



Final Grant Report

“Creating Culture of Person-Directed Dementia Care”

(SFY 2019 – 2020 Person-Directed Dementia Care Project)

Project Scope

Participants experienced the following project activities:

- Forming organizational “change agent teams” of 3-4 nursing home employees;
- Participating in 5 distinct educational experiences that support and build on one another;
- Receiving a turn-key training kit for a 1-day training that can be used internally over time;
- Applying project action plans that illustrate how to put skills they’ve learned into action;
- Sharing best practices through virtual participant gatherings;
- Tracking their own medication use data via specific indicators; and
- Completing all required aspects of the comprehensive evaluation process.

Designated team members were asked to possess skills in teaching, coaching, and leadership and be willing to return to their organizations prepared to share what they’ve learned through education and daily infusion of the concepts into operations. At least 2 members of each team were asked to hold a leadership position in the organization to help drive the change efforts and the dissemination of new skills and concepts throughout the organization.

Training	# people	# homes
Dementia Beyond Drugs	370	134
Reframing Dementia: Train the Change Agent	238	96
Care Partner Workshop	312	66
Leadership Pathways to Culture Change	66	27
Facilitative Leadership	75	18
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Dementia Care Training Package

- Dementia Beyond Drugs
- Reframing Dementia: Train the Change Agent
- Online Care Partner Workshop (Dementia-Specific Version)

Between the three educational offerings above, participants:

- Identified limitations of current approaches to care for those living with dementia
- Reframed “problem behaviors” as personal expressions of unmet needs
- Learned to understand the role of sensitivity, awareness, and presence in dementia care
- Collaborated creatively with family members as partners in care
- Deepened responsiveness to the needs of those living with dementia
- Explored the impact of loneliness, helplessness, and boredom on well-being
- Benefitted more from what individuals who live with dementia have to offer us
- Learned practical, everyday skills for enhancing quality of life and quality of care
- Recognized the importance of enhancing well-being for all

- Applied skills learned to everyday situations generating creative solutions that empower individuals to live full and positive lives
- Acted as change agents back in their organizations by sharing and demonstrating the best practices learned through their training experience

Leadership Training Package

- Leadership Pathways to Culture Change
- Facilitative Leadership

Between the two educational offerings above, participants learned how to:

- Work with ten pathways that promote person-directed leadership development
- Identify their own personal strengths and opportunities to grow as leaders
- Apply tools and processes that promote high engagement in change efforts
- Develop personal action plans designed to put the ten pathways into practice
- Ask the right questions for increasing employee engagement
- Leverage the ideas of all stakeholders
- Build on team member strengths
- Foster the inner leader in everyone
- Grow teams with a sense of ownership
- Utilize specific facilitation techniques that foster high engagement
- Use different decision-making methods
- Support challenging transitions
- Make meetings more efficient & effective

Project Evaluation Final Report

Submitted by Amy Elliot, Ph.D.

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EXECUTIVE SUMMARY

As outlined in the project proposal, expected outcomes for the project included the following:

Expected Outcome #1: *By the end of the grant period, the project will produce at least a 5% shift toward person-directed perceptions of, and approaches to, dementia care.*

Result (Goal Met): The average shift (as measured by pre- and post-training surveys) was 9.8% across 24 survey items for the *Dementia Beyond Drugs* training surveys and 16.1% across 14 items for the *Care Partner Workshop* training surveys.

Outcome #1 – Average Change in Person-Directed Perceptions of, and Agreement with Approaches to, Dementia Care Pre-to Post-Training Assessments

Assessment	% Change in Perception Agreement from Pre-to-Post-Training
<i>Dementia Beyond Drugs</i>	9.9%
<i>Care Partner Workshops</i>	16.1%

Expected Outcome #2: *By the end of the grant period, at least 60% of participating teams will submit a QAPI storyboard, based on the CMS Storyboard Guide.*

Result (Goal Met): Storyboards were requested from the 63 homes representing the original phase of the project that attended all three Phase 1 events. Of those homes, 43 of 63 (68.3%) submitted storyboards detailing their project activities. These storyboards were informative accounts of each team’s project goals, activities and process changes.

Expected Outcome #3: *By end of the grant project, the project will help affect at least an overall 5% reduction in the use of antipsychotic medications for the State of Ohio.*

Outcome #3: Changes to Nursing Home Compare Long-Stay Antipsychotic Measure by Project Participation

Long-stay Antipsychotic Measure by Project Participation	Four Quarter Average Q2 2018	Four Quarter Average Q3 2019	Mean % Change	Relative % Change ¹
Project Participants	15.58	14.38	-1.20	-7.7%
Non-Participants	14.98	14.13	-0.85	-5.7%
Ohio Overall	15.08	14.18	-0.90	-6.0%

¹ Relative % Change = (2019 % - 2018 %)/2018%

Result (Goal Met): The project Outcome Goal #3 (a 5% relative reduction in antipsychotic use for the state) relating to this measure was achieved by Q3 2019 with a -6.0% relative reduction in the four-quarter average of long-stay antipsychotic medications for the State of Ohio, and an even greater -7.7% relative reduction in the long-stay antipsychotic use for project participants from the pre- to post-timeframe. Non-project participants in Ohio also experienced a significant change of -5.7% from 2018 to 2019. Although the absolute and relative difference was higher for project participants versus non-participants, this difference was not statistically significant based on a difference-in-difference estimation. Overall, the State of Ohio moved from 27th in Q2 2018 to 21st in Q2 2019 in the state rankings of the Long-State Antipsychotic Measure (not including DC, Guam and Puerto Rico) and was below the national average in the most recent data release.

Additional Project Findings:

Additional project evaluation components were based on project activities relating to 1) Changes in Knowledge and Perceptions; 2) Practice Changes in Nursing Homes; and 3) Project Satisfaction. Results are illustrated at a high-level below.

Changes in Knowledge and Perceptions

Assessment Item	Findings
Reframing Dementia Value Assessment	Overall, 93.2% of respondents Strongly Agreed or Agreed with assessment items.
Leadership Pathways to Culture Change Assessment	Overall, 97.7% of respondents rated knowledge-based assessment items regarding the aspects of the learning experiences as “Excellent” or “Good.”
Facilitative Leadership Assessment	Overall, 93.4% of respondents Strongly Agreed or Agreed with knowledge-based assessment items.

Practice Changes in Nursing Homes

Assessment Item	Findings
<i>Dementia Beyond Drugs</i> Sustainability Survey	Overall, 92.1% of respondents Strongly Agreed or Agreed with sustainability assessment items.
<i>Care Partner Workshop</i> Sustainability Survey	Overall, 86.2% of respondents Strongly Agreed or Agreed with sustainability assessment items
Storyboards	Project storyboards detailed over 100 practice changes, educational activities and project outcomes

Project Satisfaction

Assessment Item	Findings
<i>Dementia Beyond Drugs</i> Project Satisfaction	Overall, 95.5% of respondents Strongly Agreed or Agreed with satisfaction-based items.
<i>Leadership Pathways</i> Project Satisfaction	Overall, 95.5% of respondents Strongly Agreed or Agreed with satisfaction-based items.
<i>Facilitative Leadership</i> Project Satisfaction	Overall, 92.6% of respondents Strongly Agreed or Agreed with satisfaction-based items.

EVALUATION COMPONENTS

Project Participants

Nursing home characteristics for the State of Ohio were generated from the most recent release of the Nursing Home Compare provider data (Q3 2019 - released on January 29th, 2020). Training participants were matched to the Nursing Home Compare data by registration address, resulting in 152 participating homes and 802 non-participating homes in the State of Ohio. As detailed in Figure 1, participating and non-participating homes were similar on a variety of characteristics. One notable exception is nursing home ownership, since participants in the project were from a higher percentage of non-profit nursing homes than non-participants.

Figure 1: Descriptive Statistics from Nursing Home Compare Q3 2019 (January 29th Release Date)

Descriptive Statistics from Nursing Home Compare Q3 2019 (January 29 th Release Date)	Participating homes in NHC data (152 homes)	Non-participating homes in NHC data (802 homes)
% For-Profit	65.8%	80.3%
% Non-Profit	32.2%	17.8%
% Government	2.0%	1.9%
% Corporate Ownership	78.9%	81.5%
Avg. # of certified beds	91.8	92.0
Avg. # of residents	74.8	75.5
Avg. Five-Star Overall Rating	3.1	3.0
Total number of licensed nurse staff hours per resident per day	1 hour and 35 minutes	1 hour and 34 minutes
Nurse aide hours per resident per day	2 hours and 15 minutes	2 hours and 5 minutes

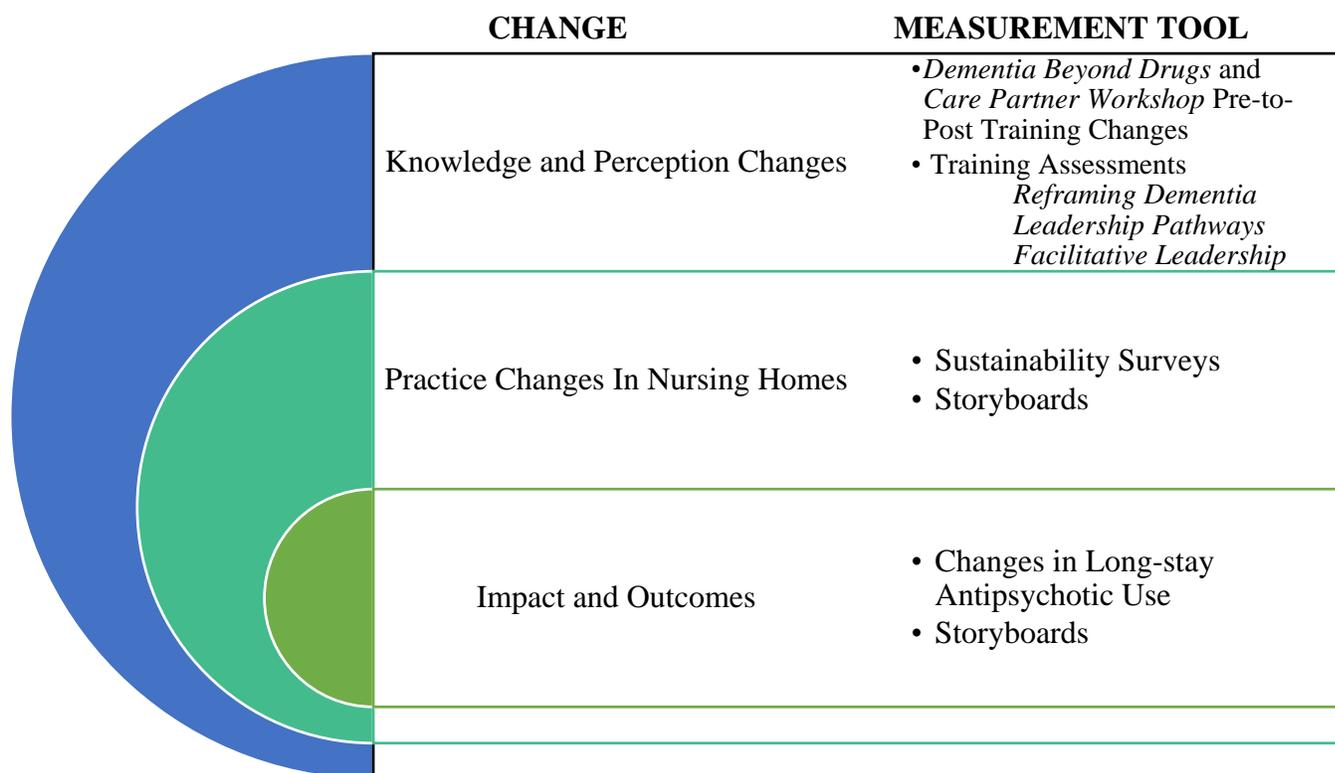
Evaluation Components

The evaluation was designed to capture measures and components from each stage of the anticipated project activities guided by the following assumptions (theory of change):

1. Project trainings developed and curated by The Eden Alternative will result in substantive **knowledge and person-directed perception changes** for project participants.
2. Knowledge and person-directed perception changes in project participants will result in **education, training and practice changes** in participating nursing homes.
3. Education, training and practice changes in participating nursing homes will result in **improved outcomes** for a participating home's residents and their care partners (employees and family members).

The assumptions above translate to the conceptual model detailed below. The model notes the changes highlighted in assumptions 1-3 and the evaluation components and measurement tools expected to measure those changes for the project evaluation. The report then details the results of each component in the project evaluation.

Figure 2: Creating a Culture of Person-Directed Dementia Care Project Conceptual Evaluation Model



Changes in Knowledge and Perceptions

I. *Dementia Beyond Drugs* and the *Care Partner Workshop*: Pre- to Post-test Differences

Substantive changes to person-directed knowledge and perceptions of dementia care are logical precursors to practice and transformational changes in the nursing home. According to The Eden Alternative, *Dementia Beyond Drugs* training “creates a shift in awareness and increases knowledge of and skills for transforming current approaches to care for those living with dementia.” In addition, The Eden Alternative describes the subsequent experience of *The Care Partner Workshop* as “building on this knowledge through a high-engagement strategy (change agent team, family member, resident, ombudsmen) incorporating additional skill-building in between sessions through experiential exercises.”

Of note, the expected Outcome #1 in the project proposal was measured by differences in the *Dementia Beyond Drugs* (DBD) trainings and the *Care Partner Workshops* (CPW) via pre-and post-tests geared towards measuring changes to perceptions and knowledge of person-directed dementia care. Specifically, the pre- and post-test surveys asked participants to respond to level of agreement based on a 5-point Likert scale (strongly disagree, disagree, neutral, agree and strongly agree) for survey items designed for each training. The *Dementia Beyond Drugs* Assessment is comprised of 24 survey items and the *Care Partner Workshop* Assessment is comprised of 14 items. Responses were scored from 1 (strongly disagree) to 5 (strongly agree) in the pre-to-post survey to create an average agreement score. Next, the % change for each item

from pre-to post-responses was calculated. Of note, certain survey items for both assessments were phrased in the negative. For example, the average expected response for the *People living with dementia cannot form meaningful relationships with others* based on the DBD training is *strongly disagree*. For the analysis, all items were first determined to have moved in the expected direction of change from pre-to post-response means (i.e., higher means for expected positive responses and lower pre- to post means for expected negative responses). Next, the absolute value of the % mean change was averaged across all 24 items for the *Dementia Beyond Drugs* assessment and 14 items for the *Care Partner Workshop* assessment.

Figure 3: Average Change in Person-Directed Perceptions of, and Agreement with Approaches to, Dementia Care Pre-to Post-Training Assessments

Assessment	% Change in Perception Agreement from Pre-to-Post-Training
<i>Dementia Beyond Drugs</i>	9.9%
<i>Care Partner Workshops</i>	16.1%

Figure 3 illustrates that the expected proposal outcome of a 5% shift in person-directed perceptions from the pre-to-post assessments was exceeded by both trainings. One potential limitation of these findings is the attrition of responses from CPW pre-to-post trainings (360 respondents for the pre-test and 229 respondents for the post-test). Since responses were not matched from the pre- to post-timeframe, there is potential for some non-response bias that could have impacted the change measure. However, the DBD pre-to-post response change was not as significant (360 pre-responses to 340 post-responses) with still a 9.9% perception change (hence, the 5% threshold does not seem to be an issue even with the attrition limitation).

For the *Dementia Beyond Drugs* assessment, pre-to-post mean differentials for three survey items were notably larger than other response changes. These three items: *I understand the difference between the biomedical model and the experiential model of dementia care* (60.4% pre-to post-mean change), *People living with dementia are able to care for others* (22.4% pre-to post-mean change), and *the Eden Alternative Domains of Well-Being® can be used as an assessment tool when a person living with dementia is distressed* (21.3% pre-to post-mean change) are unique and linked to the content of the DBD training (i.e., it is expected that many attendees would be experiencing this training content for the first time). Even with these more extreme pre-to post-values not included, the average mean change for the remaining 21 items was still 6.3% from pre-to post-responses, exceeding the project outcome goal.

Figures 4-6 below further illustrate these notable changes to perceptions based on responses from pre- to post-DBD training. For example, Figure 4 highlights that most attendees were not aware (or were neutral) regarding *the difference between the biomedical and the experiential model of dementia care* prior to the training (76% disagreeing or neutral). However, after the DBD training, 97% of attendees agreed or strongly agreed with this statement. Figure 5 illustrates that

26% of attendees strongly disagreed or disagreed that *People living with dementia are able to care for others* but only 4% disagreed with the statement post-training. In another example, Figure 6 displays that 74% of attendees strongly agreed post-training that *the Eden Alternative Domains of Well-Being® can be used as an assessment tool when a person living with dementia is distressed* (versus only 25% prior to the training).

Figure 4: Dementia Beyond Drugs pre- to post- training responses “I understand the difference between the biomedical model and the experiential model of dementia care”

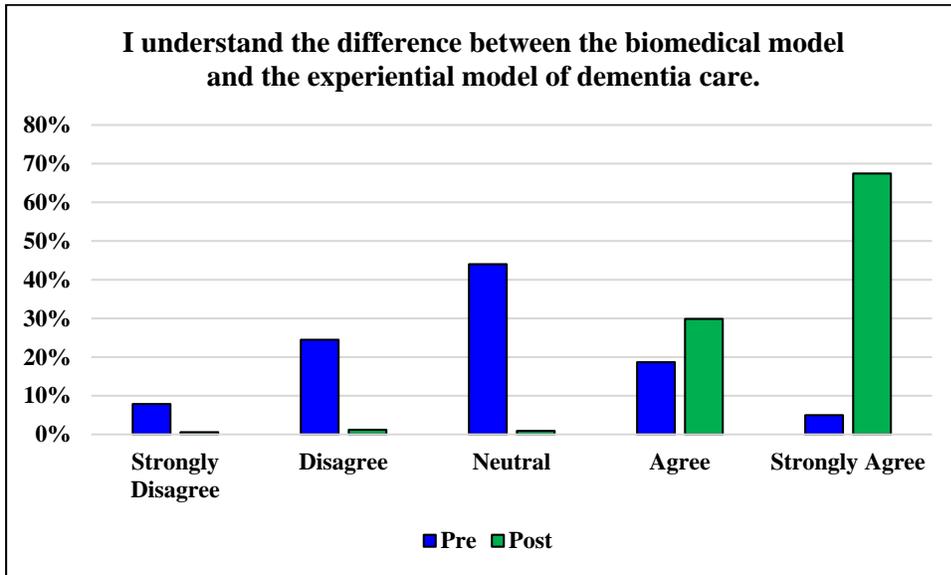


Figure 5: Dementia Beyond Drugs pre- to post- training responses to “People living with dementia are able to care for others.”

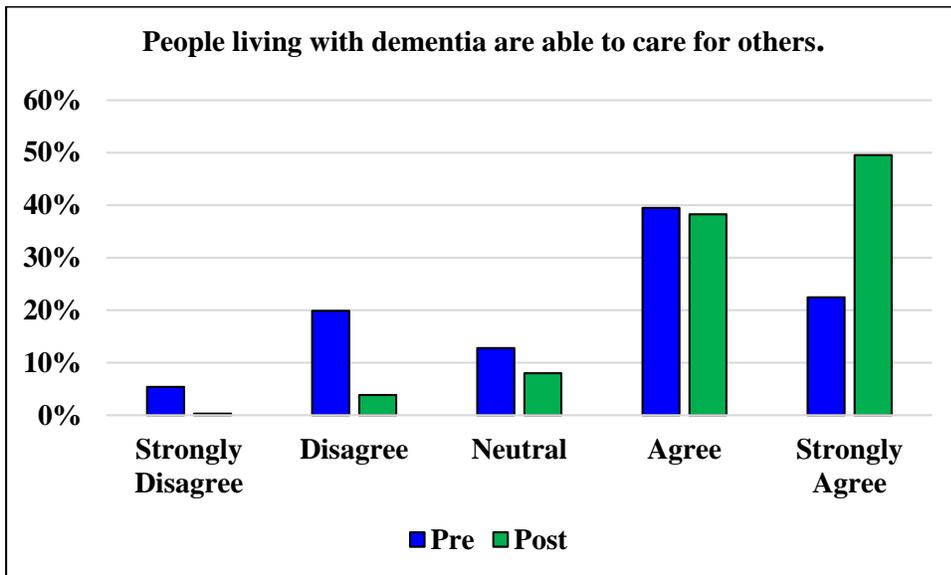
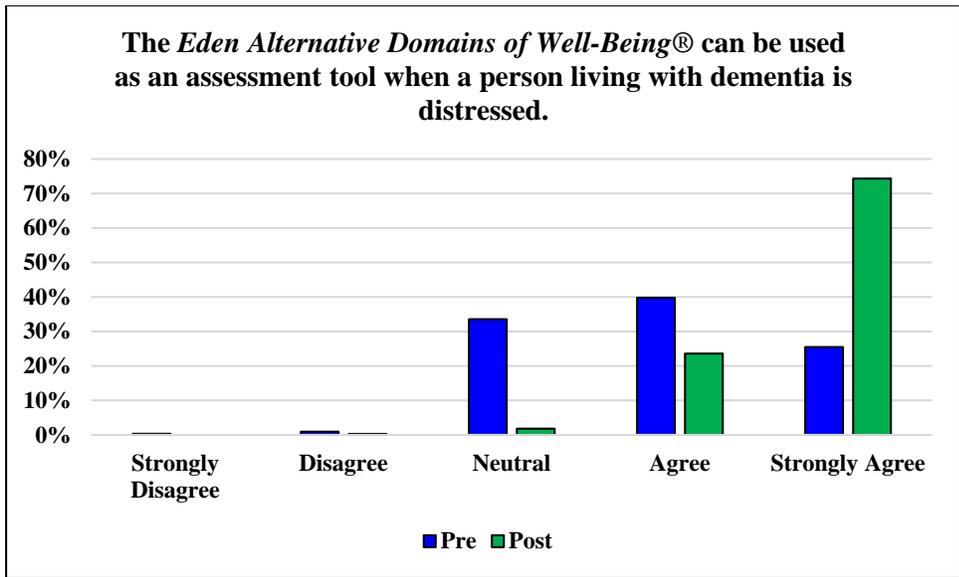


Figure 6: *Dementia Beyond Drugs* pre- to post- training responses to “the Eden Alternative Domains of Well-Being® Being can be used as an assessment tool when a person living with dementia is distressed.”



Figures 7 and 8 detail similar trends for the *Care Partner Workshop* assessment responses. In Figure 7, respondents were far more likely to agree prior to training that *Providing personal care is the most important part of caring for people with dementia* (post-training 62% strongly disagreed or disagreed). Figure 8 highlights that most respondents (51%) strongly disagreed after training with the statement, *It’s important to focus on what someone who lives with dementia can’t do anymore when planning his/her care.*

Figure 7: *Care Partner Workshop* pre- to post- training responses to “Providing personal care is the most important part of caring for people.”

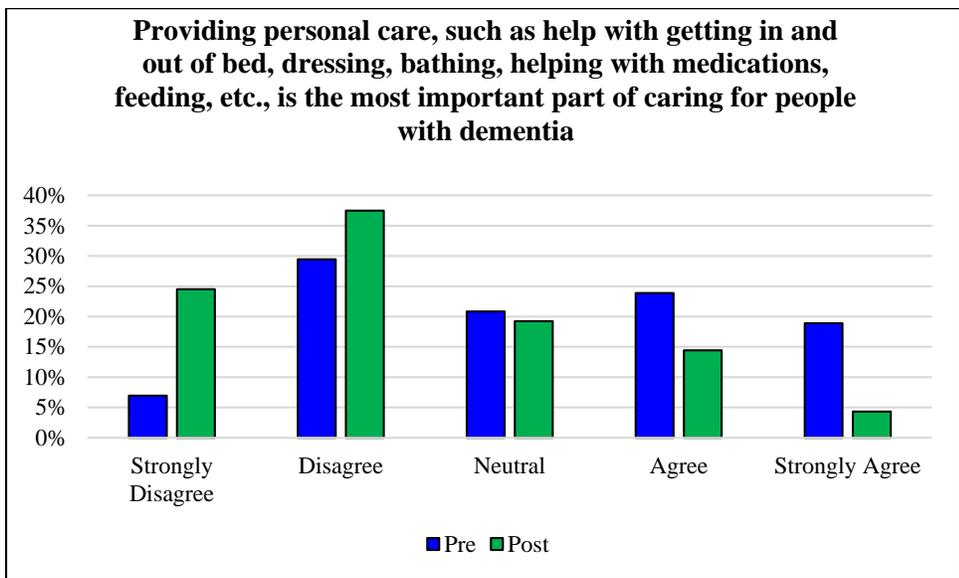
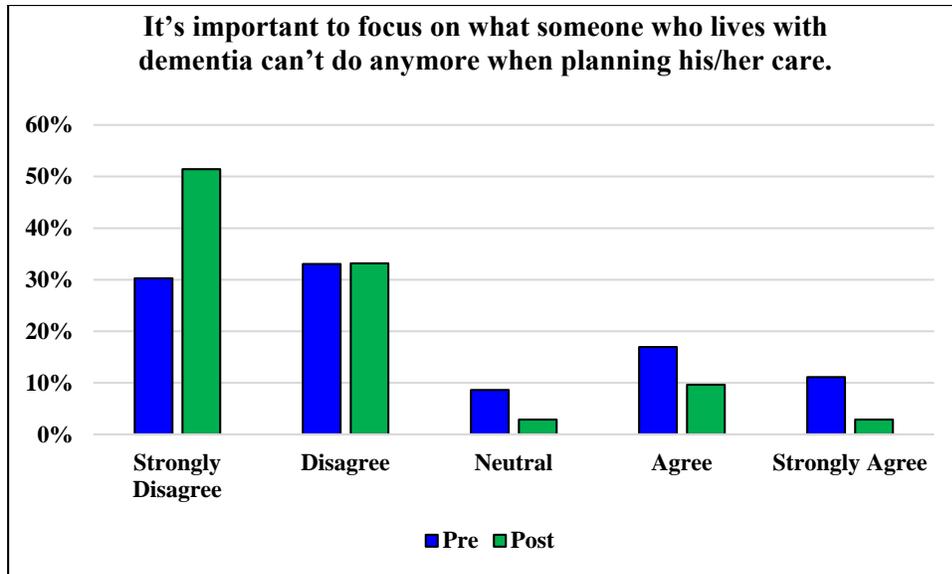


Figure 8: *Care Partner Workshop* pre- to post- training responses to “It’s important to focus on what someone who lives with dementia can’t do anymore when planning his/her care.”



II. Reframing Dementia Value Assessment

A second measurement tool of changes to knowledge and perceptions of person-directed care was the *Reframing Dementia* Value Assessment. This assessment focused on determining the value of the support and materials provided to make the use of the *Reframing Dementia Training Kit* easy and effective. This tool was administered immediately after the conclusion of the *Train the Change Agent* event to 229 respondents representing 86 Ohio nursing homes.

Overall, 93.2% of respondents Strongly Agreed or Agreed with assessment items.

Figure 9: Reframing Dementia Value Assessment Items (n=229)

Assessment Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
This training provided useful information that will help me to effectively teach Reframing Dementia back in my organization.	55.3%	39.5%	4.4%	0.9%	0.00%
I feel that experiencing the sample exercises will make me a more effective facilitator of Reframing Dementia training.	55.7%	34.7%	8.3%	1.3%	0.00%
I feel that the adult learning principles I learned to apply today will make me a more effective facilitator of Reframing Dementia.	58.6%	35.2%	5.7%	0.4%	0.00%
This training has inspired me to go back to my organization and use the Reframing Dementia DIY Education Kit that I will receive today.	57.9%	34.6%	7.5%	0.00%	0.00%
I learned techniques and received materials today that will help me to help others improve well-being for those who live with dementia.	59.0%	35.8%	5.2%	0.00%	0.00%
Overall	57.3%	36.0%	6.2%	0.5%	0.00%

III. Leadership Pathways to Culture Change Assessment

A third measurement tool of changes to knowledge and perceptions of person-directed care was the *Leadership Pathways to Culture Change Assessment*. According to The Eden Alternative®, “the intensive 2-day training explores and integrates ten leadership pathways that enable leaders to grow personally, as well as influence others to join them in transforming the culture of care for the Elders they serve. Through the ten pathways, participants explore self-awareness, personal growth, communication, empowerment, mission and vision development, and expecting the best in others.” This tool was administered immediately after the conclusion of *The Leadership Pathways* trainings (representing 60 respondents from two events). The assessment asked participants to rate both knowledge-based and satisfaction items on a scale of “Poor” to “Excellent” for each item. Figure 10 represents ratings for knowledge-based items (satisfaction items are reviewed in the Training Satisfaction section of this report).

Overall, 97.7% of respondents rated knowledge-based assessment items regarding the aspects of the learning experiences as “Excellent” or “Good.”

Figure 10: Leadership Pathways Knowledge Based Assessment Items (n=60)

Rating of the Overall Aspects of the Learning Experience	Excellent	Good	Satisfactory	Poor	Not Covered
Identification of paradigms that must be changed to begin the culture change process.	76.7%	21.7%	1.7%	0.0%	0.0%
Understanding the leadership role as the driver of deep culture change.	83.3%	16.7%	0.0%	0.0%	0.0%
Identification of attitudes, traits, and behaviors of successful culture change leadership.	73.3%	25.0%	1.7%	0.0%	0.0%
Appropriateness of topic and content for leaders in eldercare organizations.	81.7%	16.7%	1.7%	0.0%	0.0%
Usefulness of the knowledge/skills acquired for advancing person-directed care in a variety of living environments.	71.7%	21.7%	6.7%	0.0%	0.0%
Overall	77.3%	20.3%	2.3%	0.0%	0.0%

IV. Facilitative Leadership Assessment

A fourth measurement tool of changes to knowledge and perceptions of person-directed care was the *Facilitative Leadership* assessment. The *Facilitative Leadership* training is an online, interactive, webinar-based learning modality designed to “deepen the application of concepts and skills learned in *Leadership Pathways for Culture Change and Leadership*” training. The *Facilitative Leadership* Assessments represent 34 respondents from three online trainings. The assessment asked participants to rate both knowledge-based and satisfaction items on a scale of “Strongly Disagree” to “Strongly Agree” for each item. Figure 11 represents rating for knowledge-based items (satisfaction items are reviewed in Training Satisfaction section of this report).

Overall, 93.4% of respondents Strongly Agreed or Agreed with knowledge-based assessment items.

Figure 11: Facilitative Leadership Knowledge Based Assessment Items (n=34)

Assessment Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The skills I learned will strengthen my role as a leader.	55.9%	38.2%	0.0%	0.0%	5.9%
I can name 3 personal benefits of using a facilitative leadership style.	61.8%	29.4%	2.9%	0.0%	5.9%
I can name two ways that a facilitative leadership style will benefit the culture of care in our organization.	61.8%	32.4%	0.0%	0.0%	5.9%
I can describe two facilitative techniques that increase team engagement.	70.6%	23.5%	0.0%	0.0%	5.9%
Overall	62.5%	30.9%	0.7%	0.0%	5.9%

Practice Changes in Nursing Homes

V. Sustainability Surveys

Although project measurement tools of changes to knowledge and person-directed perceptions of dementia care are positive, it's often challenging to measure "how" and "to what extent" training translates to practice changes in the home. To address this gap, the *Dementia Beyond Drugs* and *Care Partner Workshop* Sustainability Surveys were designed to include a set of focused questions to assess on-the-ground use and application of knowledge in daily practice. Surveys were administered 4 months after the training (for change agent teams only). Results for each survey are detailed below.

For the *Dementia Beyond Drugs* Sustainability Check, 88 individuals from 54 nursing homes responded.

Figure 12: *Dementia Beyond Drugs* Sustainability Check (n=88)

Assessment Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I am applying the techniques and knowledge I learned to improve well-being for individuals who live with dementia.	30.7%	59.1%	8.0%	1.1%	1.1%
I have shared the techniques and knowledge I learned with other employees back in my organization.	36.4%	60.2%	2.3%	1.1%	0.0%
I feel that the techniques and knowledge I learned have had a positive impact on the individuals living with dementia that I care for.	36.2%	54.5%	8.0%	2.3%	0.0%
Overall	34.1%	58.0%	6.1%	1.5%	0.4%

Figure 12 highlights respondents' views on applying, sharing, and seeing the impact of the techniques and knowledge from *Dementia Beyond Drugs*, including:

- **89.8% Strongly Agreed or Agreed** that they were applying the techniques and knowledge from *Dementia Beyond Drugs* to improve well-being for individuals who live with dementia.
- **96.6% Strongly Agreed or Agreed** that they had shared the techniques and knowledge learned from *Dementia Beyond Drugs* with other employees back in their organization.
- **89.8% Strongly Agreed or Agreed** that the techniques and knowledge learned have had a positive impact on the individuals living with dementia that they care for.

For the *Care Partner Workshop Sustainability Check*, Figure 12 highlights 53 respondents’ views on applying, sharing, and seeing the impact of the techniques and knowledge from *the Care Partner Workshop*, including:

- **92.5% Strongly Agreed or Agreed** that they were applying the techniques and knowledge from the *Care Partner Workshop* to improve well-being for individuals who live with dementia.
- **86.8% Strongly Agreed or Agreed** that they had shared the techniques and knowledge learned from *Care Partner Workshop* with other employees back in their organization.
- **79.2% Strongly Agreed or Agreed** that the techniques and knowledge learned have had a positive impact on the individuals living with dementia that I care for.

Figure 13: *Care Partner Workshop Sustainability Check* (n=53)

Assessment Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
I am applying the techniques and knowledge I learned to improve well-being for individuals who live with dementia.	34.0%	58.5%	7.5%	0.0%	0.0%
I have shared the techniques and knowledge I learned with other employees back in my organization.	35.8%	50.9%	11.3%	1.9%	0.0%
I feel that the techniques and knowledge I learned have had a positive impact on the individuals living with dementia that I care for.	28.3%	50.9%	18.9%	1.9%	0.0%
Overall	32.7%	53.5%	12.6%	1.3%	0.0%

Across both sustainability checks, respondents replied that training-in-services and word of mouth were the most used sharing techniques for the information learned in the trainings.

Examples of common responses to *Can you provide an example of what you’ve witnessed?* include: (Note: full response list detailed in the report Appendix).

- Quality and level of engagement and interaction between staff and Elders
- Changes to staff approaches and problem-solving based on verbal and non-verbal communication from the Elders
- Fewer behaviors and decreased agitation
- Decrease in the use of antipsychotics

- Focus and awareness on individualized, person-centered approaches and addressing unmet needs
- Residents have more choices and are more involved
- Taking more time with residents

Examples of common responses to *What skill or concept learned during Dementia Beyond Drugs has been the most valuable to you?* include:

- Learning circles
- The Eden Alternative Domains of Well-Being®
- Training/staff education materials
- Hand in Hand Training
- Techniques to help learn about the individual needs and preferences of a resident and person-centered approaches
- Language changes
- Assessing needs prior to medication
- Giving Elders more options and time

Examples of common responses to *What challenges have you experienced in your efforts to apply the techniques and knowledge you learned?*

- Time for training
- Time for implementation
- Staff buy-in
- Leadership buy-in
- Turnover

VI. Storyboards and Practice Changes

A second tool to help assess the use of the knowledge and tools learned in trainings when participants return to their individual organizations were the project storyboards. The Expected Outcome #2 described in the project proposal noted that 60% of participating teams were expected to submit a QAPI storyboard, based on the CMS Storyboard Guide by the end of the project. This expected outcome was achieved. Storyboards were requested from the 63 homes from the original phase of the project that attended all three Phase 1 events. Of those homes, 43 of 63 (68.3%) submitted storyboards detailing their project activities. These storyboards were informative accounts of each team's project goals, activities and process changes.

Specific examples of changes reported by participants are detailed below (note: storyboard outcomes are detailed in the next section).

Examples of Practice Changes

- Focus on meaningful and individualized activities.
- Completing *About Me* profiles for residents and communicating the *About Me* information to care partners.

- General reports of staff learning more about each resident's past, preferences, family and professional experience so that they could better relate to each resident.
- Integrating work into QAPI activities.
- Integrating memory care support into new partner orientation: importance of approach, non-verbal cues, virtual dementia tour, music and memory program education with visual, audio, and demonstrative techniques utilized.
- Community wide Memory Care collaboration monthly meetings to focus on memory support education, programing, person-directed care, holistic approach, and environmental needs.
- Creation of memory care plans for all elders that meet the qualifying assessments ensuring holistic care that improves their well-being.
- Increasing opportunities for elders' exposure to sunlight.
- Increasing opportunities for elders' exposure to smell to increase appetite.
- Altering the dining environment to enhance individualized preferences and input.
- Quarterly family meetings with a speaker and a monthly newsletter with articles about tips for loving and helping elders with dementia.
- New programs for smaller group settings and one on one experiences with elders.
- Implementing a "Get-to-Know-You" assessment to be completed with input of resident/caregivers at the time of move-in for new residents.
- OMA (Opening Minds Through Art) where residents with dementia are paired with a high school student for 10-weekly sessions and produce artwork. A reception with art auction is held at the end of the program with invited residents, students, and families. Artwork is put on display and an auction is held with the proceeds used to continue the programs in the spring and fall.
- Music Therapy with a local college where the student engages residents to participate in singing, playing musical instruments, and song writing.
- Cooking lunch together weekly.
- Quick kits with many Montessori type activities that the partners can help the elders with or that the elder alone will be able to use to reminisce and to remain engaged.



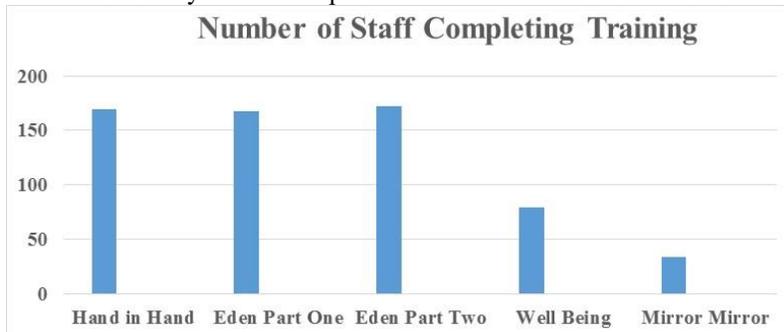
Examples of communication and education activities:

- Training opportunities (in-services) for staff on best practices for creating a person-directed cultures and Reframing Dementia.
- Mirror, Mirror education with visual, audio and demonstration techniques.

- Non-pharmacological intervention education.
- Virtual Dementia Tour training.
- Educating the employee care partners on the Elder and family’s point of view.
- Sharing the Eden Alternative Domains of Well-Being®
- Using the Learning Circles to communicate.
- General discussion about what dementia is, how it is a very individualized process, how to approach elders with dementia, and ideas on how to redirect.
- Care partner workshops.
- Family Involvement in the Online Care Partner Workshops through the project.
- Utilizing Reframing Techniques to improve communication strategies.
- Engaging in an interdisciplinary approach to develop a Care Partner Team.



SEM Haven Storyboard Example for Process Measure “Number of Staff Completing Training” Graph



Examples of challenges and lessons learned (quotes from storyboards):

- Always be flexible & resilient – try new interventions multiple times & in multiple ways.
- Encourage care-partners to complete Certified Eden Associate Training.
- Changing perception and culture of the physicians in the community.
- Mindset change for partners that allows them to be present and assist in the memory care plan of well-being.
- Continual education of various expressions including those that may have not presented themselves in our community yet.
- Just keep moving forward.
- Communication is Key- We needed to reframe our conversations in ways that affirm and nurture our relationships with our elders.

- Encourage feedback and empower the partners in all departments, not just the clinical team, to be a part of the solution.
- Solicit input from family members,

“As a result of this educational opportunity, we have learned to look beyond the disease of dementia to focus on each elder as a whole person, recognizing that their individual needs, preferences, desires, and gifts are what makes them a unique person. Using the Domains of Well-Being enables us to care for each person in a way that puts each elder at the center of their care.” - Emily, Quality of Life Coordinator



Impact and Outcomes

VII. Long-Stay Antipsychotic Use

The project proposal included certain expectations regarding potential project impact and outcomes. Of note, the proposal Expected Outcome #3 noted that, by the end of the grant period, the project would help affect at least an overall 5% reduction in the use of antipsychotic medications for the State of Ohio. This expected outcome was met as described in the findings below.

Data and Analysis

Data represent the *Percentage of long-stay residents who received an antipsychotic medication* measure publicly reported in the Centers for Medicare & Medicaid Services (CMS) Nursing Home Compare (NHC) dataset. NHC pulls this data from the Minimum Data Set 3.0 (MDS) Repository quarterly. Data in NHC are risk adjusted by CMS at the nursing home level using exclusions and resident-level adjustments. One limitation of NHC as a data source is a time lag of one to three quarters (depending on the time of the data pull). However, NHC is often used by CMS to report reductions in the use of antipsychotics through the National Partnership to Improve Dementia Care (i.e., the limitation is an accepted industry standard). Pre-project data were pulled from Q2 2018 NHC quality measure data and post-data were pulled from the most recent data release on January 29th, 2020 representing Q3 2019 (note: certain project activities were ongoing in Q4 of 2019) Relative changes were calculated from the pre- to post-timeframes². Participants at project events were matched to the Nursing Home Compare data by their nursing home registration address (and homes without data values for this measure were excluded) resulting in 152 participating homes and 802 non-participating homes in the State of Ohio.

² Four Quarter Average (Q3 2019 – Q2 2018)/Q2 2018

Analysis Notes:

- The Four-Quarter Average Measure for Long-Stay Antipsychotics was used for the pre-to-post comparison. This is the measure used by Nursing Home Compare to report state averages on the website, and it is theoretically a more resilient measure to homes’ variability.
- Since project activities continued into Q4 2019 (and it is a logical assumption that it takes time for practice implementation to translate to outcomes), these findings may not be fully representative of project impact.

Figure 14 highlights the findings. Given the relationship-based focus of the *Reframing Dementia* training, the use of antipsychotics for long-stay residents represents a valid, clinical outcome of the project’s focus. This measure facilitates circumstances where building relationships and understanding unmet needs is more likely. The project Outcome Goal #3 (a 5% relative reduction in antipsychotic use for the state) relating to this measure was achieved by Q3 2019 with a -6.0% relative reduction in the four-quarter average of long-stay antipsychotic medications for the State of Ohio, and an even greater -7.7% relative reduction in the long-stay antipsychotic use for project participants from the pre- to post-timeframe. Non-project participants in Ohio also experienced a significant change of -5.7% from 2018 to 2019. Although the absolute and relative difference was higher for project participants versus non-participants, this difference was not statistically significant based on a difference-in-difference estimation. Overall, the State of Ohio moved from 27th in Q2 2018 to 21st in Q2 2019 in the state rankings of the Long-State Antipsychotic Measure (not including DC, Guam and Puerto Rico) and was below the national average in the most recent data release.

Figure 14: Changes to Nursing Home Compare Long-Stay Antipsychotic Measure by Project Participation

Long-stay Antipsychotic Measure by Project Participation	Number of Homes	Four Quarter Average Q2 2018	Four Quarter Average Q3 2019	Mean % Change	Relative % Change ³
Project Participants	152	15.58	14.38	-1.20	-7.7%
Non-Participants	802	14.98	14.13	-0.85	-5.7%
Ohio Overall	954	15.08	14.18	-0.90	-6.0%

VIII. Storyboards and Reported Outcomes

A second potential measurement tool for project outcomes is reports of impact from project storyboards. Although not every storyboard detailed objective findings, examples from these tools are informative to the breadth and depth of project outcomes from the nursing homes’ perspectives.

³ Relative % Change = (2019 % - 2018 %)/2018%

Examples of storyboard reported outcomes:

- Individual elder stories are now documented and communicated to their care partners.
- Elder and care partner interaction has been enhanced and time spent with elders increased.
- Resident involvement and quality of life has been enriched.
- More fluid care partner communication and problem-solving.
- Activities are meaningful.
- Increased employee engagement.
- Resident agitation reduced.
- Antipsychotic use decreased.
- Falls decreased.
- Weight loss decreased.
- Rehospitalizations decreased.
- Resident sleep improved.
- Number of Staff Trained (example: *80 staff members were trained with the Reframing Dementia DIY Education Kit over the course of 8 months from April to November of 2019 from Wayne Country storyboard.*)

Otterbein Marblehead Example of documented outcomes

	1 st Quarter	2 nd Quarter	3 rd Quarter	Projected 4 th Q
Elders with memory care needs using anti-psychotics	16.14%	12.34%	8.59%	5.73%

	Beginning 2019	Current
Falls	29.44%	12.41%
Falls by multiple residents	5.7%	0.95%
Anti-psychotic use	16.14%	8.59%
Short stay re-hospitalizations	0.95%	0%
Long stay re-hospitalizations	3.80%	0.95%

Otterbein UT Storyboard Example of documented outcomes



Training Satisfaction

Although not detailed in the project evaluation conceptual model (Figure 2), the primary activities of the project involved training. Hence, satisfaction with those trainings is representative of project success. The figures below detail these satisfaction results.

- Figure 15 highlights that, overall, **95.5% of respondents strongly agreed or agreed** with satisfaction-based questions for *Dementia Beyond Drugs* training.
- Figure 16 illustrates that, overall, **96.2% of respondents rated satisfaction components as “Excellent” or “Good”** for *Leadership Pathways* training.
- Figure 17 highlights that, overall, **92.6% of respondents strongly agreed or agreed** with satisfaction-based questions for *Facilitative Leadership* training.

Figure 15: *Dementia Beyond Drugs* Training Satisfaction (n=340)

Assessment Item	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
The training met the learning objectives with the content and materials.	71.9%	22.7%	2.7%	1.8%	0.9%
The topic and content were appropriate to long-term care	76.0%	20.1%	2.7%	0.3%	0.9%
Knowledge and skills acquired will be useful.	72.8%	23.1%	2.1%	1.2%	0.9%
The instructor was knowledgeable of the materials and topic.	80.4%	17.9%	1.2%	0.0%	0.6%
The instructor's presentation skills were effective	75.6%	19.6%	2.4%	1.8%	0.6%
I would recommend this training to others	71.4%	21.6%	3.0%	2.4%	1.5%
Overall	74.7%	20.8%	2.3%	1.2%	0.9%

Figure 16: *Leadership Pathways* Satisfaction Based Assessment Items (n=60)

Rating of Satisfaction Based Items	Excellent	Good	Satisfactory	Poor	Not Covered
Instructor's knowledge of material/topic.	93.3%	6.7%	0.0%	0.0%	0.0%
Instructor's presentation skills.	80.0%	13.3%	6.7%	0.0%	0.0%
Appropriateness of teaching methods/strategies	69.5%	23.7%	6.8%	0.0%	0.0%
Objectives relative to overall purpose	75.4%	19.3%	5.3%	0.0%	0.0%
Overall Rating	71.7%	28.3%	0.0%	0.0%	0.0%
Overall	78.0%	18.2%	3.7%	0.0%	0.0%

Figure 17: Facilitative Leadership Satisfaction Assessment Items (n=34)

Rating of Satisfaction Based Items	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
This learning experience met my expectations.	58.8%	35.3%	0.0%	0.0%	5.9%
The training materials were well designed, engaging, and supported my learning experience.	64.7%	29.4%	0.0%	0.0%	5.9%
The training was structured in a logical and user-friendly way.	64.7%	26.5%	2.9%	0.0%	5.9%
I would recommend this training to others.	64.7%	26.5%	2.9%	0.0%	5.9%
Overall	63.2%	29.4%	1.5%	0.0%	5.9%

Evaluation Limitations and Conclusions

In terms of inferences regarding the project outcome of long-stay antipsychotic use, there are notable limitations to the data lag of the public use Nursing Home Compare data and self-reported outcomes of participating homes in storyboards. In addition, the level of engagement varied by participating homes and project activities extended beyond the data available for the long-stay antipsychotic analysis. These limitations make any inference of project activities to causality of outcomes challenging. However, project storyboards and responses to the project sustainability survey were very detailed and support a wide breadth of implementation activities and engagement supported by the project. Knowledge-based assessments of various project trainings were also consistent and representative of extensive project impact. Satisfaction for trainings also support value in project participation. In sum, these project evaluation components are suggestive of a link between the project activities, implementation, and project outcomes for project participants and elders living in their homes.

APPENDIX

DEMENTIA BEYOND DRUGS – Sustainability Survey Qualitative Responses

How have you applied the techniques and knowledge you learned from Dementia Beyond Drugs?

- 1:1 training with key staff members.
- Able to actually see the resident with dementia as a person.
- Accommodating the individual's schedules/wants/needs opposed to facility standards
- Adjusted staff training and retraining concepts and application including using the mirror exercise where you draw a house.
- Assessing needs prior to medication
- By listening to the resident instead of assuming they need behavior medicine
- By looking at my Elders as 'Elders' and not 'residents'
- By meeting the Elders needs without medication as much as possible.
- By touching base with physicians regarding alternative measures than medications.
- By using principle one and solving the loneliness, boredom and helplessness and understanding the behaviors.
- Careful how address residents. resident centered
- Completed Hand in Hand training for ALL staff who work on Dementia unit and started implementation of change.
- Completed staff education regarding approaches and activities for dementia elders
- Considering the person and the environment that may be causing behaviors.
- During care conferences and meeting with families- sharing ideas. Sharing with STNAs
- Educate nurses and STNAs in behavior techniques to use to calm a resident who is delusional.
- Educated partners, families and elder to new terminology in regard to memory care. I am working on. New programming to all elders' work memory loss.
- Education of staff on techniques for caring with dementia patients. Talking through approaches in care conferences.
- Elders are redirected with items from our 'Calming cubes' located in each house. Partners will choose one or more items from these shelf cubes and sit with the elder in an effort to calm them. Items include a deck of cards, aromatherapy oils and lotions, notecards, puzzles, balloons, bubbles, massagers, etc. Partners take elders for walks around the neighborhood if the weather is nice. Activities are planned with elders with dementia in mind. We are also amping up our Music and Memory program.
- "Formed committee for psychotropic drug use. Have been meeting monthly.
- More team discussions/huddles to implement individualized interventions for when expressions of unmet needs."
- Giving elder more options and time
- have begun by providing in-depth training for floor staff on residents' expressions and techniques. have really started looking at delirium vs. dementia and appropriate assessments and interventions for these cases. Slowly making changes for person centered care lifestyle atmosphere.
- I am taking time to meet with individual residents to do interviewing and apply knowledge in active listening to assist in helping with their functional deficits.

***How have you applied the techniques and knowledge you learned from Dementia Beyond Drugs?
(cont.)***

- I am using some of the techniques learned in class to educate staff on how to respond to a resident with dementia. Staff have commented that they now understand better why a resident may respond the way they do
- I pay more attention to the resident and their needs as opposed to their behaviors.
- I communicate with my Veterans in a different aspect when a Veteran mentions they need to go home. I will now ask them what their home was like, as the Veteran begins to describe their home. I am able to redirect them easier.
- I encourage the staff to take a different approach with residents that are more difficult. Residents are allowed to sleep in and make more choices in their daily life
- I have become more tuned in to the Elders living with Dementia. I take the time needed to figure out what is wrong so that I can better help them with the problem.
- I have educated my staff and family members about what I learned from Dementia beyond drugs. Residents, staff, and family are noticeably happier.
- I use the technics I learned when interacting with the people I serve. I use it in my communication and interventions.
- I was a part of creating environments that made the elder feel like they were home instead of a facility.
- I'm an advocate for the residents. I'm a leader and leading my staff by example of how I treat the residents.
- Incorporated the mirror challenge in our orientation for all new staff to help them understand and empathize with those with dementia better.
- Leadership Team education and partner Liberation Huddles, to educate employees regarding the Culture Change concept and implementation strategies.
- Leading by example and working with our team to implement a training session for staff.
- Learning Circles - all about you - Mirror Mirror training to all employee meeting
- Learning the past of residents to set their routine
- Looking at each individual and allowing them to direct the care process.
- Monthly in services education about the 3plagues interventions on how to meet unmet needs they are not just behaviors ideas and implementing activities to enrich lives of our elders incorporating the care partner team with family members as well
- Not to correct the individual, not to rush, your approach, and to just be in the moment with them.
- Seeking alternative solutions, re-evaluating residents interest skills/interest prior to request for drugs
- Sharing experience from training with staff, implementing into staff meetings, word of mouth, leading by example.
- Staff education provided and attempting alternate interventions prior to medications.
- Staff education, development of resident specific my story profiles which included family involvement
- Staff education, staff redirection
- Starting to initiate a more person-centered care for the elders in our community.
- Taught others and in process of rolling out large training piece that will reach all employees
-

*How have you applied the techniques and knowledge you learned from Dementia Beyond Drugs?
(cont.)*

- Tried harder to enter their world in order to redirect vs. reality orientation. Also, encouraged families to make story boards or picture books for residents and staff. This will help staff get to know resident better and see them as a person instead of a task.
- Trying different activities and finding out about each individual their likes and dislikes
- Trying to figure out what unmet needs the resident's 'behaviors' are a reflection of
- Understanding and implementing with the direct care staff that the unmet needs of our dementia residents is not something a pill will fix, but instead we want to know the resident better and understand where they are having difficulties and meet them where they are. Our management staff on the dementia units are taking the learning tools from the training and developing a shorter intense training for our incoming STNA's to learn and understand dementia before working on the floor.
- Using it during our behavior/psychoactive drug meetings. Using it during Orientation and during in-services with activity staff and staff that work on the Alzheimer's/dementia unit.
- Using training materials to train staff.
- We are rewriting our training program for new hires and then will roll it out to current staff
- We are constantly looking at new unmet needs from the residents or when the resident is showing dementia related things that is not normal for them. Constantly trying more sensory, hands on, back massages, warm blankets, weighted blankets, essential oils. Also anticipating the needs before they happen.
- We are continuing to do about men's and make those available to our staff
- We have Red Plates for mealtimes
- Education with management team and managers are training their partners"
- We are gathering information from their families as to activities the patient enjoys, what triggers the patient, routines, and implementing this information into our plan of care. We also are gathering information from the patient. We use consistent staff members with the patient.
- We are starting by changing the language with which we talk about our residents and changing how we do some of our dementia programming.
- We are using the exercises that we learned during the training with the partners at Otterbein. We are also integrating the 7 dimensions of well-being into our programming and education.
- We created a decorative box called the 'Calming Cube', it contains many diversional items and non-pharm interventions such as lavender oil, scented lotions for massage, activities designed to engage elders and have also place trivia jars on tables to encourage interaction and socialization among staff to elders and elders to elders/families.
- We have done several learning circles on the about me and have implemented the process in our community. We are also scheduled to complete the common ground process throughout our entire campus, between staff on different departments and with staff and elders. We have begun to include elders in our learning circles and QA processes. We have also implemented other non-pharmacological interventions - music and art therapy, aromatherapy, weighted blankets etc.
- "We have had mandatory partner meetings and have used tools and resources
- Provided from the training, about me, words make worlds, mirror mirror and discussions held on the domains of wellbeing. Continued focus on reduction of antipsychotic use and sensory intervention techniques and education as provided

***How have you applied the techniques and knowledge you learned from Dementia Beyond Drugs?
(cont.)***

- By Seniors Wellness."
- We have held huddles with each department introducing The About Me, Common Ground, What Gives you well-being, Words Make Worlds, and Mirror Mirror exercise.
- We have incorporated the domains of wellbeing to our care plans and have looked for unmet needs related to behaviors.
- We have not started the training yet, but we are working on an action plan to bring what we learned to the staff on our Dementia Unit.
- We have started training all of our staff. We have had 2 eight-hour sessions and have a plan to have all staff trained by the end of the year.
- We have used many of the exercises including Mirror Mirror and Words Make Worlds
- We have worked with environmental things within the facility as well as staff care and approach, with education to staff on an ongoing basis.
- We look beyond the behavior to see what may be causing it. We did this somewhat before but have expanded it.
- We truly utilize holistic approaches as much as possible.
- We use a dementia/activity cart. Trying to find person centered activities to divert rather than coming up with a medication.
- We work with the pharmacist, physician and CRNP to look at the medications and attempting to do gradual dose reductions.
- We've implemented the change of culture for the language we use throughout the building for geriatrics, but especially for our memory care unit. It has shown a change in our environment. We're not where I want to be, but it's a working process.
- When interacting with dementia residents I am conscious of my body language and my approach
- when talking and working with residents / families I am making sure our conversations are resident directed.
- With all staff from all departments in our dementia unit.
- Yes, in providing care partner information and training opportunities.

Can you provide an example of what you've witnessed [in terms of impact]?

- 'Personal expressions' happen less frequently
- A staff member tried to redirect a resident, but it was unsuccessful. She came to me and asked what else she could try and together we came up with another approach for the resident.
- Addressing an unmet need in a resident has decreased their behaviors.
- Allowing the elder to choose their wants/needs - making decisions for what they want.
- As I took this journey of taking time, kneeling next to residents in wheelchairs, shaking hands, hugging and holding hands with them, it has showed a positive impact on them. They smile when they see me and follow me on the unit, it is easier to figure out what is wrong because I know them better and they engage me more during an activity.
- By affirming a resident's reality with body language, approach and tone of voice.
- By letting a resident sleep in and awake naturally I am seeing a more cooperative and happier resident

Can you provide an example of what you've witnessed [in terms of impact]? (cont.)

- By listening to the resident made the resident happier and was willing to open up and discuss what was bothering the resident
- By spending more quality time with our elders with dementia, we have noticed a marked improvement in behaviors. We are looking at some of these elders' medications and seeing which ones can be eliminated.
- By working with staff on care and approach it has improved quality of life for our residents
- Calmer and slower approach when providing care.
- decreased agitation and wandering/exit seeking, an overall calm in the households
- decreased medication usage
- During small groups we have brought to attention of staff approach, body language and calmness when working with Dementia resident. Staff interaction is more positive
- Excitement and Staff by in
- Finding meaningful tasks for a resident who often wanders into other peoples' spaces. When given a task like sweeping up after meals she is not wandering and does a great job
- Giving residents choices, opportunities to participate in leisure interest according to their interest not the staffs.
- I feel like when I see the individuals I have already introduced the trainings to (STNA's) that when I witness them on the units working, they have more of a caring tone to them, they are actively listening to the residents, playing games with them in-between meals when they can now to interact, and getting down to their level to speak with them instead of talking over them. These little changes have made a big different in how the residents react to them and how they work with the residents.
- I have been taking time to spend individual time with each Veteran, especially Veterans who are prone to loneliness and boredom. I have noticed those particular Veterans are happier, since there has been a consistent visitor with them.
- I have finally gotten staff buy-in and they are slowly but surely making changes in how they are approaching residents and using different ways and approaches, especially with difficult behaviors.
- I have got to see other partners rethink their approach with those effected by Dementia and they both have a better experience during their activities of daily living. One example would be a resident was very excited and the partner set down and with a soft calm voice talked with her while giving her a hand massage and talking with her about different country singers. After talking for a while the resident and her went on to do a fun activity.
- "I have noticed a shift in a few of our employees, vocabulary and some actions. There are always the few people who really take what you say to heart and run with it and that gives you hope.
- We are in a very strange place moral wise and having a lot of staffing issues and turn over. So, it is hard for people to be open to culture change when they are frustrated with operational barriers."
- I have noticed less frustration by both care partner and resident when we are resident directed
- I have noticed staff start to use the terminology from our in-services such as 'care partner'.
- I have noticed that getting at eye level provides a better experience for both parties involved.
- I have seen elder assistants change their mind set and now say different things in front of other elders. It is a change in the language mindset
- I have watched the staff that have been in the in-services LISTENING to the residents; verbal and nonverbal communication more and then delivering care based on this information.

Can you provide an example of what you've witnessed [in terms of impact]? (cont.)

- I used communication techniques I learned. In a particular situation I felt it had a better outcome
- Individuals have less expressions when our care partners anticipate their needs and wants.
- I've sat with a specific resident with behaviors more often and tried to come up with non-traditional ideas for meeting her needs.
- I've witnessed staff understand better what makes each individual resident comfortable and happy
- Learning the past history of residents
- Less medications used and more use of re-direction.
- Looking at our elders from a different lens. Trying to be proactive in creating a focus on well-being versus how to handle behavioral reactions once they have occurred. Prevention and focus on wellbeing.
- More individualized interventions. Able to engage one veteran in a specific activity when he was not able to participate in activities before.
- More patience care partners understanding and trying interventions of how unmet needs can be alleviated Care partners coming up with ideas to help others help themselves
- More smiling and less anxiety
- My Facility had an elder who was combative and easily upset no matter what the staff would do for her. She was not very verbal so she could not tell us what she needed or wanted. I reached out to her family and learned that she used to paint beautiful pictures and loved painting. The Facility provided her with painting supplies and her eyes lit up. There has been a substantial decline in her outbursts, and she is still able to paint beautifully!
- Not at this time
- Playing music and interacting with residents by clapping to the music and dancing with them distracted the residents from having behaviors.
- Res are more involved with individual activities like coloring and folding clothes
- Resident having a behavior how staff approached used talk point
- Resident upset because he was moved in his wheelchair without his approval. Staff did say they were going to move him as dining room was closing. Stna moves him from dining room to common area. He was upset and agitated. I approached from the front with my hand extended, crouched down while shaking his hand, greeted him with his formal name - Mr. _____. He immediately calmed down. Returned the greeting and called me kiddo. We discussed how frustrating it can be to feel out of control.
- Residents are happier because we are not forcing them to conform to a time schedule
- Residents seem more involved.
- Seen less unmet needs and in turn less behaviors, crying out, verbal, wandering, and pacing.
- Staff are now 'assessing' the resident prior to judgement.
- staff are picking up on the importance of the individual and taking more time to assist them with independent choices
- Staff interactions and understanding of Dementia has improved. This is seen in the care of our residents.
- Staff understand better why a resident with dementia might not respond quickly and are more patient with them
- started QAPI project at TAV
- STNAs place a resident who is delusional and yelling in a guest dining room where is quiet and lights are dim without being reminded.

Can you provide an example of what you've witnessed [in terms of impact]? (cont.)

- The care partner team has begun to see the elders not as a task but as a partnership. On the about me we added lines to highlight the elders' strengths. This helps us all keep centered on the person and not the task.
- The elders and staff are starting to feel even more like a family unit.
- The residents' needs are met, and they can become less agitated.
- The response to employees when I do the exercises for empathy for those with dementia is priceless. They have a deeper awareness and are often amazed at the breadth of challenges the Resident experience just trying to exist day to day.
- The STNA that attended the training has been able to use some of the training to help meet unmet needs vs. 'behaviors'
- There have definitely been some challenges on changing the status quo on how things have been. Change continues to be a difficult thing to master.
- Using the robotic dog to soothe a resident who was yelling out.
- Usually in activities we rush from room to room to invite individuals to activities. I have an individual who really does not come out for anything. Yesterday, the activity assistant spent a little extra time with her doing adult coloring, in which something she enjoys. Today that same resident, who never comes out, came out for bingo.
- Various staff members are using different approaches with the residents.
- Watching the residents utilize music and memory or Art therapy is truly a blessing.
- We are a CCRC and there is an independent living resident who is living with dementia and her spouse. The team at PV has met with the resident and family on multiple occasions offering support. Throughout sharing some of the strategies and education learned the family member has really started to gain a better standing and has become more open to support of the team. This has had a significant impact on the resident because the team can now support more through individualized plans of care.
- We are able to communicate better with residents.
- We are starting to think about how we treat the elders in our community.
- We did different activities from the workbook with the care givers. This has given them a different perspective and more awareness when caring for a dementia patient.
- We had a patient that was distressed who had dementia. Was having sleepless nights due to confusion and likely the change in environment. We spoke with the family to gain knowledge of the patient routine, activities enjoyed, past history (work ethics, leisure activities, food preferences, sleep routine, etc.) Once gathering information and having family bring in sentimental items for the room, we witnessed the patient become calm and able to have rest periods. Comfort and safety were assured.
- We have a resident who has been able to settle down and become adjusted to our home. Prior to the course, staff significantly contributed to her agitation.
- We have had a decrease in psychotropics used for our elders
- When one of my residents was upset, packing her room and determined to 'Get the hell out of here,' I was able to converse with her using the techniques to get her to tell me she wanted to go home to see her husband (who is deceased) to telling me about her husband, how they met, and what a good man he is. Resident calmed in talking about him and then happily went to dinner with her friends in the dining room.

- With interventions discussed in our team meetings we now look at the impact closer on how medications may influence a resident with physician collaboration and NP collaboration.

What challenges have you experienced in your efforts to apply the techniques and knowledge you learned from Dementia Beyond Drugs?

- Adding this knowledge into our current program/trainings.
- buy in from staff to take the time to use the activities; time to determine what works for the individual.
- Care partnership vs care giving
- Certain residents do not tolerate having certain medications. Other measures have not worked for them.
- Challenges are assuring that all staff is being consistent with the implementations.
- Changing institutional mindsets is difficult
- changing the culture, opening our care givers mind and showing them in different ways on how to care for dementia patients. Some of our caregivers that have been on the unit for over 10 plus years were more resistant to the changes, but once it began, they adapted to it and actually loved it.
- Changing the overall culture.
- consistent staffing.
- Continued education and learning new partners all the time
- Encourage floor staff to participate
- Ensuring all staff are adequately trained.
- Finding the time in the workday to provide effective training
- for most part -- MDs, nurses and other staff are in agreement to use behavior modifications techniques before even considering medication.
- Getting everyone on board and being patient with process taking time to evolve into a new way of thinking
- Getting staff buy-in. A lot of our staff have been here a long time and have been doing things the way they do them, so change has been a little hard, but I feel they now see the vision and are open to making positive changes.
- Getting staff on board with change the norms
- Having others being able to be on the same level of understanding that I am on
- Having patience with the staff.
- having the time to implement it
- having time to implement new ideas/plans
- I am no longer at that facility.
- I can't say at this time
- I find it difficult at times for some of our family members to realize that Dementia is not a death sentence and their family member can still learn and grow in their community.
- I think the training should be geared more towards how to train all the staff. We have weeks of training to teach to staff and it would be helpful to learn more about how to train the staff in an effective manner.
- I think with myself personally I don't have a clinical background, so I am not front-line staff working daily with these residents. Front line staff get more day to day interaction than myself.

What challenges have you experienced in your efforts to apply the techniques and knowledge you learned from Dementia Beyond Drugs? (cont.)

- I would like to think that I am creative in coming up with different solutions to help residents when needs arise or they are trying to tell you something but cannot. It really is a team effort to come up with the solutions and methods that we can incorporate in the residents' daily regimen.
- Implementation QAPI is helping start us
- Implementing the different techniques - finding the time in a busy day- as when you plan something comes up - State or call offs, etc...
- It's been a big challenge not mostly the residents but the employees they are set in their own ways and a lot of times they think it's a joke
- Just the time required to implement the strategies with everything else that goes on in my day.
- Long term staff can be resistant to attempting drug reductions d/t fear that resident behaviors will worsen. Some not open to trying other approaches
- Making sure I reach all staff.
- Making the time to educate in a meaningful, intentional way to all staff.
- Many of the partners/staff members still want to resort to calling the nurse with the phrase 'can you give them something, they are having behaviors'
- I am not an effective leader I don't think and am new to the floor since September. The staff does not want change and actively resists change if I am not present with them.
- this is my first management job. I am trying to create positive culture change and it feels very much that I am working against the tides alone"
- Mostly time available to train staff.
- My biggest challenge is getting other staff who haven't been through our training yet to comprehend the concept
- my greatest challenge has been other partners not fully embracing the culture change we are trying to set forth
- Need more staff training.
- None at this time
- None at this time.
- Not all team members are on board and there has been no real involvement with larger community of associates. Small group and 1:1 has been with my staff- life Enrichment (already using these concepts) and STNAs when I notice an opportunity to educate. Such as the example listed above. 1:1 and small groups I feel are more impactful anyway. Many STNAs thank me once they use a "trick" I taught them. The STNAs in the example above now shakes hand and calls him Mr. with conversation before moving
- Not everyone is passionate about memory care. Working with the care partners to understand the why and the impact that they can have on someone's life. It is an easy message but a challenging one for all to embrace.
- Nursing 'push' back
- Old approaches are hard to break. My biggest challenge is being so busy with all the paperwork of my job. I do not have as much time with the residents or my staff to tell them about the Eden Alternative.
- Old school nurses don't want to take the extra time and would just rather medicate the resident having 'behaviors.'

What challenges have you experienced in your efforts to apply the techniques and knowledge you learned from Dementia Beyond Drugs? (cont.)

- Our population (all war-time veterans) have different responses to certain stimuli and can be more challenging than the typical person living with dementia. It's difficult to assess if responses are from dementia or other psychiatric issues. Have foreseen need to research Trauma Informed Care.
- Playing music calms most residents but sometimes it agitates other residents.
- Push back from staff.
- see 4.1.
- Short stay of residents, sometimes there isn't enough time to get to the bottom of the problem.
- Some elders just cannot be reached do to sever dementia.
- Some family members unwilling to change
- some of the interventions does not always work with some residents and trying to come up with different ideas
- Some staff members are very closed minded about any new ideas and need a lot of encouragement to use the new concepts.
- Some STNA's think that some of the techniques learned are more time consuming and there is no way they can fit them into their everyday work with it all being so busy. By showing her just little activities and engagement techniques that can be used that don't take much time, I am hoping will change their minds into wanting to do these activities and further engage the residents. Push back is hard, but we just have to be persistent and encouraging to our staff.
- Sometimes it is difficult attempting to figure out the individuals unmet need
- Sometimes staffing makes it difficult and not every person working has the same perspective. Some people see it as a job and a paycheck and have no interest in developing relationships with staff or residents
- Staff are stuck in the old way of think and schedules
- Staff carryout.
- Staff changes, wanting to do things 'the way we have always done them.'
- Staff do not like change. It will be an ongoing challenge.
- Staff education and reality of having new staff continue to learn over the course of time regarding training about working with residents with dementia.
- Staff pushback, resistance to change what they perceive has been 'working'.
- Staff -some just don't get it
- staffing
- staffing restraints to the time you can spend with resident
- Taking it back and teaching other partners. New techniques are hard for people. It takes practice to form a new habit and even harder for people to break their old habits. Staying consistent, continue education, and sharing what positive outcomes we have seen has been the best drive to keep our partners going.
- The buy in from staff
- The next challenge will be developing more activities/ conversations on all shifts to keep residents engaged and having more engagement form all Departments that everyone can contribute to enhancing others' lives
- The only challenges that I have had were with myself, but over time as I applied my training to a routine, there are less challenges and more victories.

What challenges have you experienced in your efforts to apply the techniques and knowledge you learned from Dementia Beyond Drugs? (cont.)

- The techniques do work for the earlier stages of dementia, but I don't feel there has been enough presented to assist in the care of residents with late stages. I feel the presenters lack the experience of dealing with the daily needs of late stages to properly educate. I was very hopeful in the beginning, but so far, I see no benefit from this training. I will continue to participate with an open mind and can only hope it will get better.
- "The time it takes to ensure that the education happens and the audits to ensure
- That what they have learned will be applied. Follow up on challenges encountered.
- Currently trying to educate on creating memory moments to learn from experiences
- As we are improving and enhancing the care we provide."
- There was so much information given to us in the training; it has taken us longer than we had anticipated to implement all the concepts that we felt would help our elders with dementia. We also realize that we need to take baby steps as opposed to changing everything at once.
- they are not always willing to do what you want them to do.
- Time and staffing for the most part. Buy in of some of the unit adjustments that should be made.
- Time as far as trying to set up in-services to share the information with staff.
- time factor of being able to do more with the information
- Time is always the biggest challenge. There are so many tasks sometimes we have to make sure we stay focused on what is important.
- Time to educate staff-staff shortage-turn over with staff-priorities shift when staffing is short-staff go into survival mode and aren't as creative in addressing individual resident needs
- Time. Time is always the challenge in SNF
- To keep care individualized not institutional
- To let the Elders help themselves or at least become a part of their care we are so used to taking full charge traditional vs care directed concept
- Trying to get everybody out of the 'old school nursing facility mentality'.
- We did have 1 nurse who didn't buy into the training because she thought she knew everything. And then the other issue is just trying to find a way to combine the training/ideas and still get the 'tasks' done each shift.
- With my care partner staff, they are resistive with the changes that are happening on the unit. I have been implementing techniques and slowly the care partner team is adapting, and I have seen some of them use the techniques I have.

CARE PARTNER WORKSHOP – Sustainability Survey Qualitative Responses

How have you applied the techniques and knowledge you learned from the Care Partner Workshop?

- A lot of the things that were presented were things we already have in place.
- application of techniques learned implemented into activity programming for our residents with dementia.
- As the family representative, I have tried to use some of the techniques in caring for my mother.
- By allowing the elders to have more choices. Liberating them in the decision-making process for the ADL's.
- By making sure to use trauma care and taking more time to talk with residents' families
- By trying to get into 'their' world, using ideas from the other participants to enrich residents' daily lives. The activities have increased also, which is a good thing.
- continue utilizing and teaching new hires
- Education with all facility staff and families. Our facility has an on-going commitment to improve our care and become more person-centered.
- Education with all staff on new techniques
- Endeavoring to allow the elder more independence, such as helping self and assisting after allowing them time to respond. Music choices.
- Enhancing what we have already been doing with our dementia residents by taking a more person- centered approach. Also making small changes in the environment to increase sunshine, food smells to stimulate appetite, and provide frontline staff access to full social history information.
- Explaining the process with staff when residents are having behaviors that there is an underlying issue, we have to figure out what's causing behaviors. sometimes it's simple, sometimes it's not
- I am trying to connect with some of the more combative elders. Instead of just approaching them when they need care, I try to touch base with them a few minutes every day even if I'm not assigned
- I have been training my staff on the topics learned in the care partner workshops. Teaching the staff, the tools I learned is key. I have begun monthly dementia training. I have been touching mostly on how to grow those care partnerships and how to effectively communicate with residents living with dementia. Non-verbal communication is more received by these residents than what words you are actually saying.
- "I redirected and did some of the techniques you taught us.
- A man was walking aimlessly and I walked with him for a bit Then I sat with him and offered a pudding and try to figure out why he was upset and within minutes it was found that he just wanted to get to his room to grab a Kleenex for his pocket that he kept touching. He put the Kleenex in his pocket and settled down. He also enjoyed the pudding."
- I stop and try to the residents all down the hallway or if they are in the rooms. Check on them see if I can do anything or they need anything
- I take more time with my elders to ensure that they feel validated and that their needs are met.
- I use them when I visit my mom and relate to the other residents.
- In daily interactions with our Elders I find that I think back to the material we learned. I've also been able to incorporate much of the material in training or on the spot learning opportunities with our Partners.
- Looking at the residents as a care partner-not looking at them as a set of tasks that require my attention

***How have you applied the techniques and knowledge you learned from the Care Partner Workshop?
(cont.)***

- More patience and understanding
- Our residents all receive person centered care instead of being time sensitive. if they sleep to 11, their care is adjusted around that.
- Part of my responsibilities is staff development, so I have an opportunity to reach both new staff in orientation and existing staff. I have presented a number of topics related to strategies that I learned in caring for people living with dementia.
- Spending more time getting to know patient.
- Staff education. In the process of changing policy to mirror information learned in the Care Partner Workshop.
- Teaching other staff, updated training we do with dementia.
- through conversations with partners / family / elders
- Through family and resident involvement when looking at non-pharmacological interventions.
- Training classes to all staff
- Until my mother died, I used what I learned to help make a more humane habitat for her. The staff at Kent healthcare were instrumental in making it possible. By both making suggestions and being a sounding board for me.
- using the domains of wellbeing to determine if we are meeting the essential needs of the person and if any of them might be a clue to expressions that the elder is having
- We are looking at behaviors as expressions of unmet needs and truly trying to find out what those needs are.
- We are working on an organization wide comprehensive memory care program in which we have integrated components of the Care Partner Workshop. New partner (employee) education, all partner education, family communication, programming and activities are all ways we are working to apply the techniques and knowledge learned.
- we do different training with staff and we look for opportunities to personalize care
- We have helped use some of the techniques discussed in the workshops with our individual resident's needs. example: today a resident was becoming agitated due to his difficulty to communicate (dementia and a language barrier) our staff has learned to create unique ways to work with him, IE google translate, music, dancing, etc. that they have not thought of in the past
- We have implemented education opportunities for our staff using the Cares dementia online learning class. We have also continued to use common ground with our staff as well as providing small reminder at our all staff meetings. The Huddles have also continued expand with additional staff participating. The STNA's have enjoyed participating.
- we have started a series of dementia education classes for staff
- we have used the Mirror, Mirror training in our new employee orientation
- We painted a dresser and placed items in it for our resident. PVC pipes for the men to put together. Purses and scarves for the women. It has been very effective. We also have painted an old table and have antique items on the table that can be touched for sensory. Staff love sitting at the sensory table.
- Working with residents and family to design a plan of care that meets individual needs. Including favorite meals, comfortable clothing and assisting in helping family members assist in making a transition to long term care as smooth as possible.
- Yes, to my coworker

Can you provide an example of what you've witnessed [in terms of impact]?

- Going to the training and doing things first-hand.
- Learning to have patience in all situations
- Giving them choices to make
- Taking the time for them and not try to rush them, it all ends up being the same timing in the end."
- A new guest of community was having a difficult time adjusting to life on the household. Staff adapted to care and wrote a very detailed plan of her care to assist others.
- A resident whose use of PRN anti-psychotics have decreased, and non-pharmacological interventions increased has shown great response to the non-pharmacological interventions since we involved her family more and asked for what worked well in the past prior to moving into our community.
- Aides going to get other aides that have a better approach with certain residents.
- An individual came into our facility from home and was very used to his routine. When coming into the facility I worked with the resident in family in regard to times of the day that he enjoyed watching TV, meals, as well as activities that he enjoyed ensuring a smooth transition.
- Answering confusing questions in a kind and compassionate manner
- Bringing my dog in once a week, it's been a treat to see how the individuals I care for with dementia light up when they see him. It's been great to see the bond they have with animals.
- Elder excited to interact with me
- Elder who was having expressions of calling out we were able to determine that the elder's quality of life was lacking in the area of identity. Elder didn't feel at home, so we worked with the family and care partners to come up with ways to make her feel more at home and like herself in our care environment.
- For those residents that line staff have difficulty in redirecting, a special activity container was provided for easy access to share with those residents and provide stimulus or structured activity.
- How staff members interact with elders.
- I am a family member, so I now try to be more aware of what these people are going through and I really do try to speak to them and actually touch their hands when possible, to make them feel loved and feel like they are in a home environment.
- I have had residents that says no one likes her or listens to her they all they she is crazy. So, I go in to her room and sit down and talk to her or listen to whatever she wants to talk about, and she enjoys it's.
- Instead of just assuming behavior and give medicine to figure out why the resident had the behavior and it came from her past that she was treated badly when growing up
- More hands-on approach to care from the front-line staff
- More interaction
- More personalized interactions between staff and residents
- Nurses not waking residents up to give them medications, rather waiting till they are up to administer them.
- One elder has had less behaviors due to being more engaged.
- See above.
- Staff changing their approach has improved the responses that they receive from the residents
- Staff has changed working about working with people with dementia
- Staff slowing down and taking more time to listen and being spontaneous

Can you provide an example of what you've witnessed [in terms of impact]? (cont.)

- Staff trying to be creative in meeting the residents' unmet needs, rather than using medications to control behaviors. I.E., Robotic dog.
- Staff using about be info in direct care
- Staff who work on that unit are more engaged with our residents and families have noticed
- The interaction observed with all
- The seminar and techniques are a reminder in the back of my mind. I try to allow and take more time for the elder to respond.
- They are more patient and not frustrated with behaviors realizing they aren't doing it to be annoying they have an issue and they don't know how to properly communicate that back to them
- Very person-centered activity plans being developed with and for residents and family members
- Watching the elders interact with my staff is amazing. I love how their faces light up when staff come onto the unit. They get excited because they know someone is there for them who cares and who will take the time with each elder as needed.
- We are having music groups come to the facility. You will see pictures of one of our residents dancing with her husband. Brought tears to the husband's eyes.
- We are keeping the residents busy, so they are not lonely
- We have a particular Elder who is very hard to redirect, and some of the techniques we learned have helped us to steer conversations in a positive direction.
- We have begun to utilize alternative strategies for care, aroma therapy, music and art therapy, as well as weighted blankets. The staff have learned more effective ways to approach elders living with dementia.
- Witnessed the way all the other patients responded to the changes I made to my mother's care

What challenges have you experienced in your efforts to apply the techniques and knowledge you learned from the Care Partner Workshop?

- As a family member, I'm not there every day--I teach school.
- Behaviors is our biggest challenge because we are a behavioral facility. The techniques I learned in this workshop not only helped me with my elders living with dementia but also helped me deal with our elders who have mental illness. This has been a great learning experience for me, and I am grateful that I had this opportunity to participate in such a wonderful class!
- Buy in
- care partners that are stuck in their ways
- CARE PLANS
- Challenges: support from leadership team due to time, staff turnover, staffing ratios
- Changeover of staff
- culture shift
- Dementia patient gets angry and has many dislikes
- Getting out of my own way.
- Getting the aides more involved. Getting them to understand the more the elders are involved the more the elders will be content and not be as 'needy' allowing the aides to accomplish other tasks.
- Getting the staffs buy in has been tough but they are pleasantly surprising me with what they already know!

What challenges have you experienced in your efforts to apply the techniques and knowledge you learned from the Care Partner Workshop? (cont.)

- Having the time to work with other partners to move forward.
- Having time to teach staff techniques to facilitate change. Our changes have been limited by this
- I occasionally have difficulty with family members that are not ready to 'face the reality' of the disease process for lack of better terms and staff that aren't ready to learn new and upcoming techniques
- I wish I had more resources to share with staff
- It's been challenging because the way I would want someone to think for the resident they don't
- It's not always easy to convince some of our partners, especially those who have been at this a while, that there are better ways to do things. We especially have a few Elder Assistants that want to keep everything on a schedule, and that if everything isn't done the same way all the time, that we won't be as efficient. Teaching them to slow down, spend the time, and try to work through an Elders' expressions isn't always the easiest task.
- Just learning that everyone has their own personality and not everything works for every person.
- Lack of follow through on the staff end. The education provided seems to be thought of as a 'nice training' and not as a springboard to change on the part of the direct care staff. We are working on implementing the techniques into daily practice.
- Leadership has had a few transitions and the team that attended this training is down to one staff member. We have pulled some pieces from this training but not had the support or ability to roll it out as the Eden Alternative at this time, while maintaining our current memory care philosophies of Comfort Matters and Opening Minds through Art at this time.
- Learning how to have patience with them and not try to rush to get done by doing it myself.
- Making sure all staff understands.
- Management indifference
- Many things require that we focus on compliance issues; staffing and employee moral often take us away from our focus.
- NA
- Need to get the information to all of our care partners
- No challenges
- No real challenges. The Director of Nursing has implemented a series of Dementia workshop training for all staff. Staff very receptive.
- None to speak of
- Not enough time!
- Obtaining a life history of the resident with dementia and has limited family.
- One of the biggest challenges I believe I have faced while trying to incorporate what I learned in the workshop is having all staff members cooperate. Unfortunately, you have some individuals who only come to work for the pay and not for the relationships that can be formed.
- Our challenges are not directly related to applying techniques as they are to industry challenges (i.e. staffing)
- Partners going back to old habits
- Some days Italy just a bad day and it seems nothing goes well no matter who approaches a certain resident
- Some dementia had progressed to far
- Some people are resistive to change.

What challenges have you experienced in your efforts to apply the techniques and knowledge you learned from the Care Partner Workshop? (cont.)

- Sometimes having the time amongst other duties, but I try to weave the knowledge thru whatever I am working on.
- staff just continuing to use what they were taught.
- Staff turn over
- Staff was not receptive to change at first. It is a continued effort to make sure staff does not fall back into old ways.
- Staffing challenged currently at the building
- The biggest challenge is always time.
- the constant staff in-services. While some associates appreciate the continues education, others are very receptive even though we use examples from residents in our community.
- Time
- Time
- Time to balance all aspects of care
- Time and turnover
- Time restraints are the biggest issue.
- Time. Getting things planned and in place is sometimes very difficult to do.
- To talk to other team members some just think this stuff is not useful. I think at least that's the way they seem to be with it because I have heard people say oh we have to sit through this 8-hour class. That's all the further it goes with them whether you talk to them or not
- Trying to get others on board

Attendee Characteristics

Dementia Beyond Drugs

Care Partner Role

Choice	Response Percent	Response Total
C.N.A, Housekeeper, Laundry,	11.53%	37
Administrator, CEO, CFO	21.81%	70
Director of Nursing, Nurse,	45.79%	147
Department Leader	15.26%	49
State Surveyor, Ombudsman	2.80%	9
Elder, family member, volunteer	0.00%	0
Unknown	0.00%	0
Not currently an active care	0.62%	2
Other	8.41%	27

Length of Time Providing Eldercare

Choice	Response Percent	Response Total
Less than 3 months	1.55%	5
3 to 6 months	0.62%	2
7 months but less than 1 year	1.24%	4
1 to 4 years	7.45%	24
5 to 9 years	21.12%	68
10 years or more	68.01%	219

Reframing Dementia: Train the Change Agent

Care Partner Role

Choice	Response Percent	Response Total
C.N.A, Housekeeper, Laundry,	8.48%	19
Administrator, CEO, CFO	19.64%	44
Director of Nursing, Nurse,	41.96%	94
Department Leader	8.48%	19
Social Services/Life Enrichment	24.55%	55
State Surveyor, Ombudsman	0.45%	1
Other	0.89%	2

Length of Time Providing Eldercare

Choice	Response Percent	Response Total
Less than 3 months	1.34%	3
3 to 6 months	1.79%	4
6 months but less than 1 year	3.13%	7
1 to 4 years	10.27%	23
5 to 9 years	19.64%	44
10 years or more	63.84%	143

**Creating a Culture of Person-Directed Dementia Care
Final Financial Report**

Item Description	Original Budget	Actual Original	Actual No-Cost Addendum	Actual Total	Variance
Personnel (budget included time for Ombudsman here)					
Collaboration with Contractors	\$ 4,109.00				
Financial Tracking and Invoicing	\$ 913.00				
Report Writing/ Submission of Reports	\$ 548.00				
Total Personnel	\$ 5,570.00				\$ 5,570.00
Travel: Contractor Travel (all within GSA limits)					
Dementia Beyond Drugs Training Event					
Educators, Facilitators, and Event Manager Travel	\$ 20,745.00	\$ 7,906.37	\$ 6,936.46		
Reframing Dementia: Train the Change Agent Events					
Educators, Facilitators, and Event Manager Travel	\$ 16,533.00	\$ 6,999.06			
Leadership Pathways Training Events					
Educators and Event Manager Travel			\$ 4,577.73		
Total Travel	\$ 37,278.00	\$ 14,905.43	\$ 11,514.20	\$ 26,419.62	\$ 10,858.38
Contractual:					
Dementia Beyond Drugs Training (DBD)	\$ 207,840.00	\$ 109,542.41	\$ 60,695.49	\$ 170,237.89	\$ 37,602.11
<i>Event Management</i>			\$ 1,583.42	\$ 1,583.42	
DBD Educators, Facilitators & Event Manager	\$ 33,700.00	\$ 19,602.25	\$ 17,169.78	\$ 36,772.03	
DBD Course Content & Materials for up to 500	\$ 141,640.00	\$ 69,971.99	\$ 27,984.89	\$ 97,956.88	
DBD Venue & Audio Visual	\$ 10,000.00	\$ 7,773.16	\$ 9,502.40	\$ 17,275.56	
Dementia Beyond Drugs Book Publisher Royalty	\$ 22,500.00	\$ 12,195.00	\$ 4,455.00	\$ 16,650.00	
<i>Amounts from Addendum (Two 2019 events) are italicized</i>					
Reframing Dementia: Train the Change Agent (RD:TTCA)	\$ 115,290.00	\$ 55,313.97		\$ 55,313.97	\$ 59,976.03
RD: TTCA Educators, Facilitators & Event Manager	\$ 24,160.00	\$ 12,835.96		\$ 12,835.96	
RD:TTCA Course Content & Materials for up to 424	\$ 86,130.00	\$ 38,236.03		\$ 38,236.03	
RD:TTCA Venue & Audio Visual	\$ 5,000.00	\$ 4,241.98		\$ 4,241.98	
Care Partner Workshops (CPW)	\$ 57,200.00	\$ 31,916.10		\$ 31,916.10	\$ 25,283.90
CPW Educators (Online)	\$ 27,600.00	\$ 18,519.66			
CPW Technical Assistance with Webinar System	\$ 9,600.00	\$ 396.45			
CPW Course Content for up to 100 Teams	\$ 20,000.00	\$ 13,000.00			
Leadership Pathways (Addendum)			\$ 34,045.56	\$ 34,045.56	\$ (34,045.56)
<i>Event Management</i>			\$ 724.18		
<i>LP Educators</i>			\$ 11,641.96		
<i>LP Course Content & Materials for up to 500</i>			\$ 16,477.42		
<i>LP Venue & Audio Visual</i>			\$ 5,202.00		
Facilitative Leadership (Addendum)			\$ 16,398.50	\$ 16,398.50	\$ (16,398.50)
<i>Educators (Online)</i>			\$ 4,787.84		
<i>Recruitment and follow-up</i>			\$ 360.66		
<i>Course Content</i>			\$ 11,250.00		
Participant Support and Follow-Up	\$ 9,000.00	\$ 7,855.32		\$ 7,855.32	\$ 1,144.68
Educator Follow-Up with Teams	\$ 9,000.00	\$ 7,855.32			
Survey and Data Analysis	\$ 10,500.00	\$ 6,545.39	\$ 3,500.00	\$ 10,045.39	\$ 454.61
Survey Development, Project Data Collection & Entry	\$ 4,500.00	\$ 545.39		\$ 545.39	
Dr. Amy Elliot, PhD, Independent Analysis	\$ 6,000.00	\$ 6,000.00	\$ 3,500.00	\$ 9,500.00	
OHOM KITS (Addendum)			\$ 4,032.00	\$ 4,032.00	\$ (4,032.00)
<i>OHOM Kits to the highest participant rates</i>			\$ 4,032.00		
Project Promotion	\$ 2,800.00	\$ 1,861.84		\$ 1,861.84	\$ 938.16
Grant Project Promotional Package Design and Production	\$ 2,800.00	\$ 1,861.84			
Total Contractual	\$ 402,630.00	\$ 213,035.04	\$ 118,671.55	\$ 331,706.58	\$ 70,923.42
Total	\$ 445,478.00	\$ 227,940.46	\$ 130,185.74	\$ 358,126.20	\$ 87,351.80