PEAK 2.0 Handbook

PEAK 2.0 is a Medicaid pay-for-performance program offered through the Kansas Department of Aging and Disability Services and administered by the Kansas State University Center on Aging.

2014-2015

Goal

The overall goal of the program is to improve the quality of life for residents living in Kansas nursing homes. To achieve this, PEAK 2.0 is designed to inspire and reward deep organizational change through the adoption of person-centered care practices. Enrolled homes engage in various opportunities including education, action planning, team engagement, consultation, exposure, recognition, and mentoring activities.

Contact Information

PEAK 2.0 Website
http://www.he.k-state.edu/aging/outreach/peak20/

PEAK 2.0 Email Address
ksucoa@gmail.com

Kansas State University Center on Aging
253 Justin Hall, Manhattan, KS 66506

Phone
785-532-2776
This Handbook is intended for use by nursing homes in Kansas. The intent of this workbook is to accompany structured experiences and trainings designed to ready organizations for change that supports the practice of person-centered care.

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Center on Aging
Kansas State University
253 Justin Hall
Manhattan, KS 66506
785-532-5945
gerontology@ksu.edu

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The Team

The Kansas Department of Aging and Disability Services partners with Kansas State University to administer PEAK 2.0. Listed below is key information to access program assistance and information.

Shawn Sullivan
Secretary on Aging
785-296-6681

Laci Cornelison, MS,
LBSW, ACHA
Project Coordinator
785-532-2776
ljh8484@ksu.edu

Jackie Sump, LBSW
Project Consultant
785-556-5746
ksucoa@gmail.com

Gayle Doll, PhD.
Co-Investigator
785-532-5945
gdoll@ksu.edu

Heath Rath, BA, ACHA
Project Specialist
785-532-2776
ksucoa@gmail.com

Migette Kaup, PhD, IIDA,
IDEC
Co-Investigator
kaup@ksu.edu

Judy Miller, RN
Project Consultant
620-727-7670
ksucoa@gmail.com

Rhonda Boose
Reimbursement Manager
785-368-6685
Rhonda.Boose@aging.ks.gov
December 23, 2013

Dear Administrator/Stakeholder:

I am pleased to announce publication of the enhanced PEAK 2.0 Handbook for the 2014-15 fiscal year. This handbook continues to support the expansion of person-centered care in Kansas nursing homes. It is your primary reference for PEAK 2.0 program details.

Beginning in 2012, PEAK expanded from a recognition program to a pay-for-performance Medicaid program in efforts to speed up the rate of adoption of person-centered care practices in Kansas nursing homes. The program had an overwhelming response, with 125 homes enrolling in PEAK 2.0 the first year. We did not expect such a large number of participants and quickly arranged a partnership with the Kansas State University (KSU) Center on Aging to administer the program.

Our office continues to manage payment of incentives earned, but the KSU Center on Aging handles program administration including application, education and evaluation.

To date, 160 homes are active with the program. Working with these 160 homes has helped us to identify areas of the program that were working well and areas that could be improved. The new 2014-15 Handbook includes improvements that, in part, came from participant feedback. Additionally, many more resources have been developed to help support homes to work through the PEAK 2.0 program, including the creation of a 47-minute person-centered care training video.

I strongly urge all homes in Kansas to adopt person-centered care practices. I know first-hand from many years of working as a provider to implement person-centered care that this is not a light undertaking and involves deep systems changes. PEAK 2.0 is designed to aid homes in this process and receive a financial incentive for doing it. I want person-centered care to be the standard in our Kansas nursing homes for current elders and those who will be served in the future, including myself should I need it. Strongly consider getting involved today.

Shawn Sullivan, Secretary
Kansas Department for Aging and Disability Services
In 2011, PEAK was revised and became PEAK 2.0. Building on the successful history of PEAK, KDADS is moving in expanding directions. PEAK 2.0 replaces the phrase “culture change” with “person-centered care”. The latter best describes the kind of practices KDADS wants to encourage. Additionally, PEAK 2.0 is now a Medicaid pay-for performance incentive program. Homes that engage in system changes to support person-centered care or who have demonstrated implementation of person-centered care receive financial incentives through Medicaid reimbursement. This change was made to quicken the adoption of person-centered care in the state. The program focuses on five domains essential to person-centered care; The Foundation, Resident Choice, Staff Empowerment, Home Environment, and Meaningful Life. KDADS contracted with Kansas State University to administer the program in 2012. KDADS continues to oversee the program and apply the incentive to Medicaid reimbursement, but Kansas State University handles all administrative functions of the program, such as application, training, and evaluation of participants. In addition, the Center on Aging strives to be a support to homes as they navigate the program. The program is open to all long-term care providers in the state of Kansas. Full program details are included later in this handbook.

“What PEAK 2.0 is trying to do is help facilities and communities make the changes that need to happen in order to put the residents back into the center of the life of the nursing home.”

- Shawn Sullivan, Secretary, KDADS
How do Homes Get Involved?

This program coincides with the fiscal year calendar, July to June. The enrollment deadline is April 30th of each year. Homes must enroll (by following the instructions below) each year to participate. Homes may not enter the program mid-year. To enroll:

**Complete the following information by May 30th:**

1. Fill out the registration form and email it to ksucoa@gmail.com with the subject line: 2014-15 Enrollment.

2. Complete the KCCI instrument:
   - Six people in your organization (the administrator OR Director of Nursing, 2 CNAs, and 3 others of your choice) must complete the Kansas Culture Change Instrument electronically.
   - Please provide this link to the 6 people chosen to take it.
     https://kstate.qualtrics.com/SE/?SID=SV_1G3vCU0KKv2EDxb

Each person should fill out the survey independently. That means the responses of those taking the survey may be different. This is to be expected.

**NOTE:** Scores on the KCCI tool have NO impact on your placement in the PEAK 2.0 incentive levels. It is used as general information for the program and as an awareness tool for your organization.

You will receive a confirmation email when these two steps are complete and you are officially enrolled in the program.

Once enrolled, you will begin PEAK 2.0 activities July 1 of the enrollment year. If you are new to the program, you will spend the first year working on the “Foundation”, which involves a structured series of activities led by the PEAK team. (Refer to the “Timeline: The Foundation” for an outline of required activities of homes working on the Foundation.)

Why Get Involved?

Check out the following video to hear one home’s experience with PEAK 2.0.
http://www.he.k-state.edu/aging/outreach/peak20/
### Overview of Incentive Levels

<table>
<thead>
<tr>
<th>Level &amp; Per Diem Incentive</th>
<th>Summary of Required Nursing Home Action</th>
<th>State Action</th>
<th>Recognition</th>
<th>Incentive Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 0</strong></td>
<td>Home completes the KCCI evaluation tool according to the application instructions. Home participates in all required activities noted in “The Foundation” timeline and workbook. Homes that do not complete the requirements at this level must sit out of the program for one year before they are eligible for reapplication.</td>
<td>Contracts with KSU to provide feedback on the KCCI evaluation and The Foundation activities. Implements incentive payment for the enrolled fiscal year.</td>
<td>Certificate of Completion granted if all requirements for this level are completed.</td>
<td>Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year.</td>
</tr>
<tr>
<td>The Foundation</td>
<td>Contracts with KSU to provide feedback on the KCCI evaluation and The Foundation activities. Implements incentive payment for the enrolled fiscal year.</td>
<td>Certificate of Recognition for successful completion action plan goals and movement to level 2 incentive payment.</td>
<td>Available beginning July 1 of the enrollment year. Incentive granted for one full fiscal year.</td>
<td></td>
</tr>
<tr>
<td><strong>Level 1</strong></td>
<td>Homes should submit the KCCI evaluation tool (annually). Home submits an action plan addressing 4 PEAK 2.0 cores in Domains 1-4. The home self-reports progress on the action planned cores via phone conference with the PEAK team. The home may be selected for a random site visit. The home must participate in the random site visit, if selected, to continue incentive payment. Homes should demonstrate successful completion of 75% of core competencies selected. A home can apply for levels 1 &amp; 2 in the same year. Homes that do not achieve level 2 with three consecutive years of participation at level 1 must return to a level 0 or sit out for two years depending on KDADS and KSU’s recommendation.</td>
<td>Contracts with KSU to provide feedback on the KCCI, review action plans and provide feedback, and evaluate homes through self-report phone calls and random site visits. KSU will make recommendations to KDADS following evaluation of homes. KDADS will make final decisions regarding the distribution of homes’ incentive payment.</td>
<td>Available beginning July 1 following confirmed completion of action plan goals. Incentive is granted for one full fiscal year.</td>
<td></td>
</tr>
<tr>
<td>Pursuit of Culture Change</td>
<td><strong>Level 2</strong></td>
<td>Culture Change Achievement</td>
<td><strong>Level 3</strong></td>
<td>Culture Change Achievement</td>
</tr>
</tbody>
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# Overview of Incentive Levels

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<tr>
<th>Level &amp; Per Diem Incentive</th>
<th>Summary of Required Nursing Home Action</th>
<th>State Action</th>
<th>Recognition</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Level 3</strong> Person-Centered Care Home <strong>$2.00</strong></td>
<td>Demonstrates minimum competency as a person-centered care home (see KDADS full criteria). This is confirmed through a combination of the following: High score on the KCCI evaluation tool. Demonstration of success in other levels of the program. Performing successfully on a level 2 screening call with the KSU PEAK 2.0 team. Passing a full site visit.</td>
<td>KSU will screen homes via a phone conference with homes potentially eligible for level 3. KDADS and KSU will facilitate a full site visit to evaluate minimum competency in all PEAK 2.0 domains. KDADS will make final determination of movement to level 3.</td>
<td>Plaque to recognize the home as a person-centered care home.</td>
<td>Available beginning July 1 following confirmed minimum competency as a person-centered care home. Incentive is granted for one full fiscal year.</td>
</tr>
<tr>
<td><strong>Level 4</strong> Sustained Person-Centered Care Home <strong>$3.00</strong></td>
<td>Homes earn person-centered care home award two consecutive years.</td>
<td>Confirm achievement of person-centered care home status for two consecutive years. If so, KDADS applies level 4 incentive payment for two years.</td>
<td>Plaque to recognize the home as a sustaining person-centered care home.</td>
<td>Available beginning July 1 following confirmation of the upkeep of minimum person-centered care competencies. Incentive is granted for two fiscal years. Renewable bi-annually.</td>
</tr>
<tr>
<td><strong>Level 5</strong> Person-Centered Care Mentor Home <strong>$4.00</strong></td>
<td>Homes earn sustained person-centered care home award and successfully engage in mentoring activities suggested by KDADS (see KDADS mentoring activities). Mentoring activities should be documented.</td>
<td>Confirm achievement of sustained person-centered care home status. Reviews and confirms documentation of mentoring activities. Apply level 5 incentive payment for two years.</td>
<td>Plaque to recognize the home as a person-centered care mentor home.</td>
<td>Available beginning July 1 following confirmation of mentor home standards. Incentive is granted for two fiscal years. Renewable bi-annually.</td>
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## Timeline: The Foundation 2014-2015

<table>
<thead>
<tr>
<th>Date</th>
<th>Enrollment Deadline</th>
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| **April 30, 2014** | • Incentive payment begins.  
                      • Home receives email correspondence from the PEAK team to distribute instructions virtual Zoom meetings and to schedule training dates for the year.  
                      • Home participates in a technology test to prepare for 1st Zoom meeting. |
| **July**           | • Home participates in virtual Zoom meeting #1: Orientation to the program            |
| **August**         | • Home participates in virtual Zoom meeting #1: Orientation to the program            |
| **September**      | • Home participates in One Day Mentor Home Experiences (dates arranged with your input in July)  
                      • Assignment #1 distributed                                                      |
| **October**        | • Home participates in virtual Zoom meeting #2  
                      • Assignment #1 Due  
                      • Assignment #2 distributed                                                      |
| **November**       | • Home participates in virtual Zoom meeting #3  
                      • Assignment #2 Due  
                      • Assignment #3 distributed                                                      |
| **December**       | ——                                                                                   |
| **January**        | • Home participates in Action Plan and Leadership Training (dates arranged with your input in July)  
                      • Assignment #3 Due  
                      • Assignment #4 distributed (This assignment includes writing an action plan. The action plan readies your organization for work in the next fiscal year of PEAK 2.0.) |
| **February-March** | • Work on Assignment #4                                                              |
| **April**          | • Home participates in virtual Zoom meeting #4 (Discuss progress on assignment #4 and answer questions.) |
| **May 1st, 2015**  | • Home submits action plans to the PEAK team                                         |
### Timeline: Level 1 & 2

<table>
<thead>
<tr>
<th>April 30, 2014</th>
<th>Enrollment deadline for the home</th>
</tr>
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<tbody>
<tr>
<td><strong>May 1st, 2014</strong></td>
<td>• Action plan due to the PEAK team.</td>
</tr>
<tr>
<td></td>
<td>• Begin work on action plan anytime.</td>
</tr>
<tr>
<td><strong>July 2014</strong></td>
<td>• Incentive payment begins.</td>
</tr>
<tr>
<td></td>
<td>• PEAK team returns feedback on submitted action plan.</td>
</tr>
<tr>
<td><strong>August-April 2015</strong></td>
<td>• Home continues work on action plan.</td>
</tr>
<tr>
<td><strong>February &amp; March 2015</strong></td>
<td>• Home participates in a site visit OR phone evaluation. (PEAK team will notify home with instructions for the evaluation.)</td>
</tr>
<tr>
<td><strong>April 30, 2015</strong></td>
<td>• Evaluation results returned to homes with instructions for next steps</td>
</tr>
<tr>
<td></td>
<td>• Homes enroll for next PEAK year</td>
</tr>
<tr>
<td><strong>May 30, 2015</strong></td>
<td>• Action plan due to the PEAK team</td>
</tr>
<tr>
<td><strong>April-June 2015</strong></td>
<td>• Level 3 full site visits (for those that quality) conducted by the PEAK team</td>
</tr>
<tr>
<td><strong>July 2015</strong></td>
<td>• New PEAK 2.0 fiscal year begins</td>
</tr>
</tbody>
</table>

Correspondence about PEAK 2.0 will come primarily through email. Please be sure to keep the email contact for your home current.
Domain #0
The Foundation
Organizational Structure Supports Person-Centered Care

Core #1 Person-Centered Care Change Team
Representatives of all areas of the organization work together to guide planning and implementation of PCC.

SP #1 Team Selection & Training
- Stakeholders from all areas are active members of the PCC change team.
- Participate in 1-Day mentor home experience

SP #2 Team Organization and Focus
- PCC change team understands the group's purpose and vision.
- PCC change team recognizes and observes team expectations
- PCC change team has regular, productive meetings

Core #2 Person-Centered Care Education
The home supports and provides formal training opportunities on person-centered care.

SP #1 Person-Centered Care Training
- 90% of all staff receive person-centered care training using PEAK 2.0 materials
- 5% of staff receive person-centered care training outside the home.

SP #2 KDADS Criteria Training
- 75% of all staff receive KDADS criteria training using PEAK 2.0 materials.
Domain #0
The Foundation

Organizational Structure Supports Person-Centered Care

Core #3 Leadership Development
Enhance leadership skills to support staff empowerment.

Core #4 Work Team Development
A variety of stakeholders throughout the organization become directly involved in the PEAK 2.0 process.

**SP #1 Leadership Training**
- Members of the PCC change team participate in a regional one-day PEAK Leadership and Action Planning training.

**SP #1 Select 4 Cores**
- Stakeholders complete the core selection activity

**SP #2 Form Work Teams**
- Complete work team selection activity.
- Work teams are formed.

**SP #3 Action Plan Development**
- Work teams write action plan for each core area.
- Submit action plan to KSU/COA
- Begin work on action plan.
### Domain #1
**Resident Choice**
*Residents Direct Their Lives*

#### Core #1
**Food**
*Residents choose what, when, and where they eat.*

#### SP #1 What to Eat
- Enhanced dining program
  - Restaurant, buffet, family
- Menu options
- Resident input

#### SP #2 When to Eat
- Food available 24/7 on a self-serve basis
- Expanded meal times of hot food availability to reflect resident eating habits
- Access to special food requests

#### SP #3 Where to Eat
- Residents are involved in décor changes and decisions
- No assigned seats in dining room
- Multiple options in where to eat

#### Core #2
**Sleep**
*Residents’ individual sleep patterns are supported.*

#### SP #1 Individual Sleep Routines
- Individual sleep preferences are gathered/communicated/supported
- No group sleep or wake-up program
- Individual sleep routines/schedules are in place
- Consistent Staffing

#### SP #2 Undisturbed Sleep Practices
- Individualized night care
- Care provided around preferred sleep
- Reduced noise and lighting conducive to sleep
- Resident bed choice
Domain #1
Resident Choice

Residents Direct Their Lives

Core #3 Bathing
Bathing practices support individual choice.

Core #4 Daily Routines
Residents decide how they spend their day.

SP #1 Bathing Choice
- Information about bathing preferences is gathered.
- Multiple bathing options exist
- Residents have input in who assists them.
- Residents have choice in when and where they bathe
- Practices accommodate daily preferences.

SP #2 Bathing Alternatives
- Staff is trained on bathing alternatives
- Residents are supported in bathing alternatives

SP #1 Move in Assessment
- Gather information about routines and preferences PRIOR to move in.
- Caregivers have access to information.
- Caregivers support daily routine from day 1

SP #2 PCC Care Plan Development
- 90% of care plans are attended by residents (family)
- Residents (family) participate in creation of the care plan
- 90% of care plan meetings are attended by direct caregivers
- Direct caregivers participate in the creation of the care plan

SP #3 Care Plan Delivery
- All caregivers have direct access to care plan information
- Direct caregivers make revisions to care plans as directed by residents
- Daily routines are lived as outlined in the plan of care
Domain #2
Staff Empowerment

All Staff are Empowered to Support Resident

Core #1
Relationships

Residents enjoy meaningful relationships with a small group of consistently assigned caregivers.

SP #1 Get Small
- Defined physical locations
- No more than 30 residents live in each work area
- Necessary supplies/equipment available in each work area

SP #2 Consistent Staffing
- A staff schedule is developed for each work area (required)
- Staff are assigned to a team in a defined work area (required)
  Meet at least 2:
  - Versatile workers
  - No “scheduled” rotation
  - No “scheduled” agency staff
  - PRN staff are assigned to work areas

Core #2
Decision Making: Resident Care

The home supports resident decisions through a team approach.

SP #1 Shared Understanding
- Formal training on how to respond when residents make a risky decision.

SP #2 Access to Information and Resources
All team members have access to:
- Information about special health needs of each resident
- Access to contact information
- Access to transportation
- Access to resident funds

Kansas State University
Department for Aging and Disability Services
PEAK
Domain #2
Staff Empowerment

*All Staff are Empowered to Support Resident*

Core #3
Decision Making: Staff Work

*Traditional “top-down” hierarchy is replaced with self-led teams making decisions that affect their work.*

SP #1 Staff Scheduling
- Direct care (DC) staff are self-scheduling OR
- The scheduling process includes:
  - DC staff input is gathered for staffing plans
  - DC staff arrange own coverage
  - DC staff coordinate and negotiate time off with one another

SP #2 Hiring and Orientation Practices
- DC staff receive training on homes’ hiring practices
- DC staff involved in hiring process
- DC staff are involved in orientation of new staff

SP #3 Leadership
- The home has a central leadership team that includes DC staff representation
- Each work area has a leadership team that includes DC staff representation
- DC staff serve on work groups addressing issues throughout the home

Core #4
Career Development

*Systems are in place to promote professional development.*

SP #1 Professional Development
- Formal career ladder or skills enhancement program in place
- Versatile worker training opportunities

SP #2 Outside Education
- At least 10% of non-managerial staff attend outside training of any kind.
Domain #3
Home Environment

The Built Environment is Recognized as the Residents’ Home and Resident Comfort is Honored over Staff Convenience

Core #1
Resident Bedrooms

Bedrooms in the home provide opportunities for privacy, personalization and comfort.

SP #1 Privacy
- Arranged to promote privacy
- Boundaries are respected
- Regular trainings on privacy expectations

SP #2 Personalization
- Décor reflects preferences
- Choose paint color
- Bed & furniture choices are supported
- Policy in place to encourage personalization

SP #3 Self-care & Mobility
- Adaptations to promote self-care
- Free of barriers to mobility and self-care

Core #2
Resident Use Space

All spaces in the home are comfortable and accommodating.

SP #1 Private Space
- Space is available to host & receive family & friends
- Bathing areas provide privacy and dignity
- Space for solitude
- Boundaries are respected

SP #2 Self-care & Mobility
- Outdoor space is accessible
- Free of barriers to mobility and self-care
- Adaptations to promote self-care

SP #3 Institutional Elements
- Overhead paging turned off (used only in emergencies)
- Equipment and carts not left in halls
- Nurse stations are eliminated
Domain #4
Meaningful Life

Opportunities/ Assistance to Pursue a Purposeful Life

Core #1
Supporting the Human Spirit

Team members work together to discover and support what gives each resident meaning and pleasure.

SP #1 Day-to-Day Life
- Information is gathered about resident routines, preferences, and daily pleasures
- Information is available to DC staff
- Residents live individualized daily routines supported by PCC care plan
- Individual spiritual and cultural preferences supported
- Residents are honored when they pass on

SP #2 Planned and Spontaneous Activities
- Residents involved in planning formal activity schedules
- Residents involved daily in determining spontaneous activity

Core #2
Community Involvement

Opportunities to build and maintain existing connections.

SP #1 Internal Community
- Residents participate in chores
- Residents have opportunities to help others
- Residents contribute to community decisions
- Residents have opportunities to express preferences and concerns

SP #2 External Community
- Home gathers information about residents’ community connections
- PCC care plans address ways staff support community connections as desired by residents
- Outside community members are welcomed by the home
- Family and friends feel welcome
- Home engages in community projects/life
DOMAIN #0
THE FOUNDATION- The organizational structure supports person-centered care.

The Kansas State University Center on Aging has prepared a training program to help homes develop an organizational structure that supports person-centered care. This yearlong program contains activities and learning opportunities outlined in The PEAK 2.0 Foundation Workbook. Assignments mentioned in this domain can be found in the workbook.

(Note: Homes new to PEAK 2.0 and other select homes are required to complete The Foundation Workbook before advancing to other domains)

CORE #1
PERSON CENTERED CARE (PCC) CHANGE TEAM- Representatives from all areas of the organization work together to guide planning and implementation of person-centered care.

SUPPORTING PRACTICE #1
TEAM SELECTION AND TRAINING-The home establishes a person-centered care (PCC) change team and completes initial training.

OUTCOMES:
• Stakeholders from all areas of the organization are active members of the PCC change team.
• Four members of the PCC change team (at least one a direct caregiver) participate in PEAK 2.0 One-Day Mentor Home Experience.

BASIS FOR EVALUATION:
• Home completes and submits the worksheet for assignment #1 to the KSU/COA staff.
• Home processes the team selection activity (assignment #1) with KSU/COA staff at virtual meeting.
• Review of sign-up sheet for One-Day Mentor Home Experience.

SUPPORTING PRACTICE #2
TEAM ORGANIZATION AND FOCUS-The PCC change team develops mutually agreed upon team vision and expectations.

OUTCOMES:
• Team members understand the group purpose and vision.
• Team members recognize and observe team expectations when interacting with one another.
• Team has regular productive meetings.
BASIS FOR EVALUATION:
- Home completes and submits the worksheet for assignment #2 to KSU/COA staff.
- Home processes the vision activity (assignment #2) with KSU/COA staff at virtual meeting.
- Home completes and submits the worksheet for assignment #3 to KSU/COA staff.
- Home processes the expectation activity (assignment #3) with KSU/COA staff at virtual meeting.
- Submit meeting agendas and minutes from last three PCC change team meetings.

CORE #2
PERSON-CENTERED CARE EDUCATION- The home supports and provides formal training opportunities on person-centered care.

SUPPORTING PRACTICE #1
PERSON-CENTERED CARE TRAINING- All staff receive person-centered care training.

OUTCOMES:
- 90% of staff receive person-centered care training using PEAK 2.0 training materials and video.
- 5% of staff receive person-centered care training outside of home. (Not to include PEAK trainings)

BASIS FOR EVALUATION:
- Home completes and submits attendance form (assignment #4) to KSU/COA staff.
- Home submits copy of certificate of completion of outside trainings.

BASIS FOR EVALUATION:
- Home completes and submits attendance form (assignment #5) to KSU/COA staff.

CORE #3
LEADERSHIP DEVELOPMENT- Enhance leadership skills to support staff empowerment.

SUPPORTING PRACTICE #1-
LEADERSHIP TRAINING- Members of the PCC Change team will receive training on leadership concepts.

OUTCOMES:
- Members of the PCC Change team will participate in a regional one-day PEAK Leadership and Action Plan training session

BASIS FOR EVALUATION:
- Review sign-up sheet for minimum of four team members (at least one a direct caregiver) at regional one
CORE #4

WORK TEAM DEVELOPMENT- A variety of stakeholders throughout the organization become directly involved in the PEAK 2.0 process.

SUPPORTING PRACTICE #1

SELECT FOUR CORES- The organization invites all team members to participate in a selection activity to choose four core areas to address in the following year.

OUTCOMES:

- A variety of stakeholders will complete the Core selection activity (assignment #6).

BASIS FOR EVALUATION:

- Home submits the completed worksheet for the Core selection activity (assignment #6) to the KSU/COA staff.
- Home will process the completion of the Core selection activity (assignment #6) with the KSU/COA staff at a virtual meeting.

SUPPORTING PRACTICE #2-

FORM WORK TEAMS- Formal work teams will be organized to address each of the four selected cores.

OUTCOMES:

- The PCC Change team completes the work team selection activity (assignment #7).
- Work teams of 4-6 people including direct care staff and members of the PCC Change team are formed to lead the home through efforts to address each of the four selected core areas.

BASIS FOR EVALUATION:

- Home submits the completed worksheet for the work team selection activity (assignment #7) to the KSU/COA staff.

SUPPORTING PRACTICE #3-

ACTION PLAN DEVELOPMENT-The work teams develop an Action plan for each of the selected cores.

OUTCOMES:

- The PCC Change team works with each of the work teams to write an action plan for each core area.
- The PCC Change team submits an action plan for their home addressing four core areas to the KSU/COA.
- The work teams begin working through their action plans with the support of the PCC Change team.
- KSU/COA is available to homes as a resource as they work through action plans.

BASIS FOR EVALUATION:

- Home submits their action plan to the KSU/COA.
- KSU/COA will send home feedback on their plan.
DOMAIN #1
RESIDENT CHOICE- Residents direct their lives.

CORE #1
FOOD- Residents choose what, when and where they eat.

SUPPORTING PRACTICE #1
WHAT TO EAT- Menus include numerous options and are developed with on-going resident input.

OUTCOMES:
- An enhanced dining program to increase resident menu selection has been implemented. (Such as restaurant style, buffet, cook to order, family style, open dining or an equivalent option)
- Residents are involved with menu development on an on-going basis.

BASIS FOR EVALUATION:
- The home demonstrates that one or more of the enhanced dining programs or an equivalent option has been implemented.
- The home will be asked to describe how numerous food options are made available to residents.
- The home will be asked to describe formal systems for gathering resident menu input.
- The home may also be asked to provide sample menus.

SUPPORTING PRACTICE #2-
WHEN TO EAT- Food and drinks are available on a self-serve basis 24 hours a day and staff are empowered to provide food when a resident desires it.

OUTCOMES:
- A system to make food and drinks available to residents on a self-serve basis 24 hours a day has been implemented. (Such as snack bars/carts, open kitchens or an equivalent option)
- Meal times are expanded to be more flexible in offering hot meals and reflect resident eating habits.
- Residents are able to access special food requests, items not normally stocked by the home.

BASIS FOR EVALUATION:
- The home will describe the procedures related to 24-hour self-serve food and drink access.
- The home will describe the scheduled meal times for serving hot meals and how these times are determined.
- The home will describe how they handle special food requests.

SUPPORTING PRACTICE #3-
WHERE TO EAT- Resident preferences are reflected in the dining atmosphere and residents determine where they eat meals.

OUTCOMES:
- Residents are involved in decisions to change the dining room décor or arrangement and placement of dining room furniture.
- There are no assigned seats in the dining room.
- Multiple options in where to eat are available and residents are supported in eating where they are comfortable.
BASIS FOR EVALUATION:
• Homes will describe dining room enhancements made recently and how residents were involved in the changes. 
• Homes will describe how decisions are made around where people sit in the dining room. 
• Homes will describe practices around supporting residents in eating where they are comfortable outside of the dining room. 

CORE #2
SLEEP- Residents individual sleep routines are supported.

SUPPORTING PRACTICE #1-
INDIVIDUAL SLEEP ROUTINES- Residents wake, nap and go to bed when they choose. 

OUTCOMES:
• Residents individual preferences around sleep are gathered, communicated and supported by the home. 
• There are no group wake-up, nap or bedtime routines/schedules. 
• Individual sleep schedules are determined by each resident. 
• Consistent staffing is in place. 

BASIS FOR EVALUATION:
• Homes will describe how information about individual sleep routines is gathered and communicated to direct caregivers. 
• Samples of tools used to gather information from residents may be requested. 
• Direct caregivers will describe their morning and evening job responsibilities and routines. 
• Homes will describe systems that are in place that accommodate resident sleep preferences. (Such as flexible meal times, bathing schedule and liberalized medication administration) 
• Homes will describe their current staffing patterns and how assignments are made. 
• Sample schedules will be provided. 

SUPPORTING PRACTICE #2-
UNDISTURBED SLEEP PRACTICES- Residents enjoy restful, undisturbed sleep.

OUTCOMES:
• Residents receive individualized night care to support restful sleep. 
• Resident care is provided around residents preferred sleep routine. 
• Noise at night is reduced and lighting is conducive to restful sleep. 
• Residents have choice of the bed they sleep in. 

BASIS FOR EVALUATION:
• Home will describe how nighttime care needs are assessed. 
• Homes will provide the tools used to assess nighttime care needs. 
• Homes will provide sample individualized night care plans. 
• Direct caregivers will describe night job responsibilities and routines. 
• Homes will describe their practices around reducing disruptive noise and light.
CORE #3
BATHING- Bathing practices support individual choice.

SUPPORTING PRACTICE #1-
BATHING CHOICE- Residents have choice in how, when and where they bathe as well as who assists them with bathing.

OUTCOMES:
• Information about resident bathing preference is gathered on an ongoing basis.
• There are multiple bathing options.
• Residents have input in who assists them with bathing.
• Residents choose when and where they bathe.
• Bathing practices accommodate the daily preferences of residents.

BASIS FOR EVALUATION:
• Homes will describe how they gather information about resident bathing preferences.
• Samples of tools used to gather resident bathing information may be requested.
• Direct caregivers will describe the bathing options available to residents.
• Direct caregivers will explain how they decide who will assist each resident with bathing.
• Direct caregivers will describe how bathing practices accommodate the daily resident preferences in when and where baths are taken.

SUPPORTING PRACTICE #2-
BATHING ALTERNATIVES- Residents are offered alternative bathing options.

OUTCOMES:
• Staff are trained in bathing alternatives. (Such as “Bathing Without a Battle” or an equivalent option)
• Residents are supported in alternative bathing options.

BASIS FOR EVALUATION:
• The home will provide samples of the training curriculum used to train staff on bathing alternatives.
• The home will provide attendance records of the bathing alternative trainings.
• The home will describe how staff training on alternative bathing practices will be maintained.
• The home will provide copies of individual resident care plans that include bathing alternatives as an approach.
CORE #4
DAILY ROUTINE- Residents decide how they spend their day.

SUPPORTING PRACTICE #1
MOVE-IN ASSESSMENT- Residents will continue to live their personal daily routine when they move in.

OUTCOMES:
- Information is gathered about daily routines and preferences PRIOR to the resident moving in (at the time of move in for emergency situations).
- Caregivers have access to information and preferences PRIOR to the resident moving in (at the time of move in for emergency situations).
- Caregivers support personal daily routines and preferences from day one.

BASIS FOR EVALUATION:
- Homes will describe how they gather information about personal routines and preferences before residents move into the home.
- Sample of tool used to gather this information will be provided.
- Homes will describe how this information is made available to caregivers.

SUPPORTING PRACTICE #2
PERSON CENTERED CARE PLAN DEVELOPMENT- Residents, family and caregivers collaborate to develop a plan of care that is based on each individual’s personal daily routine and preferences.

OUTCOMES:
- 90% of care plan meetings are attended by a resident (family members or designated decision makers may represent a resident at the resident’s request or if the resident is unable to communicate in any way).
- Residents or family members participate in the creation of the individualized plan of care.
- 90% of care plan meetings are attended by a direct caregiver.
- Direct caregivers participate in the creation of the individualized plan of care.

BASIS FOR EVALUATION:
- Homes will describe the process used to invite and encourage resident and family involvement in the care plan process.
- Homes will describe how they support direct caregivers to attend and participate in care plan meetings.
- Review of Care plan attendance records.
SUPPORTING PRACTICE #3
CARE PLAN DELIVERY- Residents live a daily routine of their choice supported by a person-centered plan of care.

OUTCOMES:
- All caregivers have direct access to care plans and information about resident preferences.
- Systems are in place for direct caregivers to make on-going revisions to care plans as directed by residents.
- Daily routines are lived as outlined in the person-centered plan of care.

BASIS FOR EVALUATION:
- Homes describe the process used make care plan information available to care teams.
- Homes describe the process used to revise care plans to reflect current resident preferences.
- Homes provide copies of sample resident care plans.
- Homes will describe how they assure residents are living their preferred daily routines.

DOMAIN #2
STAFF EMPOWERMENT- All staff are empowered to support resident choices and make decisions about their own work.

CORE #1
RELATIONSHIPS- Residents enjoy meaningful relationships with a small group of consistently assigned caregivers.

SUPPORTING PRACTICE #1
GET SMALL- The team identifies small areas of the home as work areas.

OUTCOMES:
- Work areas are defined by specific physical locations.
- No more than 30 residents live in each area.
- Necessary supplies and equipment are convenient and available in each work area.

BASIS FOR EVALUATION:
- Review of map outlining specific physical locations of each work area and number of residents who live there.
- Home describes how supplies and equipment are reallocated to support each work area.

SUPPORTING PRACTICE #2
CONSISTENT STAFFING- Teams are identified to consistently support people living in each work area.

OUTCOMES:
- A staff schedule is developed for each work area. (required)
- Team members are assigned to a team in a defined work area. (required)

OPTIONS:
- Versatile workers are assigned in each area.
- There is no “scheduled” staff rotation between work areas.
- There is no “scheduled” agency staffing.
- PRN staff are recruited and designated for each work area.
**BASIS FOR EVALUATION:**
- At least 2 of the 4 options and both required outcomes must be met.
- Homes will provide samples of staff schedules for each work area.
- Review various job descriptions.
- Direct caregivers will explain their job duties.

**CORE #2 DECISION-MAKING/RESIDENT CARE** - The home supports resident decisions through a team approach.

**SUPPORTING PRACTICE #1 SHARED UNDERSTANDING** - Team members are prepared and expected to support resident decisions.

**OUTCOMES:**
- The home provides formal training to all team members on what to do when a resident makes a risky decision. (The training must include the position of the organization as it relates to decision making when the choice of the resident may not be in agreement with policy, may pose risk to the resident, or does not agree with the caregivers’ personal value set.)

**BASIS FOR EVALUATION:**
- Review of training outline used by the home.
- Review of attendance records maintained for the training.
- Home will explain how they plan to keep new employees trained.

**SUPPORTING PRACTICE #2 ACCESS TO INFORMATION AND RESOURCES** - Team members have direct access to information and resources to support resident decisions.

**OUTCOMES:**
- All team members have access to information about special health needs of each resident in their work area.
- Direct care staff have access to contact information and facilitate communication between residents and their support systems.
- Staff have access to transportation as needed to support residents.
- Staff have access to petty cash or resident funds to support resident requests.

**BASIS FOR EVALUATION:**
- Direct caregivers explain how they access special health needs information of residents.
- Direct caregivers explain how family contact and communication is handled.
- Direct caregivers describe transportation options available to them.
- Direct caregivers describe transportation options available to them.
CORE #3
DECISION MAKING/STAFF WORK - The traditional “top-down” hierarchy is replaced with self-led teams making decisions that affect their work.

SUPPORTING PRACTICE #1
STAFF SCHEDULING - Direct care staff are actively involved in staff scheduling.

OUTCOMES:
- Direct care staff participate in self-scheduling OR
  The scheduling process includes the following three outcomes:
    1. Direct care staff input is gathered for staffing plans.
    2. Direct care staff arrange coverage when they are unable to work.
    3. Direct care staff coordinate and negotiate time off with one another.

BASIS FOR EVALUATION:
- Homes will describe their scheduling process.
- Direct care staff will explain how they have input into the scheduling process.
- Direct care staff will explain how they handle call-ins and arrange time off.

SUPPORTING PRACTICE #2
STAFF HIRING AND ORIENTATION - Direct care staff are involved in selecting and training new staff members.

OUTCOMES:
- Direct care staff receive training on the homes hiring practices
- Direct care staff are involved in the selection process of all new hires.
- Direct care staff are responsible for portions of the orientation of new employee.

BASIS FOR EVALUATION:
- Review training outline used by the home.
- Review attendance records maintained by the home.
- Direct caregivers will explain how they are involved in new hires and the orientation process.

SUPPORTING PRACTICE #3
LEADERSHIP - Direct care staff participate in leadership throughout the organization.

OUTCOMES:
- Direct caregivers are actively involved in the homes central leadership team.
- Direct caregivers serve on leadership teams in each work area of the home.
- Direct caregivers serve on various work groups addressing issues throughout the home.

BASIS FOR EVALUATION:
- Home provides the name and role of members of various teams throughout the home to demonstrate involvement.
- Review meeting attendance records maintained by the home to verify participation.
CORE #4
CAREER DEVELOPMENT- Systems are in place to promote professional development.

SUPPORTING PRACTICE #1
PROFESSIONAL DEVELOPMENT- Formal opportunities are provided for staff to develop professionally.

OUTCOMES:
- A formal career ladder or a skills enhancement program is in place.
- In-house training is available for versatile workers to learn new job duties and skills outside their traditional roles.

BASIS FOR EVALUATION:
- Review of formal Career Development policy.
- Home will describe how staff are made aware of opportunities available to them.

SUPPORTING PRACTICE #2
OUTSIDE EDUCATION- Opportunities are provided for non-managerial staff to attend outside training.

OUTCOMES:
- 10% of non-managerial staff attend outside training of any kind (in past year)

BASIS FOR EVALUATION:
- Home submits copy of certificates of completion for outside training.

DOMAIN #3
HOME ENVIRONMENT- The built environment in the home is recognized as the resident’s home and resident comfort is honored over staff convenience in the workplace.

CORE #1
RESIDENT BEDROOMS- Bedrooms in the home provide opportunities for privacy, personalization and comfort.

SUPPORTING PRACTICE #1
PRIVACY- The sanctity of home is acknowledged and respected by all.

OUTCOMES:
- Rooms are arranged to promote privacy
- Staff recognize boundaries and are respectful of resident space.
- Staff receive regular training on privacy expectations.

BASIS FOR EVALUATION:
- Home will describe room arrangements that have been made to promote privacy.
- Direct care staff explain their practices around resident privacy.
SUPPORTING PRACTICE #2
PERSONALIZATION- *Residents are encouraged and actively assisted in creating personalized space.*

OUTCOMES:
- Room décor reflects resident preferences.
- Residents have ability to choose paint color.
- Bed and furniture choices are supported.
- Policy is in place to encourage personalization of resident rooms.

BASIS FOR EVALUATION:
- A minimum of two outcomes must be addressed.
- Home will describe their efforts to assist residents with personalization.
- Review formal policy on personalization of resident space.

SUPPORTING PRACTICE #3
SELF-CARE AND MOBILITY- *The environment is adapted to promote self-care and mobility.*

OUTCOMES:
- Adaptations are made to promote self-care.
- Rooms are free of barriers to mobility and self-care.

BASIS FOR EVALUATION:
- Homes will describe their efforts to promote self-care and mobility in resident rooms.

CORE #2
RESIDENT USE SPACE- *All spaces in the home are comfortable and accommodating.*

SUPPORTING PRACTICE #1
PRIVATE SPACE- *Private space is available for resident use.*

OUTCOMES:
- Space is available to host and receive family and friends.
- Bathing areas provide privacy and dignity.
- There is space available for solitude.
- Boundaries are respected by staff in these spaces.

BASIS FOR EVALUATION:
- Homes will describe the spaces available to residents to entertain friends and family.
- Homes will describe how privacy is handling in bathing areas.
- Homes will describe their practices and boundaries around entering social areas when in use by residents.
SUPPORTING PRACTICE #2
SELF-CARE AND MOBILITY- *The environment is adapted to promote independence.*

**OUTCOMES:**
- Outdoor space is accessible and available to residents at all times.
- Resident use space is free of barriers to mobility and self-care.
- Adaptations have been made to promote self-care.

**BASIS FOR EVALUATION:**
- Homes will describe the outdoor space that is available to residents.
- Homes will describe the efforts they have made to support independence in resident use spaces.

SUPPORTING PRACTICE #3
INSTITUTIONAL ELEMENTS- *Key institutional elements have been eliminated.*

**OUTCOMES:**
- Overhead paging has been turned off and used only in emergencies.
- Equipment and carts are not left in hallways.
- Nurse stations have been eliminated.

**BASIS FOR EVALUATION:**
- Home will report what has been done to eliminate overhead paging.
- Home will describe how equipment storage is handled.
- Home will report what has been done to change nurse stations.

DOMAIN #4
MEANINGFUL LIFE- *Residents have opportunities and receive assistance in the continued pursuit of purposeful life.*

CORE #1
SUPPORTING THE HUMAN SPIRIT- *Team members work together to discover and support what gives each resident meaning and pleasure.*

SUPPORTING PRACTICE #1
FREE TIME- *Residents determine how their leisure time is spent each day.*

**OUTCOMES:**
- Information is gathered about resident routines, preferences and personal pleasures.
- Information about resident leisure preferences is shared with direct caregivers.
- Residents live individualized daily routines supported by a person-centered care plan.
- Individual spiritual and cultural preferences are supported and accommodated.
- Residents are honored when they pass on.
BASIS FOR EVALUATION:
- Homes describe how information is gathered and shared with staff.
- Review of tools used to gather information.
- Review of sample care plans that address daily routines and leisure preferences.
- Homes describe how they support spiritual/psychosocial preferences.
- Homes describe their practices around honoring residents at the time of their death.

SUPPORTING PRACTICE #2
PLANNED AND SPONTANEOUS ACTIVITIES- *Individual and group activities reflect the interests of current residents.*

OUTCOMES:
- Residents are involved in planning formal activity schedules.
- Residents are involved daily in determining spontaneous activity.

BASIS FOR EVALUATION:
- Homes describe the process used to plan formal activity schedules.
- Homes will give examples of spontaneous activity that has involved residents.

CORE #2
COMMUNITY INVOLVEMENT- *Opportunities are available to build new and maintain existing connections.*

SUPPORTING PRACTICE #1
INTERNAL COMMUNITY- *Residents have opportunities to be contributing members in the home.*

OUTCOMES:
- Residents participate with chores or tasks as they desire.
- Residents have opportunities to help others.
- Residents contribute to community decisions through formal decision making processes.
- Residents have regular opportunities to express preferences and concerns.

BASIS FOR EVALUATION:
- Homes describe opportunities residents have to contribute to the home in meaningful ways.
- Homes provide examples of how residents help others.
- Homes describe how residents are involved in decisions about day to day life in the home.
- Homes describe formal opportunities that exist for residents to voice their opinions, concerns and preferences.
SUPPORTING PRACTICE #2
EXTERNAL COMMUNITY - *Residents have opportunities to remain active members of the broader community.*

OUTCOMES:
- Home gathers information about resident’s current community connections.
- Care plans address ways staff support connections as desired by the residents.
- Outside community members and groups are welcomed by the home.
- Family and friends feel welcome in the home.
- Home engages in community projects and life outside the home in the surrounding community. (e.g. community projects, civic organizations, festivals and fairs)

BASIS FOR EVALUATION:
- Homes describe how they gather information about resident’s current community connections.
- Review tool used to gather this information.
- Home provides specific examples of outside community members being welcomed by the home.
- Home describes things they do to make visitors feel welcome.
- Home describes opportunities that residents have to be involved in life outside the home in the surrounding community.
Caleb’s Basket

The image used in this material represents the metaphor of Caleb’s basket. This metaphor helps us remember why person-centered care is important to elders in Kansas. The “Person-Centered Care Training” video found on the PEAK 2.0 website explains the metaphor in detail. The metaphor of Caleb’s basket comes from a story told by Bill Thomas in his book *Learning from Hannah: Secrets for a Life Worth Living*. This story has been told in various forms in many different contexts. The origins of the story are unknown. Bill Thomas helped us connect the metaphor to elders in long-term care.

Person-Centered Care Resources

Person-centered care is a journey. There are lots of resources available to help inform your journey. The PEAK 2.0 webpage has a link dedicated to person-centered care resources. The resources feature a 47-minute person-centered care training video that may be used to train all staff in your home. In addition, there are resources on each of the PEAK 2.0 domains.

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