Event ID: 2602663
Event Started: 4/22/2015 3:53:00 PM ET

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Welcome to the national nursing home collaborative kickoff for the states of Alaska, Hawaii, Montana and Wyoming. We are excited to have you here with us today and your commitment to ensure polity of care and quality of life in nursing homes. My name is Pat Fritz and I am the reason oh -- regional coordinator. We have placed all telephone lines on mute. In preparation for the question-and-answer period, also mute your line way hitting the mute button on your phone or the 4* on your keep have. Do not put us on hold. This will help eliminate background noise. We also encourage you to ask any questions and share any comments in our chat box which you will find on the WebEx site.

I would like to introduce the Mountain Pacific team members who are eager to support you. In Alaska we have Lisa Johnson who is your go to person. We have to way Yadao in Hawaii and Pamela Longmore as well as myself. Pamela in Montana will also have [Indiscernible - low volume] Marcy Gallagher. Marcy Gallagher is also our coordinator across all four states for our peer coach and resident and family advisor program.

Our agenda today is listed on the screen. We ask that you stay engaged with us throughout today's program. Throughout the program, we would like you to ask questions and comments -- put comments in the chat box. We all have something to learn and something to teach each other today. Following the short introductions, Carmen Bowman will engage us in a discussion on person centered care. Then Marcy Gallagher will provide information on. Singh and the resident family advising program. Lisa and were -- Ross have created fun activities and we hope you will participate in them. Towards the end of the program, we will discuss next steps along with the support that the Mountain Pacific staff will provide you. We will also have an open forum for you to ask questions, make comments or make requests. Today's program has been approved for 0.1 CEU by the Montana nursing Association through the aMCC. To receive your CEU you need to complete 80% of the program and return an of valuation to us. The evaluation can be featured -- reached either through the pop-up box at the end of today's program or with the handout that was sent to you via email for completion and return to us. The presenters have no conflict of interest relative to this activity. We would like to move on.

Carmen Bowman is a consultant, trainer, author and owner of EDU catering, catering education for compliance and education change. She was a Colorado State Senator. for nine years, a policy analyst with the EMS central office and was the first certified activity professional to be a surveyor also surveying on the for your CMS panel that developed a new guidance for activities and 249 qualified activity director. Carmen recently co-authored the power of line which to create culture, a limiting alarm and preventing [Indiscernible] way engage with like. She has a Masters degree in healthcare systems, is a certified [Indiscernible] Associates and mentor. She is a certified validation worker an practitioner. Welcome to Carmen.

Thank you pattern thank you to everybody. -- Thank you Pat and thank you everybody. What an honor to speak to four of the most beautiful states in our country. If there were five listed I am sure Colorado would be the fifth. That is where I am from.

I am going to pull it up. This is a great topic that you have chosen. One thing I want to kick it off with is someone which. Have you ever noticed that when someone moved out of their home for the first level of -- not care yet -- what do we call it -- independent living. Then they need a little bit more care, we call it assisted living. Them when they need more care guess what we call it. --, Long-term care. Where did the living go? Is in that profound? -- Isn't that profound? Wanted from me to you. I have learned it myself from other leaders in the culture change movement including Doctor Thomas. I have heard them say more than once, we need to talk more about life and living than care. I would warn you in a way, and encourage you, to talk more about life and living than care. I have come to believe that good care should be a given. Wouldn't you agree? We shouldn't even have to talk about it so much. Our system should be so clean and clear cut and great care should be given every day without even talking about it, so that people could move up on the hierarchy to self actualization, what our regulations called highest practical level of well-being, quality-of-life. We could also call it self directed living.

It was at our first CMS network training home symposium on the environment to -- environment that Doctor Maggie [Indiscernible] she said we call a person centered care, resident directed care. But I think we're still talking in the third person. What we need a self-directed living. Myself, I have come to realize what we give as staff and caregivers and providers, is individualized care. There is a lot that is said in that one word, individualized. Then we help people live self directed life. How do you like that? -- Live is -- how do you like that?

What would you say is the difference between institutional living and self-directed living? I will give you my list. I would love to hear from you as well. What do you think?

Carmen, have you put your slide up.

Yes. I never saw the opportunity to share my screen. Let me look for it. I am the presenter. I don't see where it says share screen. Here it comes. I am so sorry.

That is fine. I didn't need the slides but you sounded so good.

You are funny. Now I of lost sight -- [Pause] -- Can you see my screen?

Yes, now I do.

This is where we are. I can't see the chat box. I don't know if I am supposed to be able to. My thought was to share ideas and the chat box of anything that I of missed. Maybe you can see that, Pat . The institution, one time a CNA called it the Almighty schedule. That is sobering and sad to think about how everything in these people's lives typically is now mandated by some other schedule, someone else's schedule. None of you even built the schedule that you work under. I have been reflecting on this lately around the idea of activities. What if you want to plate bingo on a different day? -- Play bingo on a different day? What if you want to sing hymns every day?

What if you are sick on the day that there is one activity that you like? Then you have to wait another week. Everything is contrived in a traditional institution. We have the opportunity to change that, to let it be more spontaneous and less rigid and structure. That is what person centered care does.

There is a wonderful video, action-packed film, called a way back home. It is a resident that is interviewed and she says, when she moved into the household model nursing home, she asked what the rules were. She was told, there are no rules here. It is your life. Why would there be rules? You are an adult. Don't you love that. I would encourage you to make that your goal. There are no rules here. That would be amazing. Hopefully you have heard one of the kind of network values which is to put the person before the task, --. Typically our institutions of put it the opposite, putting the task before the person. Wouldn't it be amazing if you were told, Carmen, if you don't get every inch of the dining room floor mopped, because a resident needed you, that is okay. If you don't get every pill past because a resident needed you, that is okay. Residents come first.

I actually heard and administrator say if the beds are all made by nine in the morning I wonder -- 9 AM I wonder what needs were not met. Is an amazing. -- Isn't that amazing. We are somewhat guilty of the industrial way, starting to treat people as widgets. Unfortunately, there is no relationship in the culture. The new culture makes relationships number one, above all else. You will not get in trouble if a resident needed you.

In an institution, there is often no choice. As a place -- in a place where you have individualized self-directed living, you have lots of choices. I will show you a picture of a place that Nolan does not only has a buffet but restaurant style, take what you want off of the buffet or order from the menu. I always say, that is way better than my house. At an institution, the person is often lost. A lot of leaders that have gone on before us talk about institutions being non-places and your personhood is stripped. We have the opportunity to do the opposite, to make it all about the people that live there. Wait till I tell you the stories I have for you today.

If you didn't know this, the mark of an institution, one of many, is all of the programs. We have all kinds of programs, a dining program, aromatherapy program, this program in that program. We have to stop all of the programs. I encourage you. I challenge you to challenge each other to have less programs and more real-life. Instead of a walk to dine program you can talk about how you have made it a priority in your place to help residents walk, period, including to the dining room to times a day. -- Two times a day.

Building on Doctor Thomas, we have to talk more about life and living. I wrote a chapter in a book that I am writing called, engagement with real-life, no more programs. Imagine a world where we all do that. If you asked a fellow non-activity staff to help with activities, the institution has driven us to all reply with, that is not my job. I don't have time. Look at what happens if we change the language. What if we invited all staff, all families, all volunteers, to help residents engage with life. It takes on a different meaning. Nurses, you can turn on the radio in the evening when you are working. You can dance. A complex cards -- you can play cards if you have time. Live life with your residence. We can all do that.

An institution, as you all know, typically operates with a top-down hierarchy, where as the change cultures are doing it differently. They are flattening management. They are flattening the hierarchy. They are making it happen that all people have a voice in this place, especially those who live there. Guess who should have more poison anyone else? Those that live there.

If you think about -- it is coming up -- I have to save some of my thoughts. I was asked to share with you all some of the culture change measurement tools that are out there. One of them is called the stages tool by less grant and LaVrene Norton. It helps you assess the degree of culture change at you have from an organizational development perspective. -- You could guess if you are in the institutional model stage one or if you have made some moves out of it, the transformational model, stage II. Whether you are a neighborhood model, stage III. Whether you are a neighborhood model, stage 3 or whether you are a household model, stage IV. I would ask you to consider looking at all of these tools. You never know when an individual or your team will have an off moment -- an ah-ha moment. There is also a wealth -- web-based questionnaire that talks about this model. It helps you figure out where you LAN and it looks that 12 key domains. It tells you the highest model stage that you -- that your home fits. Then we have the E didn't want surveys. Eden has put together three questionnaires call the warmth survey that you use with elders and families and employees. You have to rate from strongly agree to strongly disagree. Things such as, decision-making, choices, work has meaning and purpose. You can download them for free and doing your own calculations. Eden is happy to talk to people to explain the survey or explain what you are looking at, after you do the calculations. Eating came out a few years ago with a well-being assessment. -- E didn't came out a few years ago with a well-being assessment. There is the eldercare partner, family care partner, employee care partner. They are posted online if you are a way to see member -- registered member but you can ask for a copy to do your own analysis. Get in touch with Eden and they will tell you how to work it.

If you didn't know, Eden got a grant and defined seven domains of well-being including, I don't know if I know them by heart. I don't know -- I don't think I have them listed. Things such as autonomy, connectedness, growth and even joy which is my favorite one. In writing my book, someone pointed out that she purposely uses different tools such as this, than the typical satisfaction tools that most homes use, because you start to get a different answer and a different feel for how people would rate their well-being in seven different domains. I want to put in a plug for it. It will help you get to know residence at a different level and hear their thoughts.

You can also have the Eden alternative do the analysis for you. That is a cost of one dollar per survey. There are a lot of options. Quite a while ago the Institute for caregiver education put together another survey called, the culture change indicator survey. We are finding out this tool is a degree of commitment to culture change. Under their domains of environment, organizational procedures, resident involvement and staff empowerment, it is a five-point scale that you have never considered that thing all the way to it has been fully implement it. That is another tool to consider. The way know the most about is called the artifacts of culture change measurement tool, --. CMS put out a contract and I was the person who helped put together this tool in 2006. Notice the tools that I just told you about. They all have a place but none of them captures the concrete changes that you can actually see with your eyes or touch with your fingers or read in a policy and procedure. We were hearing from many homes back in the early 2000, we do culture change. Have you ever had this experience where you heard that about a home and

then you went to visit and you wondered where the culture exchange was? We set out to help homes show some of the changes that can be hard to show. Culture change is a change of heart and mind and attitude. What can you see? I love the name that we came up with. If you think of a culture that has gone before us, we often find artifacts that prove they existed. Thus we called it the artifacts of culture change.

We also used the HATCh which stands for the holistic approach to transmissible -- transformational change. This was done in Rhode Island when they did a two your culture change scope of work and here is a picture of the HATCh model with the resident shown in the middle with the environment coming around the person, workplace practices and care practices and environment surrounded by leadership and then community and financial resources and then finally the government regulations. We adopted five of the six. We did not, believe it or not, adopt the regulation and government owning. -- Domain. We didn't think it was a port. We have care practice, environment, family and community [Indiscernible] we adapted five of the six and added our own six -- sixth section which we call outcomes. How many have you -- of you have thought over the years, wouldn't it be great if the government or anyone let us show the good things that we do? The outcomes section is that. It is showing longevity of staff, occupancy rates, turnover rates. Those things typically change when you have a change of culture. By the way Karen and I, our hope had been to make a part of the survey process, homes had to complete the artifacts tools during the survey. Instead of some of the things that you are ready fill out. Plus we found a lot of duplication. That never happen. Maybe it still could someday. Our final tool has a funny total of 79 items.

I don't have time to go through the whole thing. But I decided to pick out 5 or 6 of the top practices. That is what I was asked to do. They also are in the artifacts tool. I will start with waking and bedtimes chosen by residents. First we have to say, did you know this is not just a good idea but also a regulation, which I will show you in a minute. When it comes to this topic, it is one of my favorites. How many of us would rather be sleeping right now? [Laughter] I often get lots of hands, several people shoot their hands up fast. Once in a while someone throws up both hands. That is fun to watch. Sleep is beautiful and glorious and healthy.

My mom would say to me growing up, go to bed. Whatever else you, you will feel better in the morning. Do you know what? She was right. Whether it was emotional or physical, you do tend to feel better after a good night sleep. I added to my mom's quote, sleep is better than medicine. The picture of the alarm clock makes me think and want to ask you all, don't you love it when you don't have to set your alarm clock. Isn't that a perfect day. Why? I think it is because your body gets to decide when to wake up. That is what you have, it's a gift you can give back to residents. What some people are calling a blissful morning, to not be woken up by someone else, to not be woken up at a set time. Blissful is a good description, I think.

And if you think about the person doing the waking, how many of us like to wake someone up. That is not fun. The poor caregivers, Eric Heider in the early days of the movement pointed out, we put the CNA in an up impossible -- an impossible situation. She knows that the person doesn't want to get a. Sometimes a battle ensues but who will she listen to. Her heart wants to listen to the resident but the institution forces her to listen to the nurse -- is not the nurses fall. It's really the institution telling us to wake people up at a certain time in order to get to breakfast.

There's a lot we can say about that. How many of you don't even eat breakfast? I have been a non-breakfast eater most of my adult life. There is a lot of us in the crowd. And then we come to everybody getting older and Eric Heider would also point out that what we do to the residents is we teach them learned helplessness. They learn that if they just let us, as a caregiver, get them up, take them to the meal, eat a few bites of toast, then they can finally go back to bed. That also represents a royal waste of time. Time is of the essence. It represents a loss of money. We are wasting our time when we are waking people up and are ready to get up yet. Then we have to think what the benefits are of being well rested. We call ourselves healthcare and we're depriving people of sleep.

We all know that people are less depressed and anxious and more alert and energetic and can take in the day and do things during the day. Plus our immune system is built up. Protein synthesis to repair, muscle growth, why would we ever wake someone up? Better cognition, better thinking. Did you know that most homes that don't wake people up say that they barely have any behaviors anymore. I don't even like to call the behaviors. This is why. It's not fair. If we are waking people up before they are ready and they are upset about it, how dare we call it a behavior. Then we box them into the connotation that they are a bad person because they have behaviors, or they are a behavior problem. That all goes away when you honor the Bonners -- bodies need for sleep -- body's need for sleep. When that person's body is ready to wake up, there in a better mood. Do you want to prevent falls? Is what happens when people are well rested? You will see fewer false. Everything is better. Why would we ever want to wake people up?

Supporting sleep also leads to better outcomes. Nurses are telling me things such as, when you are not rushed in the morning, we will get to open dining in a minute. The opening up of dining times has to go hand-in-hand with stopping and waking people up. They point out, when caregivers too are not rushed, they can get in the cares that need to be done and not be rushed to get to an arbitrary this time, whether they are done, or not. This represents a practice of stopping doing something and honoring the body. I will give you another tip.

Some homes in our movement apparently walked around with a clipboard saying, when do you want to get up. Wendy want to get up? -- When do you want to get up? What if everyone said the same time? We have the same problem. My encouragement from me to you is don't do that. Flip your priority and start to say, we are going to honor sleep rather than we have be more -- better than we have before. Sleep has a lot of good outcomes. We will relax the rush. We don't wake people up. If someone asks you to be woken up at a particular time every morning, of course, do that. But don't make time the issue. There is a regulation, self-determination and participation. The resident has the right to choose their activities, here is the big one, their schedules, their healthcare consistent with their interests, assessments and plans for care. Even though we think of the assessment is ours, they should reflect what the resident wants. The plan of care as well. The right to choose a schedule. Number three is the right to make choices about aspects of their life that are significant to them. I think sleep is significant to a lot of us.

Look at what happens. As we stop waking people up and we honor sleep and we honor people to eat when they want, a person centered med pass comes along with it. We liberalized diets. All of the things are happening at once. We will be more climate -- compliance with this requirement

than we ever have before. As you move forward, lean on the strong regulations that we have ignored all of these years, residents have the right to make these choices.

I don't have it on the slide but in 2009 CMS came out with new guidance under this Tag F242 . It goes deeper to say that you as a provider should be actively seeking resident preferences. That is the verbiage, actively seeking, on when to -- it says choice over schedules, waking, bathing, eating, retiring. It lists waking in there. Think of all the health reasons.

Why would we wake people up, especially if we are about helping people be healthy? If we are going to live up to the idea of choice as being compliant with the resident such as with Tag F242 -- this is not in your hand out. This may interest you. This is not in your hand out. If you want to jot down some other regulations that are now talking about sleep, it's exciting. 309, quality of care, [Indiscernible - low volume] Lack of sleep could be a possible cause for behaviors. There is every reason on to wake people up. It may also contribute to paying. Present 29, under unnecessary drugs it talks about -- 129 -- 300-2900 necessary drugs it talks about using sleep hygiene techniques and individualized sleep routines to help someone sleep so that they will not need a drug. 248, activities talks to the fact that we should have activities available for someone who can't sleep. Maybe they worked the night shift and they are awake at night. 315 talks about urinary incontinence. 319 talks about are there sleep disturbances related to mental and psychosocial difficulties. It is difficult to adjust to living in an institution.

We have all of these good reasons to look into sleep and talk about sleep, what is someone's routine for getting a good night sleep. Do they need the Sox on their feet. Are they hot? Are they called? -- cold? Some people have to do the same thing every night in order to fall asleep. Do we even talk about that with residents. I hope you do.

Along with honoring sleep you have to look at open dining. I want to talk about open dining now.

Eric Hyder was one of our early leaders that realized he had everything a restaurant has. He had a dining room and kitchen and a buffet work why can't it be a restaurant? Since then I of worked at home in Colorado and that is what they call it. It is called a restaurant. This comes from Eric Hyder's work in Missouri in 2000. It is a funny sign. It is not fancy. Look at the message. Mealtime, eat anytime you prefer to, breakfast is from 6 AM to 9 AM. Lunches from 11 AM to 1 PM. Did or is 4:30 4:32 Max expect 30. This is where I want to say it's that are than my house. We Lisa someone wondering about the regulations. I'm sorry this is not in your hand out. Tag F368 Says there will be three meals daily. The reason they do that is become in the -- in our history of nursing homes, they didn't often have three meals each day. The reason why it LANs in the regulations is because evil want offering it. It says no more than 14 hours elapsed between supper and practice of must -- elapsed between supper and breakfast unless -- it goes on to say a nourishing spec is provided at bedtime, 16 hours can elapsed if a resident group agrees any nourishing snack is provided. It is too bad that we didn't all hear about it as the second -- 16 hour rule. The end of an open suppertime and the beginning of an open breakfast time is always within the 14 hours. Now you are compliant with Tag F368 as well as Tag F242 , honoring choices, Ettore than ever before.

-- Better than ever before.

I would also offer you this idea. Open dining, you already have it in a way. What I mean is, do you know how we hurry and get everyone in the dining room. Where is Mildred? There is everyone in a dining room. Can we serve everyone at the same time? No. Think about your first Place being served to the last -- plates being served to the last ones. Let's say it is one hour. Why don't you start saying that lunch is not at noon but from noon to 1 PM. Breakfast is not at 7 AM. This is between 7 AM and 8 AM. If you start to open up these possibilities for staff and residents, to dine when it works best for them, hopefully as people get excited, maybe you can turn it into a true open dining and start to move towards a menu, cooked to order. You have everything that a restaurant has. That is exciting.

Then we have better outcomes. I mentioned more time for here in the morning. It is -- care in the morning. It's more relaxing for everyone. We have another practice which is called the eye care planning, in the voice of the resident. The early pioneers would say it is powerful to read in a care plan, instead of back pain, medication order, what if you read, John is a hiker and he fell many feet when he was 20 years old and he has had back pain ever since. That is the powerful piece of learning people story of knowing them as a person. It is very powerful. It gives residents their lives back. When they could to say, -- get to say, in their own voice, that is excellent. If I have dementia and I spit out my green beans, what did I just tell you? Caregivers work with these people day in and day out. They know the person well and they know what they are telling them, whether they knew -- use words are not.

I would be curious to know how many of you are using this eyecare plan. What -- "I care" plan. If you think about people wanting to know about you and you wrote it down, think about how you would write it. I asked people in workshops, who wrote in the first person -- third person and who wrote in the first person. The majority of them say they did it in first person. This is one way to help us to better.

CNA's attend care conferences. This is another practice. I was asked to highlight 5 or 6. If you think of the meetings that CNA's should go to, if you go to the one -- think of the one meeting that they need to be at, which one is that? Which one have they typically not been invited to. It blows my mind. It is the care conference which they should be at. A few things that I have learned, CNA's want to be at the meetings they are needed at. They may -- you might predict they would say, we know a lot. Do you know what they actually say? They say, if I could go to a care conference I think I would learn about my resident even more. It blew my mind to hear these loving statements. With beautiful words being shared. Families thinking the CNA's.

I once witnessed, I was in a care conference once where we read something about the resident, someone looked up and said, do you know if she still does that. No one in the room knew. CNA knows. What I come to view it as is a royal waste of everyone's time unless the CNA is there work I am a rebel. If I was working in --. I am a rebel. I could see myself revolting. I am not going unless all the right people are there.

The research actually bears out that you will have lower rates of turnover. People want to be involved at this level. You will have higher staff satisfaction. There is one more thing I wanted to

say. This is a sweet story. I was working with a homer wanted to experiment with this. The message didn't get passed on. The day that I came to consult, there would be no CNA's there. We started the conference and about 10 minutes into the conference, here came a CNA out of breath, holding her lunch she said, --. She said, is this the care conference. I have never been to care conference but this is my lunchtime, --. I really wanted to come. This depicts how badly they want to be there. We have residents and family members serving key way QA --. We were aware what we came out with this tool in 2006, now it is going on a lot more. If you haven't gotten on the bandwagon, it doesn't necessarily mean that your residence fit exactly on the -- sit on the QA committee . They could. But with QAPI we are starting to see this idea branch out. The idea of huddles that people are doing. A huddle can be done on one issue for one resident with all of the right people, even with the resident. A huddle can be on one issue such as pulling your people together and saying, we just found out the infection rate when up. What will we do? This person fell again. You can turn anything into a huddle. Getting residents more involved, asking the more questions is important. I have another point coming up.

Evergreen retirement center in Wisconsin not only had a resident server on the QA committee but also in their Board of Directors . And administrator in Colorado has a great quote. Residents and families care about that home is much as you do. I wonder if they care even more than you do. You care a lot. But that's not your mom or dad. As I said, 1015 has come -- QAPI has come so you can involve them more in any ad hoc committees and PIP's. Here is one way to heal from people better.

I would love to know in the chat if you want to say if any of you use learning circles. Let me tell you about them. A learning circle gives residents and staff the opportunity to share their opinions and ideas in a much better way than we have ever done before. This fun picture is a community that has used learning circles for many years, so much so that if there is a grumbling in the culture about something, someone will run to the administrator and say, we need an emergency learning circle. That is profound.

I have worked with a few homes lately that are turning resident Council into a learning circle. Just by making a circle, they have had more people interested in resident councils. More people come and they are saying things such as, it makes me feel more involved in more listened to. If you do nothing else, try holding more and more meetings in a circle. That would be step 1.

You have probably all talked about the -- heard about the talking stick concept in the Native American culture. Whoever has the stick as the floor. Nowadays it is a microphone. It can be a phone. I have the talking stick. In a learning circle, I would pass it on. You pose a question and if you have a culture that you need to start softening, the learning circle could be about getting to know each other better. Ask the questions around the circle. Where were you born? Where did you go to school? What is your favorite ice cream? Have fun with this.

Then you can use this to solve problems. You pose an issue. We had this problem over the weekend. Let's all share what we think could have prevented the problem or could make next weekend go better. You commit to hearing from each other first. You don't have crossed discussion yet. You don't add to what someone just said. You may want to add something but you don't. You hear from one another. That is why it is called a learning circle. You will learn,

learned, learn from each other. Then once everyone has share come a you open it up for discussion.

My favorite question to ask in a learning circle is, where do our inefficiencies live. Every single worker always knows what is inefficient in their place. Community meetings are a wonderful tool as well. -- To get people talking. They come to us from Barry and Debbie Barkan in California. A community meeting is for staff and residents. It's not just for residents. It's not just for staff. It is not a neighborhood meeting. Those have their place. When you bring your whole community together, you create connection as a group. You can talk about someone who just passed away. You explore meaning together. I love how they say it is gathering as a community to discuss things that mutual interest and concern, to celebrate, to remember and to mourn.

And then there is an agenda that I don't know if I have time to go into. Pat, I want to ask you a question. Since we started late, can I go a few minutes over and open it up for questions?

Yes, you may.

Thank you. Here are two tax. I don't know if you know what this beautiful Texas. I don't hear a lot of people talking about this but this is a requirement of a certified nursing home. The facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. Test yourself. Talk about this. Are you really acting upon people's ideas and recommendations, even their grievances? Our residents and families a -- affecting policies and decisions in your place? That should be our goal. Plus, it is a requirement. In some of these practices I covered would help you get there. What about Tag F 520 which is a quality assurance regulation which will probably be a QAPI soon. They want everyone in their residence to make decisions about everything. If a complaint car just got filled out today, they will talk about it tomorrow morning in the community meeting. They don't even have resident Council anymore because it was a waste of time to meet monthly when they have already been handling things in real time. They make budget decisions. They make the vendor decisions, product decisions. This is exciting.

Last but not least come in the idea of everybody -- I don't like to say activities -- everyone engaging residents with life. Staff need permission to do it. They may need spontaneity to be mandated. This is funny. Eric Heider said he wanted a spontaneous activity every day. This means he mandated spontaneity. You can do that too. Consider the artifact tool.

Don't let one person fill it out. You have to do it as a group. Sometimes there are things going on that you are not aware of. We have our own website. You can fill out your artifact tool online. We would invite you to do that because we are try to collect data across the country. There are some reports that may interest you. I have a fun story.

They did a grant project with homes in Colorado which had to pick three artifacts. Most of them have a point structure of five being the most points. If they pick three practices it should have been an increase of 15 point. The average point increase was 47. Consider these tools because

they will prompt you to do things differently. I will close with some ideas that I was asked to cover. These are ideas of overcoming resistance to change. The first idea is what I call exposure.

Take the residents and staff to see the homes in your state that have changed. When a nurse can talk to a nurse, they will be quicker to jump on board. When they see it with their own eyes, I would say that would be a great thing. Sensitivity exercises, anything you can do. Having people sit on alarms would want your teammates to get rid of alarms. Instead of talking about change, if that makes people nervous, talk about growth and transformation.

There aren't that many training videos. By them all. -- Buy Them all. Have them before you. It is easy to let the crisis of the day swallow up any initiative you have for the culture change. Challenge each other to not go back to the old ways, to keep going in a new direction. Put something about this on people's performance evaluations. If you want action, put it on their performance evaluation and they will buy in quickly. Invite speakers to come with you or have a conference call with someone. Get your team excited. It doesn't cost that much money to get someone on the phone.

Take part in these webinars. You can move so much quicker. A speaker like that often supports what a leader is trying to say and maybe people aren't getting it yet or hearing it yet. Maybe give up the next conference and send other people to conferences so that they can get onboarding here the things are other people. Create committees and give him power. Let them make decisions. Honor that power of a committee.

The learning circle, is important. How about expecting everyone every day, hold each other accountable. That doesn't sound resident focus. Did you check with any residents? Maybe it is suggestion box. Whenever you have a culture committee, it should always be open to everybody. I InVision posters collecting ideas. How can we make this place like home? 80 we could have a culture change minute where we just have one principle from the Eden alternative for the Pioneer network. Don't call it a pilot. That implies that if we don't like it, we won't do it. Think of it as an experiment. This grew into a bistro. This came out of a deficiency. They put it into a plan that they would do breakfast cooked to order. Put it on a plan of correction if you want it to take place. It will hold you accountable.

They grew the bistro to also be a general store. Collect everyone's ideas for the values that you want to uphold, maybe a new vision our mission, new language. Always be collecting ideas. Be an innovative place to work, wanting to know how things could be better. When you have naysayers, what I would do is say, we are going to pretend that we are going to do open dining. What would need to happen to make it work? Force people's things to think about what would make it work. My last idea is to get an easy button and encourage ourselves not to press it. If you don't keep going back to the old ways, it will become easier to do with the new way.

I think I am out of time. I have resources to show you. We better open it up for questions.

Carmen, you still have about six minutes of presentation and 10 minutes for question and answers.

That's great. Here are some resources I wanted to share. I have had involvement with them. Regulatory support for culture change is a book, a two-part book which shows how the rakes support -- regulations support these ideas of culture change at have now been around for about 20 years. The other half of the book shows -- dives into the typical culture change practices and the regulations that you still have to comply with. If you're going to have a buffet, you have to pay attention to infection control and temperatures and how long the food is out there. Quality-of-life, the differences between deficient, common and culture change practice, this book goes into the 19 quality-of-life regulations. We try to show what would be deficient. What is common and what is better culture change? The goal is to try to move things that are commonly found in an institution such as undignified language over into the other column of culture change or what is better. Living life to the fullest, a match -- match made in OBRA '87 is a book about getting you to know you -- getting to know your assessment and psychosocial needs. We have worksheet to help you figure out what that is for each resident. We have activity programming according to interests and not problems. It is a myth that you have to have a problem statement for every issue on a care plan. That is not true. It's not in the regulations. I got tired of looking for a really good activity assessment.

I attempted to put one together that follows the 248 activities guidance. It has the MDS 3.0 within it but goes deeper into each item. And there are some unique culture change questions. What are you famous for in your family? What are you famous for in your community? Things like that, changing the culture of care planning, a person directed approaches another book that goes into narrative care planning.

Narrative takes away the columns. It is getting to know a person better than in an institutional column format. We show how the regulations support this. My colleagues shows everything that she did. --, Sample care plans, her policies, it comes with a visual plan which is an "I Care" plan. When you pick the right song it will draw you to tears. Soften the assessment process is a workbook that goes with a training DVD. We use this as a device, we have people showing these six different practices. During the initial time that someone moves in and we have all of the assessment to do, ideas on supporting someone as far as their simple pleasures, if you are a Pepsi person, how would you feel if a 12 pack was waiting for you when you moved in. Offer options. Instead of a nurse having to say, I need to see your skin. Get naked. She could say, if you haven't had a bath in the three days you are in the hospital, I could do it later when you have a bath. The choice is yours. You could foster friendships. Tie in to tasks, the idea that our tasks don't always have to be the focus. If a therapist needs to watch someone walk, they could say, have you seen the garden yet rather than making it about I need to watch you walk. Equalize everyone. We are all people. Staff and residents are people first, all of us. Normalize now. This is sold as a kid.

Vibrance living is a coffee table book that we wrote to residents. Every page, it doesn't need to be read in order, are inspirations to energize daily life. This is meant to sit on a coffee table and be available for residents, staff, families to flip through and come up with ideas. We did a book also called the alarms -- alarms and -- the new deficient practice. A limited taking -- of eliminating alarms in preventing falls by engaging with life. This is things like being proactive and checking in with residents. Anticipating needs, especially bathroom needs. And it's this idea of engaging people with real life. We think it is great to do these things.

I also do a monthly web talk show which is called conversations with carbon. In May I have Beth Baker talking about her new book, with a little help from my friends, creating community as we grow older. This is about baby boomers and their new ideas about how to grow old together and avoid institutions.

This idea of eliminating alarms, if it interests you, we did a show last Friday that is archived. All of our shows are archived, as most webinars are. As Pat mention, this paper is free at Pioneer network. This is called the power of language to change culture. There is so much power in mind which. If you keep using the words such as facility embeds and all of the institutional lingo, admission, discharge, you keep creating that kind of culture. You could move towards talking more about people, the people that live here. Some homes have gone to neighbors which is a lovely name and neighborhoods. I can't say facility anymore. A lot of you are probably the same. I can only say home or community. Think about what your worms can do -- words can do to create a better culture.

Even doing these teleconferences are great because they are less expensive. While I close, I have a grant project that I am going around the state talking about. I'm talking about getting rid of alarms. I'm getting teams to join me to commit to getting rid of alarms. I am posing this as, who is going to be the first state to be the no alarm state. I am also looking at first no-bid state -- "no bib" state and the first "no get up" state.

I am now taking everyone off of mute for the question and answer session. Please make sure that you take yourself off mute and don't put yourself on hold.

Does anyone have a question they would like to ask Carmen?

[Indiscernible - multiple speakers]

Someone doesn't have their phone on mute and you are going to say something embarrassing.

Pat, can you take the ball back so you are the speaker again? I don't seem to be able to give it back to you.

No, I can't. I just hovered over it and I clicked down on it and dragged it over.

And I say shop sharing dose ago -- can I say, stop sharing?

Yes. Do we have any questions from participants? Let's see what we have of the chat. There was a question about materials from action-packed. They need to be purchased.

Most things aren't free. The language paper is free. Pat, I am seeing in the chat, Alaska says it's going to be them and Hawaii says is going to be them.

What was a question? Your question, IC.

I am looking -- I understand.

I am looking in the chat box.

Kathy asks me, have you seen this successful in Colorado facilities. I don't know what you mean Kathy. Have I seen what successful? Can you type it in? What do you do with your residence to honor living? -- residents To honor living? I will take a stab at that. I am writing a chapter on that right now.. We need more real babies unless dolls. Dolls are an artificial thing to nurture. I know it is hard to have babies in there at all times. I would challenge you to get babies, family babies, staff babies. Invite the real babies in. People should be not doing fake life anymore. Do you know how we have people with dementia folding towels? That is fake. Only have people fold things that need to be folded. That we need to be someone who has good practice. Have people set real tables with real silverware and invite them to clear the tables, if that is something someone wants to do. To be honest, that kitchen belongs to them. How dare we say, no residents allowed. They could be peeling potatoes if they wanted to. We also have to have infection control practices followed. That doesn't necessarily mean that we all have to wear gloves. People can wear gloves and have terrible practice. You have to keep an eye on whether a person has good practice are not. If I have bad practice, don't have me be the one working in the kitchen.

Think real life, real-life, we have to move out of the institutional fake life.

What do you do to promote sweep in your home -- sleep in your home? Where do you find these regulations? These are the state operations requirements for long-term care facilities.

These are questions for each of you. Learning circles work great, is a comment. Someone says thank you, I am learning so much. Does anyone have any questions for me?

There is one of the and that says, how do you implement [Indiscernible] not having them where a bib when the residents get every speck of food on their close ?

Go to 241, this has been listed as undignified practice since 1987. There is a second line that we call them clothing protectors because, it doesn't matter what you call them. They are an example of undignified practice either way. We can do better to make things more normal. What surveyors are getting at is that the undignified food on the clothing -- is about the undignified food on the clothing. What are other ways to keep people cling? Homes that don't have bibs are using linen napkins. Make sure you do not order linen napkins that are polyester only. You need to have a cotton polyester blend so that it absorbs instead of the food rolling off.

Other people are telling me to order the oversized linen napkins because the bigger the better. You may need two per-person, one on the left and one talked in perhaps. Some homes have kept -- have purchased some alligator clips that you may see at the dentist, if it won't stay tucked in. You can use it as a plan B. Even if a linen napkin is around someone's neck with an alligator clip it is still a linen napkin. We can get rid of the bids and tell people not have food on their clothing, at the same time.

We have another question. Please explain President centered med pass -- resident centered centered [Indiscernible]

As you start waking people up and they wake up on their own, what homes are doing is when the CNA's [Pause] I realizing -- are realizing some of the way there is while getting dressed. They say, she is ready for her pills or. Some have moved the resident medications into the room. This is more personalized. The nurse can spend time alone with the person. She can be around the room.

[Background Noise] This is person centered instead of institutional centered. You can start outside of the dining room. Many homes that started off small, decided they would not do it in the dining room anymore. It is noisy and interrupted -- and it interrupts. You can slowly move it towards more individualized. Maybe you can move it towards people's rooms. I think that is our future. You could be ahead of the future.

We have one last question. Where can we find evidence-based material on eliminating bed and fall on arms?

If you can email me I will email you my list. There is not much out there. There is one study that shows alarms didn't work. There is also one study that shows they getting out of alarms, the fall rates actually went down. Can you believe that? There are only to evidence-based studies that I am aware of. If you want to talk anecdotal, we have homes around the country that could also give you their anecdotal research, unless we could call that evidence-based. The good news is that as most homes get rid of alarms and replace alarms with better practice, their fall rates are going down. Isn't that exciting?

That is something to look forward to. We want to see more of that going on. Thank you very much, Carmen. If there are other questions in the chat box, we will collect those and send them to you for comments. We can distribute the answers to all of our participants.

Pat, I want to make sure that you are the leader. It still has the circle around my name. Can you make sure you are the leader?

I am the leader now.

So if I leave, you are okay.

Yes, I just advance the slide. Thank you so much for joining us.

My pleasure. God bless. Thank you everybody.

Goodbye.

Does everyone see the slides that I have up that says do you have your scavenger hunt list available?

No.

No.

No X

-- No?

No.

Jennifer from WebEx, are you on? Carmen was not successful in getting me moved up to the present or. -- Presenter. Let me call WebEx and see if they can come in and help us out. If you want to get up and take a little break, feel free and come back in no more than five minutes please. [Session is on a 5 minute break. Captioner on standby.] [Session is on a 5 minute break. Captioner on standby.]

We are going to proceed now. Hopefully technical difficulties are over. I now want to introduce Lisa Johnson for our next activity.

Hello everybody. I am Lisa Johnson and I have a scavenger hunt challenge for you. Hopefully everyone has your sheets in front of you with 10 items. We will have a couple of slides that will have some animation popping in and out. Some of these are red herrings. Some of these are items on your scavenger list. Checkoff the items as you see them and at the end we will have a friendly competition to see how everyone is doing and if you are fighting our hidden items.

Ready, satcom ago -- set, go.

Apparently the muting isn't working.

Did everyone get all of those?

Thank you Lisa. We will have another opportunity later on in case you missed some of those. I would now like to introduce Marcy Gallagher who will provide us with an overview of the peer coaching and resident and family advisory program.

Thank you Pat. Did you want to try to mute the lines. We never heard the message that all lines are needed.

I will do that.

Thank you Marcy.

Thank you Pat and thank you to everyone joining us today. What a tough act to follow with Carmen and her fantastic presentation. We were lucky to have her on today. I will be brief but I would like to visit with you about our peer coaching program. We have labeled our peer coaches as leaders of change which we think is a great description. Our goal is to create a network of

nursing home staff, leaders and residents and family members who are willing to share and support their peers.

Peer coaching is a process through which 2 or more colleagues work together to reflect on current practices, build new skills, share ideas, teach one another, and solve problems. It is our hope that the peer coaching will be the beginning of a strong network of colleagues working together to support and learn from each other. The purpose of this program is to promote quality improvement and to provide support to those who are participating in the national nursing home care collaborative. With the highest percentage of nursing homes in Alaska Mahal way he, antenna and Wyoming --, Hawaii, Montana, and Wyoming is significant.

How will we build a peer coaching program? We will recruit nursing homes, staff, leaders, residents and resident family members to service. Just or other nursing homes. The network of peer coaches will represent a diverse levels of nursing home staff, from leadership took direct care -- to direct care. In addition to staff, we are also looking for residents and/or resident family members to serve as. Just. You could also think of the resident and/or family member as advisors. The -- the resident and family members are those who would be positive and with the able to speak up ensure solutions to help nursing home care for others as well as talk about their experiences.

We plan on trying to match.'s is -- peer coach is based on compatibility all to support information bottom -- among our nursing homes. There are a lot of benefits to being a peer coach. You will be able to share knowledge and best practices with other nursing homes, foster quality centric nursing homes, gain recognition for participating as a coach, satisfaction of assisting and supporting your colleagues, and assisting them to Pacific with our quality improvement efforts.

On the flip side of that, there are also benefits to receiving assistance from our coaches. You will be able to receive practical and applicable education and support from colleagues. You will be able to solidify your commitment to improving the quality of care. You will have self-motivation and facility goalsetting. You will have -- receive one-on-one assistance from Mountain Pacific and our participating coaches.

We know that you are all very busy so it is not our intent to make participation time-consuming. We want to make sure. Coaches are prepared and comfortable in this role. To facilitate this we are asking our coaches to participate in brief free training sessions I can be done at your convenience. These training sessions can be viewed via our website or by viewing materials in a hard copy format. We are also asking coaches to be included in a contact list of available. Just -- of available. Coaches, participate in regional and statewide nursing home listserv and participate in quarterly calls to provide feedback to Mountain Pacific. The feedback could be about how we could strengthen [Indiscernible] and resources to distribute best practices for clinical as well as operational excellence. We could possibly -- you may possibly speak at one of our LAN events. Lastly we would be asking coaches to provide assistance to nursing homes over the length of the collaborative by phone, email or even in person if possible.

Mountain Pacific can provide all of you folks with lots of training resources and tools. We believe that the peer to peer sharing, appear -- that the peer coaching program offers is invaluable. There is no faster or better method than learning from your peers.

If you are interested in serving as a peer coach, either as a staff member from your facility or if you know of a resident or family member who would be a great peer coach, let us know. You can also get in touch with us if you feel like you need assistance from one of our peer coaches. You can contact me directly or reach out to a state representative, Pat in Wyoming, [Indiscernible] we are excited to get this up and working for all of you.

Pat Amma if you want to unmute the lines people can ask questions. --, If you want to unmute the lines, people can now ask questions.

Does anyone have any questions about the peer coach family advisor program?

I am not sure I heard the unmute message unmute -- Pat.

Are there any questions? We may be reaching out to some of the out in the audience to solicit you in being a peer coach. If you need more information, Marcy's contact information is on the screen. Or you can contact your Mountain Pacific representative in your state. Thank you Marcy.

Thank you Pat. If you want to advance the next slide I will turn it back over to Lisa for more of the scavenger hunt activities.

The list is on the screen. If you have your worksheet, this is your final chance to find all 10 items. Ready, set, go!

Thank you Lisa. I hope everyone enjoyed that fun activity. We know it can be difficult to stay engaged for so much time. I hope this provided you with a little bit of a break. Please share your name any chat box so you can get recognition, if you got all 10 items. I would now like to talk about what we're working together on in the collaborative.

The goal of our collaborative is multi fold. We would like to have our teams engage residents and family members in quality improvement projects. We would like to reduce the antipsychotic medication rate, improve resident mobility, and reduce each facilities -- facility's composite measure score to 6 or lower. This is the designation of the top 10 in the nation. We want to help all of you get into that category.

Our collaborative is organized into a series of four learning sessions and action periods. Learning sessions are advanced -- are designed to provide education on clinical and organizational subjects. Action periods follow each morning session. When teams are expected to be actively conducting performance improvement projects on facilities selected topics. The work collaborative one will last for 18 months, April 2015 through September 2016. Collaborative number two will run from April 2017 through September April 2017 through September 2018.

The model for improvement is the tool that we support for performance improvement. The key elements include using data to identify, measure and monitor an issue for improvement and to utilize Root Cause Analysis tools to identify the possible root causes and solutions for an issue. Once a potential solution is identified, we would like you to use the PDSA model to test your solution. By using small test of change, this allows you to test on a small Carol -- improve your process before the full-fledged spread into your facility, -- this is a proven means of getting successful in -- performance improvement. Mountain Pacific will provide you with the tools to utilize a small. If you would like additional assistance contact your state representative. What would you expect during action period one? Resources that Mountain Pacific will provide to each team include a collaborative planner with PDR -- periodic [Indiscernible] good ideas to create lasting positive changes in a nursing home. Mountain Pacific will provide a periodic copy of the composite score report along with the access to the peer coaching and resident family advisor program, assistance with your QAPI program in implementation. [No Audio] [Technical Difficulties]

Pat, we are having trouble hearing the audio .

Lisa and joy can you hear us? Have we lost all audio or just PDSA -- Pat ?

[Technical Difficulties] [No Audio]

Pat, are you back on . --?

We lost all of the phones in the Casper office. I think we are still missing some of our participants from Casper. Where did you last hear me speaking? When was it?

Slide 29.

You didn't lose too much other than I went over the events. Root Cause Analysis for long-term care, understanding the composite score, key public health issues in an a coagulant and -- anticoagulant 10 diabetes medication safety, promoting mobility and the leadership communication -- the TeamSTEPPS leadership into medication. I am sorry for those technical difficulties. I would now like to turn it over to Pamela Longmire so she can conduct an open forum question-and-answer period.

[Background Noise] I want to thank you all for staying engaged in on the line. Your time is valuable. When we get to participate in these activities, it helps us all. What we would like to do is a quick polling question to find out -- we want your input. How are we doing? Are we doing a good job? Our goal is to provide good services to you. If you could answer that poll question, that would be great.

[Class is being polled] I will give you a few more seconds to answer that question and then we will move on in our open forum time.

When we get the polling results we will review them. What I would like to do is encourage relationships. We have the all teach/all learn model that we are encouraging. We are hoping that

we can get that established so that we can sustain relationships [Indiscernible - Intermittent Audio] We would like your relationships to go on fire after that. [Indiscernible - Intermittent Audio]

[Indiscernible - multiple speakers]

Could you mute your phones if you are not participating? There are some conversations we are able to hear. Please mute your phone online shoe are sharing -- unless you are sharing.

I know we still have people on. Who will be brave and talk? We have results from the pole -- the poll question. It looks like the majority does not want to participate in a list serve. They want more stayed in regional help. We will offer that. [Indiscernible - Intermittent Audio] Everyone can be included. Thank you for participating in that poll.

Can someone please unmute their line? Someone just got a brand-new car.

[Laughter]

I would like to ask those if you working on staffing stability, have any of you consider to working with high school students? Considered -- have any of you considered to working with high school students?

[Background Noise]

I see Andy is putting in chat that she has high school CNA classes. Can some of you unmute your phones and speak into this instead of just doing this in the chat section?

This is Sandy. We run for CNA classes through our facility -- four CNA classes through our facility. One is with all high school students.

How successful are you with that?

We are usually able to get one or 2 employees from that class.

Surprised -- Chicago did a project like this and I would like to do something like this in Montana. They are finding that a lot of people are choosing to go into long-term care. It sounds like you are getting some staying with the facility but are others choosing to go to other long-term fields?

There is one hospital in one long-term -- long-term care facility. There aren't a lot of options. I am not sure. A lot of them are doing it for college credit. A lot of them do it for that. We had been able to get a few employees from the class as well. They are not as mature as some of the other classes we have done.

This is Kathleen and Helena. Our high schoolers do the class here. The facilities do not. We actually have used them, especially in the summers and during breaks and have had really great

success. I have one CNA that we use in our L Kern -- in our Elkhorn facility. I had the honor of writing her a recommendation to met school. She is going into med school for geriatrics. We have had her since I.

That is great. That is so awesome. I am so glad to hear that. What I am hoping is for some of the rural areas, where staffing can be an issue, maybe the volunteer, high school students, can be used.

I am sure this girl would share her story if you wanted to use it. We consider this pretty rural.

That is great. Kathy, let's try to connect afterwards.

In Baker we have one high school student interested. We usually try to have a June class. Sometimes a high schoolers wax and wane. I started at the facility I am currently at at the age of 16 and now I am the long-term care supervisor. If you get them early, it helps invest in the future.

That is great. I am glad to hear that. There are a lot of areas doing it. I was speaking with someone earlier today who told me that she has fourth and fifth graders coming in the volunteer time. If she is on she can correct me. It sounded like she is having them [Indiscernible - Intermittent Audio] Some of the residents. They also do gardening. That was a lot of fun. The residents enjoy that. Jenny, are you on?

Is anyone other then Helena and Baker doing this?

I don't know how to unmuted work -- unmute it..

[Indiscernible - low volume]

We have heard of a lot of Montana people doing this. Are there any Wyoming, Alaska or Hawaii people doing this?

Can you hear me?

I can hear you.

I am from Wyoming. We actually do have high schools that do CNA classes and we serve as the clinical base for them. I think currently we have two high school students that were care that are part-time and will be going full-time when summer comes.

That is great. I am excited to hear that. I like the interaction. We should bond between the younger people and the elderly. The elderly get excited to be around the younger ones.

Has it been a positive experience for everyone?

I think so. Someone mentioned maturity. I think sometimes you have to help them overcome some of the nitpicking and things of that nature. All in all, I came straight out of high school and have been a CNA, LPM -- LPN, are and now the director RN -- and now the director.

I think the maturity issues, if you give them clear direction any definite job might help, on still -- until they feel like they know what they are supposed to be doing. Do you think that would help with the maturity aspect?

This is Janice from Fort Benton. We do a unique program in Fort Benton. We do it for a long CNA course. They come and they do one hour in the morning come of the first class of the day and then they come at six in the morning as they progress and work until 9 AM working towards her certification. Then we have field trip days. We had been doing it for about 15 years. We usually have between four and eight students and we have been very successful. The maturity, we talked to them about that. You see them grow in that very quickly.

That is great. It sounds like we have some special programs. [Indiscernible - multiple speakers]

We also have another one called help occupation class. They come -- health occupation classes. They shadow each department for one hour for about three weeks. We do three weeks per department. That way they know what the health needs are. That is another program too. We do that each semester also.

Justin looking at the chat, I see that in Hawaii and Wyoming and Montana -- I haven't seen any from Alaska. I am not sure if they are doing this in Alaska. I have a question for the people who haven't experienced it. Is there an interest, if I were to [Indiscernible - Intermittent Audio] Start pilot programs. Would there be an interest in getting this started in any of these states?

I have one yes. What state was the yes from?

Penny says yes but I am not sure what state she is from. You are in Montana. I recognize that name. What about other states? Are other states interested in a program like this?

What are some of the other issues? I know staffing is a big one and one oh everyone in the state's -- in the state of Montana knows I want to work with to engage with our CNA's and help them to feel and know that they are an important part of the team and we want to empower them. I am hoping that that will add to staffing stability and raise up some people are using our high school students. The idea that Jennifer had of engaging even the younger students, fourth and fifth graders, I think that's great. I bet the nursing home residents love to see the younger kids come in there. I can see where that would help them to feel better about their day. There is something about children that brightens most people days -- people days.

Out side of the staffing issues, are there any other issues that are important that you guys would like to CS get training on and focus on? -- That you would like to see us get training on and focus on?

It looks like we have some people in Alaska that say they were inspired. [Indiscernible - Intermittent Audio] That is good. I would bet that you guys have something else to talk about that is important.

Let's put up the second polling question.

That sounds like a good idea. [Class is being polled]

There is no time. There is only five seconds left. Can we extend the time on the polling question? Can we restart it?

Give me one second and I will restart the polling.

We are going to do a polling question and we are restarting the time. The question is, we are planning to create small work groups. How do you prefer they be organized? The work groups should be state specific, Wyoming subgroup to Wyoming subgroup etc. The group should be regional and broken out by subject and topic. The work groups should be state specific and broken out by subject. [Indiscernible - Intermittent Audio] The time limit is [Indiscernible - Intermittent Audio] Once it populates we will get you the results.

We need to pretty music -- Jeopardy music.

We miss that. I would sing that that would make everyone hangup.

I was thinking about that but being flat and off key might not help. They might get a good laugh. [Laughter]

When those populate, we will do the answers to those. What area of focus do you see besides staffing?. I think something that we like to work on through inter-departments, dietary, working on the teamwork and coming together, remembering that the residents are the number one priority.

[Indiscernible - Intermittent Audio] That is a big deal comment getting teamwork. The safety part of it as well, where everyone feel safe on the team so they can speak up. That's important. The person that was brave and spoke up, where are you from?

I am Michelle Smith from Baker, Montana.

Thank you Michelle. I have met a lot of you. I know you are not that Chai. Most people shows Choice C, the workgroup should be state specific and subject specific. This helps us identify how we can best help you. I am looking to see if I missed anything. [Indiscernible - Intermittent Audio] Elementary kids are enjoyed by the residents. That is great.

The person who is having difficulty getting unmuted. To on mute you would hit 4* again.

[Indiscernible - multiple speakers] Did the person who wanted to get unmuted, did that happen?

We have a question, legal ideas on what talks the residents can participate in, especially the men. I probably have the most experience on this. I can talk to Jill about this. [Indiscernible - multiple speakers]

I think the state surveyors are always the folks to clarify this but it all goes back to a careful assessment of the resident's needs and defining activities and care planning and monitoring and evaluating on an ongoing basis that the activity is meaning to them, not just of benefit to the facility. It is a ball -- it's about care plan assessment and documentation.

Any other comments?

I think we can hear you talking about -- I think it's and are, [Indiscernible - Intermittent Audio] -- Sandra [Indiscernible - Intermittent Audio]

Are there any more questions?

What was that?

I did ask the last question. I asked the question about the legalities of having them do something that is meaningful.

Do you feel like Pat properly address that or do you have more questions?

The question of if it is an activity that is meaningful, for ladies you can have them clean a table or put gloves on and mix the bread dough. There are a lot of things that men would prefer to do such as drive their car, which we will not let them do. What kind of activities can they do that would not be considered unsafe?

Do you have any kind of gardening, even if it is indoor gardening? A lot of times men enjoy gardening.

We have a small garden box.

[Indiscernible - Intermittent Audio] [Indiscernible - multiple speakers] Another thing I have heard other facilities doing is they brought in real radios or models [Indiscernible - multiple speakers] He would fix them and put them back together. It didn't matter if he broke them. [Indiscernible - Intermittent Audio] It was great if he could fix them and not a big deal if he couldn't. [Indiscernible - multiple speakers]

Are we able to lock them -- let's and paint something such as a birdhouse? Is that a safety issue?

I would clarify. If it is a non-toxic paint, I don't know why they wouldn't be allowed to do that. [Indiscernible - Intermittent Audio]

It goes back to a safety assessment for each activity. It's not one blanket answer. Every situation needs to be assessed for it safety. If you had a resident that liked to eat paint, that would be a bad idea. But if the resident had no inclinations to eat the paint, there would be no issue.

In care plans you can make that [Indiscernible - low volume]

I think it is a challenge for the men. I was fortune -- fortunate enough to work at a facility that had primarily men. The they -- maintenance people were of great use. A lot of the men would follow them and they could help them but not be in an unsafe situation. [Indiscernible - multiple speakers] The residents played around with them. Be creative. Except -- assess each situation.

Thank you.

If you guys have more questions, that is what we want to be here for. Each one of us, we get excited at the help of -- the idea of assisting you. We have reached the top of our our. Our time is up. I just want to thank you all for their participation. We look forward to working together to improve quality.

Thank you Pamela. I would like to thank all of you for your active participate in today. We hope that you found the program Hoeffel and that you are eager to move forward. Please remember to contact your state nursing home contact for any further information or assistance. If you would like B.C.E. use or just to give us some feedback of how the program work -- went, please complete the evaluation that will pop up as you exit the WebEx program or complete the paper when it was sent along with your handout and return it to Mountain Pacific. We appreciate it and we enjoyed having you here today. Thank you again for your attention. We look forward to working together with you over the next few years.

Thank you everybody. This ends our call. [Event Concluded]