Disclosure of Commercial Interests

I have no commercial interests to disclose.

Behavioral Health:

Caring for a New Generation

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Assessing Human Needs

What is Quality of Life?

- Subjective, multidimensional, encompassing positive and negative features of life.
- A dynamic condition that responds to life events

http://www.forbes.com/sites/iese/2013/09/04/quality-of-life-everyone-wants-it-but-what-is-it/

Person-Centered Care

"…a framework for heath and social care assessment, including risk assessment, within a comprehensive, person centered, multi-disciplinary care planning process.' (Thiru et al., 2002, p. 11)

The Woodstock Generation

THEN

NOW

Alcohol Use Disorders (AUDs) in the Elderly

- Most commonly abused substance in the elderly;
- Physiological changes in the elderly increase their sensitivity to alcohol;
- Psychosocial factors associated with aging, such as the loss of a spouse or social networks, loneliness, isolation, and depression, contribute to AUDs;
- Inadequate screening by physicians due either to lack of training or bias that such disorders are not worth treating in this population;
- Treatment is effective across the spectrum of AUDs in the elderly.

http://www.psychweekly.com/aspx/article/article_pf.aspx?articleid=19

Drug Abuse and Mental Health Issues

A 2011 study by the Substance Abuse and Mental Health Services Administration found:

- Baby Boomers who came of age in the '60s and '70s when drug experimentation was pervasive, are far more likely to use illicit drugs;
- Among adults 50-59, current illicit drug use increased to 6.3 percent in 2011 from 2.7 percent in 2002;
- The most commonly abused drugs were opiates, cocaine and marijuana.

Drug Abuse and Mental Health Issues

2010: An estimated six to eight million older Americans – almost 20 % of the elderly population – had one or more substance abuse or mental health disorders.

2030: Adults 65 and older is projected to increase to 73 million from 40 million between 2010 and 2030.

http://newoldage.blogs.nytimes.com/2013/04/29/a-rising-tide-of-mental-distress/

Substance Use Disorders and Mental Illness among Adults Aged 18 or Older - 2014

- 43.6 Million Adults Had Mental Illness
- 35.6 Million Mental Illness, SUD
- 20.2 Million Adults Had SUD
- 12.3 Million SUD, no Mental Illness
- 7.9 Million SUD and Mental Illness

*SUD = substance use disorder

Increased Numbers of Disabled Young Adults

- The number of children and young adults with disabilities is increasing.
- Life-saving and life-prolonging medical care and new technologies have increased the survival of seriously ill younger people.
- These children, teens and young adults will need long-term care to assist them in their homes or in nursing homes and residential facilities.

LTC Panel Report 2009

Cultural Facts to Consider

CHINA

Health and Wellness: Countless Chinese people, especially the middle-aged and elderly, have developed the habit of exercising each morning to improve their health.

The Importance of Face: The concept of 'face' roughly translates as honor', good reputation or respect. There are four types of Face:

1) Diu-mian-zi: this is when one's actions or deeds have been exposed to people.
2) Gei-mian-zi: involves the giving of face to others through showing respect.
3) Liu-mian-zi: this is developed by avoiding mistakes and showing wisdom in action.
4) Jiang-mian-zi: this is when face is increased through others, i.e. someone complementing you to an associate.

It is critical you avoid losing Face or causing the loss of Face at all times.

Cultural Facts to Consider

CHINA

- **Learn to use chopsticks**.
- Wait to be told where to sit. The guest of honor will be given a seat facing the door.
- You should try everything that is offered to you.
- Never eat the last piece from the serving tray.
- Be observant to other peoples' needs.
- Chopsticks should be returned to the chopstick rest after every few bites and when you drink or stop to speak.
- **Do not put bones in your bowl. Place them on the table or in a special bowl for that purpose**.
- **Hold the rice bowl close to your mouth while eating.**
- Do not be offended if a Chinese person makes **slurping or belching sounds**; it merely indicates that they are enjoying their food.
- There are no strict rules about finishing all the food in your bowl.

Chronic Homelessness

- 94.1 percent of people living on the street have behavioral health challenges: 12.1 percent mental health, 12 percent substance use, 70 percent dual diagnosis.

  http://www.projecthome.org/how-to-help/advocate/facts-homelessness
- Health care is the major expense due to frequent and avoidable emergency room visits, inpatient hospitalizations, sobering centers, and nursing homes.

  http://usich.gov/population/chronic

Behavioral Health

New Federal Regulations

§ 483.40 Behavioral health services.

- Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.
- Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the ***prevention and treatment of mental and substance use disorders***.

Behavioral Health

New Federal Regulations

(a) The facility must have ***sufficient staff*** who provide direct services to residents with the appropriate ***competencies and skills sets*** to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial wellbeing of each resident, as determined by resident assessments and individual plans of care and ***considering the number, acuity and diagnoses*** of the facility's resident population in accordance with § 483.70(e).

Behavioral Health

New Federal Regulations

These competencies and skills sets include, but are not limited to, knowledge of and appropriate training and supervision for:

- Caring for residents with mental and psychosocial disorders, as well as residents with a history of ***trauma and/or post-traumatic stress disorder***, that have been identified in the facility assessment conducted pursuant to § 483.70(e), and
- ***Implementing non-pharmacological interventions.***

Behavioral Health

New Federal Regulations

(b) Based on the comprehensive assessment of a resident, the facility must ensure that—

- A resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being;

Behavioral Health

New Federal Regulations

- A resident whose assessment did not reveal or who does not have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder ***does not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors,*** unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable; and

F319
Trauma-informed care

Interpretive Guidelines:

"Mental and psychosocial adjustment difficulties" refer to problems residents have in adapting to changes in life's circumstances. The former focuses on internal thought processes; the latter, on the external manifestations of these thought patterns.

PASRR
Federal Regulations

The timeframes are:

- The Level I PASRR SCREEN must be completed prior to admission to a RHCF for every person, for any reason and any length of stay.
- As soon as a person has been **newly diagnosed** with a mental illness and/or intellectual disability/developmental disability.

PASRR
F285 § 483.20(e) Coordination

- Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.
- Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment.

Defining Mental Disorder

- (A) A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability; but

Defining Mental Disorder

- (B) Not a primary diagnosis of dementia, including Alzheimer's disease or a related disorder, or a non-primary diagnosis of dementia unless the primary diagnosis is a major mental disorder as defined in paragraph (b)(1)(i)(A) of this section.

PASRR
Significant Change

§ 483.20(k)(4) A nursing facility must notify the state mental health authority or state intellectual disability authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.

Behavioral Health

New Federal Regulations

- A resident who displays or is diagnosed with dementia, receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

Dementia Focus Survey

- Is behavior acknowledged as a form of communication?
- Is it expected that all staff strives to understand the meaning behind these behaviors?
- Are non-nursing staff (particularly recreational therapy staff) trained in dementia care practices?

Dementia Focus Survey

- Does the overall philosophy of care in the nursing home acknowledge behaviors as a form of communication and is there an expectation that all staff strives to understand the meaning behind these behaviors?

Dementia Focus Survey

- Does the QAA Committee monitor for consistent implementation of the policies and procedures for the care of residents with dementia?
- Has the QAA Committee corrected any identified quality deficiencies related to the care of residents with dementia?

Assessment: Understanding the Individual

Who is the person behind the behavior?

- Personality
- Ego
- Common triggers
- Responses
- Rituals
- Preferences

Understanding the Individual

- Known or potential triggers to behavior
- Known self-soothing remedies
- The pre-dementia or pre-illness personality
- Social and occupational history
- Family dynamics
- Preferences and routines

Assessment

- Impact of neurodegenerative disease, mental illness, and stress on behavioral health and social functioning;
- Assessment of symptoms and behavioral triggers;

Assessment

- The importance of distinguishing between signs and symptoms of dementia/mental illness/brain injury, personality, and responses triggered by environment or circumstance.

What Is Behavior?

- **Symptom**: Related to or caused by clinical diagnosis, such as dementia, mental illness, pain, etc. Behavior in this category should be anticipated, based on what the clinical team understands about the diagnosis.
- **Reaction**: Related to or caused by circumstance or environment. Behavior in this category should also be anticipated, based on what the team understands about human nature and human response.
- **Personality**: This type of "behavior" is usually the caregiver's issue, not the resident's. In many circumstances, the expression of a preference is labeled **behavior**.

Behavioral Health Assessment Considerations

Psychosocial Adjustment:

The "Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM/IV)," specifies that adjustment disorders develop within 3 months of a stressor (e.g., moving to another room) and are evidenced by significant functional impairment.

*Bereavement with the death of a loved one is not associated with adjustment disorders developed within 3 months of a stressor.

Behavioral Health Assessment Considerations

Other manifestations of mental and psychosocial adjustment difficulties may, over a period of time, include:

- Impaired verbal communication;
- Social isolation (e.g., loss or failure to have relationships);
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Spiritual distress (disturbances in one's belief system);
- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

Is Your Family DYSFUNCTIONAL?

The Nature of Relationships

- Assessing personalities, office politics, and respect issues.
- What sort of first impression does your organization make?
- What resources or support systems does your organization foster to improve relationships?

Relationships

- How well do staff interact with residents?
- How well does the team do at pairing roommates?
- How effective are the procedures for resolving grievances and conflicts?

Social Groups

1. Are you selective about choosing friends?
2. How do you choose a seat at a gathering where you don't know many people?

SOCIAL REACTIONS

Have you ever:

- Declined an invitation because you didn't know anyone else who would be attending or because you learned someone you didn't like would be there?
- Moved from your original seat because of the behavior of someone else at the table?
- Left a gathering or program because you found it wasn't as interesting as you'd thought it would be or because another guest arrived wearing your dress?

Behavioral Health

Assessment & Care Plan Considerations

Clinical conditions that may produce apathy, malaise, and decreased energy levels that can be mistaken for depression associated with mental or psychosocial adjustment difficulty are: (This list is not all inclusive.)

- Metabolic diseases (e.g., abnormalities of serum glucose, potassium, calcium, and blood urea nitrogen, hepatic dysfunction);
- Endocrine diseases (e.g., hypothyroidism, hyperthyroidism, diabetes, hypoparathyroidism, hyperparathyroidism, Cushing's disease, Addison's disease);

Behavioral Health

Assessment & Care Plan Considerations

- Central nervous system diseases (e.g., tumors and other mass lesions, Parkinson's disease, multiple sclerosis, Alzheimer's disease, vascular disease);
- Miscellaneous diseases (e.g., pernicious anemia, pancreatic disease, malignancy, infections, congestive heart failure);
- Over-medication with anti-hypertensive drugs; and
- Presence of restraints.

Evaluate Existing Medications

- Consider the following issues:
  - Drug induced cognitive impairment
    - **Anticholinergic Load**
  - Medication induced electrolyte disturbance
  - Recent medication additions that may alter metabolism of a drug that the person has been taking for a while
  - Withdrawal reaction to a recently discontinued medication

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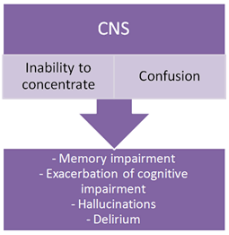
Anticholinergic Load

- Cholinergic neurotransmission enhances cognitive functions such as arousal, attention, and memory encoding.
- Drugs that increase acetylcholine concentrations at the synaptic cleft (acetylcholinesterase inhibitors) are used for the treatment of Alzheimer's' disease and other dementias.
- Thus, it can be inferred that blocking acetylcholine receptors in the CNS can cause a number of cognitive disturbances.



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Behavioral Health Unnecessary Drugs: Evaluation

To determine if each resident receives:

- Only those medications that are clinically indicated in the dose and for the duration to meet his or her assessed needs;
- Non-pharmacological approaches when clinically indicated, in an effort to reduce the need for or the dose of a medication; and
- Gradual dose reduction attempts for antipsychotics (unless clinically contraindicated) and tapering of other medications, when clinically indicated, in an effort to discontinue the use or reduce the dose of the medication.

Behavioral Health
Unnecessary Drugs: Evaluation

To determine if the facility in collaboration with the prescriber:

- Identifies the parameters for monitoring medication(s) or medication combinations (including antipsychotics) that pose a risk for adverse consequences; and for monitoring the effectiveness of medications (including a comparison with therapeutic goals); and
- Recognizes and evaluates the onset or worsening of signs or symptoms, or a change in condition to determine whether these potentially may be related to the medication regimen; and follows-up as necessary upon identifying adverse consequences.

SYMPTOMS, SIGNS, AND CONDITIONS THAT MAY BE ASSOCIATED WITH MEDICATIONS

•Anorexia and/or unplanned weight loss, or weight gain
•Apathy
•Behavioral changes, unusual behavior patterns
•(including increased distressed behavior, social
•isolation or withdrawal)
•Bleeding or bruising, spontaneous or
•unexplained
•Bowel dysfunction including diarrhea,
•constipation and impaction
•Dehydration, fluid/electrolyte imbalance
•Depression, mood disturbance
•Dysphagia, swallowing difficulty
•Falls, dizziness, or evidence of impaired
•coordination
•Gastrointestinal bleeding
•Headaches, muscle pain, generalized or nonspecific aching or pain
•Lethargy
•Mental status changes, (e.g., new or worsening confusion, new cognitive decline, worsening of dementia (including delirium), inability to concentrate)
•Psychomotor agitation (e.g., restlessness, inability to sit still, pacing, hand-wringing, or pulling or rubbing of the skin, clothing, or other objects).
•Psychomotor retardation (e.g., slowed speech, thinking, and body movements)
•Rash, pruritus
•Respiratory difficulty or changes
•Sedation (excessive), insomnia, or sleep disturbance
•Seizure activity
•Urinary retention or incontinence

EVALUATE HOW THE FACILITY MANAGES MEDICATIONS FOR THE RESIDENT

Does the facility policy and procedure include the following standards?

•Clinical indications for use of the medication
•Consideration of non- pharmacological interventions
•Dose, including excessive dose and duplicate therapy
•Duration, including excessive duration
•Consideration of potential for tapering/GDR or rationale for clinical contraindication
•Monitoring for and reporting of:
  - o Response to medications and progress toward therapeutic goals
  - o Emergence of medication-related adverse consequences

- Adverse consequences, if present and potentially medication-related, was there:
  - o Recognition, evaluation, reporting, and management by the facility
  - o Physician action regarding potential medication-related adverse consequences

Behavioral Health

Inadequate Indications for Use of Anti-Psychotic Medication

- Failure to document a clinical reason or demonstrate a clinically pertinent rationale, verbally or in writing, for using medication(s) for a specific resident;
- Prescribing or administering a medication despite an allergy to that medication, or without clarifying whether a true allergy existed as opposed to other reactions (e.g., idiosyncratic reaction or other side effect);
- Failure to provide a clear clinical rational for continuing a medication that may be causing an adverse consequence.

Behavioral Health

Inadequate Indications for Use of Anti-Psychotic Medication

- Initiation of an antipsychotic medication to manage distressed behavior without considering a possible underlying medical cause (e.g., UTI, congestive heart failure, delirium) or environmental or psychosocial stressor;
- Initiation of a medication presenting clinically significant risk without considering risks and benefits or potentially lower risk medications; or
- Concomitant use of two or more medications in the same pharmacological class without a clinically pertinent explanation.

Behavioral Health
Clinical Documentation

Did staff describe the behavior in the medical record with enough specific detail of the actual situation to permit underlying cause identification to the extent possible?

- Onset
- Duration
- Intensity
- Possible precipitating events
- Environmental triggers
- Related factors (appearance, alertness, etc.)

Behavioral Health Clinical Documentation

- If the behaviors represent a sudden change or worsening from baseline, did staff contact the attending physician/practitioner immediately for a medical evaluation, as appropriate?
- If medical causes are ruled out, did staff attempt to establish other root causes of the behavior using individualized knowledge about the person and when possible, information from the resident, family, previous caregivers and/or direct care staff?

Behavioral Health Clinical Documentation

- As part of the comprehensive assessment did facility staff evaluate:
  - The resident's usual and current cognitive patterns, mood and behavior, and whether these present a risk to the resident or others?
  - How the resident typically communicates a need such as pain, discomfort, hunger, thirst or frustration?
  - Prior life patterns and preferences customary responses to triggers such as stress, anxiety or fatigue, as provided by family, caregivers, and others who are familiar with the resident before or after admission?

Behavioral Health Clinical Documentation

- Did staff, in collaboration with the practitioner, identify risk and causal/contributing factors for behaviors, such as:
  - Presence of co-existing medical or psychiatric conditions, or decline in cognitive function?
  - Adverse consequences related to the resident's current medications?

Behavioral Health Care Plan Strategies

Appropriate treatment and services for psychosocial adjustment difficulties may include:

- Providing residents with opportunities for self-governance;
- Systematic orientation programs;
- Arrangements to keep residents in touch with their communities, cultural heritage, former lifestyle, and religious practices; and
- Maintaining contact with friends and family.

Appropriate treatment for mental adjustment difficulties may include crisis intervention services; individual, group or family psychotherapy, drug therapy and training in monitoring of drug therapy and other rehabilitative services.

Non-pharmacological Interventions

- Increasing the amount of resident exercise;
- Reducing underlying causes of distressed behavior such as boredom and pain;
- Individualized bowel regimen to prevent or reduce constipation and the use of medications;

Non-pharmacological Interventions

- Improving sleep hygiene;
- Accommodating the resident's behavior and needs by supporting and encouraging activities reminiscent of lifelong work or activity patterns;
- Using massage, hot/warm or cold compresses to address a resident's pain or discomfort; and
- Enhancing the dining experience.

101 ACTIVITIES ANYONE CAN DO

1. Listen to music
2. Make homemade lemonade
3. Count trading cards
4. Clip Coupons
5. Sort poker chips
6. Rake leaves
7. Write a poem together
8. Make a fresh fruit salad…

Source: Alzheimer's Association Web Site – www.alz.org

Combining ADL, Leisure and Therapeutic Activity

The simplest way to begin improving the manner in which meaningful activity is made available to residents is by redefining what "meaningful" is.

Find ways to turn ADL activity into activity that occurs between leisure and therapeutic groups. Consider all the disciplines that could contribute real and valuable programming to the day. There may be more resources than you think.

There are hundreds of tasks that make up a person's daily routine. Evaluate what already happens in your environment with regard to common sense ADL and leisure tasks.

Activities for a New Age

- Diversify therapeutic activity offerings to include education, self-help, and support programs;
- Collaborate with community addiction services;
- Promote positive self-esteem through meaningful socialization and therapeutic activity;
- Collaborate with community vocational services organizations in discharge planning;
- Foster opportunities for volunteerism.

Behavioral Health- Care Plan Strategies

Bipolar disorder: symptoms and behaviors

Bipolar disorder causes dramatic mood swings – from overly "high" and/or irritable to sad and hopeless, then back again, often with periods of normal mood in between. Severe changes in energy and behavior go along with these changes in mood. The periods of highs and lows are called episodes of mania or depression.

Signs and symptoms of mania include:

- Increased energy, activity and restlessness
- Excessively "high, overly good mood
- Extreme irritability
- Racing thoughts, jumping from one subject to another
- Easily distracted, trouble concentrating
- Little sleep needed
- Unrealistic beliefs in one's abilities or powers
- Poor judgment, spending sprees
- Increased sexual drive
- Abuse of drugs or alcohol
- Denial that anything is wrong

Behavioral Health- Care Plan Strategies

Bipolar disorder: symptoms and behaviors

Signs and symptoms of depression include:

- Lasting sad, anxious or empty mood
- Feelings of hopelessness or pessimism
- Feelings of guilt, worthlessness or helplessness
- Loss of interest in activities once enjoyed, including sex
- Decreased energy, feeling slow
- Easily distracted, trouble concentrating, restless or irritable
- Sleeps too much, or can't sleep
- Changes in appetite, gains or loses weight
- Chronic pain or other body symptoms not caused by physical illness
- Thoughts of death, suicide, or suicide attempts.

Behavioral Health- Care Plan Strategies

Bipolar disorder: Managing symptoms and reactions

1. Mood Swings:
   - Anticipating Patterns of Behavior
   - Monitoring Consistency of Medication
   - Encouraging Therapeutic Activity
2. Avoiding Mood Escalation:
   - Identifying Triggers
   - Validation vs. Reality Orientation
   - Developing Consistent Responses to Common Mood and Behavioral Issues
3. Building Bridges:
   - Reassurance
   - Fostering Trust and Belonging

Behavioral Health Care Plan Evaluation

- Did your plan succeed?
- If yes, what will the resident's next goal(s) be?
- If not, why not?
- How will you modify it to improve your opportunity for success?

Behavioral Health Quality Monitoring

Probes: For those residents exhibiting difficulties in mental and psychosocial adjustment:

- Is there a complete accurate assessment of resident's usual and customary routines?
- What evidence is there that the facility makes accommodations for the resident's usual and customary routines?
- What programs/activities has the resident received to improve and maintain maximum mental and psychosocial functioning?
- Has the resident's mental and psychosocial functioning been maintained or improved (e.g., fewer symptoms of distress)?

Behavioral Health Quality Monitoring

Probes: For those residents exhibiting difficulties in mental and psychosocial adjustment:

- Have treatment plans and objectives been reevaluated?
- Has the resident received a psychological or psychiatric evaluation to evaluate, diagnose, or treat her/his condition, if necessary?
- Identify if resident triggers CAAs for activities, mood state, psychosocial well-being, and psychotropic drug use. Consider whether the CAAprocess was used to assess the causal factors for decline, potential for decline or lack of improvement.
- How are mental and psychosocial adjustment difficulties addressed in the care plan?

Behavioral Health Quality Monitoring

Probes : For sampled residents whose assessment did not reveal a mental or psychosocial adjustment difficulty, but who display decreased social interaction or increased withdrawn, angry, or depressed behavior, determine, as appropriate, was this behavior unavoidable.

- Did the facility attempt to evaluate whether this behavior was attributable to organic causes or other risk factors not associated with adjusting to living in the nursing facility?
- What care did the resident receive to maintain his/her mental or psychosocial functioning?
- Were individual objectives of the plan of care periodically evaluated, and if progress was not made in reducing, maintaining, or increasing behaviors that assist the resident to have his/her needs met, were alternative treatment approaches developed to maintain mental or psychosocial functioning?
- Identify if resident triggers CAAs for behavior problem, cognitive loss/dementia, and psychosocial well-being. Consider whether the CAA process was used to assess causal factors for decline, potential for decline or lack of improvement.

Behavioral Health Quality Monitoring

Probes : For sampled residents whose assessment did not reveal a mental or psychosocial adjustment difficulty, but who display decreased social interaction or increased withdrawn, angry, or depressed behavior, determine, as appropriate, was this behavior unavoidable.

- Did the facility use the CAA process for behavior problems, cognitive loss/dementia, and psychosocial well-being to assess why the behaviors or change in mental or psychosocial functioning was occurring?
- Impaired verbal communication;
- Social isolation (e.g., loss or failure to have relationships);
- Sleep pattern disturbance (e.g., disruptive change in sleep/rest pattern as related to one's biological and emotional needs);
- Spiritual distress (disturbances in one's belief system);
- Inability to control behavior and potential for violence (aggressive behavior directed at self or others); and
- Stereotyped response to any stressor (i.e., the same characteristic response, regardless of the stimulus).

Steps to Creating a Livable Environment

- Evaluate Relationships
- Evaluate the Environment
- Educate Everyone
- Structure the Environment
- Consider the ***Boredom Factor***
- Increase Pleasure

Becoming The Change You Want To See

Changing the nature of relationships is the best foundation for changing the way the organization achieves its goals.

- Demonstrate respect
- Educate equally
- Give everyone a voice in addressing challenges
- Be prepared to try, try again
- Acknowledge a job well done
- Express your gratitude

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