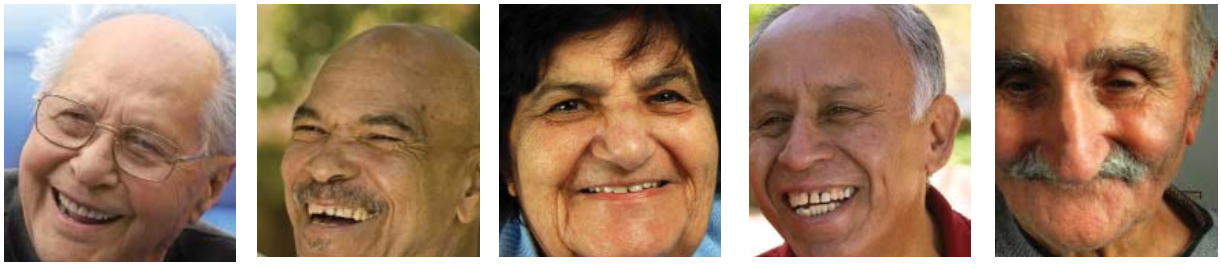
LUTHERAN WELLSPRING ALLIANCE
OF THE CAROLINAS

A Process Evaluation of the Implementation of the Lutheran Wellspring Alliance of the Carolinas



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The Institute for the Future of Aging Services (IFAS) is a policy research institute whose mission is to create a bridge between the practice, policy and research communities to advance the development of high-quality health, housing and supportive services for America's aging population. IFAS is the applied research arm of the American Association of Homes & Services for the Aging (AAHSA). AAHSA members serve two million people every day through mission-driven, not-for-profit organizations dedicated to providing the services people need, when they need them, in the place they call home. AAHSA's commitment is to create the future of aging services through quality people can trust.

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Executive Summary

The purpose of this project was to conduct a process evaluation of the implementation of the Wellspring model in the Lutheran Carolina nursing homes. The team of researchers used qualitative and quantitative analyses to understand how the model was implemented and the changes related to residents, staff and families.

The Wellspring model for improving quality of care in nursing homes was pioneered in 1994 by an alliance of 11 not-for-profit providers in Wisconsin. Wellspring seeks to enhance the well-being of residents by improving the quality of care, increasing staff skill levels and reducing employee turnover. The model includes clinical training modules, interdisciplinary teams whose members attend the trainings and create and implement interventions to improve the quality of care for residents within the facility, a Wellspring Coordinator at each facility to guide the teams through the implementation process and a Wellspring Nursing Consultant who serves as an advisor, educator and consultant.

Lutheran Services for the Aging of North Carolina (LSA) and Lutheran Homes of South Carolina (LHSC) received a grant from The Duke Endowment to fund the Wellspring program from January 2005 through June 2008. The Duke Endowment grant covered a little more than one-fourth of the program's costs; the two Lutheran organizations covered the rest. The AT&T Family Care Development Fund provided additional money that helped pay for an evaluation of the program by the Institute for the Future of Aging Services (IFAS).

The two organizations formed an alliance, the Lutheran Wellspring Alliance of the Carolinas (LWAC), to adapt the Wisconsin Wellspring model in the Lutheran North and South Carolina facilities (five North Carolina nursing homes and four South Carolina nursing homes). The goal was not to replicate the model precisely, but to tweak and change the program to meet the specific needs of the group as well as the individual facilities. This study documents the experience of the participating facilities' implementation of Wellspring and the changes among residents, staff and families.

LWAC's adaptation of the Wellspring model focused on implementing best practices through teams. Unlike the original Wellspring Alliance, LWAC did not emphasize continuous quality improvement among all levels of staff. This activity occurred among the department mangers and the Wellspring Nursing Consultant and was not part of the care resource teams' activity.

The Wellspring model provides clinical trainings to all levels of staff across disciplines to learn best practices that they can apply to care for residents. It creates a more collaborative work environment by empowering nursing assistants and non-nursing staff to participate in decision-making and gives them the opportunity to contribute. The model provides a structure for all departments to work together and break down the silos. The LWAC nursing homes strived to change how they operate systematically by incorporating the Wellspring concepts. Each of the facilities achieved this to some extent. The staff is more confident in their skills and ability to care for residents. The front-line staff is more empowered to make decisions and changes for residents. The focus is more on residents and their needs than on staff schedules. The care resource teams have made changes to improve the quality of life and care for residents. The facilities as a group improved nursing stability, and family members rated the LWAC group as a whole more positively on satisfaction, quality of care and quality of service over time.

Chapter 1 — Introduction

The purpose of this project was to evaluate the implementation of the Wellspring model among Lutheran facilities in the Carolinas. The evaluation was to provide the Wellspring management committee with information to help support their respective facilities in implementing Wellspring. A secondary goal was to help staff, corporations or facilities new to Wellspring to understand the journey and processes of Wellspring in the Carolinas. The team of researchers used a multi-faceted methodology, including site visits, telephone interviews and focus groups with staff, observation of the module trainings and analyses of My InnerView (MIV) data, a Web-based data entry tool in which facilities receive reports from the survey findings. The final report summarizes the findings, including a description of Wellspring in the Carolinas, how well the model was implemented and the changes among staff, residents and families.

Background

An alliance of 11 not-for-profit skilled nursing facilities in Wisconsin developed the Wellspring model in 1994. Wellspring seeks to enhance the well-being of residents by improving the quality of care, increasing staff skill levels and reducing employee turnover. This is achieved through the learning and teaching of national best practices, creating a flattened organizational structure and developing teams to implement interventions to improve the quality of care for residents (The Commonwealth Fund). [1]

Lutheran Services for the Aging of North Carolina (LSA) and Lutheran Homes of South Carolina (LHSC) received a grant from The Duke Endowment to fund the Wellspring program from January 2005 through June 2008. The Duke Endowment grant covered a little more than one-fourth of the program's costs; the two Lutheran organizations covered the rest . The AT&T Family Care Development Fund provided additional money that helped pay for an evaluation of the program by the Institute for the Future of Aging Services (IFAS).

The two organizations formed an alliance, the Lutheran Wellspring Alliance of the Carolinas (LWAC), to adapt the Wisconsin Wellspring model in the Lutheran North and South Carolina facilities. The goal was not to replicate the model precisely, but to tweak and change the program to meet the specific needs of the group as well as the individual facilities. Some key differences between the original Wellspring model and the Carolina Wellspring program were:

- LWAC held boot camps for the Wellspring Coordinators that was not part of the original Wellspring model.
- The original Wellspring model had a Geriatric Nurse Practitioner (GNP) who worked with each of the facilities. The GNP was selected because of her expertise in geriatric issues, as well as her good educational and training skills. LWAC did not have a GNP as a consultant to the facilities.
- The original Wellspring Alliance had monthly meetings with the CEOs of the participating facilities and quarterly meetings of the GNPs and Wellspring Coordinators. These meetings did not occur in the Carolina Wellspring Alliance. LWAC did have meetings with the Wellspring Coordinators, but they were less frequent.
- LWAC did not share data across facilities as occurred among the Wisconsin Alliance facilities.

[1] Stone, R. I., Reinhard, S.C., Bowers, B. Zimmerman, D., Phillips, C., Hawes, C., Fielding, J. and Jacobson, N. (2002). Evaluation of the Wellspring Model for Improving Nursing Home Quality. New York, NY: The Commenwealth Fund.

The Wellspring model includes clinical training modules, interdisciplinary teams (care resource teams or teams) whose members attend the trainings and create and implement interventions to improve the quality of care for residents within the facility, a Wellspring Coordinator at each facility to guide the teams through the implementation process and a Wellspring Nursing Consultant who serves as an advisor, educator and consultant to all the participating facilities. The alliance is an opportunity for the organizations to share information and best practices, share the initial cost of implementation and provide a focal point for accountability and leadership for the initiative.

Evaluation Process

The evaluation was guided by five research objectives:

- Document the components of Wellspring at the LWAC and individual facility levels.
- Understand the context in which Wellspring is being implemented at the nine facilities.
- Understand the successes and challenges the organizations and facilities faced when implementing the components of Wellspring and how they have addressed them.
- Understand the teams' activities and short- and long-term goals.
- Understand the value of Wellspring for staff and their perspectives on the value for residents.

Methodology

The research team used both qualitative and quantitative research methods to meet the research objectives. The qualitative evaluation was a participatory process and occurred at the same time as the facilities rolled out the model. The researchers wrote memos and held conference calls with the management team after each round of interviews and site visits. This provided impartial, timely feedback to inform and refine the implementation process. The research design is not "pure" and has "contamination" because information was used to make changes to the program. The evaluation employed the following data collection strategies:

- Telephone interviews with staff across the nine facilities.
- Site visits with seven of the nine facilities.
- Analysis of My InnerView (MIV) family and staff satisfaction surveys.
- Analysis of My InnerView (MIV) clinical indicators and workforce measures.

The research team conducted over 64 telephone interviews with staff across the nine facilities. The telephone interviews were with the Wellspring Coordinator at each facility, select staff of a care resource team (CRT) and staff who were not part of the care resource teams. Each telephone interview lasted between 15 and 20 minutes. The interviews focused on general impressions and understanding of Wellspring and the module trainings, the role of LWAC and the Wellspring Coordinator, the perceived future impact of the program and activities of the care resource teams within six weeks of the training and one year after the training. In addition, the research team conducted telephone interviews with the Wellspring Nursing Consultant and members of LWAC, as well as a survey of the administrators at the end of the evaluation.

In addition to the telephone interviews and survey, the researchers conducted site visits from January 2005 through August 2007, with the majority occurring in 2005. The researchers visited five facilities in North Carolina and two in South Carolina. During these site visits, the research team interviewed a total of 76 staff (e.g., Wellspring Coordinator, director of nursing or assistant director of nursing, facility administrator or assistant administrator and certified nursing assistants (CNAs) or other line staff who had attended at least one Wellspring module). Each site visit lasted approximately one-half day and

encompassed in-person interviews with facility staff and, at select sites, observation of unit operations (staff interactions, direct care, documentation systems, etc.). The researchers observed four of the eight Wellspring training modules (three in 2005 and one in 2006) and had informal conversations with attendees at these training modules.

The research team analyzed the My InnerView (MIV) data of each facility. The Wellspring Coordinator or director of nursing at each facility entered the clinical indicator and workforce metrics data each month. The family surveys were conducted three times during the evaluation (2005, 2006 and 2007), and the employee surveys were conducted twice during the evaluation (2006 and 2007).

The team analyzed changes over time and compared LWAC facilities to the results from facilities, not part of the LWAC group, that enter data into My InnerView. It is important to note that the comparison group sample of MIV facilities is not random and includes select facilities across several states that chose to participate in the survey, for which MIV charges a fee for participation.

Study Limitations

The evaluation had limited funding and assessed a program that was ongoing. The interviews were not comprehensive, and the research team interviewed select staff at each facility. The evaluation findings are based on the select interviewees' understanding of the program and activities. The interviewees varied in their level of awareness and knowledge about Wellspring and the team activities. It is possible that important perspectives were missed and are not captured in this report.

The research team focused the evaluation on the process for LWAC facilities to implement the program. Most of the resources and budget were allocated to the telephone interviews and site visits. Fewer resources were available to assess outcomes, including the impact of Wellspring on quality of care measures, workforce measures and satisfaction among family and employees. The research team was not able to collect new data but instead analyzed the data the facilities entered into the My InnerView Web-based program. The project team did not have access to individual resident information, but only to aggregated data from each facility. The data available limited the analysis to descriptive statistics, and statistical tests could not be performed to determine significant differences and causal effects. The evaluation, therefore, can only describe the changes at the facilities and how they compare to non-Wellspring organizations who participate in MIV. Due to the limited funding, the non-Wellspring facilities were not matched on the characteristics of the Wellspring participants. Additionally, the research team did not make intra-facility comparisons. The analysis cannot attribute any changes to the Wellspring program. The descriptive analysis, however, still provides useful information about the changes within each facility and how LWAC facilities as a group compare to MIV facilities.

The third limitation is that the evaluation was designed to assess each team a few months after the related training topic and approximately one year later. The six initially scheduled clinical trainings (falls, skin care, elimination/continence, nutrition, psychosocial and pain/palliative) were separated over time and occurred from 2005 through 2007. This resulted in follow-up with some teams early in the evaluation and implementation of Wellspring and others later in the program rollout. The analyses from the interviews are, therefore, a snapshot of the teams' activities during the interview period. The researchers were not able to follow up throughout the program with the teams formed early in the program. It is possible that these teams had changes in members and activities, and these are not captured in this report.

Background on Facilities

The participating facilities varied in their size and type of payments and had some variation in their prior experience with culture change programs. The facilities included the full spectrum of sizes—from small facilities of less than 100 beds to mid-size facilities with 100 to 200 beds and large facilities with over 200 beds.

Similarly, the facilities ranged in their percentage distribution of revenue from Medicare, Medicaid and private payment (one facility, as seen in the table below, is 100 percent private pay). According to the administrators in 2005, the table below lists the percentage revenue of payment by facility (F). The location of the facility is indicated by NC (North Carolina) and SC (South Carolina).

Table 1: Facility Percentage Distribution of Revenue

	NCF1	NCF2	NCF3	NCF4	NCF5	SCF6	SCF7	SCF8	SCF9
Medicaid	52%	75%	61.5%	60%	94%	0%	52%	0%	0%
Medicare	37%	10%	6.5%	20%	5%	5-12%	10%	0%	12.5%
Private Pay	11%	15%	32%	20%	1%	88-95%	36%	100%	87.5%

The North Carolina and South Carolina facilities as a group have similar medium percentages of distribution from Medicare (NC, 10 percent and SC, 9.25 percent). The two groups differ in the medium percentages of distribution from Medicaid and private pay. The North Carolina facilities have a higher medium percentage of distribution from Medicaid (61.5 percent). Only one of the four South Carolina facilities accepts Medicaid, with 52 percent of the revenue distribution from Medicaid. The remaining three South Carolina facilities have zero percent. On the other hand, the South Carolina facilities have a medium percent revenue distribution from private pay of 88.9 percent, while the North Carolina facilities have a medium percentage of 15 percent.

Chapter 2 — Description of Wellspring in the Carolinas

The Wellspring model seeks to improve the care and change the culture of the workplace environment. The components of the Wellspring program, as initiated in Wisconsin, are what drive the strategies to achieve this goal—the modules, the Wellspring Nursing Consultant, the Wellspring Coordinator, the alliance, the care resource teams (CRTs) and the collection of data. The model implemented in the Alliance facilities differs in some significant ways from that implemented in Wisconsin. This chapter describes the Wellspring model as originated in the Wisconsin Alliance. The next chapter describes how the model was actually implemented in the Carolinas and analyzes the effectiveness of the implementation.

Clinical Module Trainings

The clinical module trainings are designed to teach participants about best practices in clinical care. The goal of the module education is to have all disciplines become active participants in the implementation process. The trainings are conducted during an intensive two days, and each facility is expected to send a multi-disciplinary team of frontline staff and managers to each training. The model is based on a "train the trainer" approach, and participants are expected to educate staff at the facility about the information they learned to help incorporate the best practices into everyday care of residents. The trainings not only impart clinical knowledge, but also are a means of initiating change both within and across facilities. An overnight stay at the trainings is an opportunity for staff to bond and break down the hierarchical structure across disciplines. Additionally, the trainings allow connections among staff across facilities.

The cornerstone for each module is evidence-based practices originally guided by the Agency for Healthcare Research and Quality guidelines, American Medical Directors Association guidelines, other national standards of care that reflect best practices and current literature. The trainings are a combination of didactic and interactive techniques to present the materials. Each educational session has a speaker who presents the clinical information and case studies of best practices in the area. Participants from each facility deliver a five-minute presentation or skit on the topic area. The participants from each facility work together during the educational sessions to determine a plan for implementation when they return to the facility.

Wellspring Nursing Consultant

The Wellspring Nursing Consultant should have the clinical knowledge and expertise to help the facilities implement Wellspring and solve problems that may arise. She should be a key resource for the administrators, Wellspring Coordinators and care resource teams at each facility due to her knowledge and the advice she can provide on best practices. The Wellspring Nursing Consultant:

1. Makes, at a minimum, quarterly visits to each of the facilities to check on the status of the teams and the overall Wellspring implementation in each facility and provides feedback.
2. Shares the best practices from other facilities and connects facilities.
3. Works with care resource teams to overcome problems and move forward.
4. Works with facilities struggling to implement and continue Wellspring.
5. Facilitates meetings among the Wellspring Coordinators.
6. Assumes responsibility for analyzing the data from the facilities.
7. Is available to each of the member facilities, particularly the Wellspring Coordinators and administrators, for consultation.

Wellspring Coordinator

The Wellspring Coordinator has a critical role within the facility for the successful implementation of Wellspring and links all components of the Wellspring program. The Wellspring Coordinators help recruit staff to attend the module trainings and become members of the care resource teams, work with the teams to implement change and help to educate staff about the teams and the Wellspring program. In addition, the Wellspring Coordinator is a conduit between the Alliance and the facility.

The Alliance

The Alliance is the joint body composed of each of the member facilities. The function of the Wellspring Alliance is to provide economies of scale to the participating organizations and a forum to share information and resources about quality improvement in the individual facilities. The Alliance functions at two levels—among the Wellspring Coordinators and among the staff members of each care resource team at the individual facilities. The Alliance provides opportunities for these levels to meet at the module training and other occasions. It allows the organizations to work collaboratively, share solutions to similar challenges and avoid having each organization operate in isolation. There are opportunities for staff at these different levels to interact and share learned concepts. They can learn best practices from each other and, at times, visit facilities that have already implemented activities planned at their organization.

Care Resource Teams

The CRTs are the main vehicle for the implementation of best practices within the facilities. Each module corresponds directly to a care resource team. For example, those who attend the module on nutrition are members of the CRT focused on nutrition. The teams are, for the most part, interdisciplinary (e.g., nursing, dietary, social work, activities, chaplain, housekeeping, laundry, environmental services, etc.), do not have a hierarchy (frontline staff can lead the teams) and are a mix of volunteers and selected staff. The teams have the responsibility for ensuring that each organization is utilizing best practices in resident care. They plan for implementation, educate staff about the best practices, initiate change, monitor implementation and analyze data related to the issue. The team members are the experts on the individual topics and a resource for other staff.

Data Collection

The original Wellspring model focused on using data to inform practice. The process of collecting, analyzing and sharing data to inform practice is a key element of continuous quality improvement. Without this, team members are focusing on best practices and not systematic quality improvement. Individual facilities are expected to enter their data (e.g., trends in clinical areas such as number of falls, weight loss, acquired pressure ulcers, etc. and workforce metrics such as absenteeism, stability and turnover) into a data entry program. The data are indicators to help the teams and facilities problem solve and to determine the effectiveness of the interventions.

Chapter 3 — Analysis: Effectiveness of Learning of Wellspring and the Network

This section of the report describes the implementation of the Wellspring model in the Carolinas and evaluates the nine Carolina facilities' effectiveness in implementing Wellspring during the research period. The different elements to implementation include learning of Wellspring and the network through the module trainings and Alliance, implementation of Wellspring through the CRTs and Wellspring Coordinator, dissemination and challenges.

The Wellspring program has different mechanisms for staff at the participating facilities to learn and understand Wellspring, as well as access resources. This is through the collaboration among the participating facilities, Wellspring Nursing Consultant and the module trainings.

Alliance

The most effective aspect of the Alliance occurred among the Wellspring Coordinators and directors of nursing. The Wellspring Coordinators and directors of nursing met twice outside of the module trainings at boot camps organized by the Wellspring Nursing Consultant. The boot camps were an opportunity for the Wellspring Coordinators and directors of nursing to share information and brainstorm about how they could implement culture change at the facilities. Additionally, they set aside time during three of the module trainings to meet and discuss relevant issues. This provided an important network of colleagues to share information and solve problems on implementing Wellspring and other clinical issues.

LWAC was not instrumental in the collaboration among managers and frontline staff across facilities. LWAC did not actively operate at these levels and did not have a formal structure to support these activities. Middle managers and frontline workers across the facilities had little opportunity and no organized structure to network, support each other and share ideas. Most information sharing and networking took place at the module trainings, which was extremely valuable but limited. A few facilities did arrange visits to other LWAC facilities to see ongoing activities that were being considered by their CRT. For example, staff members on one CRT visited a facility that had a Snoezelen room. The CRT members could see the room and learn from the experiences of the facility. This was educational and useful to the team members.

Wellspring Nursing Consultant

LWAC did not have a Wellspring Nursing Consultant for the first year of the program. The initial person hired for the position did not work out, and the current Wellspring Nursing Consultant started in December 2005. The Wellspring Nursing Consultant in the Carolinas was not a Geriatric Nurse Practitioner/Advanced Practic Nurse, as in the original Wisconsin model. She was an RN with several years of experience in the field. Interviewed staff at the facilities and administrators described the Wellspring Nursing Consultant as an advocate, cheerleader and problem solver and said she was responsive to the needs of management and the care resource teams.

The Wellspring Nursing Consultant was key to the success of implementing Wellspring in the Carolinas. The rate of progress to execute Wellspring increased with the hiring of the Wellspring Nursing Consultant. The quarterly visits held each of the facilities accountable. Her expertise and sharing

of information helped the care resource teams to move forward. Without the Wellspring Nursing Consultant, it is questionable whether the alliance among the Wellspring Coordinators would have been as effective.

Boot Camps

The Wellspring Nursing Consultant organized boot camps for the Wellspring Coordinators and directors of nursing. The boot camps were not part of the original Wellspring model, but were developed by the LWAC and became part of its model. The Wellspring Nursing Consultant held the two-day boot camps twice during the evaluation (a third one was scheduled for August 2008). The boot camps started as an educational tool where participants received information they could take back to their facilities. Over time, the boot camps transformed into a Wellspring working committee.

In the first meeting, the Wellspring Coordinators and directors of nursing brainstormed about how they could implement culture change at the facilities. During the second meeting, the group determined the module trainings for the following year. Another purpose of the boot camp was to thank the Wellspring Coordinators for their work and generate and continue momentum for Wellspring. They also provided an opportunity for the Wellspring Coordinators and directors of nursing to meet with other facilities and learn new ideas. The Wellspring Coordinators met three additional times a year, typically at lunch during a training module.

Clinical Module Trainings

LWAC facilities participated in eight module trainings during the evaluation that were separated over time from January 2005 through September 2007. The specific training modules were:

- Leadership
- Observing and understanding older adults
- Falls/restorative
- Skin care
- Elimination/continence
- Nutrition
- Psychosocial well-being
- Pain/palliative care

The Leadership module was one of the first education sessions. It laid the groundwork for supporting organizational change and gave formal and informal facility leaders the skills necessary to create this new environment. This was achieved through teaching exemplary leadership skills and defining culture change. The other module trainings during the evaluation were on clinical care.

In general, participants were positive about and liked the module trainings. In the evaluations after each module, the majority of participants had an overall satisfaction level of "very satisfied" or "satisfied," and they rated most of the speakers highly. They viewed the trainings as informational and said they raised their awareness in areas where they lacked more information. The modules also increased their knowledge and understanding of how to provide better care to residents. The participants enjoyed the interaction among the staff from other facilities, as well as learning new ideas they could implement. Many staff participants, particularly frontline staff, found the trainings valuable and believed they could apply what they learned.

A few participants, predominantly managers, expressed concerns about the substance and process of the trainings. They did not believe the trainings provided the necessary information for staff, felt they were too elementary or too sophisticated based on the different levels of staff at the training or thought that the clinical material was too overwhelming for the certified nursing assistants (CNAs). Some CNAs and non-nursing staff concurred that they did not have the background to understand the information, and this caused some frustration. Most participants, however, described the trainings as very valuable and used the information they learned in their everyday practices.

Another criticism was the balance of time spent on didactic versus experiential learning. Some felt the presenters focused too much on the clinical information and less on the hands-on training. They did not feel prepared to implement the learned practices when they returned to the facility.

The pivotal experience of the training for many participants was the bonding that occurred among staff and the opportunity to network with other facilities. The trainings evoked an emotional response, and participants were excited about Wellspring. They got to know facility co-workers better, and the trainings lessened barriers between departments, management and staff. They also got ideas from other facilities to take back and implement.

In the beginning of the program, several of the facilities sent primarily managers and the same one or two frontline staff. While the overnight stay helped bond staff at the facilities, it was a barrier for others to attend the modules. Some staff members, particularly frontline staff, were unable to attend the overnight trainings because of family responsibilities, second jobs and other commitments. Additionally, it was difficult for some facilities to pull frontline staff off the floor for two days. The lower attendance among frontline and non-nursing staff made it more difficult to integrate work practices and workers across departments.

Chapter 4 — Analysis: How Well Wellspring Was Implemented

Implementation Team

The Implementation Team has oversight for all of the care resource teams within the facility and includes managers from all departments. The Implementation Team's role is to oversee all of the activities of the teams and review any recommendations brought to it by the CRTs. The members discuss proposed recommendations for feasibility and determine whether to accept the proposed idea or activity.

The Implementation Team, at most facilities, stopped meeting regularly mid-way through the program. The Wellspring Nursing Consultant, during one of the boot camps, worked with the Wellspring Coordinators and directors of nursing to develop plans to reengage the Implementation Team. This effort was effective and the Implementation Teams have since continued their role within the Wellspring model.

Care Resource Teams

The care resource teams play a central role in the implementation of Wellspring. The teams set a goal focused on a clinical outcome that corresponds with the specific module topic and develop a facility-wide plan to achieve that goal. For example, a team may want to decrease the number of falls in the afternoon, increase the length of time residents remain continent, stabilize residents' weights, etc. The teams develop a plan and strategy to achieve the outcomes.

Each LWAC facility developed at least four or five teams to address the core issues from the trainings—falls, nutrition, elimination/continence, skin care, psychosocial and pain/palliative. Some of these teams combined to make them more efficient and because the issues were interrelated. This was a necessity at facilities where it was difficult to find staff who could attend the meetings. A handful of the combined teams later split because members found they did not have enough time to address all the issues of the combined team adequately.

The care resource teams generally met for 30 minutes each month. Some teams met more often when they were working to implement a particular activity. The meetings were limited to 30 minutes to make it easier for staff to attend and be away from their job responsibilities. A handful of teams did not meet regularly as a group.

The majority of teams had five or six key members. Most of the members attended the module trainings, although this was not always possible. Some of the CRTs also involved ad lib members who attended meetings when the discussion related to their work. Most of the teams experienced some changes with their members. Members left the team because they changed jobs, had illnesses or for personal reasons or because they were not active members of the team. The CRTs generally replaced team members who left with someone from the same department.

The members of the different teams varied from primarily nursing staff to include representatives from multiple departments. The skin care and elimination/continence teams, particularly early in their formation, had heavy representation of the nursing staff. The other departments typically on

these teams were dietary and/or activities. The falls, psychosocial, nutrition and pain/palliative teams tended to be comprised of staff from several different departments. The members consisted of social work, activities, physical therapy, chaplain, dietary, housekeeping and maintenance.

Ideally, the care resource teams should include staff across departments, shifts and levels. In the LWAC facilities, team composition varied across the facilities and teams, particularly during the first year. Within the first year, several CRTs had little active involvement of frontline staff, who did not regularly attend team meetings. The frontline workers interviewed often were not aware of the changes the CRT made or the education of staff about the team's activities. There were inconsistencies between management and frontline staff on the CRT activities and goals and the departments or positions represented on the team. The research team tended to find more inconsistencies among the more clinical teams (e.g., skin care/wound and elimination/continence). Some CRTs had active involvement of frontline staff in the first year, however. The CNAs and/or Licensed Practical Nurses were the team leaders. They tended to be able to discuss the CRTs, including the members, purpose of the meetings, changes made at the facility, education of staff, etc.

During the second and third years of the Wellspring program, the research team found more frontline staff had an active involvement and voice on the CRTs. They could articulate and describe the activities and goals of the team. The descriptions between management and frontline staff were more consistent. Several frontline staff members indicated that the CRTs were a mechanism for them to have input in the care for residents.

There were several challenges to how effective the CRTs were in implementing changes within the facility. Some of the challenges identified in the beginning of the program persisted throughout the three years. The successful facilities and teams found ways to work with the system and overcome the challenges. They did not view these barriers as reasons to discontinue the teams or the commitment to Wellspring. The challenges described by interviewed staff included:

- Difficulty in assimilating the teams and having available staff to participate in Wellspring and attend CRT meetings.
- Difficulty in having all CRT members actively engaged and regularly attending meetings. The low attendance affected implementation because the activities took longer than anticipated. Many CRTs addressed this challenge by attempting to make meetings more efficient and sticking to the 30-minute time limit to minimize the time staff members were at the meetings. In addition, many teams held meetings on regularly scheduled days so staff had advance notice. At one of the smaller facilities, the CRTs met on the unit so they could hear the call bells.
- A lack of follow-up on activities assigned. Some CRT leaders discussed that while staff members attended the meetings, not all followed up on their assigned activities. This resulted in the CRT leaders picking up the incomplete tasks and feeling overburdened by their work for the CRT.
- Budget constraints and a lack of resources to implement the ideas.
- Turnover at the facilities, which affected the continuity of some teams. A few teams stopped meeting for a period of time, and some disbanded and then had to be revamped.
- Difficulty implementing specific activities. For example, a few skin team members stated that it was difficult to establish routines for task-specific teams (i.e., bath/turn teams).
- Difficulty maintaining staff commitment and enthusiasm. CRT members lost interest and left the teams. It also was difficult to have staff commitment when they had other job responsibilities. Teams tried to brainstorm new ideas and activities to continue the momentum.

Each of the facilities initiated changes because of the CRT activities. Depending on the focus of the care resource teams, some addressed the needs of individual residents as they related to the topic rather than implementing more systematic changes across the facility. The majority of teams, however, did initiate changes across the facility that would help all residents. Some teams initially piloted the planned activity on select units or residents before facility-wide implementation. This allowed staff to assess any problems with the initiative and work them out.

Over the three years in the Wellspring program, the majority of the facilities had sustained systematic facility-wide changes. The key changes were both tangible and intangible. The intangible changes were better communication and teamwork, more frontline staff involvement and increased knowledge and awareness of resident needs because of the CRT focus on a specific topic.

The tangible changes across the facilities were the results of the CRTs. Several teams initiated changes to improve the care or quality of life for residents. These changes cut across the different focus areas of the CRTs. Some examples include:

- A Code Purple/Code Yellow falls program. When a fall occurs, an announcement is made or staff is paged. The employees on that floor are expected to respond and assess why the resident fell. An incident report is completed about the fall and solutions to prevent future falls. The team members educated staff about the new approach through an in-service and new employee orientation.
- More activities for residents during the afternoon when falls tend to be higher.
- A three-day bladder assessment program, which the staff felt is enough time to evaluate residents and have them on scheduled toileting sooner.
- Routine turning and repositioning of residents.
- Regular rounds to assess wounds, e.g., wound stage, wound size, progression in treatment.
- Buffet dining, multiple seating times, menu selections and/or walk to dine where residents walk or staff take residents to the dining room.
- Nutrition cart to provide snacks and fluids to residents.
- Snoezelen rooms that offer a wide variety of safe stimulating items such as aromatherapy, music, kaleidoscope-type pictures projected on the walls, soft colored lights and/or different types of seating. These rooms are designed to improve the lives of people with Alzheimer's disease and other dementias by helping to reduce agitation and apathy and improve activities of daily living.
- Bathing without a battle by using person-centered care techniques to make the bathing experience more enjoyable for caregivers and the people they are bathing, particularly persons with Alzheimer's disease and dementia.
- A hospitality suite for family members who have a loved one who is dying. Snacks are provided in the room.
- A prayer quilt for each resident near the end of life, which the family can keep as a memento when the resident passes.
- Comfort measures for residents near end of life, including evaluating pain medications to make residents more comfortable, taking residents off medications when necessary, etc.
- Non-pharmacological interventions for addressing problem behaviors with resident rights and dignity.
- Educating staff and families on end-of-life and palliative care issues to increase their knowledge and awareness.

Most employees interviewed believe that the majority of the CRTs will continue at the facilities. Some teams did not work out in the beginning, but many felt the current teams will remain. The clinically oriented teams are more likely to continue because more attention is paid to these issues in terms of

surveying and reporting. The CRTs have made positive changes that benefited both staff and residents. Many did not feel that staff will want to go back to the "way things used to be." The CRT is one of the primary mechanisms for making improvements at the facility.

The team that has been the most difficult for facilities to keep going is elimination/continence. Once the team members identified residents who were incontinent, set-up the schedule for toileting, etc., it was difficult for them to develop new ideas. The facilities have tried to overcome this by putting the incontinence team with other teams so the entire meeting does not focus exclusively on incontinence.

The administrators contributed a variety of reasons for continuing the care resource teams. One key reason was that the teams produce results and help improve the quality of care and life for residents. The teams deal with issues that directly relate to resident care. The successful teams are multidisciplinary (most of them), collaborative and have empowered staff and strong leadership.

Monitoring and Evaluation of Care ResourceTeam Activities

In the original Wellspring model, the CRT members are expected to use data to plan and evaluate their implementation, as well as monitor the activities to ensure that staff members are correctly implementing the new procedures. The quality improvement component of the model occurs at the level of the care resource team members. The data and monitoring make the team members accountable for the new activities. They help the teams identify resident care areas that need attention, as well as plan new strategies in areas that need further improvement in care practices.

The facilities, for the most part, consistently entered their data in the My InnerView program. However, CRT members' monitoring of the activities and review of the data were not well implemented. The team members generally did not analyze the data to judge the effectiveness of the interventions and inform decisions. The quality improvement component only occurred among department managers and not at the care resource team level. The CRT members focused on implementation of best practices rather than a continuous quality improvement activity. This also made the teams less accountable for the changes made at the facility or on individual residents.

Monitoring of the programs was often through the Implementation Team or documentation in the care plans reviewed by the director of nursing or nurses. A few facilities brought completed reports to the CRT meetings to review and ensure that the employees were accurately following the process and to determine the effectiveness of the activities. For example, several teams did generate reports or records about wound status, progression and treatment. The CRTs members discussed the reports, why problems were occurring and possible solutions.

The analysis of data occurred among the Wellspring Nursing Consultant and members of the Implementation Team (department managers) at each facility. The Wellspring Nursing Consultant used the My InnerView data as a monthly accountability report for the teams. She reviewed the data for the CRT she was meeting with that day. It was the responsibility of the Implementation Team to talk with the CRT leader of the teams that did not meet their targets. The CRT leader and the team then took corrective action to improve the numbers. This process did not allow frontline staff or team members to be directly involved in using data to develop plans and strategies.

A recent development is that the participating facilities now are required to set monthly targets for each quality of care measure on My InnerView. The Implementation Team members review the data each month and, if the facility is off target, they are expected to implement a correction plan.

Wellspring Coordinator

The original Wellspring Alliance of Wisconsin encouraged facilities to have the Wellspring Coordinator separate from the director of nursing to encourage more open dialogue with staff and to focus exclusively on the program and daily activities. The Carolina facilities had a mix of positions as the Wellspring Coordinator. In some facilities, the Wellspring Coordinator position was the person's only responsibility. In other organizations, particularly smaller ones, the director or assistant director of nursing or the staff development coordinator had the dual responsibility of her current position and the Wellspring Coordinator role.

Most Wellspring Coordinators provided education to staff about Wellspring and worked with the care resource teams. The Wellspring Coordinator's level of involvement with each of the CRTs varied across the facilities and different types of CRTs. For some CRTs and at some facilities, the Wellspring Coordinator was an active team member who regularly attended the meetings and worked with other team members to develop and implement change. This differs from the Wellspring Coordinators who had a less hands-on role. The Wellspring Coordinator in this role helped initiate and coordinate the team and, after it was formed, was available to help solve problems. The Wellspring Coordinator could be effective at both levels, but the evaluation did not allow us to assess whether one method was more successful than another. It could be burdensome on the Wellspring Coordinators who have dual roles to be intimately involved with each team.

Education of Staff, Family and Residents

Wellspring is built on a train-the-trainer premise in which participants at the module training share the information they learned with staff back at the facility. Additionally, the teams inform staff about their activities and the changes being made at the facility. This helps to share the best practices learned and have staff utilize those practices.

Many of the facilities made efforts, particularly in the beginning, to discuss Wellspring across all shifts and departments either through formal channels or informally within departments. The facilities held mandatory in-services and posted information on the bulletin boards (general information about Wellspring and the CRT activities). New employees were educated about Wellspring during the new employee orientation, which all employees are required to attend on their yearly anniversary. In addition, some facilities had huddle meetings with all staff or meetings with nursing staff, information in the paychecks and/or one-on-one trainings. When CRTs piloted changes on one unit or with select residents, the team members informed and trained the staff affected by the changes about the new procedures.

In general, the research team found that participants who attended the module trainings were aware of and had a basic comprehension of Wellspring. This did not always translate into practices that supported the Wellspring philosophy. For example, particularly in the beginning of the program, staff at a few facilities described Wellspring as involving all levels of staff in making decisions for resident care. However, the care resource teams consisted primarily of department managers, and most decision-making appeared to be at the director of nursing or managerial level. It did not seem that frontline staff had an active role in making decisions at the facility. The frontline staff's role evolved over time to become more active.

The level of understanding about Wellspring did not differ across departments or between management and frontline staff. It seemed to depend more on whether a person had attended the module trainings or whether their job was affected by changes made because of Wellspring. Staff members who did not

attend the module trainings were less likely to understand and be able to describe Wellspring. The majority of these staff heard about and was aware of Wellspring, but their knowledge of the program was often limited. They did not have the details of Wellspring or of the changes and programs the CRTs were implementing. The lack of knowledge among several "non-active" participants occurred even when a facility had facility-wide meetings to discuss Wellspring. This lack of awareness and knowledge among all staff is evidence that the facilities did not get full staff buy-in from the beginning or have mechanisms to involve all staff. All staff, including those who do not attend the module training, should know about and understand Wellspring.

It should be noted that some facilities purposely did not use the term "Wellspring" in the beginning because they wanted it to be seen as "the way we do business" and avoid the perception that this was just the latest innovation to be tried and fail. This may have influenced whether "non-active" participants linked the Wellspring program with the activities and changes taking place at the facility. While not all staff comprehended Wellspring, it is not clear whether they were utilizing best practices from Wellspring in their everyday routine care. It is possible that "non-active" staff members did not connect the practices with the program.

Facilities were less likely to share information about Wellspring and the CRT activities with residents and family members. When facilities communicated information, the teams waited until they had clearly defined their plans. Among those who did formally inform residents and family members, it was generally through articles in facility newsletters, Family Education Night, packages sent to families or town hall meetings. Several facilities discussed Wellspring as it relates to individual residents during the care plan meetings. The staff informed individual residents about Wellspring changes that would affect them individually. These facilities did not necessarily provide general information about Wellspring to all residents.

LSA and LHSC, the management organizations of the participating facilities, provided information about Wellspring in their newsletters and other venues to residents and families.

Challenges to Implementation

The challenges specific to the care resource teams were described in the Implementation section of this report. This section describes the general challenges the LWAC facilities experienced in implementing Wellspring. These challenges included:

- Staff resistance to change, particularly among employees who had been with the facility for several years. Many of the facilities did not appear to get buy-in from all staff at the start of the program. Additionally, facilities were faced with staff skepticism because of previous efforts that had gone by the wayside. Facilities tried to overcome this barrier by directly involving those who were resistant to the changes. They also found that these staff members tended to leave the organization. Some staff embraced Wellspring more when they witnessed the positive changes at the facility and the benefits for residents.
- Early concern among some department managers that insufficient staffing and budget, perceived higher resident acuity levels and working in a crisis mode (high caseload, short staffing) would make it impossible to do Wellspring.
- The belief that ideas staff generated as part of the Wellspring process would require more staff than were available to assist residents in doing the activities.

- Difficulty in pulling people off the floor to attend meetings when departments were already working short.
- An inability to share staff across departments and campuses to cross boundaries in taking care of residents.
- The lack of recognition that administrator support is a key force in the beginning of the program. As the program moved forward, it became apparent that the facilities needed structure and administrator backing to empower the frontline staff.
- A lack of administrative support, which led some facilities to struggle with the implementation of Wellspring. The empowerment of workers cannot happen without the support of the administrator and the director of nursing. The CRT can decide to do an activity or make a change, but it can be axed by the director of nursing and administrator and cause frustration among the team members.

Chapter 5 — Change Analysis on Staff

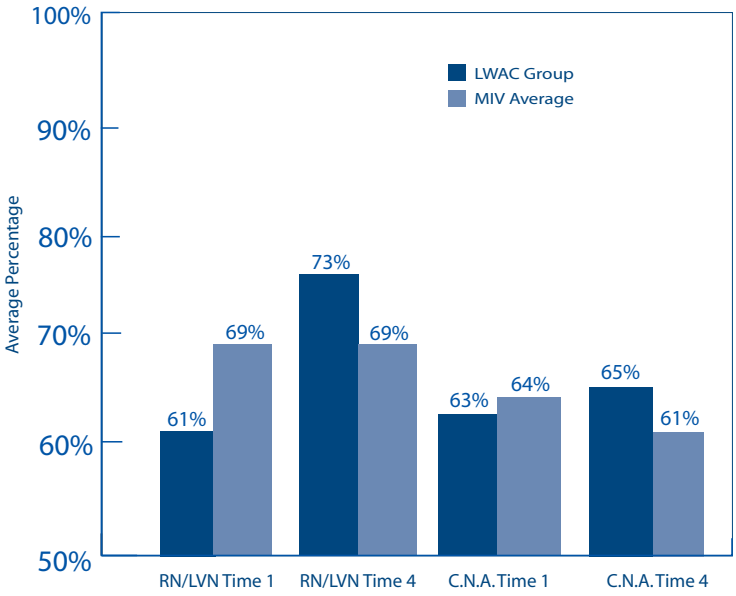
The Wellspring program is a continuous process for the facilities, and the eventual goal is that it becomes an integral part of how the organizations provide care to residents. It can take time to see improvements in the clinical indicators and workforce measures. How staff perceive the value of the program is just as important as the results of the quantitative data.

One aim is that the investment in Wellspring will improve the work environment, and staff will have higher job satisfaction and retention rates. This section describes the results of the workforce metrics, perceived staff changes through the interviews and results from the employee survey.

Nursing Stability, Absenteeism and Turnover

- The Alliance facilities as a group and a number of individual facilities had the strongest improvement in the stability of nurses and nursing assistants. The improvements were higher for RNs and LVNs than nursing assistants.

Exhibit 1
Comparison of Average Percentage of RN/LVN and Nursing Assistant Stability:
LWAC vs My InnerView



- There was little change in nursing absenteeism and turnover, both among RNs/LVNs and nursing assistants. LWAC facilities, for the most part, started with high percentages of no absenteeism and no turnover and had little change by the end of the evaluation.
- LWAC facilities as a group performed better over time on the stability of RNs and LVNs compared to the My InnerView facilities. In all other areas, there was no difference between the LWAC and MIV facilities.

Frontline Staff Decision-Making and Involvement of Care Resource Teams

Wellspring helps create an environment in which frontline staff can express their ideas and opinions more freely. The flattening of the organizational structure from a top-down approach to one where all staff members have input can be an adjustment for many organizations. It takes time for managers to get used to not making decisions on their own and involving other staff. Some managers had a difficult time letting go of the control and struggled with how to share the decision-making. It took more time for decisions to be made because more staff was involved. Managers sometimes found that the decisions made by the group differed from the decisions they would have made on their own. However, the value of hearing from the frontline staff who works directly with the residents is well worth the transitions and adjustments.

The research team found much variation among the facilities in the level of frontline workers with a voice and input into resident care. Some facilities actively involved the frontline workers, while at other participating nursing homes, the frontline staff played a more indirect role. At times, there was a disconnect between belief and practice. At a few facilities, interviewees stated that the frontline workers were part of the decision-making; however, in practice they were not active members of the teams, and management made the decisions. Generally, as the facilities progressed through the program, the line workers became more active in the decision-making process. At some facilities, the frontline workers had ownership of their decisions and were accountable.

The venue for frontline staff input was often the CRTs. Some facilities asked frontline staff as a group for their input, while others tended to have one-on-one conversations. One facility felt that frontline staff had always been involved in the decision-making, and the change since Wellspring was primarily establishing a more formal process through the CRTs.

The collaboration between the frontline staff and management allows frontline workers to be more comfortable speaking with management, and it encourages them to take more initiative than they did in the past. Some interviewees felt that because of Wellspring, management had more respect for frontline staff and recognized the importance of their work in the day-to-day care of residents. The CRT members and frontline staff not part of the team were asked for ideas and suggestions on ways to improve areas that were identified as problems. Nurses and management were more likely to listen to and consider suggestions from the frontline staff. For example, one CRT asked frontline staff for their ideas on a toileting program that they wanted to implement. Another facility had huddle meetings that included all staff and got them involved in the decision-making on how to best accommodate residents. At a third facility, the CNAs provided suggestions for the assignment sheets that listed residents' "do's" and "don'ts," which are a big part of residents' day-to-day care. One activities assistant said, "Wellspring opened the administration staff up to asking frontline staff more questions and to not making decisions on their own. In turn, frontline staff feels good when they are asked their opinions."

Early in the program, some managers were not confident in the frontline staff's ability to make decisions. They felt the frontline staff needed to be educated on the issues and learn how to make decisions. Some of these managers struggled to embrace the concept that all employees are of equal standing and empowered to make decisions.

It was not always clear to what extent (if at all) frontline employees were involved in resident care planning meetings. A few interviewees were not sure whether frontline staff was actively involved in these meetings. Some mentioned that the CNAs give input into these meetings but do not participate. This

was particularly true if there was a special situation regarding one of their residents. A few interviewees indicated that their facilities planned for the CNAs to participate in the care planning meetings regularly. While most of the interviewees did not believe the CNAs were involved in the care planning meetings, the Wellspring Nursing Consultant said that all facilities included the CNAs in the care planning meetings.

Departments Working Together

One area that was a positive change was how different departments worked together. Prior to the Wellspring program, many of the departments worked in silos, and issues related to residents were assigned to a specific department. The Wellspring program provided an environment in which the different departments worked together, communicated with one another and made decisions together. The multi-disciplinary CRTs brought different perspectives—housekeeping, maintenance, activities, nursing, dietary, therapy, etc.—to brainstorm ideas on how to improve the care provided to residents, as well as to solve problems. This helped create a greater bond between management and frontline staff. Interviewees gave examples of how when a situation occurred with a resident, it was not considered a "nursing" issue. Instead, the departments worked together to determine how to rectify the situation and provide better care for the resident. One RN noted that staff at her facility now feels more like a team, instead of management and frontline staff being "us" versus "them."

Perceived Skill Improvement

Beyond the communication and collaboration, through interviews it appears Wellspring improved staff skills and the care they provided to residents. Staff became more knowledgeable and aware of the issues that affect older adults. The facilities and CRTs created an environment in which they could not only learn new skills and information, but also utilize it with residents. The employees were more observant with residents and were able to apply information they learned at the module trainings in their care for residents. Additionally, staff outside of nursing, such as housekeeping, recognized their role in helping residents and reporting situations to the nursing staff.

Employee Satisfaction Survey Results

The LWAC group had comparable ratings from employees each year and did not improve the numbers in any area. The employees in each organization, on average, gave medium ratings—ranging from 59 percent to 75 percent of the respondents giving a "good" or "excellent" rating—on global satisfaction and their satisfaction with the work environment, training, supervision and management in 2006 and 2007. Similarly, the LWAC facilities as a group did not differ from the My InnerView facilities. They had similar percentages in 2006 and 2007, without significant change between the two years. The one exception is that the LWAC facilities had higher global satisfaction mean percentages in both 2006 and 2007 compared to the MIV national facilities (LWAC, 75 percent and 74 percent; MIV, 65 percent and 64 percent, 2006 and 2007 respectively).

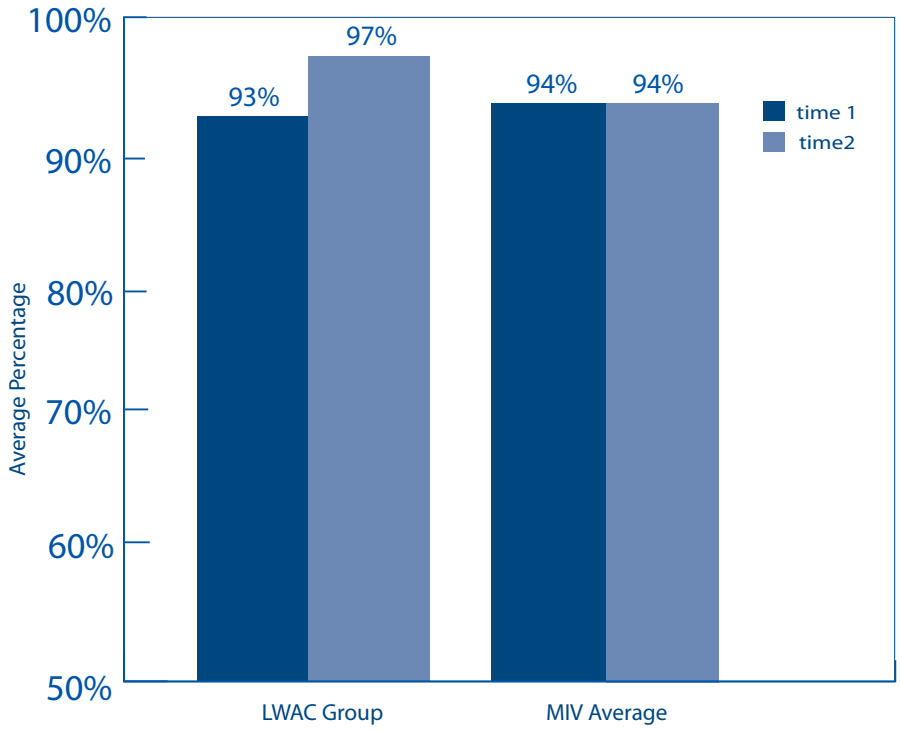
Chapter 6 — Change Analysis on Residents and Family Members

Clinical Indicators/Quality of Care Measures

The LWAC facilities as a group had initial high mean percentages of residents without falls, acquired pressure ulcers, anti-psychotic medications, acquired catheters, ordered physical restraints and unplanned weight loss or gain. Prior to the implementation of Wellspring, the LWAC group received high ratings of 90 percent or greater on four of the six clinical indicators, and the other two were between 76 percent and 85 percent. The mean percentages for all of the clinical indicators were unchanged between the start and end of the evaluation.

The LWAC and MIV facilities had similar percentages at the start and end of the evaluation on four of the six clinical indicators. The LWAC facilities as a group had a greater increase in the mean percentage of residents without unplanned weight loss or gain. The LWAC group increased four percent while the MIV facilities had identical scores at Time 1 and Time 4. On the other hand, the MIV facilities increased the percentage of residents without anti-psychotic medication usage from 67 percent to 72 percent from the start to the end of the evaluation, while the LWAC facilities as a group had a one-percent increase during the same period.

Exhibit 2
Comparison of Average Percentage of Residents without Unplanned Weight Loss/Gain:
LWAC vs My InnerView (MIV)



Staff Perceptions of Effect on Residents

The nursing home workers interviewed believed that the Wellspring program improved the quality of life and care for residents. The Wellspring program provided workers with best practices and tools that enabled them to better care for residents. The staff, therefore, has a better understanding of the overall care process for the resident and can provide better care.

Wellspring provides a more home-like environment for residents, as well as more activities and fun things to do. For example, several psychosocial teams had new activities and games they could play with residents. A falls care resource team created a box of activities residents could use during specific times of the day when staff members noticed falls were more likely to occur. The teams also made decorative changes within the building to create a more home-like atmosphere and gave residents more choice, such as a selection of food choices and providing a continental breakfast for residents who did not want to eat at the designated breakfast time. These types of activities and changes resulted in the staff belief that residents were happier and more comfortable.

At a few facilities, employees stated that residents benefited through changes in staff attitudes or staff approaches to residents. Staff knew the residents better, was more involved with residents and was more attuned to residents' needs. Several interviewees felt there was more resident-to-staff bonding. The staff at several facilities learned how to better address the needs of residents and difficult situations that arise. Staff also said they were more sensitive to and aware of changes residents experience. Staff at one facility was said to have greater commitment to putting the resident first. One example was a social worker who mentioned that residents could choose who attended the care planning meetings. This allowed more staff to be involved in the meetings, and residents liked having input into who attends.

A few interviewees did not believe Wellspring had much impact on residents. A social worker at one facility felt that many residents would not realize anything was different because they always received good care. Another interviewee believed Wellspring had a neutral effect on residents in that there have not been any significant improvements for residents, nor have there been any negative results.

Effect on Family Perceptions

The LWAC facilities as a group made great improvements in how family members rated the organizations. A higher mean percentage of family members rated the facilities as "excellent" or "good" on three of the domains from 2005 to 2007:

- Global satisfaction: 5 percent increase
- Quality of care: 5 percent increase
- Quality of service: 6 percent increase

The LWAC facilities as a group outperformed the MIV facilities in the mean percentage increase for each domain. The LWAC facilities had a four or five percentage increase in global satisfaction, quality of life, quality of care and quality of service. The MIV facilities, on the other hand, had similar percentages in 2005 and 2007 in each domain, with increases of no more than two percent.

Chapter 7 — Recommendations/Lessons Learned

There are a number of important lessons learned and recommendations from the qualitative component of this study, which examined the process of implementing the Wellspring model in nursing homes. These lessons are particularly useful when considering possible changes as the LWAC facilities continue with the Wellspring model and other facilities choose to replicate it.

- The organizing superstructure (the Alliance) is not fully utilized. LWAC could create occasions for communication across the participating facilities outside of the module trainings. This does not always require in-person visits, which can be difficult when staff members are away from the facility. LWAC could have a newsletter that provides information on common issues faced by the facilities or new best practices. It is important that the newsletter not only reach facility leadership, but also frontline workers. Another option is monthly conference calls to link Carolina Wellspring teams to share information in addition to the module trainings. At a minimum, the calls could be among the Wellspring Coordinators and the Wellspring Nursing Consultant or possibly the team leaders across the facilities and the Wellspring Nursing Consultant to discuss observations of the CRTs and allow participants to share ideas. They could take that information back to the facility and communicate it with the appropriate people.
- The module trainings are a consistent and important component of the Wellspring model. Through the interviews with staff and observations of the trainings, there are ways to improve the training process:
    - Participants need more time to work within their own facility group to apply what they have learned, plan goals and implement plans and strategies to bring back to the facility.
    - More break-out groups are needed for problem solving and case studies.
    - Training should include more frontline staff at each module at the beginning and throughout the program. Also, it is important to ensure that frontline staff on each unit and each shift attends the module. This is critical to get the buy-in and understanding of all frontline staff.
- The review and use of data is an integral part of Wellspring, and CRT members must understand what the data mean and how to use them. Team members, both frontline staff and managers, should regularly review the data. Training may be required to help staff understand how to interpret and use the data. One idea is to have a one-day training on the use of data for employees and incorporate this information into each of the module trainings to reinforce the concept. The data help to provide validation of the successful interventions and identification of problems in care. The use of data to inform decisions distinguishes the program from the implementation of best practices to a model of continuous quality improvement.
- The successful implementation of Wellspring and other culture change models requires the full commitment of administrative staff. The empowerment of frontline staff and their active participation in decision-making are only operational when the administration is supportive. The training modules are not sufficient to change the culture of a nursing home.
- Organizations need environments in which all departments and all levels of staff make decisions together and bring them to the administration and corporate office. This requires that all departments and frontline staff are active participants and regularly attend team meetings. Department managers should not be attending the meetings and passing the information to the frontline staff. This results in the frontline staff being less engaged.
- LWAC adapted the original model. It was not an exact replication of the model, and they changed it to meet the needs of the organizations. These changes then became part of the Carolina Wellspring model.

Post-Evaluation

The Lutheran Homes of South Carolina has seen an annual decrease in their liability premiums. They had a 42% decrease from FY 2005 through FY 2009.

LSA and LHSC plan to continue with the Wellspring program and the communities are expected to sustain the program and make it part of how they operate. LSA and LHSC will fund the program completely, and LWAC will develop the future module trainings. Some of the nursing homes have changed how they operate the care resource teams. Instead of having each team focus on one topic, these facilities have a care resource team for each unit that addresses all the topics (e.g., falls, nutrition, pain and palliative, psychosocial wellbeing, elimination/continence, etc.) for that unit.

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