Staff were task driven and organized work around delivery of care and staff preferences.**

V. Common Themes in the Physical Environment Prior to Implementation

Table 2 - Common Themes in The Mount's Physical Environment Prior to Implementation
Institutional sterile environment (modeled after a hospital environment); **Long halls and hard surfaces;** **Floor, wall and ceiling materials designed for durability and ease of maintenance;** **Tight spaces clogged and crowded with people and equipment;** **Four floors of nursing units with approximately 56 beds per unit;** **Double-loaded corridor approximately 300 feet long;** **A small centrally located dining and activity space;** **Design of spaces physically separated residents and staff.**



Photos Prior to Culture Change Implementation

VI. Strategies for Planning

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

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

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

Other tips for early and ongoing planning:

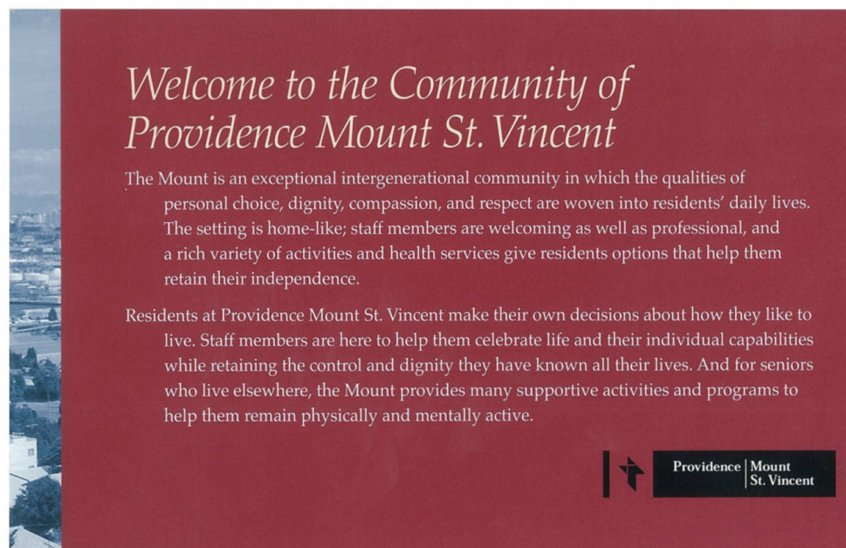
- Visit organizations already implementing change (Mount employees visited Benedictine Nursing Home in St. Cloud, Minn);

- Aim to be the "Provider of Choice" and the "Employer of Choice" (see The Mount Welcome) and ask the tough questions to achieve that goal;

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

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

• Analyze processes and environment to determine change priorities. According to Charlene, ***"It's really systemic. You can't change just one thing."***



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

VII. Case Study and Assessing Impact

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

• Regional Director and Administrator
• Operations Support
• Planning & Development

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

The Mount case study was designed to identify qualitative and quantitative elements to track and support the effects of this innovation on organizational outcomes. In Figure 1, the model on the left represents an ongoing sustainability process including innovation, evaluation (analysis and measurement), additional change management, and resulting subsequent implementation based on previous experience. This ongoing change management strategy requires measurement of person-directed impact on outcomes.

In Pioneer Network case studies, impact is categorized by quality of care/life improvements (most directly affecting residents and family) and staffing impact. The model on the right in Figure 1 highlights organizational impact which is defined as impact in quality and/or staffing impact that increases revenue and/or decreases operational costs for the organization.

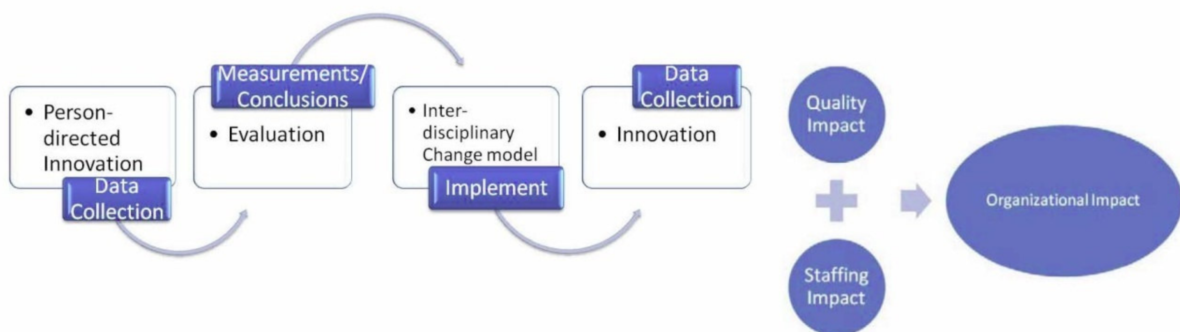


Figure 1 – Ongoing Sustainability Process and Organizational Impact

To analyze and track innovative processes to resulting outcomes, five common themes were identified in *Resident Systems* (most directly affecting quality of care/life) and *Overall Organizational Systems* (most directly affecting staff). Common themes are highlighted below in Tables 3 and 4 and discussed in further detail on subsequent slides.

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

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

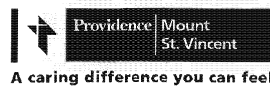
VIII. Resident Systems Transformations

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

According to Charlene, an organization has to ***"find the initial fit and then keep going back and implementing changes to support the needs of the organization."***

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

Based on case study findings, the below examples expand on Table 3 and describe systems discovered through The Mount's ongoing organizational transformations. These are the systems identified as most likely to affect resident and family outcomes.



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

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

Marketing Information on The Mount's Nursing Neighborhoods

The below transformations are based on Table 3 and are most likely to affect resident and family outcomes. Examples are listed below each strategy.

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

- The document highlighted above provides an example of the use of a resident-directed focus in marketing materials, so that residents and families are introduced to expectations regarding resident-directed care at an early stage.

- There are no uniforms at The Mount to delineate between community members and staff.

- Resident choice is respected. ***"I don't want to work somewhere without banana ice cream." - A staff member commenting on how happy a resident was when her favorite ice cream was ordered for her.*** Other examples: residents' dogs and cats are welcome and each neighborhood has a "neighborhood cat"; residents' preference of no cell phone use is respected.

- Payment for services is transparent to all residents and most staff (i.e. others do not know which residents are utilizing Medicaid). When residents spend down in

community areas such as Assisted Living, they stay in their apartments and utilize Medicaid as a payment source.

- Family education regarding person-directed care and support is a priority.

- Death and dying are honored. ***"We want to be with them, particularly in their final journey." - Sister of Providence***

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

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

- Nursing Care Neighborhoods - The Mount utilizes consistent assignment of residents with care assistants which leads to a relationship and "knowing" individual preferences. Staff are cross-trained and able to help residents with multiple requests (going to the restroom, brewing coffee, doing laundry, fixing a sandwich, and eating). Activities are meaningful. Residents maintain personal schedules based on preferences. Each neighborhood maintains mixed acuity levels. Resident choice is documented in the care plan. ***"We encourage residents to tell us how they want it." - Neighborhood Coordinator.***

- Short-term Sub-acute Medical Rehabilitation - Unlike other parts of the community, this area still has a clinical focus and older adults utilizing sub-acute, short-term services prefer to be called "patients" instead of residents. In addition, the rehabilitory and therapeutic nature of stays requires a more structured schedule. To accommodate a person-directed focus, therapy will ask individual preferences and schedule services accordingly. For example, if a patient is not a "morning person" therapy will be scheduled in the afternoon. Older adults also have choice on elements from diet to meal times and bring in their own street clothes.

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

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

- Each neighborhood has a shared staff of about 18 people including: a neighborhood coordinator, resident assistants, recreational therapists, food and nutrition workers, a social worker, nurse, spiritual care worker and housekeeper. Similar types of coordination occur in other parts of the community.

- The inter-disciplinary team also allows for organizational balance where staff are empowered to concentrate on more than one aspect of the community. ***"Clinical still cares about clinical and regulatory but we also balance that with caring about our 'home' for residents." - Neighborhood Coordinator (and RN).***

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

- ***"We are always trying to make life better for the residents. When I have new ideas, our administrators listen." - Resident Assistant.***

- Tom Mitchell, The Mount's Administrator, attends resident council meetings to understand pervasive concerns and act on resident needs (during the case study visit, initiatives in dining and laundry were as a result of this attendance).

- ***"This is the residents' house, and we work to meet their needs. They are the boss." - Resident Assistant.***

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

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

IX. Organizational Systems Transformations

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

The below "overall" organizational and staff transformations from Table 4 are those that will most likely affect staff and organizational outcomes. Examples are listed below each strategy.

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

- The Mount's inter-disciplinary leadership team participates in weekly meetings that focus on resident-directed concepts as part of the agenda For example, leadership team members filled out the below form, compared differences and preferences and then contemplated a life based on someone else's schedule and preferences.

Resident Sensitivity Exercise Used in Leadership Meeting

Your daily routine and the benefits of resident directed care!

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

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

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

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

When I have free time, I like to walk

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

Right before bed I like to relax by Knitting

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

- The Mount maintains journal and publication subscriptions (examples from the case study include Assisted Living Consult, Modern Healthcare, Gerontological Nursing, RN, McKnights, and Long-term Care News). The Education Department scans publications and provides employees with summaries of relevant journal articles (employees can request the full copy for those articles of interest).

- The Mount provides in-house training with a person-directed focus. For example, dementia training is provided to employees and The Mount works with all staff to create some standardization tools for regulatory issues.

- Training includes "plugging" all levels of staff into available resources**.** ***"What takes a lot of time for a Resident Assistant is not knowing what resources are available. When you have access to resources and know what's available, you have that extra 30 minutes to spend getting to know residents. I prioritize extra training with staff, one-on-one, so they understand where the resources are and resources are within an arm's reach." - Neighborhood Coordinator.***

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

- In case study interviews, staff use words like "organic" and "flexible" to describe problem-solving at The Mount. This means focusing on resident choice instead of working on maintaining hierarchical constructs. ***"We focus on resident choice instead of paper." - Neighborhood Coordinator.***

- Neighborhoods have their own budgets and receive monthly variance reports to help guide spending.

- To achieve maximum outcomes, each staff member's "role" includes understanding multiple areas of focus and many are cross-trained. ***"Our staff are generalists and need to know many areas." - Mount staff member.***

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

- The Mount leadership encourages inter-disciplinary teams to problem-solve among and between themselves. ***According to one staff member, "We typically don't use work requests or paper bureaucracy. Everyone can just call each other, and you can get things done pretty quickly with a phone call."***

- The Mount takes advantage of organizational synergies. For example, The Mount's Occupational Therapist also educates employees on injury and preventive wellness. In another example, the intergenerational childcare center is used by employees for daycare (providing a convenient and cost affordable option).

- Staff engage in regular communication within and between teams to explore best practices and lessons learned. For example, neighborhoods meet regularly to discuss team needs, but neighborhood coordinators also schedule breakfast with each other to share experiences and best practices. ***One staff member commented, "People are free of judgment or repercussions across teams."***

- Staff report that the Medical Director and Nurse Practitioner are extremely accessible and supportive of person-directed care in clinical issues.

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

- After 5 months with The Mount, new employees meet with the administrator. The purpose of this interview is for leadership to ask-"What can we do for you? How do you like the job?" ***According to Charlene, "After the first few minutes, employees realize that it is about them and getting their opinion and feedback. We really want to know about their experiences and how we can help."***

- The Mount helps to support education and scholarship for employees (tuition reimbursement and scholarships for CNA's and LPN's).

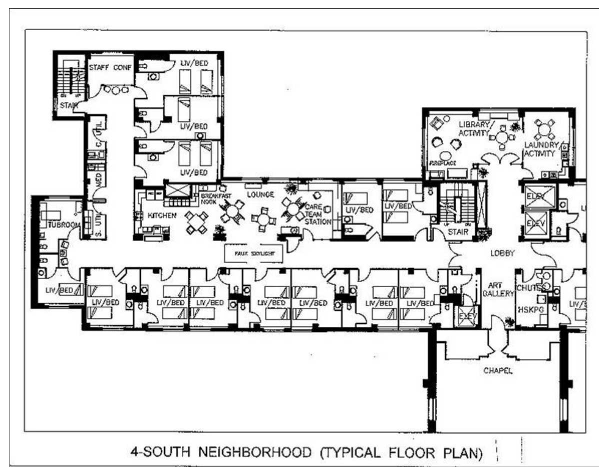
- There are numerous examples of The Mount engaging with employees on a personal level including providing Christmas bags with toys for the children of staff. ***"The Mount is a family and great support system. I'm able to feel safe and provide for my family. I wouldn't move and wouldn't leave. I take care of people here and feel like they take care of me. Charlene and Tom help me, care about the residents and care about employees... they are good people." - Mount staff member.***

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

- During the case study visit, the Administrator, Tom Mitchell, was utilizing process maps and analysis to reduce wait times at the "Cafe" for residents. Residents enjoy the tray line and picking out their own food; however, this was causing a queue. By utilizing data (# of meals served) and observation (where dietary staff can help residents), The Mount identified approaches to ameliorate the problem.

- "***Leaders are accountable for social interactions, budget and clinical responsibilities, so we use toolboxes [data and process maps] to get things done." - Neighborhood Coordinator.***

X. Physical Environment Transformations



4-SOUTH NEIGHBORHOOD (TYPICAL FLOOR PLAN)

"Form follows function." – Charlene Boyd

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

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

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

NEIGHBORHOODS
• Floors are divided into nine 20 to 23 person "neighborhoods"; **• Each has a spacious kitchen with round tables and all the usual home supplies, from tablecloths to tea kettles;** **• Residents' favorite snacks and drinks are stocked in the kitchen and available at any time;** **• Steam trays support delivery of food from the central kitchen;** **• Staff and resident workspaces are no longer segregated. At the far end of the kitchen space is the open care station for social workers, nurses and other staff;** **• A laundry room is available for each neighborhood;** **• Rooms are private or semi-private (for 2 residents) and remodeled to provide space for resident's personal belongings;** **• Each neighborhood has a distinct personality with changes in style and color;** **• Multiple inviting settings for spontaneous interaction;** **• Each neighborhood has access to a solarium designed as a green house;** **• A game room;** **• A library;** **• An intergenerational classroom complete with an aviary.**
ASSISTED LIVING APARTMENTS
• Remodeled to promote independence; **• Showers with grab-bars replaced bathtubs;** **• Microfridge in each apartment;**
INTERGENERATIONAL LEARNING CENTER
• Shared spaces on various floors; **• Permanent intergenerational classroom on the third floor nursing neighborhood;** **• Classrooms on first floor with windows to the main hall (so that residents can peek in to classroom activities);** **• Playground visible from sub-acute and neighborhood floors. Residents in these areas can hear children laughing and playing.**
SHORT-TERM, SUBACUTE MEDICAL REHABILITATION
• Kitchen and dining area similar to neighborhoods. **• Mini meeting areas.** **• Open environment for nurses' station.** ***"99% of the day someone can find a nurse or staff." – Staff member.*** **• Computerized medical records.**

Other Examples

- Remodeled and open therapy areas in Adult Day Health;
- A cosmopolitan "Cafe" with an open buffet tray line where all members of the community can dine;
- An Emilie's Treasures Thrift Boutique – Donated items from The Mount and outside community provide the inventory for this unique shop. Case study interviews and observations revealed it to be a favorite meeting place in the community. Proceeds from purchases benefit the foundation and residents in need;
- A Wellness Clinic provides services like acupuncture and foot care and is open to staff as well as residents;
- Lounge areas containing computers and the Never 2 Late system.

XI. Quality of Life Impact

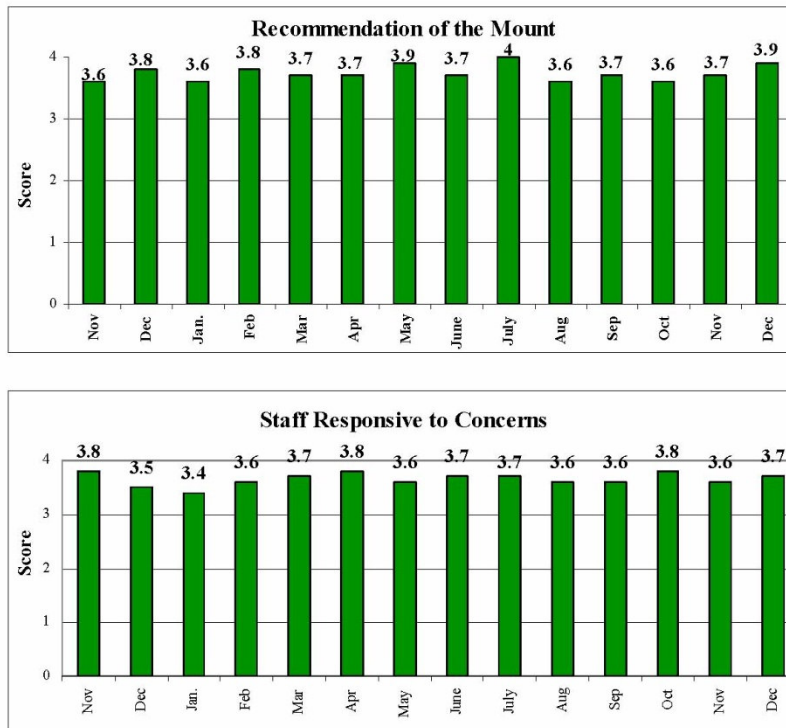


Figure 2

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

Table 5 - Quality of Life Quantitative Findings
➢ The Mount internally surveys older adults receiving subacute medical rehabilitation services before they return home. In all 16 measures, The Mount consistently maintains high averages on a 4 point scale (all averages above 3.2 and most averages at 3.5 or above). The graphs in Figure 2 provide instructive examples of outcomes and tracking mechanisms.
➢ The Mount maintains high averages in Resident Satisfaction surveys including ranking in the 97th percentile of the 2006 Press Gainey Nursing Home Survey national results for the response indicating that "residents were likely to recommend services." The highest scores of the Press Gainey survey are from those questions relating to relationships.
➢ The Mount consistently maintains a close to 100% occupancy rate (to be discussed in more detail on Organizational Impact findings).

Table 6 - Quality of Life Impact Qualitative Findings – Engagement of Residents (measured through resident interviews and based on Table 3)
1) *Create an inclusive community and "home" for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus.* ➢ **The "Hello Phenomenon" was observed during the entire term of the case study. Every staff member said hello to each passing individual in halls and common spaces.** ***"There is something about going through the hall and every person that works here says hello, asks how we're doing and calls us by name."- Resident of Assisted Living. "The people were all so friendly. They said hello I knew then this is where we had to be."- Resident of Independent Living.*** ➢ ***"I like the fact that they allow you so much independence. That this isn't a facility. This is home. The people here are so friendly. There are so many little touches. They just think of everything"- Resident of Nursing Neighborhood.***
2) Work is organized around maintaining resident's autonomy and preferences with inclusive language supporting residents to be "known" as individuals instead of medical conditions ➢ ***"We have men and women in their 90's who look like they are in their 60's. They have kept themselves active socially. We play pinochle and bridge, have conversation groups, Wii bowling. Play horseshoes. There is just something for everyone. We have lots of field trips. People read a lot. There is a computer available for the residents with a touch screen program so they don't have to work the keys. We have intergenerational art and music and a lot of our people volunteer there." – Resident of Assisted Living.*** ➢ ***"What I enjoy the most is that there are very few people that sit around and talk about how awful it is too be old. They are too busy." – Resident of Independent Living.*** ➢ ***"When I had to be in a wheelchair, I thought my life was over. Even though, I***

have pain, I'm in wheelchair, I can't do much – I actually do a lot. I do needlework, I work on the computer, I read. It's certainly different than what I imagined it to be, but it is probably one of the happiest times in my life." – Resident of Assisted Living.

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

- ***" I like the way they have teams of people. The nurse, social worker, somebody from spiritual care, someone from therapy divided into neighborhoods and each neighborhood has its own cat. Ours is Sunshine." Resident of Nursing Neighborhood.***
- ***"It's very cohesive. All the different types of professions all work together. Something that I learned early on is that any person working here will do anything. They are not just confined to one job." – Resident of Nursing Neighborhood.***

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

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

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

- ***"The aides are wonderful – one always asks how I am feeling and says 'If you're not happy, I'm not happy'. When I wake up in the morning, the first thing I hear is laughter. It is wonderful to hear that." – Resident of Nursing Neighborhood.***
- ***"She has 6 children and 4 of them are at the daycare center downstairs. One of her little boys is growing so fast. I go down to see him all of the time."- Resident of Assisted Living after an aide visits the apartment to take her blood pressure.***

XII. Quality of Care Impact

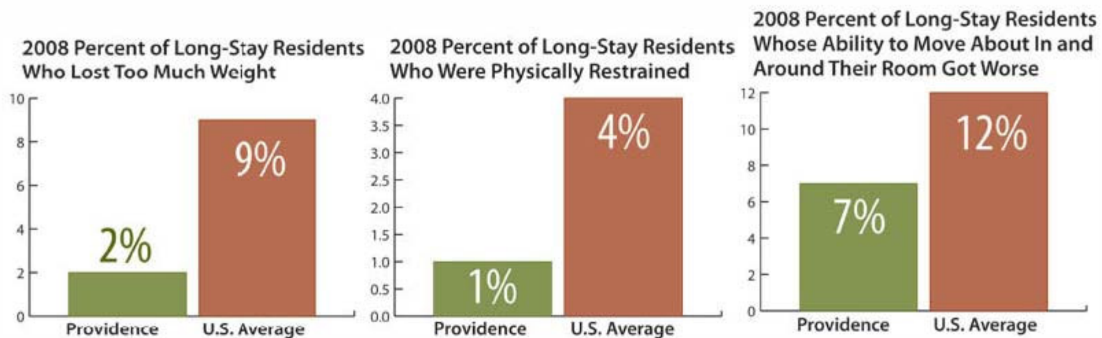


Figure 3

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

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

Table 8 - Quality of Care Impact - Qualitative Findings (based on Table 3)
Create an inclusive community and "home" for residents, families, and the outside community that is constantly communicating and reinforcing resident-directed choice and focus. ➢ ***"Clinical still cares about clinical and regulatory but we also balance that with caring about our 'home' for residents."*** **[As an example]** ***"We have a resident that loves to spend time with me. She has diabetes and typically doesn't enjoy exercising. So, I ask her if she wants to join me when I need to leave the neighborhood for a few minutes. It's the clinical value added of having her walk a 1000 feet a few times a day coupled with spending time with her and building a relationship." – Neighborhood Coordinator***
Work is organized around maintaining resident's autonomy and preferences with inclusive language supporting residents to be "known" as individuals instead of medical conditions. ➢ In one example, a resident of a Mount neighborhood was losing weight and staff were concerned. This elder, an English woman, loved to drink tea. In this instance, the staffs' understanding of the resident's likes and preferences was extremely powerful. Working with dieticians and clinical care, staff utilized traditional English "tea times" to fortify her tea. The result was an elimination of weight loss for the resident and proud, empowered staff.
Inter-disciplinary, cross-trained teams operate throughout the organizational structure with an objective of putting residents before task and taking advantage of synergies in the organization. ➢ ***"Our social worker captured the social history and communicated his story to***

the neighborhood staff directly. We didn't have to read about him on paper and his story never went through more than two people before it was heard. We know he likes the Sea Hawks and he'll enjoy the activities where all of the men get together"- Neighborhood Coordinator explaining how she was able to comfort the wife of an incoming resident with such personal and specific information about the husband.

- ***"If we can develop a creative, reasonable way to do it, we'll do it. Who would want to give up their home?" – AL staff describing ways to support residents with increasing frailty to stay in apartments.***

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

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

XIII. Staffing Impact

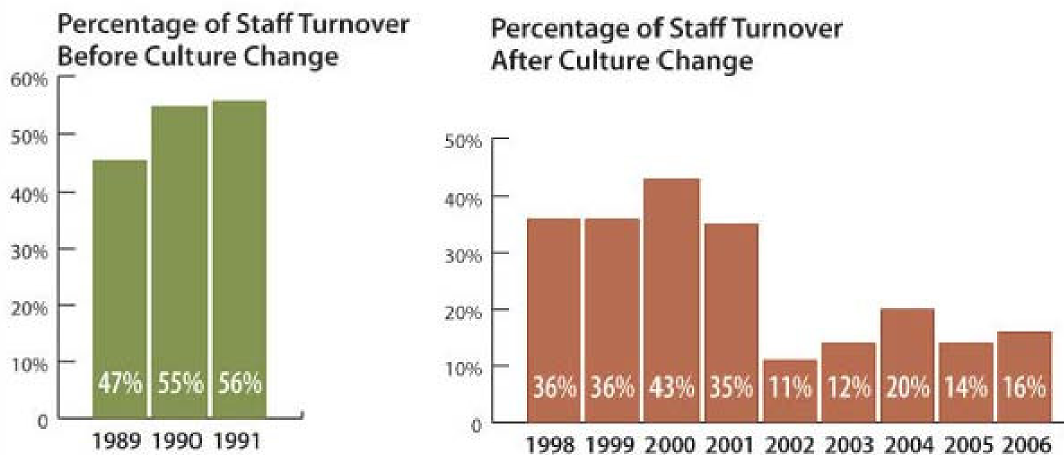


Figure 4

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

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

Table 9 - Staff Impact Quantitative Findings
➢ Turnover percentages decreased significantly from pre- to post-culture change. Figure 4 above displays that annual employee turnover at The Mount fell from 50 percent prior to the implementation of the "neighborhood" model to 15-18 percent voluntary turnover in 2006-2007. Very modest estimates put cost savings of lower turnover and increased retention at $270,000 per year (nearly 2 million dollars in savings from 2000-2008).
➢ Even with over 400 staff, retention and average years of service for most positions is greater than 5 years. Average length of tenure for a CNA at The Mount is 7.6 years (See Figure 5). "***Retention is through the ceiling. I've never worked at an organization like this where it's common to find out people have been here for 10-20 years." – Neighborhood Coordinator.***
➢ The Mount scores consistently high on staffing surveys. As with resident surveys, this is particularly true for questions directed at relationships or commitment to residents.

Table 10 - Staff Impact Qualitative Findings (based on Table 4)
Create an inclusive community for staff that is constantly communicating and reinforcing a resident-directed focus through formal and informal educational opportunities and relationship building. ➢ **95% of staff interviewed utilized words that describe The Mount as a cohesive unit (e.g. family, team, home).** ***"I don't feel like they are old. I see them as young. I spend more time here than with my own family. For some residents, we are their only family." – Mount staff member.*** ➢ **100% of staff demonstrated knowledge of culture change principles.** ***"This is their home and they are letting us come into it." Staff member of 5 years. "The difference is that before [culture change] it was us telling them. Now, it's them telling us. They aren't 'patients' anymore. This is their home and we let them tell us what they want to do." – Staff member of 20 years.*** ➢ **The Mount maintains a diversity committee that celebrates the staff.** "***We try to model it (not just with the residents) but with each other." – Mount staff member.***
Through a flat organizational structure, employees feel empowered to help control quality, waste, and problem-solve throughout the community. ➢ **90% of staff interviewed at The Mount reported that they felt empowered to reach-out to fellow employees to brainstorm on operational issues.** For example, one of the neighborhood coordinators observed that resident assistants were over-serving residents at meal times (leading to food waste). The neighborhood coordinator solved this problem by scheduling an "in-service" for staff on serving and portioning. The outcome was positive for residents, staff and the organization (substantially controlling waste and food costs). ➢ Staff indicated that, when compared to previous employers, this type of empowerment was unique to The Mount and resulted in a reduction of time, resources and expense to solving day-to-day problems.
Leverage the value-added potential of inter-disciplinary, cross-trained teams throughout organizational structure to take advantage of synergies in the organization.

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

XIV. Organizational Impact

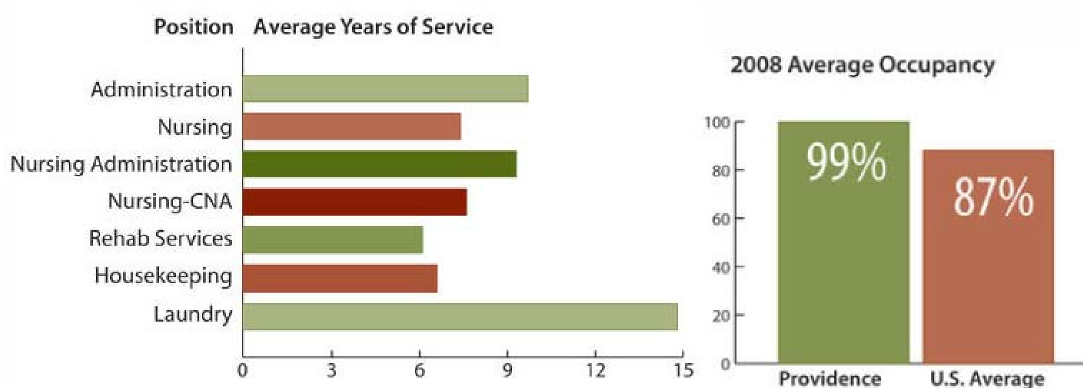


Figure 5

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

Table 11 - Organizational Impact Quantitative and Qualitative Findings
➢ One of the graphs in Figure 5 describes average years of service (staffing impact). Very modest estimates put cost savings of lower turnover and increased retention at $270,000 per year.
➢ Another of the above graphs describes average occupancy for nursing neighborhoods (quality impact). Even at an extremely conservative scenario of $50,000 total yearly revenue per resident, The Mount still generates $1,200,000 in additional revenue over the national average (200 bed assumption). ***Market Reality – Consumers want choices, and the choices (food, activities, schedule) provided by The Mount elevate market position. Labor Market Reality- Staff***

generally want to feel listened to by leadership and empowered to make residents happy. With this structure, retention goes through the roof.
➢ The above findings point to return on investment for The Mount from culture change efforts. Findings are consistent across years and indicate that The Mount has achieved sustainability in ongoing culture change efforts. Case study findings also revealed additional examples of quality improvements that lead to cost efficiencies (examples below).
➢ A private pay nursing neighborhood resident was having trouble adjusting to her new environment (and would likely have left) until she met and formed a friendship with the neighborhood cat (cost of cats $500 a year). Measuring return on investment as yearly revenue of private pay versus the Medicaid rate equates to a return in the tens of thousands of percentage points. The investment also translated to the resident's quality of life and sparks conversations with the staff and her family.
➢ ***"As neighborhood coordinators, nurses are looking at environmental things as well." – Neighborhood Coordinator.*** For example, a neighborhood coordinator noticed a rug that she felt needed some securing to prevent a fall. She generated the repair (cost of repair-negligible estimate $50). With the average healthcare cost of a fall (according to the CDC) of $19,040, the ROI for empowering nursing staff to view the bigger picture is also in the tens of thousands of percentage points. Of course, quality of care and life are also significantly improved by avoiding this type of trauma.
➢ The Mount's policy of empowering employees and encouraging problem-solving extends to recognizing the talents of staff members. One employee began a career at The Mount by answering phones. His ability to provide excellent customer service to residents and employees was quickly recognized and he was identified as a perfect candidate for operations support. During case study interviews, this employee was identified as the person who "fixes" everything. Examples include his ability to set-up electronics by simply purchasing equipment ($77) as opposed to calling for an outside company to consult and do the job ($1000 cost). In another example, there was an issue with TV reception that was burdensome to residents and staff. The staff member identified the problem and fixed it himself eliminating the need to call an engineer and pay a fee. Residents and staff were thrilled with the quick fix.
Additional Examples of Revenue Enhancement from Culture Change Transformations: ➢ ***"The best advertising is word of mouth."- Mount staff member.*** Community-based programs such as Adult Day and the Intergenerational Learning Center generate referrals. So, although those programs may not operate with the highest margins in the community, they still increase occupancy in the higher margin areas and lower advertising costs. Since employees take advantages of those services for families, these programs also increase employee retention. ➢ The Wellness Clinic and Emilie's Treasures generate revenue with high margins. ➢ The inclusion of the outside community in Mount activities adds to quality of life and atmosphere while also generating financial support. For example, designers decorate Christmas trees that are auctioned off generating as much as $107,000 to

resident programs.

XV. Additional Case Study Findings

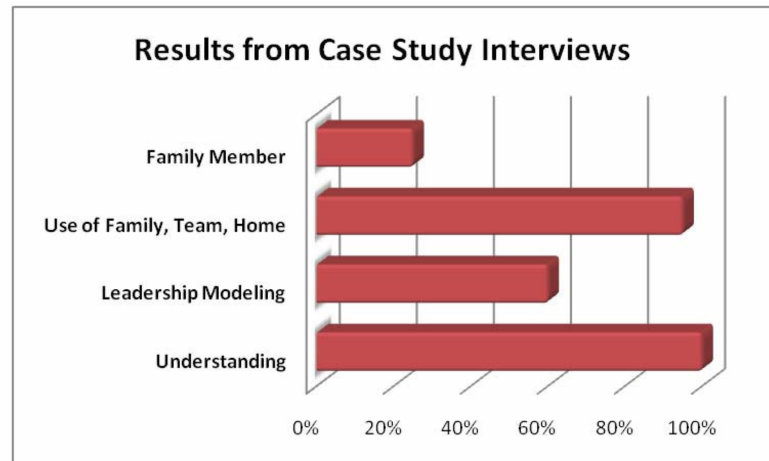


Figure 6

Case study interviews exhibit a high level of congruence between stated goals of leadership and the support for those goals from residents, staff, Board and community members. Examples of these results (in Figure 6 include):

- **20% of staff interviewed also utilized Mount services for a family member (either for intergenerational childcare or a parent or grandparent in the community) indicating integration and trust of relationships.**

- 95**% of staff and 100% of residents interviewed utilized words that describe The Mount as a cohesive unit (e.g. family, team, home).** Perhaps this statement is best exemplified when former Mount employees choose to come back to the community after retirement and make it their home. One of these former employees, now a current resident, sees the person-directed philosophy as similar for staff and residents in the community. As a former staff member and current resident, she states, ***"It is the same loving, supportive care for whatever you need physical, emotional, spiritual (no matter your background)."***

- A consistent finding in The Mount case study was the importance that leaders place on modeling person-directed care practice for staff and elders. **In interviews, 60% of the leadership team used the word "modeling" as the predominant method of mentoring staff in culture change.**

- As stated previously, **100% of staff and residents demonstrated understanding and knowledge of culture change principles.**

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

Community Support: Quality care, committed staff and exemplary leadership often lead to a community reputation which improves occupancy and market competitiveness. The Mount receives local and national recognition for innovation in the workplace. This level of support leads to high impact and return for culture change investment (a list of publications is available on Pioneer Network's web site).

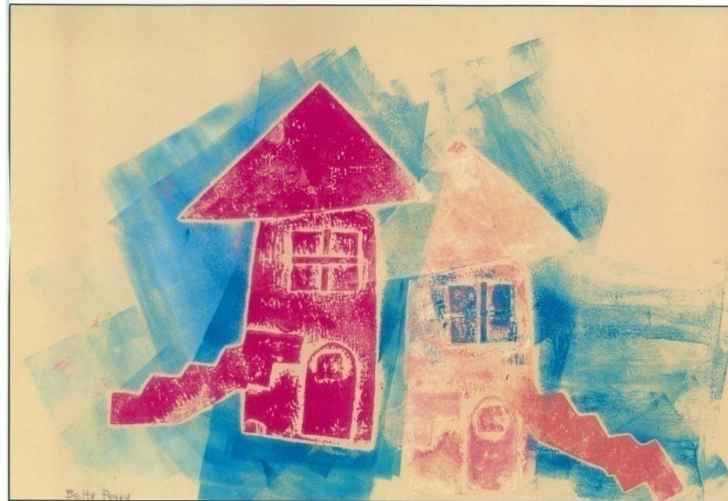
XVI. Challenges and Lessons Learned

Table 12 - Challenges and Lessons Learned
➢ **Change doesn't happen overnight and leadership must stay the course**. It's not a magical practice. It's consistency. For example, adopting language like "home" and "neighborhood" takes time but is important to transform action. Ultimately, complex interactions build the relationships and those take time to develop and understand. ***According to Charlene Boyd, "There were more stops and starts than we expected. You test something, try, learn….You do what's needed to change the foundation of the work, but it takes longer than you think."***
➢ **Sustainability requires constant innovation.** This means that The Mount spends time and resources maintaining the resident-directed focus. Thus, The Mount is constantly re-investing back into the organization (making it difficult to track all of the positive quality and financial outcomes).
➢ **Relationships and engagement are tangible and observable outcomes for staff and residents at The Mount but difficult to measure. *"Having good relationships in life is one of the greatest challenges for all of us – this is an extension of that."- Mount staff member.***
➢ **Jobs change when an organization transforms to a resident-directed focus**. Tasks formerly done by administrative and licensed nursing staff are now shared by the team including resident assistants. Switching to a resident-directed focus also requires ingenuity and innovation by staff to organize work around residents' schedules. For example, interaction and activities need to be available for residents that stay up later (as opposed to staff having all residents in bed by 7:00). ***"The difficulty is accepting that you are not the one directing care and the schedule anymore." – Mount staff member.***

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

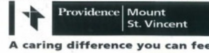
XVII. Summary

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



Upstairs Downstairs

Intergenerational Art Show Betty Perry 2007



"Upstairs Downstairs" from The Mount's Intergenerational Art Show

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