

# Engagement and Adoption of Person-Centered Care

## Participant Experiences in the Kansas PEAK 2.0 Program

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### ABSTRACT

The Promoting Excellent Alternatives in Kansas (PEAK) 2.0 program provides training, evaluation, and support in person-centered care (PCC) for nursing homes across Kansas. To represent the participant voice, nursing home employees ( $N = 141$ ) provided feedback on their experiences and their home's level of engagement in PEAK 2.0 as well as achievement of PCC adoption. Analyses were conducted to capture the positive/negative valence and specificity of their comments and examine how engagement in PEAK 2.0 relates to the process and outcome of PEAK 2.0. Qualitatively, staff participants demonstrated that PEAK 2.0 is viewed positively overall, with approximately twice as many participants with more positive (e.g., community support, satisfaction with resources) than negative (e.g., over-regulation, too structured) comments. Employees reporting moderate engagement in PCC provided the majority of specific suggestions for improvement. In addition, higher levels of engagement were significantly associated with higher levels of PCC achievement. Based on these results, suggestions are offered to enhance nursing staff experiences and engagement that will help support PCC adoption. [*Journal of Gerontological Nursing*, 45(11), 5-10.]



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Person-centered care (PCC) in long-term care (i.e., culture change movement) began in the 1980s with multiple initiatives calling for improved conditions in nursing homes around quality of life and quality of care (Koren, 2010). It is widely acknowledged that PCC is

meant to be comprehensive in nature rather than limited to individual components or practices (Zimmerman, Shier, & Saliba, 2014). Benefits to resident quality of life (Poey et al., 2017) and health (Hermer et al., 2018) occur primarily after PCC is thoroughly, rather than partially, adopted. Despite

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*The authors have disclosed no potential conflicts of interest, financial or otherwise.*

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*doi:10.3928/00989134-20191011-02*

**TABLE 1****DESCRIPTIVE STATISTICS OF NURSING HOMES OF PROMOTING EXCELLENT ALTERNATIVES IN KANSAS (PEAK) 2.0 PARTICIPANTS**

Variable	n (%)
PEAK 2.0 level	
Foundation	28 (22.2)
Level 1	28 (22.2)
Level 2	46 (36.5)
Level 3 to 5	24 (19.1)
Length of time in program	
1 year	24 (17.1)
2 years	12 (8.6)
3 years	45 (32.1)
Since origination	45 (32.1)
Off and on	14 (10)
Nursing home level of engagement in PCC	
0 to 25%	32 (22.9)
26% to 50%	40 (28.6)
51% to 75%	34 (24.3)
76% to 100%	34 (24.3)
Profit status	
Not-for-profit	86 (62.3)
For-profit	52 (37.7)
Size (no. of residents)	
<60	81 (58.3)
60 to 90	27 (19.4)
>90	31 (22.3)

*Note.* Percentages based on total number of responses per item.

efforts to promote such changes, the long-term care community has been slow to adopt deep organizational changes to support PCC practices (Miller et al., 2014).

The Promoting Excellent Alternatives in Kansas (PEAK) 2.0 program began in 2012 as a tiered payment structure to incentivize nursing homes in Kansas to implement PCC (Poey et al., 2017). Participating homes are provided with training and education about PCC, and a structured, external evaluation process is used to determine each home's PCC level annually (Doll, Cornelison, Rath, & Syme, 2017).

This process allows for uniformity in the definition and implementation of PCC, a gap previously found in the literature (Poey et al., 2017). PEAK outcome studies have provided evidence that PCC improves satisfaction with quality of life and clinical quality of care (Hermer et al., 2018; Poey et al., 2017); however, little is known about the experience of the program from participants' point of view.

Participants in the PEAK 2.0 program (i.e., employees of enrolled nursing homes) are called on to implement the deep organizational change required for PCC adoption, and in

turn, to achieve the subsequent benefits to residents. However, deep organizational change is often reported as a difficult task for employees and organizations to accomplish (Mauer, 2010). It is important to identify the experiences, benefits, and challenges of PEAK 2.0 participants that lead to overall positive experiences and successful outcomes (i.e., PCC achievement).

In addition, the level of nursing home engagement (i.e., the percentage of employees engaged in PCC implementation) in the PEAK 2.0 program may add to or take away from the experience. In organizational research, participation or employee engagement is reportedly related to successful implementation of strategic change, and high engagement reduces employee resistance to organizational change (Lines, 2004). Taken together, engagement at all levels of the organization may be key in the participant/employee experience of PEAK 2.0 (process) and advancing PCC implementation (outcome) in long-term care.

The purpose of the current study was to understand PEAK 2.0 participant (i.e., nursing staff) experiences, providing insight into the benefits and challenges of PCC adoption from the nursing home point of view. Further, given the importance of engagement in adopting deep change, relationships between nursing home engagement and (a) participant experiences (process) and (b) achievement of PCC (outcome) were assessed.

## METHOD

### Participants

Participants were 141 nursing facility staff—at various levels of training and tenure—from nursing homes in Kansas participating in the PEAK 2.0 program during the 2016-17 program year. **Table 1** provides the descriptive sample characteristics.

### Measures

The study used a 29-question survey. Responses to six close-ended questions were extracted for descrip-

**TABLE 2**

**DESCRIPTION OF QUALITATIVE PROGRAM FEEDBACK CATEGORIES**

Label (Category)	Description	Example
Positive valence	Comment provided had an overall positive tone	"This program has given our facility a lot of new ideas and different ways to look at how to make our facility different and better for our residents..."
Negative valence	Comment provided had an overall negative tone	"Has not really helped us because sometimes we get caught up in the focus on the parts of the program instead of the residents' needs..."
Specific suggestion	Specific suggestion for improvement of the program	"Mentor home visits regularly..."
Specific challenge	Specific challenge or barrier experienced with the PEAK 2.0 program	"The failure comes at the facility level executing the action plans and that's not something the PEAK team can control. It's super frustrating because you have the plans and absolute chaos of operating a nursing home on a daily basis happens and the PEAK goals go to the back burner..."

Note. PEAK = Promoting Excellent Alternatives in Kansas.

tive and quantitative analysis of nursing home participants and their reported engagement. Sample items included, "What level is your home currently at in the PEAK 2.0 program?" and "What percentage of staff in your organization have had an active role in your PEAK 2.0 participation?" Responses to six open-ended questions were extracted and coded for qualitative analysis of participant experiences, both the overall valence (positive vs. negative) of the comments and specificity (suggestions for improvement and challenges). Sample items included, "Tell us how the program has either aided or hindered your implementation of person-centered care," and "What suggestions for improvements to the program do you have?"

**Procedures**

The self-report feedback survey was e-mailed from program staff to all nursing homes participating in PEAK 2.0 during the 2016-17 year (*N* = 197), with a request for any program staff to complete and return. A total of 141 participants returned the

online survey, resulting in a convenience sample.

**Coding and Analyses**

The experiences of PEAK 2.0 participants were assessed at the process level (qualitative feedback) and outcome level (quantitative responses). Sixty-nine (49%) of 141 participants provided any form of comments to the survey. For process-level qualitative analysis, two research assistants were trained and subsequently coded responses for their overall valence (positive vs. negative comments related to PEAK 2.0 experience) and specificity (specific suggestions for improvement, specific challenges experienced as part of the program) (Table 2). For valence, each comment regarding experience of the program was coded as either positive or negative. Frequency counts of each type were converted into a percent of positive to negative comments (number of positive comments/total number of comments). This calculation indicated the overall valence of each participant's comments and resulted in two types: (a) overall posi-

tive valence and (b) overall negative valence. For specificity, each comment was separately coded for the number of specific suggestions and specific challenges provided. The coded data were also considered in context of participants' reported level of nursing home engagement in PEAK 2.0 by examining the dispersion of positive/negative valence and specificity across reported nursing home engagement levels.

Quantitative analysis of the relationship between outcome (i.e., achievement of PCC or level in PEAK 2.0 program) and reported engagement was also performed with a Kendall's Tau correlation and chi-square test, with odds ratio calculations. The outcome variable, PEAK 2.0 program level, was recoded from six levels (Foundation through Level 5) into four meaningful groups: Foundation, Level 1, Level 2, and Level 3 to 5. Levels 3 to 5 were consolidated, as they have all achieved PCC across all core program requirements, with time sustaining full adoption being the only varying component.

## RESULTS

### Engagement and PEAK 2.0 Process

Participants' experiences were categorized by valence and specificity. In terms of valence, approximately twice as many PEAK 2.0 participants (65.2%) reported more positive than negative comments about the program. Participants who were the least engaged (0% to 25% category) provided the fewest valence comments.

Participants' positive comments described appreciation for the resources and materials, a venue to obtain support for a goal their organization already had, an incentive to keep going, and found value in how the program simplified a complex concept into a more manageable process. One participant reported, "We had worked on person-centered care

is too structured, criticisms of lack of PEAK staff experience, frustration with regulations, a dislike of the evaluation process, and reports of too much paperwork. One participant commented, "There are a lot of steps involved in getting the program up and running." Another participant commented, "The phone consultation just didn't do it for us because she was suggesting things we felt like we have already accomplished." **Table 2** provides additional examples. Taken together, these comments highlight areas where the program creates frustration and informs areas of potential improvement.

Participants across all engagement levels reported specific comments about the program and noted challenges to achieving PCC through the

portant to get a sense of what barriers nursing homes perceive in achieving success in the program. "Right now with the changes in CMS [Centers for Medicare & Medicaid Services] regulations and Life Safety requirements, providers have many areas of concentration to change." These illustrated concrete barriers help inform PEAK administrators on how to address providers' unique and important needs and also empathize with their situations.

### Engagement and PEAK 2.0 Outcome

The relationship between reported engagement in PEAK 2.0 and achieved PCC level of participants' nursing homes was examined using a Kendall's Tau correlation (Field, 2009). As hypothesized, higher levels of engagement were significantly related to higher levels of PCC ( $\tau = 0.40$ ,  $p < 0.001$ ). A chi-square comparison tested the in/dependence of engagement and PCC level, indicating a significant association between the two ( $\chi^2[9] = 32.498$ ,  $p < 0.001$ ). Further, the results of odds ratio analysis suggest that if a nursing home is reported to be at the highest level of engagement (76% to 100%) with PEAK 2.0, they are 84.5 times more likely to be at the highest level of PCC achievement than if they had been at the lowest engagement (0% to 25%). Taken together, these results provide promising evidence of the importance of organizational engagement in PEAK 2.0 in the achievement of PCC.

## DISCUSSION

Although PEAK 2.0 has demonstrated the ability to enhance resident satisfaction with quality of life and clinical outcomes (Hermer et al., 2018; Poey et al., 2017), participant voices have received little attention. The current research highlights their experiences with the program, implementing PCC, and how their reported level of organizational engagement influences their experience of PEAK 2.0 and ultimately their organiza-

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for many years and had not been successful, but when we became involved in PEAK, we finally have the right tools." Another participant stated, "This program is continually driving us to strive for more improvements. We have found that the staff empowerment piece to PCC has helped drive the ideas and initiatives to being successful." This particular comment highlights the synergy of engagement and advancing in the program levels. As they engaged more staff through staff empowerment, this participant noted more ideas and momentum in moving forward with PCC. **Table 2** provides additional examples.

Participants' negative comments described feelings that the program

PEAK 2.0 program. Of note, participants in the 25% to 50% engagement category provided the most specific suggestions (42.9%). Overall themes included: desire for more assistance with action planning, more in-person interaction, increased opportunities to visit nursing homes performing well in PEAK, and resources noting best practices in PCC. One participant reported "more one-on-one interaction" would help him/her. Another participant said, "It could be helpful to have more information on what other facilities have done to implement PCC. We don't need flowery stories on their success, just what they did. Pictures of changes in environment would be nice." Specific challenges were im-

tion's level of PCC adoption. These voices are valuable for program staff to develop empathy for participants' unique challenges, inform specific areas in which the program can be improved, and validate the effectiveness of engagement as key to the success of quality improvement efforts critical in quality nursing practice.

### **Engagement and PEAK 2.0 Process**

Overall, participant voices show more positivity toward the program than negativity. Those positive experiences may serve to support and advance PCC on a larger scale as participants share their experiences with others. Positive experiences also provide evidence that PEAK 2.0 is not only achieving improved resident outcomes (Hermer et al., 2018; Poey et al., 2017), but the majority of nursing home employees in the program perceive it to be positive.

The story told by participants also assigns meaning to their experiences. Positive comments tell a story of feeling supported in a challenging task by having access to resources/tools, connections with other nursing homes on the path to change, and communication with PEAK staff. For instance, at a recent training, several nurse leaders and direct care staff from multiple nursing homes noted a challenge with eliminating the practice of transporting highly dependent residents to bathing areas in a shower chair covered in a bath blanket. Nurse leaders and direct care staff from nursing homes that have eliminated the practice shared how they are able to avoid this practice. They suggested different products and techniques and brainstormed with the other nursing home employees. All involved noted this as a major benefit to involvement in the program.

Negative comments demonstrated frustration and lack of utility of program details and expectations, such as paperwork. In some cases, negativity reflected lack of understanding about resources available through the program. This lack of understanding highlights potential gaps in under-

standing and opportunity for improved communication by PEAK staff and greater access to resources. These perspectives are pivotal in understanding what fuels negative valence toward the program, exploring what can be changed for improvement, and having empathy toward participants' lived experiences. Engagement may affect these stories, in that those who are the least engaged also provide the shallowest narrative (i.e., fewest comments). This finding suggests that higher investment in the program may create more freedom or need for employees to provide feedback. The challenge for program staff is to find ways to encourage feedback for those just beginning to engage, who are also at highest risk for dropout.

Specific comments and challenges noted are essential in understanding where participants see gaps and can inform future directions and maintain the relevance of PEAK 2.0. Rather than program staff making informed guesses, the survey revealed concrete ideas to help improve the program. For instance, as suggested, in-person action plan review instead of written feedback is being considered as a future option. In addition, audit tools were developed based on participants requesting ways to help sustain practices. This response to participant feedback underscores the value of program evaluation and leveraging participant voices in program administration.

Participants from nursing homes that were moderately engaged (26% to 50%) provided the majority of the specific suggestions, indicating that those past the initial buy-in phase (0% to 25%) are forming and/or reporting the most insights about how to best use the program. A focus group with individuals from nursing homes at this level may be useful, as they are in that "sweet spot" of engagement where they have bought-in, but are still learning what resources and tools will best support them in PCC adoption.

### **Engagement and PEAK 2.0 Outcomes**

The association found between high engagement and higher levels of PCC is consistent with research on organizational change and beneficial outcomes (Brown & Cregan, 2008; Lines, 2004). However, nursing homes are often characterized as organizations with rigid hierarchical structures, where decision making is reserved for those at the top of the hierarchy. This authoritarian structure disincentivizes participatory decision making and high engagement, thus placing many nursing homes at a disadvantage when attempting PCC implementation, and as the current study suggests.

The current study reinforces the practical nature of enhancing engagement to help advance PCC adoption for nursing homes. Program staff can develop tools and focus on resources that enhance employee engagement, thus addressing specific engagement challenges cited by nursing home employees (e.g., staff resistance to change, difficulty getting started, fear of change). The experiences of PEAK 2.0 participants suggest these will be integral tools for PEAK 2.0 staff and those developing and refining PCC programs aimed at deep organizational change.

### **LIMITATIONS**

The current study used a convenience sample of participants in PEAK 2.0, which may affect the generalizability of these results to all PEAK 2.0 participants. In addition, the survey was anonymous; thus, researchers were unable to track the number of unique homes represented. However, the descriptive statistics of each participant's nursing home are available to describe the overall sample. Small sample sizes precluded the use of more predictive statistical analyses, and a larger sample would allow for future studies on the predictive role of engagement in the process and outcome of PEAK 2.0. Finally, the measure of engagement was limited by the survey

responses to four different categories. A continuous measure of engagement would provide more variability and allow for more nuanced assessment of engagement thresholds.

## IMPLICATIONS FOR PRACTICE AND POLICY

The current study underscores the value of high staff engagement when implementing PCC. The challenge is to create a culture of engagement wherein nursing staff feel supported, surrounded by culture change, and are active participants in the feedback loop. Ongoing training and support for care teams should include tools and resources to increase engagement of all nursing staff. One example from PEAK 2.0 is team action planning, conducted in teams with expert guidance—a product from qualitative feedback from this study. Overall, the current study shows the importance of feedback and valuing participant voices (i.e., nursing staff) as well as

team engagement for successful implementation of PCC.

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