



# CULTURE CHANGE Network of Georgia

**CCNG Advisory Group**  
**July 15, 2011 9:30 am – noon**  
**Special Orientation for New Members at 9 am**  
**MINUTES**

Team Members Present		
<input type="checkbox"/> <b>Kim McRae</b>	<input type="checkbox"/> <b>Sue Burgess</b>	<input type="checkbox"/> <b>Meredith Swinford</b>
<input type="checkbox"/> Linda Kluge	<input type="checkbox"/> <b>Walter Coffey</b>	<input type="checkbox"/> Louise Linder (phone)
<input type="checkbox"/> <b>Anne Hernandez</b>	<input type="checkbox"/> Marsha Bond	<input type="checkbox"/> <b>Melody Brown (phone)</b>
<input type="checkbox"/> <b>Mendee Rock</b>	<input type="checkbox"/> Melanie McNeil (phone)	<input type="checkbox"/> <b>Vicki Morton</b>
<input type="checkbox"/> Eric Lucas (phone)	<input type="checkbox"/> Zandra Matthews	<input type="checkbox"/> Kellee Chassner
<input type="checkbox"/> Michelle Nelson	<input type="checkbox"/> <b>Joan Carlson</b>	<input type="checkbox"/> Patrice Earnest
<input type="checkbox"/> <b>Deb Addis</b>	<input type="checkbox"/> <b>Laura Prough</b>	<input type="checkbox"/> <b>Scott Morrison</b>
<input type="checkbox"/> <b>Lisa Brooks</b>	<input type="checkbox"/> <b>MaryLea Quinn</b>	<input type="checkbox"/> <b>Lisa Meeks</b>
<input type="checkbox"/> <b>Majisa Boyd</b>	<input type="checkbox"/> <b>Ms. Elizabeth Baxter</b>	

**NEW MEMBERS** are highlighted in yellow.

**DISCUSSION**  
**Anne Hernandez and Kim McRae, Co-Facilitators**

Topic Discussed	By Whom	Main Points
<b>Welcome and Introductions</b>	Anne Hernandez	Special welcome to all of our new members! A special warm welcome to our first “Elder,” Ms. Elizabeth Baxter! There was a special orientation for new members at 9 am this morning.
<b>Review Minutes</b>	Anne Hernandez	Minutes from April 15, 2001 meeting were reviewed and accepted.
<b>Brief Updates</b>		
Congratulations to Anne Hernandez	Linda Kluge	Anne has been named Deputy Director of the qio!
Congratulations	Linda Kluge	The William Breman Jewish Home for their recognition from the qio for their culture change work.
Congratulations	Kim McRae	The Green House in Columbus for opening their SECOND assisted living memory care Green House.
LANE/Advancing Excellence	Linda Kluge	Linda explained to the new members the role of the qio (quality improvement organization). She defined the Advancing Excellence in America’s Nursing Homes Campaign (AE). She explained the role of the LANE (Local Area Networks for Excellence), which provides leadership and support to nursing homes participating in AE. The GA LANE is “housed” within



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		<p>the CCNG. (See more about qio, AE and LANE at the end of the minutes.)</p> <p>The GA LANE just wrapped up a pilot with three nursing homes in Macon. Linda announced that there was a NEW pilot on the horizon – really good quality improvement program. She said that GA is always volunteering to participate in new leading-edge pilots.</p>
<p>MDS 3.0 Webinar Series</p> <p>Barbara Frank and Cathy Brady to do</p>	<p>Linda Kluge/Anne Hernandez/Michelle Nelson/Kim McRae</p> <p>Mendee Rock</p>	<p><b>A National Learning Collaborative: Integrating the MDS 3.0 Into Daily Practice:</b> Pioneer Network is holding a three-part webinar series to introduce why and how to put in place the organizational changes necessary to implement MDS 3.0 so that it contributes to strong organizational performance. Includes up-to-date information from the CMS MDS team and concrete strategies presented by Barbara Frank, Cathie Brady and MDS Team and Practitioners from Maine and New York.</p> <p>The qio purchased a “viewing” of the series, and LANE members have been attending to watch together, then strategizing how to “spread” this wonderful information throughout GA. We have watched the first two, and the third is on September 15<sup>th</sup>. Each series purchases gets five additional viewings. We are working on how to maximize the reach of these webinars throughout the nhs in GA.</p> <p>Michelle Nelson showed the first webinar to the state surveyors, which was a real coup.</p> <p>Only six of the webinar series have been purchased in GA: 1/ The William Breman Jewish Home, 2/ Ethica Health and Retirement, 3/ Satilla Health Services, 4/ SavaSenior Care, 5/ gmcfc and 6/ LTCI (contract surveyor).</p> <p>On August 1 at <a href="#">Pioneer Network's National Conference</a> there is an in-person session, <b>Maximizing MDS 3.0 to Catalyze High Quality Individualized Care</b>, and will include a launch packet for participants in a <b>National Learning Collaborative</b>. Kim will be attending.</p> <p>Note that you can sign up for these webinars at any time – the first two are available “on demand.”</p> <p>Mendee shared that Barbara and Cathy are coming to GA to</p>



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<p>“MANDATORY” training for ghca</p>		<p>do MANDATORY training tied to reimbursement. Starting August 8<sup>th</sup>, they will be doing one day sessions in Savannah, Tifton, Macon, Stockbridge and [redacted]. They are also going to do a preconference session on nurse leadership at ghca’s Nursing Convention on September 13<sup>th</sup>. Kim explained that Barbara and Cathy are also speaking at the CCNG 4<sup>th</sup> Summit. We have been very careful to make sure that they will be covering different topics that will be meaningful and important for nh folks. We will continue to work together on communicating on their topic areas.</p> <p>Barbara Frank, Cathy Brady and David Farrell have just released a new book, “<b>Meeting the Leadership Challenge in Long-Term Care: What You Do Matters</b>” By David Farrell, MSW, LNHA, Cathie Brady, MS, and Barbara Frank, MPA (<a href="http://www.healthpropress.com/store/farrell-29708/index.htm">http://www.healthpropress.com/store/farrell-29708/index.htm</a>)</p> <p>Mendee shared that David Farrell has presented to ghca.</p>
<p>QIO 10<sup>th</sup> Scope of Work Update</p>	<p>Linda Kluge</p>	<p>Linda reviewed the Program Priorities Going Forward (see <b>handout</b>), which is designed to make necessary changes to achieve the goals of better health care, better health for people and communities, and affordable care through lowering cost by improvement. They will work on these four aims over the next three years: 1/ Beneficiary and Family-Centered Care, 2/ Improving Individual Patient Care, 3/ Integrating Care for Populations and Communities (building on previous Care Transitions pilot work), and 4/ Improving Health for Populations and Communities.</p>
<p>Partnership for Patients: Better Care, Lower Costs</p>	<p>Linda Kluge</p>	<p>A new public-private partnership that will help improve the quality, safety, and affordability of health care. Make hospital care safer, more reliable, and less costly. Goals: 1/ Keep patients from getting injured or sicker, 2/ Help patients heal without complication. (see <b>handout</b>)</p>
<p>Eden at Home Creating Quality of Life for Care Partner Teams</p>	<p>Kim/Zandra Matthews/Scott Morrison/</p>	<p>Kim gave brief history of the three-day Eden at Home Trainer Certification Workshop held in March. GA was first state coalition to host this, and we had about 25 participants from varied settings and job responsibilities. We were very intentional in inviting representation from the key stakeholder groups so we had representation from across the continuum and across “transitions in care.”</p> <p>Zandra and Linda Matthews were invited to present at the 2012</p>



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		<p>Eden International Conference! (YEAH!) Zandra shared how this was eye-opening to her – “it makes good sense to do what’s right.” The Language was a HUGE piece for them. (since cc started in nh, most of what’s written about cc is in the language of nhs – this gave them a LANGUAGE to use!)</p> <p>Zandra and Linda Shelles and Cori Sakin presented EAH at the Service Coordinator’s Conference.</p> <p>Scott Morrison has been very prolific in sharing and spreading the news about Eden at Home. He loves explaining how we can create a life worth living. He has been putting it into practice in his organization, spoken to the Pickens Co. Senior Network, been on two radio shows, and has plans for several other presentations so far.</p> <p>Vicki Morton explained how EAH created “the feeling” that’s key to make cc happen. Measurement is key, but you have to FEEL IT first.</p> <p>Kim and Diana Cutright presented a one hour session on EAH at the Elder Abuse Conference in Augusta. It got media coverage.</p> <p>It takes a village and we are all care partners in this community – and in creating this “community of caring” in our state.</p> <p>TO DO: We need a Consumer Team! The Education and Communication group will get the ball rolling with this.</p>
<b>Elder Advocacy</b>	Ms. Baxter	<p>Been around NHs since 15. Promised her Mom no nursing home. Seniors need to SEE these places. They are afraid to leave because they don’t know what’s next. It’s so important for them to know what is available out there. At Lutheran Towers they do tours to personal care homes quarterly. Gives them assurance there can be love and goodness there too. Next want to go see snfs.</p>
<b>Best Friends Approach and Dementia Education</b>	<b>Meredith Swinford</b>	<p>Ten from St George attended the two day BEST FRIENDS TELL STORIES. Now ALL of their dementia care employees views the entire Teepa Snow dvd during orientation. They have a career Ladder: 1/ Pal, 2/ Friend, 3/ Best Friend. In the memory unit they have changed job descriptions. They have assigned best friends to all of the management to get them more involved “on the floor.”</p>



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<b>Best Friends Event</b>	Majisa Boyd	She was very surprised that there were so many care workers who didn't really know about dementia!
<b>Virtual Dementia Tour</b>	Melanie McNeil	25 – 30 Ombudsman went through VDT training and every program got a kit. Everyone was moved! All came away with Ah-Ha moments. For those who went through it, it was quite an eye opener! Some of the local programs are providing VDT for providers in their area.
<b>Residents' Rights Month</b>	Melanie McNeil	There is no state plan for this – each program decides and implements their own plan. Kim shared the theme, “Welcome Home” and how it ties in with the Summit theme.
<b>\$ Follows the Person/ARC</b>	Sue Burgess	They hired Karen Lucas and Lisa Brooks (MDS Question Q). Transition programs were explained – GA given funds to Transition people out of NHs in 12 sites. About 150 in transition. Follow folks for about 12 mos. There is much to be done. ADRC is the gateway system. “Culture Change must permeate throughout all of this. Listen to their voice!” Options counselors can be very helpful. Partnership relationships key. ARC wants to start Ad hoc Advisory Group.
<b>Picker</b>	Kellee Chassner	When she held a meeting at AG Rhodes the residents did NOT hold back with their comments! Gave them (staff) a 1 <sup>st</sup> person perspective. Because of picker they have hired a 2 <sup>nd</sup> person to help with admission/move in. Residents started a WELCOMING COMMITTEE – they did this on their own after attending the meeting. The elders thought the evaluations were too long.
<b>Picker</b>	Linda Kluge	When she did a meeting last year, the elders were all very angry. They wanted to revolutionize Wesley Woods! Linda noted that if you ask, you'd better make sure you want to hear what they say. It was GREAT feedback for their business.
<b>Summit/Posters for Summit</b>	Kim McRae	4 <sup>th</sup> Annual Culture Change Summit Oct 6 <sup>th</sup> in Atlanta. Theme is “Make Yourself At Home.” Joanne Rader, Barbara Frank and Cathie Brady presenting. Agreed to do poster session again this year. Day of summit conflicts with ARC. Source in Macon but Mendee was going to check on that date as it was not set in stone. Rosalyn Carter Caregiver Institute as well.
<b>GA Tech/ Design/Architect</b>	Eric Lucas	He was invited by GA Tech – Sr Living & Aging in Place. To age in place is what people want! Design trends are hot now.
<b>Consumer/Picker</b>	All	Conversation tabled – everyone so excited but we had to move on...



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<b>Changing the Culture of LTC Webinar Series</b>	Kim McRae	CMP funds received through LTCO program. Last fall hosted symposia in Athens and Valdosta. Videotaped and made into FREE three part webinar series. CEUs available. Info in packet.
<b>Steering Committee Report</b>	Walter Coffey	<p>Described make-up of steering committee. Purpose: to access CMP funds to support work of CCNG. Must have measurable outcomes. Link with MyInnerView data, Lane, MDS. Walter has already met with Jerry Dubberly to discuss appropriate use of funds and CMS' views and new info from CMS on CMPs. Multi-year plan okay. Next steps: much education needs to be done. Continue working on multi-yr plan with measurable.</p> <p>Need financial support from organizations on CCNG Advisory Board. Creative ways to cover costs (ex Buddy Pass from Delta or printing).</p>
<b>Task Group Updates</b>		
Policy	Walter Coffey	CMP funds a priority. Accomplished \$10 left in dedicated fund instead of moving it to the general fund.
Practice	Kim McRae	Pioneer has great resources now. To create spot on CCNG for a good healthy "well stocked" practice section.
Educ/Outreach	Kim McRae	To focus on new logo – getting all "re-branded" and updated on the site. Website suggestions send to Kim. Showed business card and brochure.
<b>Old/New Business</b>		
NEW IRS RULES for NON-PROFITS??	??	Someone mentioned new IRS rules for non-profits – maybe regarding volunteer time???
CC Presentation	Joan Carlson	Has cc presentation coming up.
NEW PICKER/Consumer COMMITTEE	Open to Volunteers	Linda Kluge, Mendee Rock, Eric Lucas, Majesa Boyd, Debbie Addis, Vicki Morton
NEW MEMBERS FOR EDUCATION COMMITTEE	Open to Volunteers	Lisa Brooks, Mendee Rock, Eric Lucas
Announcement and Adjourn		



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Next Co-Facilitator	Vicki Morton	

## HANDOUTS/LINKS

Title
CCNG Advisory Group List
Minutes April 15, 2011
CCNG 2011 History to Date
MDS 3.0 Webinar Series ( <a href="http://www.pioneernetwork.net/Events/Webinars/MDS30/">http://www.pioneernetwork.net/Events/Webinars/MDS30/</a> )
The QIO Program Priorities Going Forward ( <b>NEED THIS LINK</b> )
Partnership for Patients: Better Care, Lower Costs ( <b>NEED THIS LINK</b> )
Article on Eden At Home: Creating Eden in Georgia ( <a href="http://www.culturechange.org/special_projects/eden%20at%20home/Creating%20Eden%20in%20Georgia%20">http://www.culturechange.org/special_projects/eden%20at%20home/Creating%20Eden%20in%20Georgia%20</a> )
“The Ties That Bind: Consistent Assignment Gives Residents a Sense of Security, Family” article ( <a href="http://www.ahcancal.org/News/publication/Provider/Prv0611_CoverStory.pdf">http://www.ahcancal.org/News/publication/Provider/Prv0611_CoverStory.pdf</a> )

## NEXT STEPS

Person Responsible	Activity	Due Date
ALL  Send to Kim McRae (kim@haveagoodlife.com)	Everyone send in the culture change activities, presentations, training opportunities that you are doing in your organizations so can be posted to the website, the Culture Change Connection Newsletter and/or the 2011 History to Date	ONGOING
LANE	MDS 3.0 Webinar Series – Continue planning regarding reaching GA.	ONGOING



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Education/Communication Team	Get ball rolling to create a CONSUMER TEAM for CCNG	SEPTEMBER

## ADDITIONAL BACKGROUND FOR NEW MEMBERS

### **OIO and GMCF**

Imagine a health care system where every person receives the right care every time, and where providers have the tools and resources to deliver that care. The Centers for Medicare & Medicaid Services (CMS) is helping to realize this vision through its national network of [Quality Improvement Organizations \(QIOs\)](#). GMCF, a physician-sponsored organization, is the Medicare QIO for Georgia.

GMCF assists physician offices, hospitals, nursing homes and home health agencies in adopting and implementing systems, redesigning processes and developing organizational cultures to accelerate the rate of quality improvement. A key strategy involves forming partnerships with other professional organizations to extend our reach and broaden our effectiveness.

### **ADVANCING EXCELLENCE and LANE**

The Advancing Excellence in America's Nursing Homes Campaign (AE) is reinvigorating efforts to improve the quality of care and quality of life for those living or recuperating in America's nursing homes. The Mission of AE is to help nursing homes achieve excellence in the quality of care and quality of life for the more than 1.5 million residents of America's nursing homes. The goal of AE is to make nursing homes better places to live, work and visit ([www.nhqualitycampaign.org](http://www.nhqualitycampaign.org)). AE has eight goals of focus: staff retention, consistent assignment, restraints, pressure ulcers, pain management, advance care planning, resident/family satisfaction, and staff satisfaction. Nursing homes that participate in the campaign sign up to focus their improvement efforts on three goals. AE has excellent measurement tools for the homes to use.

AE also helped establish a coalition of nursing home stakeholders within every state, called [LANEs \(Local Area Networks for Excellence\)](#), whose purpose is to provide leadership and guidance for the Campaign at the local level. The LANE is the central organization within a state to support participating nursing homes in achieving their clinical and organizational goals and help the Campaign succeed. The GA LANE is "housed" within the CCNG.

### **CMS and MDS 3.0**

Centers for Medicare and Medicaid Services (CMS) is housed within the US Department of Health & Human Services. In November 2002, the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services, began a national Nursing Home Quality Initiative (NHQI).



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There is a Nursing Home Quality Initiative (NHQI) website to provide consumer and provider information regarding the quality of care in nursing homes. NHQI discusses quality measures that are shown at the Nursing Home Compare website ([medicare.gov](http://medicare.gov)), which allows consumers, providers, States and researchers to compare information on nursing homes. Many nursing homes have already made significant improvements in the care being provided to residents by taking advantage of these materials and the support of Quality Improvement Organization (qio) staff.

The nursing home quality measures come from resident assessment data that nursing homes routinely collect on the residents at specified intervals during their stay... These measures assess the resident's physical and clinical conditions and abilities, as well as preferences and life care wishes. These assessment data have been converted to develop quality measures that give consumers another source of information that shows how well nursing homes are caring for their residents' physical and clinical needs.

**Minimum Data Set, Version 3.0 (MDS 3.0):** national validation study information and implementation timelines. The MDS is a powerful tool for implementing standardized assessment and for facilitating care management in nursing homes (NHs) and non-critical access hospital swing beds (SBs). Its content has implications for residents, families, providers, researchers, and policymakers, all of whom have expressed concerns about the reliability, validity, and relevance of MDS 2.0. Some argue that because MDS 2.0 fails to include items that rely on direct resident interview, it fails to obtain critical information and effectively disenfranchises many residents from the assessment process. In addition, many users and government agencies have expressed concerns about MDS 2.0 data quality and validity. Other stakeholders contend that items used in other care settings should be included to improve communication across providers.

MDS 3.0 has been designed to improve the reliability, accuracy, and usefulness of the MDS, to include the resident in the assessment process, and to use standard protocols used in other settings. These improvements have profound implications for NH and SB care and public policy. Enhanced accuracy supports the primary legislative intent that MDS be a tool to improve clinical assessment and supports the credibility of programs that rely on MDS.

### **MDS 3.0 WEBINAR SERIES**

Every nursing home has to use MDS 3.0, but not all homes are using it to its fullest potential. The MDS process has the single biggest impact on every nursing home's quality care, reimbursement, survey results and public ratings, yet in most nursing homes, very few staff are even familiar with the elements of the MDS or use it as a tool in their daily care-giving. Learn how to integrate the MDS 3.0 into daily practice in a way that engages staff, invigorates unit-based quality improvement and care planning, advances person-centered care, and contributes to staff stability, morale, and performance. Homes that have these practices in place have seen improvements in workforce stability, quality of care, census, reimbursement for services, and other organizational performance measures. More than just a new form, the MDS 3.0 has the potential to drive resident-centered care. This webinar series goes beyond the form to identify how to take a team approach. It is targeted to administrators, DoNs, and other organizational decision-makers.

<http://www.pioneernetwork.net/Events/Webinars/MDS30/>



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