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Actualizing Culture Change: The Promoting Excellent Alternatives in Kansas Nursing Homes (PEAK 2.0) Program

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Nursing homes have been challenged in their attempts to achieve deep, organizational change (i.e., culture change) aimed at providing quality of care and quality of life for nursing home residents through person-centered care. To attain deep change, 2 well-defined components must be in place: a shared understanding of (a) the what, or content goals, and (b) the how, or process of change. However, there are few examples of this at a macro or micro level in long-term care. In an effort to enact true culture change in nursing homes statewide, the Kansas Department for Aging and Disability Services implemented the Promoting Excellent Alternatives in Kansas Nursing Homes program. This program is a Medicaid, pay-for-performance program that formalizes the content and process of achieving culture change through person-centered care principles. This article aims to detail the content (what) and process (how) of a model macro-level program of culture change throughout the State of Kansas. Applications to the micro level (individual homes) are presented, and implications for psychologists' roles in facilitating culture change are discussed.

Keywords: culture change, nursing home, organizational change, person-centered care, pay-for-performance

Recent efforts to shift toward quality care and quality of life for nursing home residents have been called culture change. This has proven to be a challenging process, because nursing homes have been attempting to achieve deep, organizational change. Over the past 20 years or more this movement has been built around *innovations,* a term that implies changes that are mostly untested and with uncertain outcomes (Rahman & Schnelle, 2008). National policies such as the Omnibus Reconciliation Act of 1987 and the Patient Protection and Affordable Care Act of 2010, along with the Centers for Medicare and Medicaid's (CMS, 2015) proposed regulatory changes, have created much-needed support for person-centered care (PCC) initiatives that are at the heart of culture change in nursing home care. Despite the momentum, the efforts for culture change and its evaluation at the micro and macro level have been fraught with difficulties, such as nonstandardized definitions, poorly defined implementation processes, and flawed outcome measurement (Shier, Khodyakov, Cohen, Zimmerman, & Saliba, 2014; Zimmerman, Shier, & Saliba, 2014). Culture change is a demanding process, and a deep level of change requires a coordinated interdisciplinary effort and a high level of leadership buy-in (Klein & Knight, 2005). This article suggests methods to strengthen the content and process of changing culture at a macro level as well as translating the lessons learned to a micro level, with aims to improve residents' lives and improve the ability to draw conclusions about culture change. Finally, it discusses the role of the psychologist in playing a significant role in facilitating culture change at the micro and macro levels through clinical practice and research initiatives.

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Background and Rationale

Traditional Nursing Home Model

Goffman's (1968) definition of the total institution is a fitting description of the traditional model of nursing home care. In the total institution, all aspects of life are conducted in the same place and under a single authority. Each member of the institution is compelled to carry out daily activities with a large group of similar members who are treated alike and required to do the same things. All activities are tightly regimented and under a single rational plan that seeks to fulfill the official aims of the institution. In these environments, residents' bodies become the property of the institution (Wiersma & Dupuis, 2010). Residents are trained to be docile, with no input. Their emotional and cognitive experiences are often disregarded, and they lose personal autonomy and control.

In these traditional environments, residents' quality of care and life is compromised. For example, older adults living in long-term care facilities have higher fall rates than do persons living in the community (Sorensen et al., 2006), with 10%–25% of falls resulting in fractures or lacerations (Becker & Rapp, 2010) that may lead to higher costs. Further, pressure ulcers, incontinence, dehydration, errors in medication, poor end-of-life care, and rehospitalization are all prevalent in nursing homes (Barber et al., 2009; Carrier, Ouellet, & West, 2007; Kayser-Jones et al., 2003; Kayser-Jones, Schell, Porter, Barbaccia, & Shaw, 1999; Ouslander et al., 2010; Palmer, 2008; Russo, Steiner, & Spector, 2008). Advocates of culture change contend that many of these factors can be improved with the adoption of PCC practices that are at the heart of the culture change movement. An example of a PCC practice familiar to psychologists is utilizing nonpharmacological or behavioral interventions to manage dementia-related behavioral symptoms instead of using antipsychotic medications (see Kales, Gitlin, & Lyketsos, 2015).

Culture Change: A Promising Solution

Culture change represents a transformation from the traditional to PCC and aims to improve residents' quality of life by deinstitutionalizing nursing home systems and stressing the importance of PCC principles (Zimmerman et al., 2014). Person-centered care principles include (a) resident direction of care and activities, (b) staff empowerment, (c) encouragement of collaboration versus centralized decision making, (d) a homelike versus institutional living environment, and (e) the breakdown of nursing home spaces into small "households" (Miller et al., 2013; Rahman & Schnelle, 2008).

For nursing homes to achieve culture change, they must enact deep, organizational change, or a comprehensive change impacting the organizations' mission, strategy, leadership, and culture (Burke, 2014). Unfortunately, to date, implementation of culture change in nursing homes has been limited both in number of homes and in degree of change (Shier et al., 2014). National surveys have shown a modest adoption of culture change, with one study reporting 31% of directors of nursing (DONs) indicating that culture change was "completely" or "for the most part" implemented (Doty, Koren, & Sturla, 2008, p. 4) and approximately one fourth of DONs reporting some adoption. In 2013, Miller et al. found that 33% of the DONs they surveyed reported complete culture change in some or all areas of the nursing home, and an additional 53% reported at least some culture change implementation.

Notably, implementation numbers have been challenged, because implementation has been fraught with conceptualization and measurement issues. For example, Zimmerman et al. (2014) conducted a review of culture change studies, intending to examine the extent of implementing six domains of culture change. Of the 36 studies, only nine specifically examined the level of adherence that study participants achieved regarding the domains they intended to implement. This lack of information about the implementation process undermines the ability to generalize such processes to other homes or to discover the extent to which culture change affects outcomes.

It is not surprising that implementation has been a challenge for nursing homes, because *culture change* is an amorphous term that has been interpreted and implemented in a myriad of ways. Individual homes often develop their own definitions of culture change and PCC, which may be skewed (Cornelison, Johns-Dansell, Poey, & Doll, 2015). Further, it is these potentially skewed perceptions of culture change that are being self-reported as degree of implementation of culture change adoption in national studies. Also, measurement of culture change is often aimed at a surface level of culture, as opposed to deep, organizational change, which is meant to be comprehensive in nature (Zimmerman et al., 2014). Although some practices may change within an organization and be measured by these existing culture change instruments, it does not necessarily indicate a shift in organizational culture.

Organizational Change Theory

Organizations must change to remain relevant and survive in the current competitive climate (Burke, 2014). Unfortunately, many changes are small, incremental, planned changes (*evolutionary*), but rarely do organizations undertake major, intentional organizational change (*revolutionary;* Burke, 2014). Both forms of change, evolutionary and revolutionary, are important for organizations to remain healthy and relevant (Pascale, Milleman, & Gioja, 2000). What does this mean for nursing homes? For decades nursing homes have remained relatively the same, with small, evolutionary changes occurring across the industry as a whole. This is typical of most organizations, especially those that are highly regulated like nursing homes, unless there is some external force encouraging deeper level change (e.g., leadership changes, financial incentives). That being said, true organizational change in long-term care also needs to be revolutionary, or transformational, rather than just evolutionary, or transactional (Burke, 2014). Revolutionary change is essential to the future of nursing home care and may be further facilitated by the recent changes in policy (e.g., the Affordable Care Act) and incentivization of PCC practices (Grabowski, Elliot, Leitzell, Cohen, & Zimmerman, 2014; Koren, 2010).

A key ingredient in the successful implementation of deep, organizational change is a clear understanding of what will be changed. This has to do with the purpose, mission, strategy, and values of the organization (Burke, 2014). Currently, in the culture change movement, the what is somewhat outlined on a macro level, though not yet completely clear and largely missing at the micro, or individual home, level. Culture change is lacking another key element of organizational change: the how. This concerns the implementation and adoption of the change (Burke, 2014). Innovative organizations—some of which were early adopters of culture change—have discovered not only the what but also the how and made it work (e.g., Green House model, Pioneer Network). Unfortunately, these examples are rare (Kane, Lum, Cutler, Degenholtz, & Yu, 2007). There are excellent examples of micro-level changes to increase PCC practices, many developed and/or practiced by psychologists, such as PCC approaches to dementia assessment (Mast, 2012) and behavioral interventions for behavioral symptoms of dementia (Fossey et al., 2006). However, for organization-wide culture change to take root, there must be an effort to learn from organizations that have enacted deep, organizational change by implementing a universal what and how. Then a greater number of nursing homes can embark on the revolutionary endeavor of culture change.

Many of the aforementioned issues with defining, operationalizing, and implementing culture change via PCC practices can be addressed at a macro and/or micro level within nursing homes, with key roles for individuals and organizations across disciplines, including psychology. We focus here on macro-level changes by examining how the State of Kansas has endorsed the adoption of culture change for long-stay residents. This was accomplished via the Medicaid pay-for-performance (P4P) incentive program Promoting Excellent Alternatives in Kansas Nursing Homes (PEAK 2.0). The PEAK 2.0 program has created an objective framework and shared definition (the what) of PCC and the specific means to implement those practices (the how) in the State of Kansas.

PEAK 2.0: A Model Program for Culture Change

The PEAK 2.0 program is a unique examination of systemwide culture change and is one of few statewide programs implementing culture change. The Kansas Department of Aging and Disabilities Services (KDADS), in collaboration with Kansas State University's (KSU) Center on Aging, has focused its culture change efforts on the PEAK 2.0 program. It began as an award and recognition program for homes making strides in nontraditional models of care. Nursing homes that applied and met the program criteria would be conferred PEAK Home status. This practice was in line with KDADS's stated intention to be "committed to ensuring high quality services for Kansas nursing home residents" (KDADS, n.d., para. 1). In 2011, the state gathered key stakeholders with interests in long-term care to revamp the program in order to motivate higher levels of involvement and initiate greater adoption of person-centered care practices and thereby achieve culture change. The retooled program would use designated Medicaid P4P incentives to reward nursing homes that demonstrated implementation of PCC practices. To improve rigor and facilitate implementation of the retooled program, KDADS contracted with Kansas State University's Center on Aging to administer PEAK 2.0 in 2012. This program was designed to solve some of the problems previously faced in culture change implementation.

PEAK 2.0: Program Description

PEAK 2.0 is a Medicaid pay-for-performance (P4P) program aimed at improving the quality of life for residents living in Kansas nursing homes. It is designed to inspire and reward deep organizational change through the adoption of PCC practices and is funded through the Quality Care Assessment, or the nursing facility provider tax (K.S.A. 75–7435), designated specifically for improving the quality of life for elders in nursing homes (M. Warfield, personal communication, September 1, 2016). Enrolled homes receive an escalating per diem based upon the level of PCC practices they adopt organizationally. Enrolled homes are evaluated by external reviewers and measured upon specified program criteria for PCC. They engage in various opportunities including education, action planning (strategic planning), team engagement, consultation, exposure to PCC in action, and mentoring activities.

The Kansas State University Center on Aging program and research staff implement the administrative functions of the program—application, training, consultation, and evaluation. In terms of staffing, the program employs one lead program administrator (90% full-time equivalent, or FTE) with a gerontology and social work background; two additional part-time program administrators (25% and 50% FTE), both with extensive long-term care leadership experience; and two graduate assistants (50% FTE). During the annual evaluation period, the Center on Aging also provides a small number of volunteer staff to assist. For the State of Kansas, KDADS oversees the program, provides feedback, recognizes homes statewide, and handles the Medicaid reimbursement.

The what of PEAK 2.0. Strengths of the PEAK 2.0 program include the clear, detailed, and organized framework developed to guide statewide implementation of culture change (see Figure 1). Within this framework, the PEAK 2.0 program focuses on five domains essential to PCC and implementation of culture change: The Foundation, Resident Choice, Staff Empowerment, Home Environment, and Meaningful Life. The four primary domains—Resident Choice, Staff Empowerment, Home Environment, and Meaningful Life—were developed through the collaboration of a

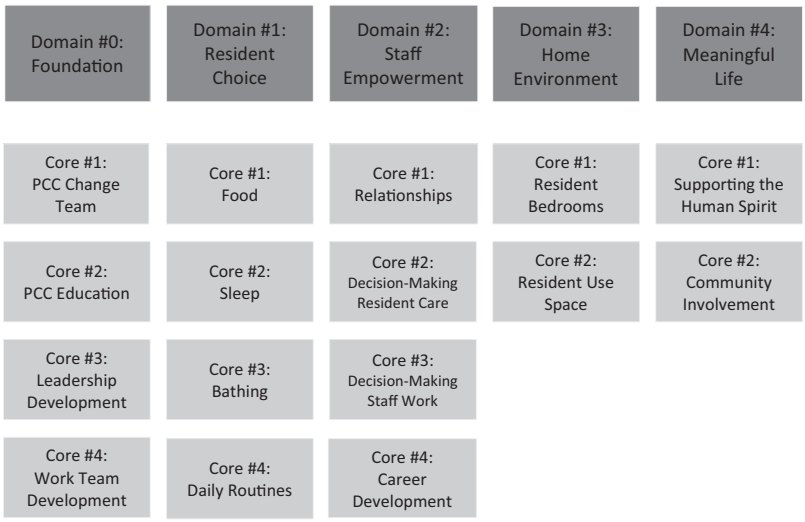

Figure 1. The primary domains and 12 core areas that nursing homes may address through the Promoting Excellent Alternatives in Kansas Nursing Homes (PEAK 2.0) program. PCC = person-centered care.

Kansas stakeholder group. The group utilized a comprehensive literature review published by the Colorado Foundation for Medical Care that was sponsored by CMS, which outlined these four domains plus quality improvement as the primary elements of person-centered care (Harris, Poulsen, & Vlangas, 2006). The Foundation domain was added later in response to the needs of program participants. The Foundation serves as an initial structured year of education and organizational development (readying or priming an organization for change), whereas the remaining four domains are broken down into 12 cores that homes may address across their participation in the program. Each of these 12 cores addresses a unique aspect of PCC and is subsequently broken down into supporting practices. For instance, the food core, which falls under the Resident Choice domain, includes three supporting practices: what to eat, when to eat, and where to eat. Expected outcomes in the food core include, but are not limited to, items such as resident input in menu development, enhanced dining options, expanded meal times, and food availability 24/7. Details about the expectations of each core are provided in a handbook and criteria manual and are considered criteria or expected outcomes of the PEAK program (KDADS, n.d.).

The how of PEAK 2.0. To achieve deep, organizational change a nursing home cannot stop at just having excellent content and/or criteria. It must also translate that content into an effective and measurable process. This issue has been purposefully attended to by KDADS and the Center on Aging, with specific implementation practices outlined for the PEAK 2.0 program, illustrated in Figure 2 and further described in the next sections.

Participation. Participation in PEAK 2.0 is voluntary and incentivized with designated Medicaid funds. As of summer 2016, of the 350 nursing homes in Kansas 212 were actively participating in PEAK 2.0. Notably, the PEAK 2.0 program has successfully engaged a wide variety of nursing home types, even those typical nonadopters such as for-profit, rural, and stand-alone nursing homes (Hermer, 2015). Engagement of less likely adopters is a potentially positive impact of the program. The overrepresentation of not-for-profit and larger homes has been noted in the culture change movement (Grabowski et al., 2014), which PEAK 2.0 and similar programs may be better able to address.

Program levels. The PEAK 2.0 program consists of six levels, each of which is tied to a respective Medicaid financial incentive (see Figure 2). For instance, homes entering at the Foundation level and homes at Level 1 receive $.50 per Medicaid resident per day; when the home moves to Level 2 it receives $1.00 per Medicaid resident per day. At the highest level, homes receive $4.00 per Medicaid resident per day. The program is designed as a progressive program so that homes enter and progress through as they achieve outcomes. Levels 0–2 are considered developmental levels that work up to a mastery of PCC, with Level 0 being the earliest developmental stage. Level 0 (The Foundation)—as described in the core criteria—is a yearlong education and training period wherein homes participate in several educational and experiential activities to learn and begin to implement change. In Level 1 (The Pursuit of Culture Change), homes actively work on four chosen cores of the PEAK 2.0 criteria, which are selected by each home at the end of the Foundation year. Level 2 (Culture Change Achievement) is a multiyear, transitional period during which homes continue the selection of four core areas per year until they have passed evaluation on all 12 core areas. Ideally this process would take 2 years, if all core areas are passed on the first attempt, but homes are given a 3rd-year grace period to revisit cores not achieved on the first attempt. If homes do not pass evaluation of all 12 core areas within 3 years of entering Level 2, they are reverted to Level 1. KDADS is currently considering dropping the stipulation to revert to Level 1 and instead permitting homes to stay at Level 2 as long as they are meeting a minimum threshold of adoption.

Level 3 (Person-Centered Care Home) is achieved after the home passes a full onsite evaluation of all 12 cores of the PEAK 2.0 criteria, and it is the gateway to the upper levels of the program, which focus on sustainment and mastery of practices. The main objective of Level 3 is to sustain all PCC practices outlined in the core criteria. To ensure these practices are maintained, a second onsite evaluation of all 12 cores is conducted at the end of the Level 3 year and if passed would move the home to a Level 4. If this evaluation is not passed, the home is reverted to Level 2. Level 4 (Sustained Person-Centered Care Home) is a 2-year period during which homes participate in and record mentoring activities in order to attain and demonstrate the characteristics of a mentor home. To move from a Level 4 to a Level 5, homes must continue to demonstrate sustained PCC practices in the criteria. They must also reach a threshold of mentoring activities. Level 5 (Person-Centered Care Mentor Home) homes participate in mentoring activities with homes below their level. They are evaluated biennially to ensure the sustainment of the PCC practices outlined in the KDADS criteria. If a home does not maintain PCC practices, it is reverted to lower levels of the program.

Education and activities. After enrollment and completion of a self-assessment, homes begin working on the task associated with their respective level. The different levels require differential effort on the homes' part. A full description of the participant's responsibility can be found in the *PEAK 2.0 Handbook* (Kansas Department of Aging and Disability Services & Kansas State University [KDADS & KSU], 2016b). Many resources and educational opportunities are made available to PEAK program participants. Homes at the Foundation level receive the most intensive "hands on" contact with PEAK staff, including five virtual meetings, four assignments, two in-person trainings, and unlimited access to PEAK 2.0 staff via phone and e-mail (KDADS & KSU, 2016b). These activities are aimed at developing organizational readiness for change and require participation by multiple members of the participating organization, including administrative and direct care staff. Homes at other levels are not required to have as much contact with PEAK 2.0 staff; however, they do create actions plans and receive feedback on those during the evaluation process, as well as access to PEAK staff through phone and e-mail consultation.

Last year the PEAK 2.0 staff fielded numerous phone calls and e-mails, conducted document reviews and evaluations for 181 homes (151 virtually, 30 onsite), reviewed and provided feedback on 165 action plans, conducted 10 education training sessions in locations across Kansas, conducted 24 virtual meetings with Foundation participants, collected survey data from 215 participating homes, released five newsletters, and continued to develop materials. Notably, an additional two to three consultants will be added next year to aid with the high-volume evaluation and action plan review.

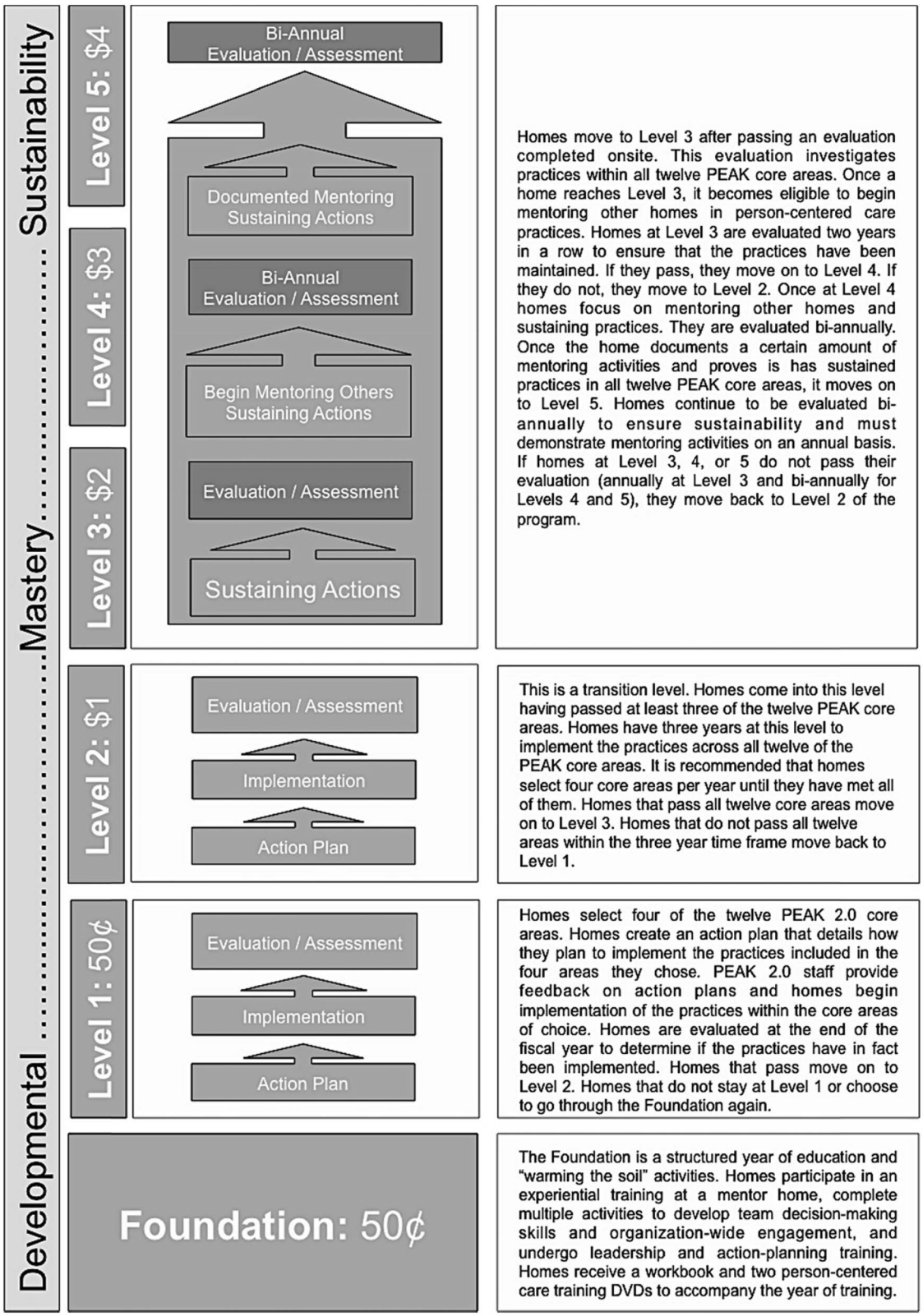

Figure 2. PEAK 2.0 program overview: Levels and incentives. All incentive dollar amounts noted above indicate a per Medicaid resident, per day rate (Cornelison, Doll, & Kaup, 2014).

Evaluation. The Peak 2.0 evaluation process includes several components. One evaluative component that all PEAK 2.0 homes complete is an annual self-assessment, the Kansas Culture Change Instrument (KCCI; Bott et al., 2009). This instrument is designed to assess seven conceptual dimensions or constructs of culture change and has been evaluated for reliability and validity (Bott et al., 2009). The KCCI data are not representative of a home's level, performance, or success in the PEAK 2.0 program but is intended to be a learning tool and a mechanism for measuring perceptions of performance.

For evaluation of level attainment, homes participating in Levels 1–5 undergo an external evaluation that is directly tied to program standards and is conducted by PEAK 2.0 staff members. Three distinct forms of external evaluation exist within the PEAK 2.0 program: (a) virtual evaluations conducted via the video conferencing software Zoom (Zoom Video Conferencing, 2011), (b) random mini on-site visits, and (c) full on-site evaluations. All three evaluations require submission of documents prior to the evaluation. For example, if the core is Sleep, homes are required to submit any interview tool(s) used to gather information about residents' preferences, two examples of individualized night care plans, and 2 weeks' worth of staff schedules for each work area. The external evaluation process incorporates interviews with multiple staff members in the home from various disciplines and levels of the organization. On-site evaluations include interviews with residents and additional staff members and observations of the home. Outcomes of the external evaluation determine the home's progression through the levels and informs next steps. As mentioned, in the last program year the PEAK team conducted 181 evaluations (151 virtually and 30 on-site). Over time, homes are progressing through the levels; whereas initially many homes were at the Foundation level or Level 1, now fewer homes are at these early levels and are more are at Level 2 (see Figure 3 for an overview of homes' progression through the program levels from 2014 to 2017).

In conclusion, PEAK 2.0 is uniquely designed not only to aid individual homes in adopting PCC principles indicative of culture change but to motivate nursing home reform on a statewide level. Through a clearly defined what and how, the program aids individual homes in clarifying these qualities for their own organization to carry out action while also having an objective voice to identify areas of needed quality improvement in PCC.

Lessons Learned From PEAK 2.0

The PEAK 2.0 program is the chosen culture change mechanism for the State of Kansas. The comprehensive nursing home program described earlier has been evolving since 2011, as lessons are learned and changes implemented. One lesson learned is the importance of measurement tools. The use of the KCCI instrument is both a strength and a challenge. It provides key insights into how homes evaluate themselves, providing an important reflective component. However, a challenge has been the differences between the self-assessment instrument and the objective assessment and reiterating to individual homes that their self-assessment should not be expected to dictate their program level. One way to alleviate this challenge is to emphasize and clarify up front that internal, or self-assessment (e.g., KCCI), is not linked to evaluation of program level. Alternatively, an organization or home may choose to use a similar, if not the same, instrument for internal and external evaluation to avoid discrepancies between the two. In fact, the leadership of PEAK 2.0 is currently considering transitioning to one assessment tool for both internal and external evaluation.

Implementation of PEAK 2.0 has illustrated the difficulties faced in implementing deep, organizational change within nursing homes. As a result, the program has received critical feedback from nursing homes across its tenure. There have been complaints over time that the program is too prescriptive and limits the boundaries of PCC. Though the criticism is appreciated in light of the difficulty of implementing such changes, the assumption that it is too prescriptive is limited. Although the PEAK 2.0 criteria are explicit in their expectations concerning program outcomes, enrolled homes have full autonomy to achieve said outcomes by any means they see fit. The PEAK program in no way prescribes the

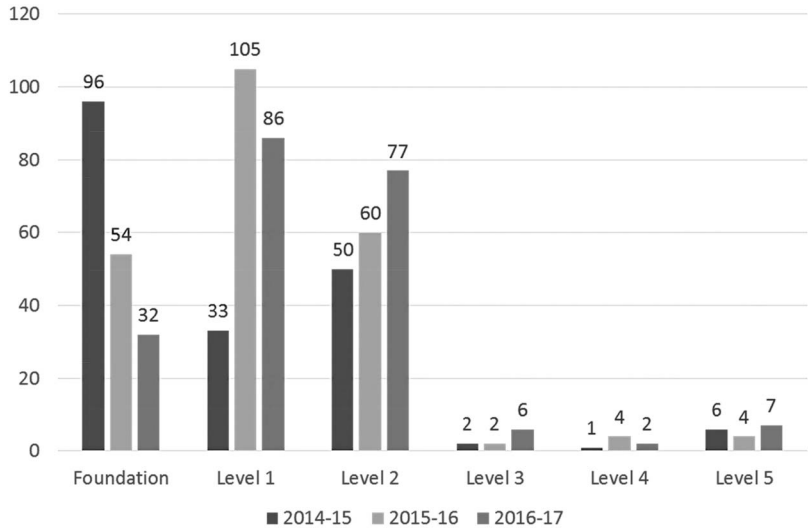

Figure 3. Frequency of nursing home participation in the Promoting Excellent Alternatives in Kansas Nursing Homes (PEAK 2.0) program by level and year from 2014 to 2017.

process in which nursing homes achieve the criteria. Rather the program details what outcomes must be met and leaves the process of implementation up to the homes, providing guidance if requested. This creates the opportunity for creative problem solving within enrolled homes and encourages staff empowerment by giving ownership to the individuals involved in the change.

Another concern with PEAK 2.0, as with most P4P programs, is the possibility that enrollees participate for financial reasons. This issue speaks to the concept of extrinsic versus intrinsic motivation. Essentially, are enrolled homes engaging in the PEAK 2.0 program solely for the purposes of receiving a Medicaid incentive payment, or are they fully committed to the implementation and provision of the quality person-centered care that all older adults deserve as a fundamental human right? For the purposes of PEAK 2.0, it may not matter. Although the existence of intrinsic motivation may help address barriers to PCC implementation, the PEAK program has been designed to ensure specific outcomes are met in order to be successful. Therefore, if concerted efforts are not made in the adoption of PCC practices in a timely manner, homes are reverted to lower levels or have their incentive payments suspended. This is not to say that intrinsic motivation for the implementation of PCC practices is not important. The PEAK program places great emphasis on the importance of leadership and staff buy-in and support for the process of change within their organization, as evidenced by several assignments completed in the Foundation year. These safeguards built into PEAK 2.0 help mediate the likelihood that nursing homes will participate for financial reasons only.

Although concerns have been raised, it is clear that more positive than negative attributes exist. One of the more encouraging pieces of data is uptake in enrollment in PEAK 2.0. In the program year following the transition to a P4P program (2012–2013), there were 122 nursing homes across the state enrolled in PEAK 2.0. The next program year (2013–2014) had 157 homes, the last program year (2014–2015) had 224 homes, and the present year (2015–2016) has 229 homes enrolled. These figures represent an 87.7% increase in enrollment over the last 4 years. Additionally, there is movement of participating homes through the levels of the program. In the early years of the program, a majority of homes were at the Foundation level and Level 1. At present, many homes have moved upward through the program levels (see Figure 3). Furthermore, anecdotally, there has been a fundamental shift in the tone of the leadership and staff of participating homes over the last few years. The rhetoric has shifted from "This can't be done" or "Why do we have to do this?" to "How can we make these changes happen?" It is encouraging to observe the increase in PCC knowledge and implementation of culture change across the state.

Another positive lesson learned from PEAK 2.0 is that implementation of PCC principles affects residents' lives. Preliminary findings have suggested that PEAK 2.0 has a positive effect on quality of care and resident life. For example, preliminary results from data collected in 2014–2015 have suggested that resident-related outcomes such as the incidence of pressure ulcers, use of physical restraints, antipsychotic use, and depressive symptoms have shown improvement (Hermer, 2015, 2016). Several homes in the PEAK 2.0 program have noted qualitative evidence of the impact on staff and resident quality of life. In one home, a certified nursing assistant described the change to the neighborhood concepts as improving her job satisfaction significantly, saying it is like "having this big extended family" (Foust, 2016, p. 3). A board member from a home that advanced to the upper levels noted, "It is so rewarding to walk through our facility and see our residents engaged in activities and the staff interacting with them. Just this aspect alone makes it worth the effort it took to get to this point" (KDADS & KSU, 2016a). Another home noted that a resident who initially was not in favor of the change now says she would not live anywhere else, because she loves being able to decide for herself how she is going to spend her day (J. Colp, personal communication, September 14, 2015).

Conclusions and Implications

The PEAK 2.0 program has been shown to be an effective mechanism to implement culture change statewide, with preliminary positive outcomes. By promoting practices integral to deep, organizational change (Burke, 2014), PEAK 2.0 has been able to help nursing homes achieve revolutionary change by implementing a well-defined what via a well-designed how.

Several key principles can be translated to the micro level from the macro-level PEAK 2.0 program as individual homes attempt to change their culture to PCC. Furthermore, we want to highlight the significant role of psychologists in this process, because they have been less represented in leadership within national initiatives promoting culture change, though they have made key contributions in the development and implementation of person-centered practices that support culture change (e.g., supporting resident choice, empowering the resident or promoting collaborative decision-making). Notably, the role of psychologists in individual homes within the PEAK 2.0 program is largely unknown, because this information is not readily available to the PEAK 2.0 team at this time. It is likely that psychologists are contributing to the PCC efforts across the state, and it is information that is of interest going forward. However, in many homes, especially those in rural areas, it may be a challenge for nursing homes to identify psychologists who are either interested in or prepared to do clinical work and PCC in nursing home settings due to the shortage of geropsychologists in the workforce. Across nursing homes in the United States, psychologists can and do play a central role in culture change through clinical practices that promote PCC (Carney & Norris, 2016; Norris, Molinari, & Ogland-Hand, 2003; Rosowsky, Casciani, & Arnold, 2009), as well as through program development, evaluation, and other research initiatives.

First, the culture change process must be led by an interdisciplinary group of change leaders who understand the transformational quality of organizational change and buy into it deeply—becoming the conscience of culture change for their home. Psychologists can play a key role here, assisting with assessment of team members' strengths and using group facilitation skills to help with the team's process. It may also include resolving cognitive dissonance among members who may not fully buy into culture change (Cornelison et al., 2015).

Another necessary component is establishing a well-defined what, or definition and goals of culture change, for that particular home. This clarification should be based on the best research and clinical evidence and be adapted to the context of that home, requiring an understanding of the research literature and clinical or practice environment in the home. Self-assessment of environment and resources must occur to inform goals, including strengths of existing staff, attitudes and buy-in, resources for implementation

and evaluation, and training. Goals for culture change must be closely followed by the how, or process determined to reach these goals. This process is led by the change leaders and must take into account the contextual strengths and challenges of the home. Psychologists are well suited for this process, with training and expertise in program development and evaluation processes as well as team facilitation skills.

PEAK 2.0 also teaches that culture change is not an easy process. Changing culture is a multiyear endeavor that requires resources and attention to the everyday practices of staff and residents. In terms of supporting the everyday culture change practices, psychologists have several skills to contribute. For example, they can implement training in behavioral interventions that are not only more consistent with PCC principles than traditional medical model solutions (e.g., medication to manage behavioral symptoms) but also in line with national recommendations for dementia care (Joint Commission, 2014). Studies have shown behavioral interventions to be very effective in dementia care (Bird, Jones, Korten, & Smithers, 2007; Fossey et al., 2006; Sloane et al., 2004), and they are integral to the culture change process. Further, psychologists can support nursing home staff through the process, because staff have been found to perceive culture change in unique ways (Abbott, Heid, & Van Haitsma, 2016). Support can be offered through various activities such as assessing attitude, understanding culture change practices, normalizing staff frustrations, and encouraging self-care to prevent staff burnout during the culture change process.

Also, PEAK 2.0 teaches that there is opportunity for an abundance of research as criteria and objectively evaluated outcomes are standardized. This research can be done on a micro as well as a macro level. Psychologists can significantly contribute to the research process in areas such as conceptualization, methodology, and evaluation processes. Their strengths in research and program evaluation will be much needed within an interdisciplinary nursing home setting. The involvement of psychologists can lead to the discovery of reliable outcome data supporting culture change as well as the utility, if not necessity, of a shared definition and standardized implementation of culture change. In fact, the next steps in the PEAK 2.0 program include a continued focus on program evaluation. These steps will incorporate outcome and process-related data from homes, designed to improve program implementation through standardized feedback. Also planned is a more comprehensive evaluation of quality care and quality of life outcomes of PEAK 2.0 over time. Of note, this multidisciplinary team of researchers will include a psychologist playing a key role in program evaluation activities.

Finally, PEAK 2.0 teaches that these changes are developmental, occurring over a long period of time. Leaders should develop ongoing goals, short and long term, and not expect organizational change immediately. Culture change should develop and deepen over time with benchmarks such as the levels in PEAK 2.0 to identify levels of development. Culture change is not about complacency, because the goal for residents' quality of life should be ever evolving.

References

Abbott, K. M., Heid, A. R., & Van Haitsma, K. (2016). "We can't provide season tickets to the opera": Staff perceptions of providing preference based person centered care. *Clinical Gerontologist, 39,* 190–209. http://dx.doi.org/10.1080/07317115.2016.1151968

Barber, N. D., Alldred, D. P., Raynor, D. K., Dickinson, R., Garfield, S., Jesson, B., . . . Zermansky, A. G. (2009). Care homes' use of medicines study: Prevalence, causes and potential harm of medication errors in care homes for older people. *BMJ Quality and Safety, 18,* 341–346. http://dx.doi.org/10.1136/qshc.2009.034231

Becker, C., & Rapp, K. (2010). Fall prevention in nursing homes. *Clinics in Geriatric Medicine, 26,* 693–704. http://dx.doi.org/10.1016/j.cger.2010.07.004

Bird, M., Jones, R. H. L., Korten, A., & Smithers, H. (2007). A controlled trial of a predominantly psychosocial approach to BPSD: Treating causality. *International Psychogeriatrics, 19,* 874–891. http://dx.doi.org/10.1017/S1041610206004790

Bott, M. J., Dunton, N., Gajewski, B., Lee, R., Boyle, D., Bonnel, W. Q., . . . Coffland, V. (2009). *Culture change and turnover in Kansas nursing homes, Kansas Nursing Facility Project Report submitted to the Kansas Department of Aging*. Kansas City, KS: author.

Burke, W. W. (2014). *Organizational change: Theory and practice* (4th ed.). Thousand Oaks, CA: Sage.

Carney, K. O., & Norris, M. P. (2016). *Transforming long-term care: Expanded roles for mental health professionals*. Washington, DC: American Psychological Association.

Carrier, N., Ouellet, D., & West, G. E. (2007). Nursing home food services linked with risk of malnutrition. *Canadian Journal of Dietetic Practice and Research, 68,* 14–20. http://dx.doi.org/10.3148/68.1.2007.14

Centers for Medicare and Medicaid. (2015). *Medicare and Medicaid programs; Reform of requirements for long-term care facilities* (Proposed Rule 80 FR 42167, pp. 42167–42269, Doc. No. 2015–17207). Retrieved from https://www.federalregister.gov/documents/2015/07/16/2015-17207/medicare-and-medicaid-programs-reform-of-requirements-for-long-term-care-facilities

Cornelison, L., Doll, G., & Kaup, M. (2014). *PEAK 2.0: A Medicaid pay-for-performances incentive for nursing homes adopting person-centered care*. Poster presentation at the Gerontological Society of America Annual Meeting, Washington, DC.

Cornelison, L., Johns-Dansell, N., Poey, J., & Doll, G. A. (2015, November). Cognitive dissonance: A barrier to implementation of person-centered care. In G. A. Doll (Chair), *Person-Centered Care: Policy and Practice (A State-Wide Perspective).* Symposium conducted at the annual meeting of the Gerontological Society of America, Orlando, FL.

Doty, M. M., Koren, M. J., & Sturla, E. L. (2008). *Culture change in nursing homes: How far have we come? Findings from the Commonwealth Fund 2007 National Survey of Nursing Homes*. Retrieved from http://www.commonwealthfund.org/Publications/Fund-Reports/2008/May/Culture-Change-in-Nursing-Homes-How-Far-Have-We-Come-Findings-From-The-Commonwealth-Fund-2007-Nati.aspx

Fossey, J., Ballard, C., Juszczak, E., James, I., Alder, N., Jacoby, R., & Howard, R. (2006). Effect of enhanced psychosocial care on antipsychotic use in nursing home residents with severe dementia: Cluster randomised trial. *British Medical Journal, 332,* 756–761. http://dx.doi.org/10.1136/bmj.38782.575868.7C

Foust, L. (2016, April). "Life as we know it—The neighborhood concept. *PEAK 2.0 Times*. Retrieved from http://www.he.k-state.edu/aging/outreach/peak20/times/201604.pdf

Goffman, E. (1968). *Asylums*. Harmondsworth, United Kingdom: Penguin.

Grabowski, D. C., Elliot, A., Leitzell, B., Cohen, L. W., & Zimmerman, S. (2014). Who are the innovators? Nursing homes implementing culture change. *Gerontologist, 54*(Suppl. 1), S65–S75. http://dx.doi.org/10.1093/geront/gnt144

Harris, Y., Poulsen, R., & Vlangas, G. (2006). *Measuring culture change: Literature review*. Englewood, CO: Colorado Foundation for Medical Care.

Hermer, L. (2015, November). Theory and practice in evaluating large-scale culture change programs: Preliminary results. In G. A. Doll (Chair), *Person-Centered Care: Policy and Practice (A State-Wide Perspective).* Symposium conducted at the annual meeting of the Gerontological Society of America, Orlando, FL.

Hermer, L. (2016). *Overview of progress on PEAK 2.0 analyses* [Unpublished PowerPoint slides].

Joint Commission. (2014). *Approved: Memory care requirements for nursing care center accreditation*. Retrieved from https://www.jointcommission.org/assets/1/18/JCP0114_Memory_Care_NCC.pdf

Kales, H. C., Gitlin, L. N., & Lyketsos, C. G. (2015). Assessment and management of behavioral and psychological symptoms of dementia. *British Medical Journal, 350,* h369. http://dx.doi.org/10.1136/bmj.h369

Kane, R. A., Lum, T. Y., Cutler, L. J., Degenholtz, H. B., & Yu, T. C. (2007). Resident outcomes in small-house nursing homes: A longitudinal evaluation of the initial Green House program. *Journal of the American Geriatrics Society, 55,* 832–839. http://dx.doi.org/10.1111/j.1532-5415.2007.01169.x

Kansas Department for Aging and Disability Services. (n.d.). *Promoting Excellent Alternatives in Kansas Nursing Homes (PEAK)*. Retrieved from http://www.kdads.ks.gov/commissions/scc/peak

Kansas Department for Aging and Disability Services & Kansas State University. (2016a, July). *Attica long term care: A story of getting out of our own way. PEAK 2.0 News*. Retrieved from http://www.he.k-state.edu/aging/outreach/peak20/times/201606.pdf

Kansas Department for Aging and Disability Services & Kansas State University. (2016b). *PEAK 2.0 handbook*. Retrieved from http://www.he.k-state.edu/aging/outreach/peak20/2016-17/peak-handbook.pdf

Kayser-Jones, J., Schell, E., Lyons, W., Kris, A., Chan, J., & Beard, R. (2003). Factors that influence end-of-life care in nursing homes: The physical environment, inadequate staffing, and lack of supervision. *Gerontologist, 43,* 76–84.

Kayser-Jones, J., Schell, E. S., Porter, C., Barbaccia, J. C., & Shaw, H. (1999). Factors contributing to dehydration in nursing homes: Inadequate staffing and lack of professional supervision. *Journal of the American Geriatrics Society, 47,* 1187–1194. http://dx.doi.org/10.1111/j.1532-5415.1999.tb05198.x

Klein, K. J., & Knight, A. P. (2005). Innovation implementation: Overcoming the challenge. *Current Directions in Psychological Science, 14,* 243–246. http://dx.doi.org/10.1111/j.0963-7214.2005.00373.x

Koren, M. J. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs, 29,* 312–317. http://dx.doi.org/10.1377/hlthaff.2009.0966

Mast, B. T. (2012). Methods for assessing person with Alzheimer's disease: Integrating person-centered and diagnostic approaches to assessment. *Clinical Gerontologist, 35,* 360–375. http://dx.doi.org/10.1080/07317115.2012.702647

Miller, S. C., Looze, J., Shield, R., Clark, M. A., Lepore, M., Tyler, D., . . . Mor, V. (2013). Culture change practice in U.S. nursing homes: Prevalence and variation by state Medicaid reimbursement policies. *Gerontologist, 54,* 434–445. http://dx.doi.org/10.1093/geront/gnt020

Norris, M. P., Molinari, V., & Ogland-Hand, S. (Eds.). (2003). *Emerging trends in psychological practice in long-term care*. New York, NY: Haworth.

Omnibus Reconciliation Act of 1987, H.R. 3545, 100th Cong. (1987).

Ouslander, J., Lamb, G., Perloe, M., Givens, J. H., Kluge, L., Rutland, T., . . . Saliba, D. (2010). Potentially avoidable hospitalizations of nursing home residents: Frequency, causes, and costs. *Journal of the American Geriatrics Society, 58,* 627–635. http://dx.doi.org/10.1111/j.1532-5415.2010.02768.x

Palmer, M. H. (2008). Urinary incontinence quality improvement in nursing homes: Where have we been? Where are we going? *Urologic Nursing, 28,* 439–444, 453.

Pascale, R. T., Milleman, M., & Gioja, L. (2000). *Surfing the edge of chaos: The laws of nature and the new laws of business*. New York, NY: Crown Business.

Patient Protection and Affordable Care Act. (2010). Pub. L. No. 111–148, 124 Stat. 378.

Rahman, A. N., & Schnelle, J. F. (2008). The nursing home culture-change movement: Recent past, present, and future directions for research. *Gerontologist, 48,* 142–148. http://dx.doi.org/10.1093/geront/48.2.142

Rosowsky, E., Casciani, J. M., & Arnold, M. (Eds.). (2009). *Geropsychology and long term care: A practitioner's guide*. http://dx.doi.org/10.1007/978-0-387-72648-9

Russo, A., Steiner, C., & Spector, W. (2008). *Hospitalizations related to pressure ulcers among adults 18 years and older, 2006* (Statistical Brief No. 64). Rockville, MD: Agency for Healthcare Research and Quality.

Shier, V., Khodyakov, D., Cohen, L. W., Zimmerman, S., & Saliba, D. (2014). What does the evidence really say about culture change in nursing homes? *Gerontologist, 54*(Suppl. 1), S6–S16. http://dx.doi.org/10.1093/geront/gnt147

Sloane, P. D., Hoeffer, B., Mitchell, C. M., McKenzie, D. A., Barrick, A. L., Rader, J., . . . Koch, G. G. (2004). Effect of person-centered showering and the towel bath on bathing-associated aggression, agitation, and discomfort in nursing home residents with dementia: A randomized, controlled trial. *Journal of the American Geriatrics Society, 52,* 1795–1804. http://dx.doi.org/10.1111/j.1532-5415.2004.52501.x

Sorensen, S. V., de Lissovoy, G., Kunaprayoon, D., Resnick, B., Rupnow, M. F., & Studenski, S. (2006). A taxonomy and economic consequences of nursing home falls. *Drugs & Aging, 23,* 251–262. http://dx.doi.org/10.2165/00002512-200623030-00007

Wiersma, E., & Dupuis, S. (2010). Becoming institutional bodies: Socialization into a long-term care home. *Journal of Aging Studies, 24,* 278–291. http://dx.doi.org/10.1016/j.jaging.2010.08.003

Zimmerman, S., Shier, V., & Saliba, D. (2014). Transforming nursing home culture: Evidence for practice and policy. *Gerontologist, 54*(Suppl. 1), S1–S5. http://dx.doi.org/10.1093/geront/gnt161

Zoom Video Conferencing. (2011). Zoom Video Conferencing [Computer software]. Retrieved from https://zoom.us/

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