Changing the culture of an organization takes a long time.

True, False, or It Depends?

Facilitating quality improvement at the frontlines: lessons learned from a national program

Christine W. Hartmann, Ph.D.

Lisa Minor, RN, MSSL

A. Lynn Snow, Ph.D.

VA Central Office's Office of Geriatrics and Extended Care

CLCs' Ongoing National Center for Enhancing Resources and Training (CONCERT) team

Shared vision

If you observe and communicate about what you're doing well

You can apply your strengths to change other situations

Apply what you know to change this…

to

this!

Our journey

POLL QUESTION #1

- #1: What experience have you had with frontline health care? [pick all that apply]
  - Am a clinician (i.e., that’s my job)
  - Am not a clinician but work(ed) with frontline staff
  - Have visited frontlines, for research or other reason
  - Work with people who work on frontline
  - Have no contact with frontline

Importance of partnership…

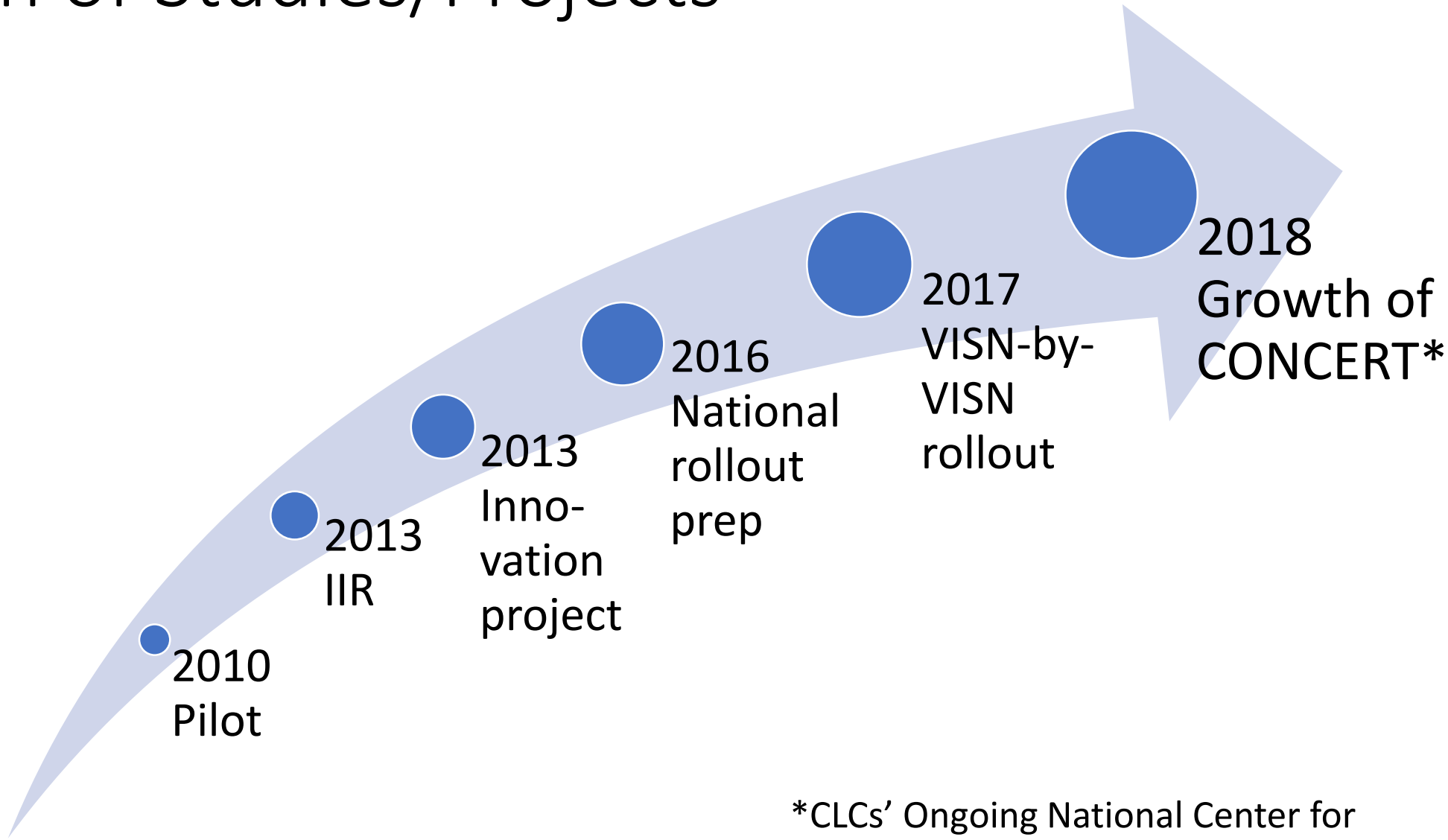
Lessons about Partnership

- Remember: it’s all about relationships
- Establish mutual agendas (and re-evaluate)
- Be patient
- Be flexible
- Partner broadly

Current Office of Geriatrics and Extended Care Snapshot

- **Acting Executive Director**: Scottie Hartronft, MD
  - **Director, Community Living Centers (CLCs)**: Lisa Minor, RN,MSSL
    - Program Manager, CLC and Survey Program: Sheryl Terkildsen, RN, MSN
    - Program Analyst: Janet Barber, MPRTM, MDiv
    - CLCs' Ongoing Center for Enhancing Resources and Training (CONCERT): Hartmann & Snow

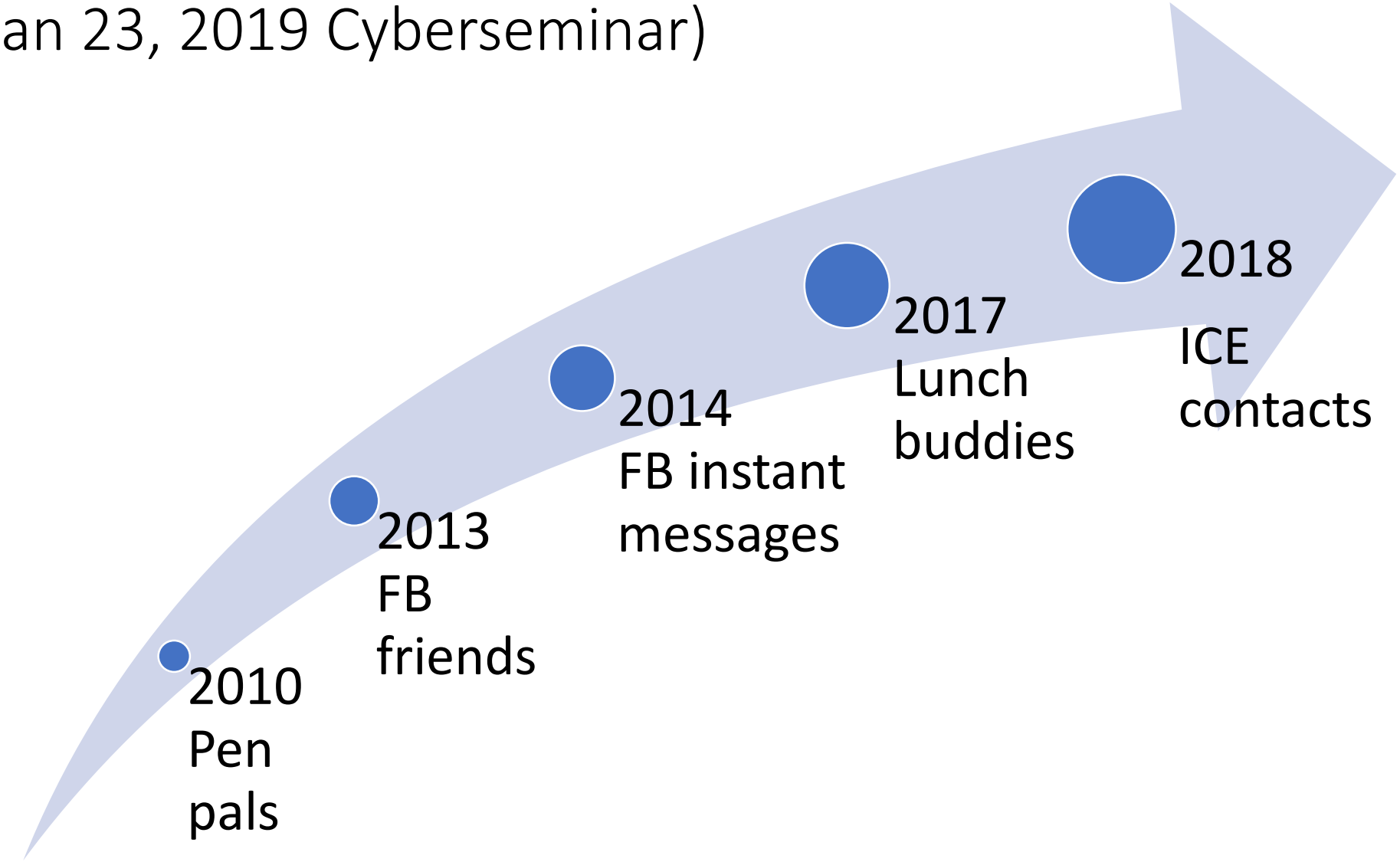
Growth of Studies/Projects



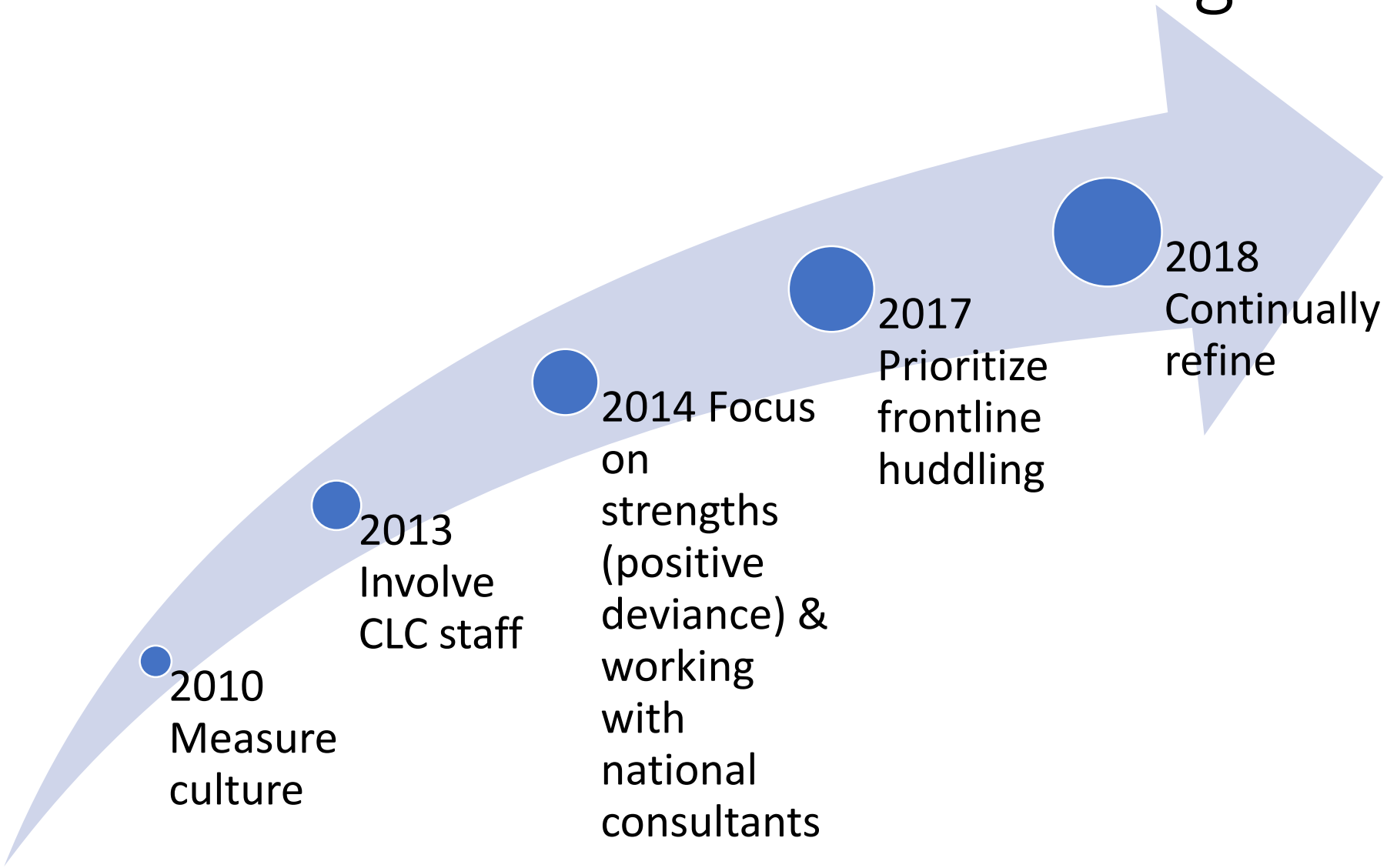
*CLCs' Ongoing National Center for Enhancing Resources and Training

Growth of Partnership

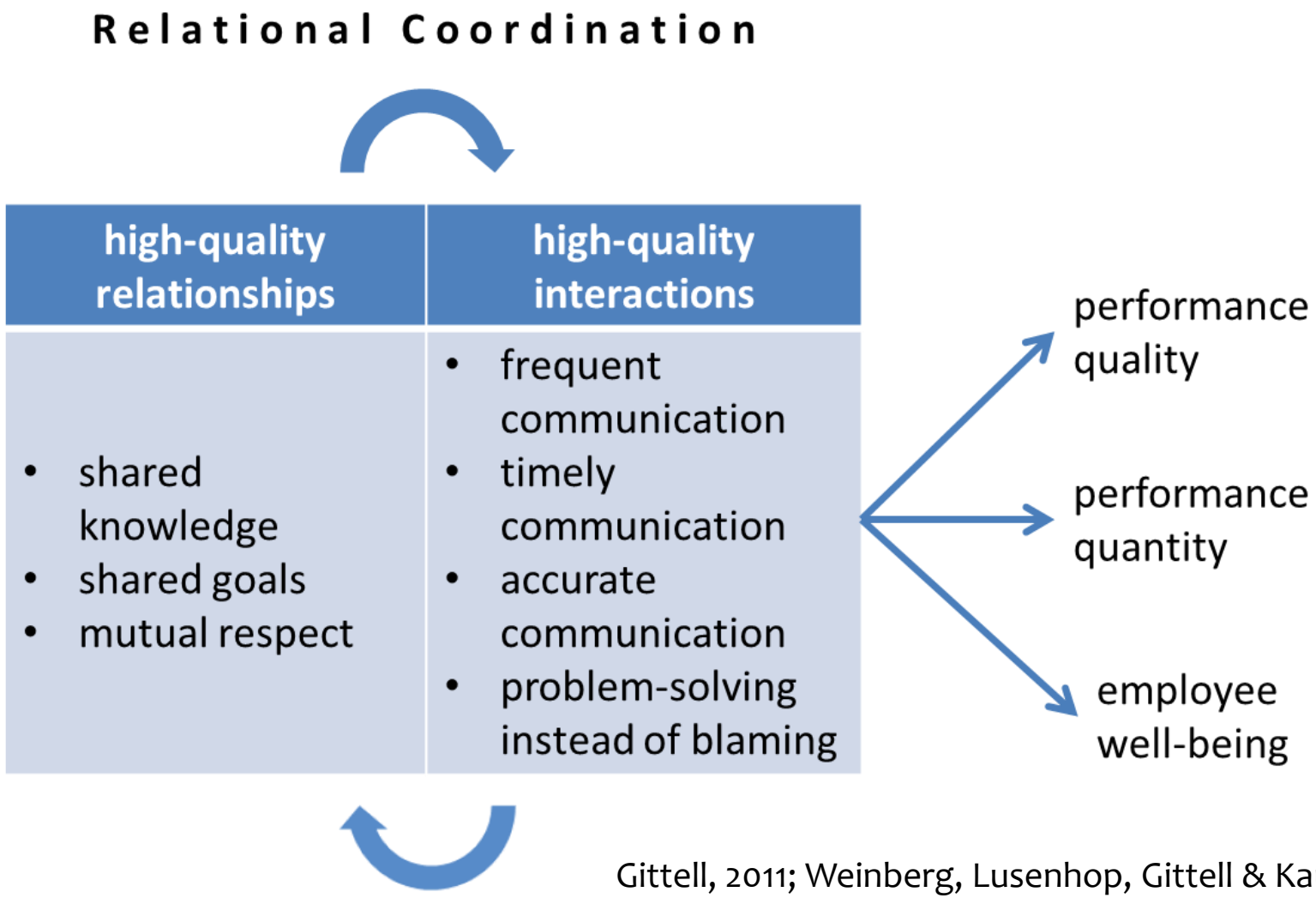
(see Jan 23, 2019 Cyberseminar)



Growth of Researchers' Understanding



Relational Coordination



Gittell, 2011; Weinberg, Lusenhop, Gittell & Kautz, 2007

Other Principles

- Live our conceptual framework
- Focus on positive deviance (be strengths-based)
- Be nimble and flexible
- Pilot everything (PDSA)

Growth of Studies/Projects

2010
Pilot

2013
IIR

2013
Inno-
vation
project

2016
National
rollout
prep

2017
VISN-by-
VISN
rollout

2018
Growth of
CONCERT*

*CLCs' Ongoing National Center for Enhancing Resources and Training

Rating session start time: _____ Rating session stop time: _____ Rater Initials: ____OBS_ID:_____ (*circle one*): Video#/Live IRR ID #:_____

Date: _____ Site_____Unit_____ **RAISE Data Record Sheet ver 20160530: USE THIS FILE FOR FRONT PAGE** PAGE: ___of ___

Line Number/ Video Start Time & Descriptors (no PHI)	Column 1 Target	Column 2 WHO is NEAR-BY	Column 4a - Staff (S) ACTIVITY Codes	Column 4b - Resident (R) ACTIVITY Codes	Column 5 Staff Interaction Type	Column 7 Emotional Tone	Column 6 Social Role	Column 9 ACTIVITY Initiation	Column 11 ENGAGE-MENT
[if video, use format xx.xx: example 09.30]	S =staff R = resident O=other O(init)= rater U = Unknown E = Empty (of people) TP/TR = Time Pause/ Time Resume DC = Time Dis-continue	1=Resident(s) only 2=Resident(s) & Staff 3=Resident(s) & Family/other 4 = Resident(s) & Unknown 5=Resident(s) w/ All other Combos 6=Staff only 7=Staff & Family/other 8 = Staff & Unknown 9 = All other Combos (NO Resident) 10= Solo 90=cannot rate	**STAFF ASSISTING RESIDENT - (SAR-S)** 1= Dress/groom/hygiene (Assisting) *[P or NB]* 2=Food/Drink (Assisting) *[P or NB]* 3P = S Cleans-or-Meal Preps WITH R P 4=Large Group Formal ACTIVITY (GFA) *[P or NB]* 5=Small GFA *[P or NB]* 6P=Medication Administration (Resident P) 7=Minor Medical Procedure *[P or NB]* 8P=Moving (Assisting) 9P=Transferring R(s) 100P =Touching (R(s)) 11=Keeping an Eye on R(s) ***(no interaction)*** 11INT = Interacting w R & not doing other tasks 12=Attending Distressed R *[P or NB]* 13NB=Helping R(s) *(other than above-listed assistance)* and Nearby 13P = Helping R AND Proximal **RESIDENT NEEDS ASSISTANCE (RNA-S)** 14=Ignoring R 15= Not Attending Distressed R **INTERACTION w RESIDENT (INT:R-S)** 160=VERBAL INTERACTION (w R) 170= NONVERBAL INTERACTION (w R) **INTERACTION w STAFF/OTHERS (INT:S/O-S)** 161=VERBAL INTERACTION (S/O) 171 =NONVERBAL INTERACTION (S/O) 18S=Helping (S OR O) OR **Given Help** by S (**not** O) 19R=**Requesting** Help (Target S Requests Help) 20=Telephone **OTHER TASKS (OT-S)** 21=Food/Drink (Self; (if R P , code 21P) 22=Moving (Self; (if R P, code 22P) 26=Chart/Computer/Paperwork (if R P, 26P) 27=Cleaning-or-Meal Prep-W/O RP (if R P, code 3) 28=Medication Cart (if R P, code 28P) 29=Supply [Readying/moving equip/materials/supplies] (if R P, code 29P) **NON-WORK (NW-S)** 31=TV watching 32=Eyes closed 40=Non Work Interaction 41=Non Work Other (***Specify:*** *describe ACTIVITY)* **ALL ELSE (AE-S)** 50=ALL ELSE (***Specify:*** *describe ACTIVITY)* 90=CANNOT RATE **OTHER TASKS & NONWORK STAFF IN PROXIMITY TO RESIDENT(S) (OT:P-S) and (NW:P-S)** 21P, 22P , 26P , 3(i.e., 27P), 28P, 29P, 31P-41P	**STAFF ASSISTING RESIDENT - (SAR-R)** 1= Dress/Groom/Hygiene (Assisted) *[S P or NB]* 2=Food/Drink (Assisted) *[S P or NB]* 3P=S Cleans-or-Meal Preps-WITH R.P 4=Large GFA 5=Small GFA 6P=Medication Administration *[S P]* 7=Minor Medical Procedures *[S P or NB]* 8P=Moving (Assisted by Staff) *[S P]* 9P=Transfer *[S P]* 105=Touch (Staff) *[S P]* 106=Touch (another Resident) 107 = Touch (Other) 11=Being "Kept an Eye On" ***(no S interaction)*** 11INT = Interacting w S; S is NOT doing other tasks, just Interacting with the target R 12= Distressed (Attended by S) *[S P or NB]* 13NB=Given Help by S *(other than above-listed assistance)* and Nearby 13P = Given Help ([illegible]) and Proximal **RESIDENT NEEDS ASSISTANCE (RNA-R)** 13R=Requests Help (e.g. "Help!" "Nurse!") 14=Ignored 15=Distressed (no one attends) **INTERACTION (INT:R/O-R) (INT:S-R)** 165=Verbal INTERACTION (S) 166=Verbal INTERACTION (another R) 167=Verbal INTERACTION (O) 175=NONVERBAL INTERACTION (S) 176= NONVERBAL INT (another R) 177= NONVERBAL INT (Other) **RESIDENT ACTIVITIES (RA-R)** 18=Helping (another R or S or O) 20=Telephone 21=Food/Drink (**Independent**) 22=Move (**Independent**) 23= Read/Write/All Other **Independent** Actively ENGAGING ACTIVITIES 24=Dress/Groom/Hygiene (**Independent**) 25=People/Event Watching 31=TV watching **OTHER TASKS BY STAFF IN P (OTS:P-R)** 21SP,22SP,26SP,3(ie,27SP),28SP,29SP **NONWORK BY STAFF IN P (NWS:P-R)** 31SP, 32SP,40SP,41SP **ALL ELSE (AE-R)** 32=Eyes Closed 33=Staring into Space 34=Self-stimulation/Fidget/Talking to Self	1=negative 2=positive 3=neutral 4 = not applicable 90=cannot rate	1=negative 2=positive 3=neutral 90=cannot rate	C=Communi-cator A = Actor R= Recipient W= GFA Watcher NSR= No Social Role NP = Not Possible 90 = Cannot Rate	YES NO 90 = Cannot Rate	1= Actively ENGAGED 2= Receiving only 3= ENGAGED Off-GFA 80=No ENGAGE-MENT/ ACTIVITY *(EC, SS, SS/F)* 90 = Cannot Rate

Pilot

ROR/MOR = **(a) SAR/RNA CODE + (b) INT-R code** involving R&S (one of whom is the Target) = ROR; (a) SAR/RNA Code + **(b) no INT-R code** = MOR; *all other* = ***NOR.*** *[FYI, scored via computer: lessMOR = S is P to R for OTHER TASKS/NONWORK + no **INT-R** code; ROR+ = S is P for OTHER TASKS + **INT-R** code].* All codes presented in order of Trump Rules (e.g., C2 code 1 TRUMPS code 2 which TRUMPS code 3 etc); All Columns are completed for BOTH S and R targets ***except C11*** is R only. **ABBREVIATION LEGEND: S = STAFF; R = RESIDENT; O = OTHER; P = PROXIMAL; NB = NEARBY; -S**

THE GERONTOLOGICAL SOCIETY OF AMERICA®

The Gerontologist
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OXFORD

Measurement Article

Development of a New Tool for Systematic Observation of Nursing Home Resident and Staff Engagement and Relationship

A. Lynn Snow, PhD,[1,2,*] M. Lindsey Jacobs, PhD,[3] Jennifer A. Palmer, PhD,[4] Patricia A. Parmelee, PhD,[2] Rebecca S. Allen, PhD,[2] Nancy J. Wewiorski, PhD,[4] Michelle M. Hilgeman, PhD,[1,2] Latrice D. Vinson, PhD,[5] Dan R. Berlowitz, MD,[4,6] Anne D. Halli-Tierney, MD,[7] and Christine W. Hartmann, PhD[4,6]

[1]Research & Development, Tuscaloosa VA Medical Center, Alabama. [2]Alabama Research Institute on Aging and Psychology Department, The University of Alabama, Tuscaloosa. [3]Mental Health Service, VA Boston Healthcare System Brockton Division, Massachusetts. [4]Center for Healthcare Organization & Implementation Research, Edith Nourse Rogers Memorial Veterans Hospital, Bedford, Massachusetts. [5]Mental Illness Research, Education & Clinical Center, VA Maryland Health

IIR

ENGAGE TOOL

Active engaged residents demonstrate physical or mental effort in a purposeful manner. You must see "extra" behaviors beyond direction of gaze that indicate the person is actively participating. Examples: ▪ Drawing a picture ▪ Stroking and talking to a baby doll ▪ Listening to someone or something leaning forward and nodding at an exciting part ▪ Talking to another person ▪ Reading a book ▪ Inching their wheelchair toward others ▪ Showing excitement	**Not Engaged** residents do not demonstrate attention to any activities within their environment. Examples: ▪ Closed eyes ▪ Staring into space (with no indication that resident is listening to anything) ▪ Tapping table repetitively, rubbing head repetitively ▪ Talking to self or talking to others who are not there; using repetitive words/sounds ▪ Fidgeting with clothes/objects, body parts, hands, feet, etc.
Only Receiving engaged residents demonstrate an attention to an activity b[illegible] no[illegible]ctively participating, interacting [illegible] Examples: ▪ Receiving assistance from staff with eating/drinking but no other engagement is occurring ▪ Watching TV or other individuals	**Can't See/Hear** is used when observer cannot see or h[illegible] resident well enough to de[illegible]e engag[illegible]ent. If appropriate, observers can mo[illegible] to better see residents.

IIR

Phase 1

DATE: TIME: am/pm←please circle UNIT: *Options for observer locations: #1 Dining RM-meal, #2 Dining RM-other, #3 Day RM, #4 Hall, #5 RM to RM, #6 Other (specify)*					LOCATION OF PERSON OBSERVED (per line, enter applicable #)
1	☐ Active	☐ Only Receiving	☐ Not Engaged	☐ Can't see/hear	
2	☐ Active	☐ Only Receiving	☐ Not Engaged	☐ Can't see/hear	

Psychological Services
2017, Vol. 14, No. 3, 337–346

In the public domain
http://dx.doi.org/10.1037/ser0000137

Adaptation of a Nursing Home Culture Change Research Instrument for Frontline Staff Quality Improvement Use

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Edith Nourse Rogers Memorial VA Hospital, Bedford, Massachusetts

Whitney L. Mills
Michael E. DeBakey Veterans Affairs Medical Center, Houston, Texas, and Baylor College of Medicine

Camilla B. Pimentel
University of Massachusetts Medical School

Rebecca S. Allen
University of Alabama

Nancy J. Wewiorski and Kristen R. Dillon
Edith Nourse Rogers Memorial VA Hospital, Bedford, Massachusetts

A. Lynn Snow
Tuscaloosa Veterans Affairs Medical Center, Tuscaloosa, Alabama, and University of Alabama

Enhanced interpersonal relationships and meaningful resident engagement in daily life are central to nursing home cultural transformation, yet these critical components of person-centered care may be difficult for frontline staff to measure using traditional research instruments. To address the need for easy-to-use instru-

Innovation Project

- National consultants
- Made 6 visits to a CLC
- Implemented relational coordination principles
- Worked directly with staff to pilot and refine changes

LOCK

- Learn from Bright Spots
- Observations by Everyone
- Collaborate in Huddles
- Keep it Bite-Size

IIR Phase 2

LOCK Tenet	Explanation	Fictional Example
Look for the bright spots	Look for positive outliers (e.g., “positive deviants”) to identify instances of success from which to learn	A neighborhood has 35% active resident engagement/week. Staff pinpoint areas of highest engagement and investigate what contributes to those bright spots.
Observations by everyone	Have staff step back from regular routines and conduct specific observations to collect data	Each staff member conducts a 5-minute observation of resident engagement during a meal, using a structured observation form.

LOCK Tenet	Explanation	Fictional Example
Collaborate in huddles	Discuss (a) risk factors for an issue, (b) what can be learned from bright spots, (c) results of observations, and (d) changes to pilot.	Charge nurse uses 5 minutes at start of shift-change huddle to get staff input on risk factors for residents not being engaged and discuss bright spots of resident engagement identified through observation. Based on lessons learned from the bright spots, staff identify small action items to try.
Keep it bite sized	Keep all LOCK components to 5-15 minutes.	Existing meetings are shortened by 5-10 minutes to make room for stand-up huddles. Pilot changes are chosen to be small but meaningful.

Post vs. pre intervention association of the LOCK-based intervention with RAISE measures, adjusting for site

	Beta	95% CI	P-value
Resident engagement, active	0.017	-0.034 – 0.069	0.585
Realized opportunities for relationship	0.083	0.040 – 0.126	0.001
Quality of staff interactions with residents			
Positive	0.055	0.000 – 0.111	0.1
Negative	-0.035	-0.062 - -0.009	0.029
Emotional Tone			
Positive	0.011	-0.027 – 0.048	0.585
Negative	-0.003	-0.011 – 0.004	0.563

Semi-Structured Interviews

- Staff consistently credited the LOCK intervention with helping them
  a) develop awareness of the importance of identifying opportunities for engagement
  b) act to improve the quality of interactions between residents and staff

“It becomes an instinct. When they see someone walking around on his own, they just go over and meet them in the middle and hold their hand and walk together instead of letting him wander around. You think it’s just a very small thing, but those are the ones that prevent bigger things from happening.”

-Registered Nurse

“Huddles allowed you to hear from peers about your own mostly good behaviors that you didn’t even realize about yourself, in a way that was easy to hear.”

-Registered Nurse

“The physician was involved in the huddles. It really meant a lot when he spoke up about the different bright areas to the staff.”

-Registered Nurse

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The Gerontologist
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OXFORD

Intervention Research

Applying a Theory-Driven Framework to Guide Quality Improvement Efforts in Nursing Homes: The LOCK Model

Whitney L. Mills, PhD,[1,2,*] Camilla B. Pimentel, MPH, PhD,[3] Jennifer A. Palmer, MS, PhD,[4] A. Lynn Snow, PhD,[5,6,7] Nancy J. Wewiorski, PhD,[4] Rebecca S. Allen, PhD, ABPP,[5,6] and Christine W. Hartmann, PhD[4,8]

[1]Center for Innovation in Quality, Effectiveness and Safety, Michael E. DeBakey VA Medical Center, Houston, Texas. [2]Department of Medicine, Section of Health Services Research, Baylor College of Medicine, Houston, Texas. [3]Department of Quantitative Health Sciences, University of Massachusetts Medical School, Worcester. [4]Center for Healthcare Organization

Methods Discussion

Blended Facilitation as an Effective Implementation Strategy for Quality Improvement and Research in Nursing Homes

Camilla B. Pimentel, PhD, MPH; Whitney L. Mills, PhD; Jennifer A. Palmer, PhD, MS; Kristen Dillon, PsyD; Jennifer L. Sullivan, PhD; Nancy J. Wewiorski, PhD; Andrea Lynn Snow, PhD; Rebecca S. Allen, PhD, ABPP; Susan D. Hopkins; Christine W. Hartmann, PhD

ABSTRACT

Background: Blended facilitation, which leverages the complementary skills and expertise of external and internal facilitators, is a powerful strategy that nursing stakeholders and researchers may use to improve
rovement (QI) innovations and research performed in nursing homes.
esent myriad challenges (eg, time constraints, top-down flow of communication,
ementation and research.
icle describes the theory and practical application of blended facilitation and its
tion, internal facilitation, relationship building, and skill building), using examples
intervention in Veterans Health Administration nursing homes.
ation invites nursing home stakeholders to be equal partners in QI and research
may overcome many existing barriers to QI and research performed in nursing
g relationships between researchers and stakeholders, may accelerate imple-
practices.
d practice, implementation science, nursing homes, quality improvement, re-

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OXFORD

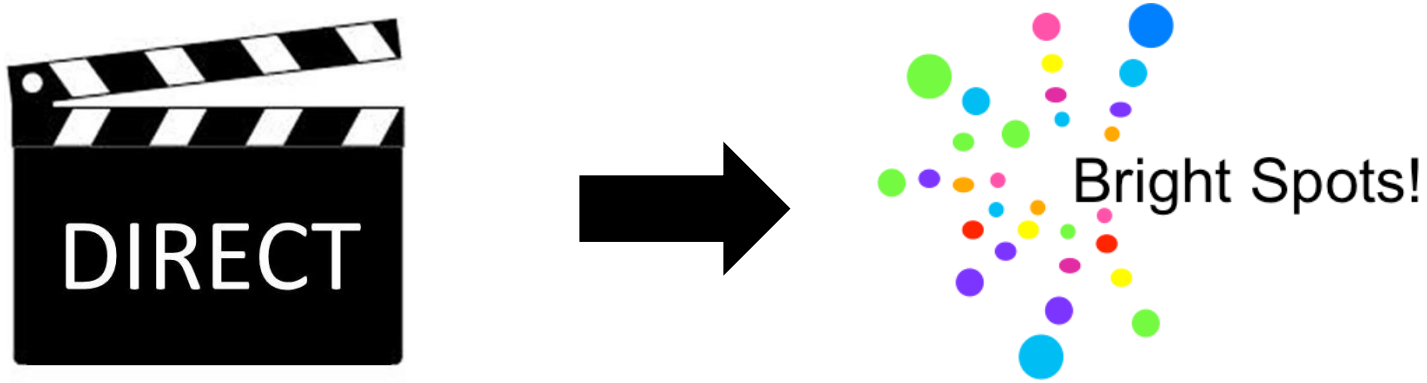
Intervention Research

Impact of Intervention to Improve Nursing Home Resident–Staff Interactions and Engagement

Christine W. Hartmann, PhD,[1,2,*] Whitney L. Mills, PhD,[3,4] Camilla B. Pimentel, MPH, PhD,[5,6] Jennifer A. Palmer, MS, PhD,[7] Rebecca S. Allen, PhD, ABPP,[8,9] Shibei Zhao, MPH,[1] Nancy J. Wewiorski, PhD,[1] Jennifer L. Sullivan, PhD,[2,10] Kristen Dillon, PsyD,[11] Valerie Clark, MS, RD,[1] Dan R. Berlowitz, MD,[1,2] and Andrea Lynn Snow, PhD,[8,9]

[1]Center for Healthcare Organization and Implementation Research, Edith Nourse Rogers Memorial Veterans Hospital,

October 28, 2015



POLL QUESTION #2

- #2: What is your most pressing question about facilitating change at the frontlines of care? [pick one]
  - What do you think is the biggest hurdle?
  - What do you think is the most important facilitator?
  - Do you think the changes can last?
  - Looking back, what would you do differently?
  - How was your operational partner involved?

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National Program

What is Bright Spots Program?

About Bright Spots Program

Keys for QI Huddle Success

QI Frontline Huddles

Bright Spots Observation Tools

Observation Tools

Learn & Share Experiences

Bright Spots Blog & Community Discussion

Curriculum Materials

CLC Leadership Launch

Link to SharePoint for Optional Data Entry

Data Entry

Relational Coordination in Action: Focus on Frontline Huddles

Frontline Huddles: A Quality Improvement Priority

- **Frontline staff involvement in QI is critical**
  - Building on frontline staff-resident relationships by empowering frontline and problem-solving with frontline produces higher quality care
- **Huddles are realistic way to ensure input from frontline staff**, who spend most time with patients/residents
  - Huddles are bite-size, occur on the floor, and support group collaboration and two-way dialogue

Note: Frontline staff need strong invitations to share their knowledge

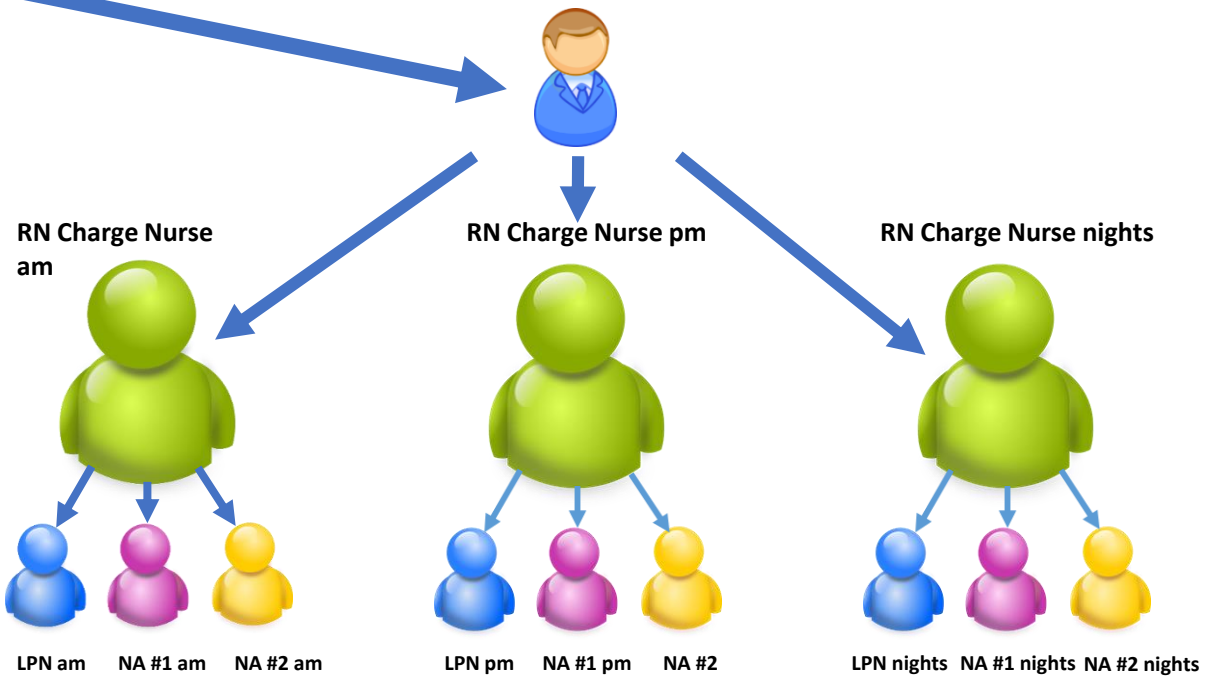
- Authority/power differentials & history of not being systematically included means more than usual effort is needed

Without Frontline Huddles

Conference Room

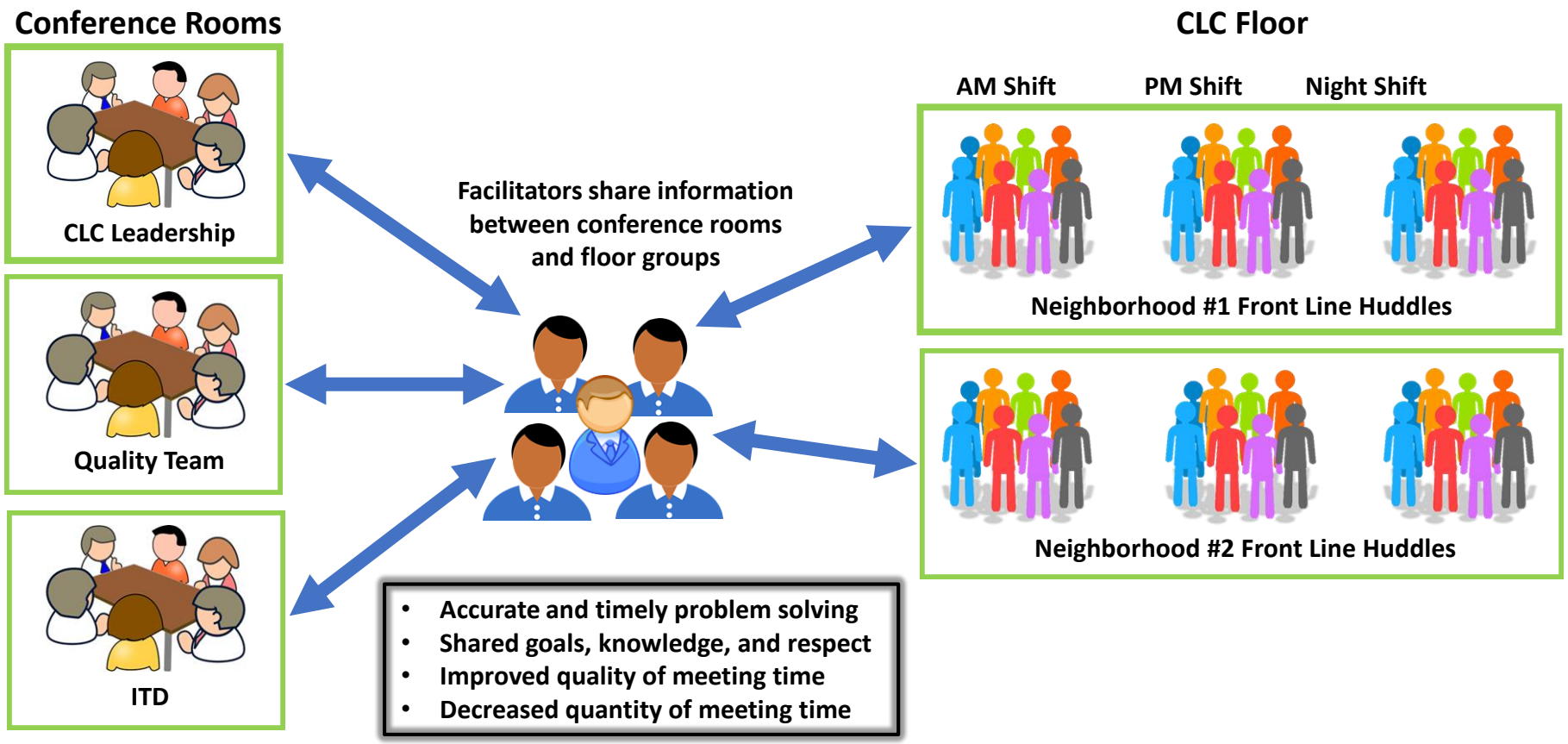
Chief Nurse
Nurse Manager #1
Nurse Manager #2
Nurse Manager #3
QMO, MD, NP, Other Staff

Information from the conference room is shared by Nurse Manger #1 to Charge Nurses who then share with some staff on CLC floor in neighborhood #1

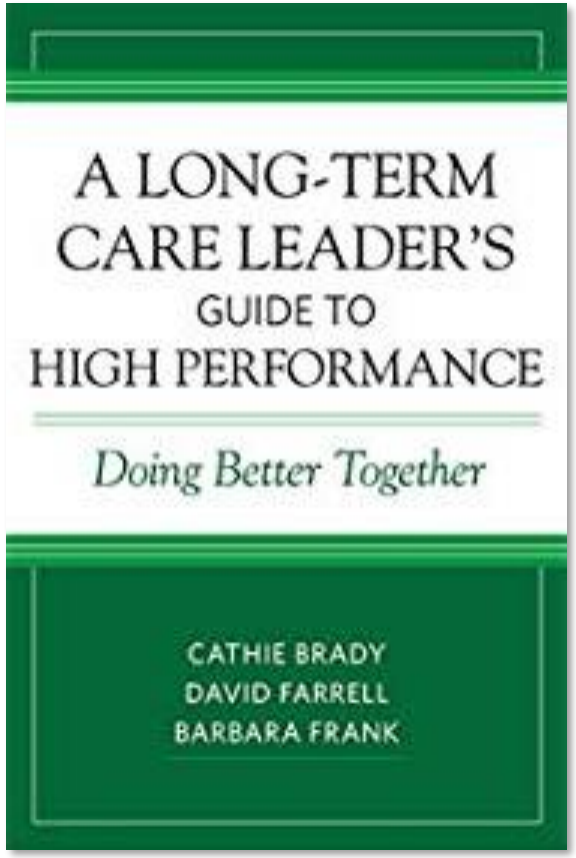


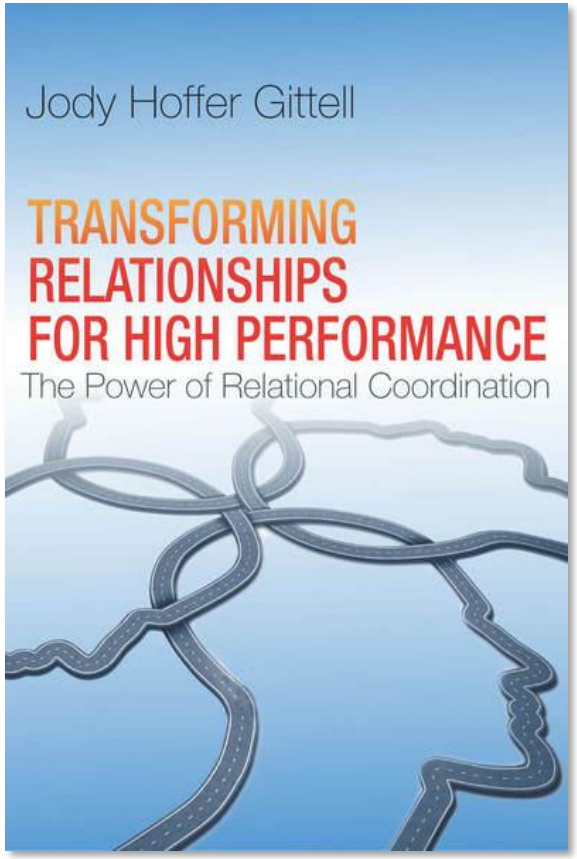
- **Information is reported in directive style**
- **Due to repeated communication, some parts are left out or communicated differently**
- **1:1 exchanges offer less opportunity than group discussions to share unique perspectives or brain storm courses of action**
- **No reciprocal communication means missed opportunities and increased cycle time**

Using Frontline Huddles



Communication in Action

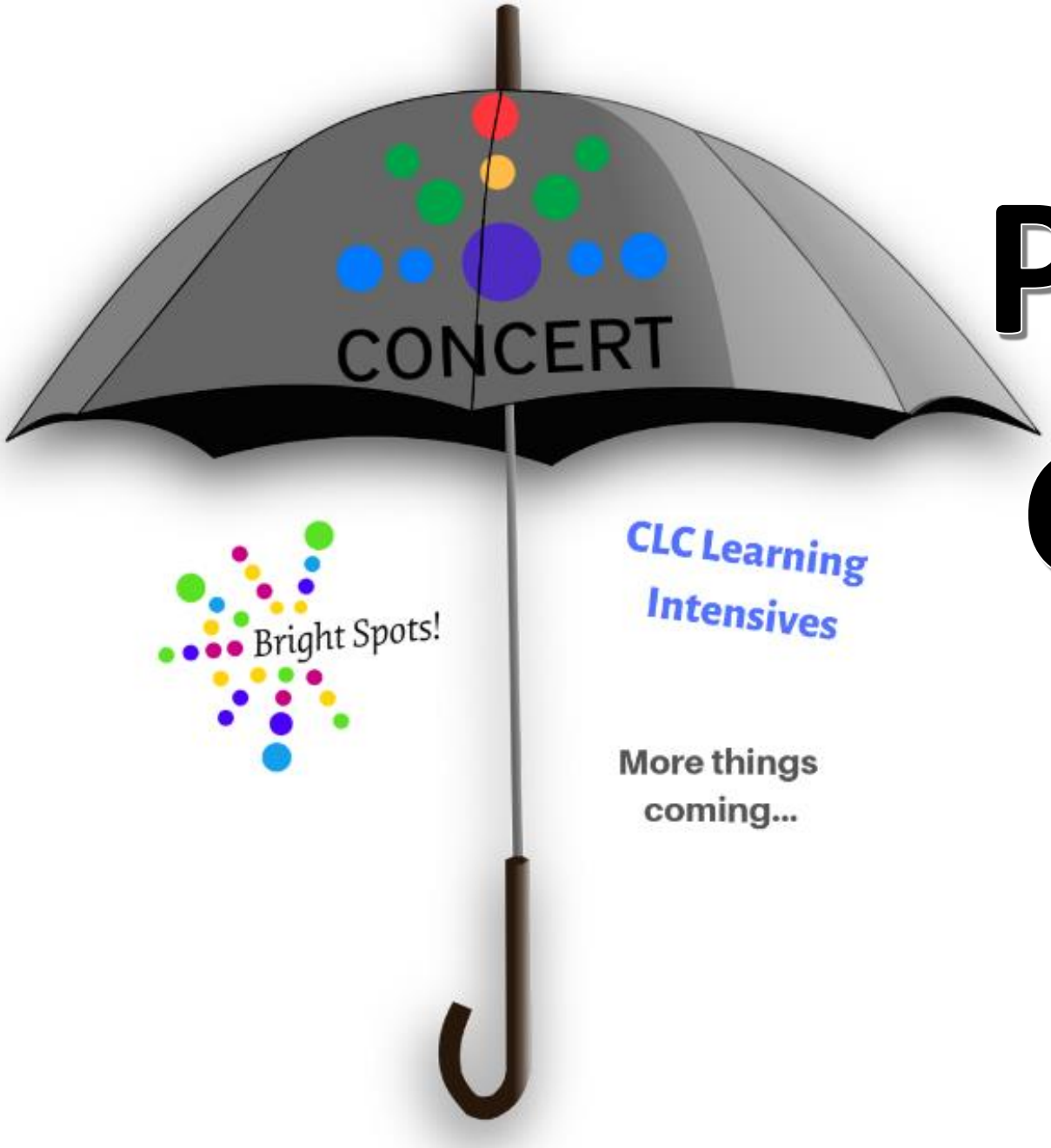

A LONG-TERM
CARE LEADER'S
GUIDE TO
HIGH PERFORMANCE
Doing Better Together
CATHIE BRADY
DAVID FARRELL
BARBARA FRANK


Jody Hoffer Gittell
TRANSFORMING
RELATIONSHIPS
FOR HIGH PERFORMANCE
The Power of Relational Coordination

POLL QUESTION #3

- #3: What would you like to hear more about? [pick one]
  - How the CONCERT team is organized
  - How this program is received by CLCs nationally
  - What you do when a CLC doesn’t want to participate
  - How you balance your research/operations work
  - What’s next

Program Growth



Questions?

christine.hartmann@va.gov
lynn.snow@va.gov

Resources
https://www.vapulse.net/groups/bright-spots-program-in-clcs