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Person-Centredness In the Workplace: An Examination of Person-Centred Skills, Processes and Workplace Factors Among Medicaid Waiver Providers In the United States

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ORIGINAL PRACTICE DEVELOPMENT AND RESEARCH

Person-centredness in the workplace: an examination of person-centred skills, processes and workplace factors among Medicaid waiver providers in the United States

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Abstract

Background: Existing research supports the effectiveness of person-centred practices in working with persons with physical, intellectual and developmental disabilities, but less clear is the influence of workplace factors on the implementation and quality of person-centred practices.

Aims: This article explores the influence of workplace factors on job satisfaction and on the implementation and quality of person-centred practices in healthcare agencies that provide home- and community-based services through a Medicaid waiver in Mississippi, a state in the southeastern United States.

Methods: Purposive sampling was used to collect data via online surveys to explore the interrelationships among person-centred workplaces, job satisfaction and person-centred practices.

Results: Path analysis reveals that a person-centred workplace influences both skill implementation and person-centred processes. Job satisfaction was significantly correlated to skill implementation and person-centred processes in bivariate analysis but was not detected in the path model.

Conclusion: This study suggests that organisations may improve the provision of person-centred practices by investing in policies that create a person-centred workplace.

Implications for practice:

- A person-centred workplace environment is a critical factor that influences person-centred practices and job satisfaction among employees
- Adapting practices to be person-centred should occur at every level of an organisation
- Social care organisations should maintain continuous assessments of person-centredness to ensure a person-centred workplace where employees consistently use person-centred skills and processes with the people whom they support

Keywords: Person-centred planning, job satisfaction, person-centred workplace, intellectual disabilities, developmental disabilities

Background

Over the past 30 years, there has been a dramatic change in the orientation of services and support offered to individuals with physical and intellectual disabilities and older adults (Taylor and Taylor, 2013). Service models have shifted from task-centred approaches focused on the completion of identified care objectives that often ignore a person's psychosocial needs to a person-centred approach (Robertson et al., 2005; Brownie and Nancarrow, 2013; Bölenius et al., 2017). A person-centred approach focuses on individualisation, tailoring services and supports and prioritising the personal vision for life of the person being supported (Robertson et al., 2005; Sanderson et al., 2006). Principles of person-centred practices have become embedded within agencies and governmental policies in the US, UK, and Australia, meaning proper training and education for professionals is necessary (Robertson et al., 2005, 2006; Edvardsson et al., 2011; Centers for Medicare and Medicaid Services, 2014a).

Although there are international frameworks covering person-centred practices (McCance et al., 2013), there is currently a lack of research on the subject, both in quantity and in quality, in the US (Brownie and Nancarrow, 2013; Ratti et al., 2016; Allen Christensen et al., 2019). An increase in the breadth of person-centred research would have the potential to further the knowledge and application of person-centred practices. To ensure the adoption of such practices, it is imperative to understand the factors that drive their implementation and success, especially among staff members delivering person-centred care. These factors can then be addressed at organisational level to propel the shift from task-centred to person-centred approaches.

U.S. Medicaid home- and community-based services settings rule

In 2014, the US Centers for Medicare and Medicaid Services (CMS) issued CMS-2249-P2, the Medicaid Home and Community-Based Services (HCBS) settings final rule (CMS, 2014b). This rule amended the Medicaid regulations for the provision of HCBS by state entities that receive federal Medicaid funds (CMS, 2014b). A central requirement of the rule is that person-centred planning must be used, and US state entities have until March 17, 2023 to comply (Lynch, 2020). Since the issuance of the rule, each state has varied how it applies person-centred practices in HCBS settings.

The Mississippi context

In 2020, there were 23,135 persons in Mississippi in receipt of HCBS Medicaid waivers (Mississippi Division of Medicaid, 2020) across five programmes. The five waiver programmes relate to: traumatic brain injury/spinal cord injury; assisted living; intellectual/developmental disabilities; independent living; and elderly and disabled. The state implemented the Mississippi Person-Centered Practices Institute, a partnership between the Mississippi Division of Medicaid and the University of Southern Mississippi's school of social work, to provide training in person-centred practices to professionals from the waiver programmes during the transition period (University of Southern Mississippi, 2021).

Literature review

Person-centred practices

Person-centred practice involves a specific way of assessing, planning and organising services and support to improve the quality of life of individuals receiving services. Its origins date back to the 1970s and 1980s in North America (Robertson et al., 2005) and its successful use shifts power from staff members to those receiving care (Sanderson, 2000). This shift fosters an environment of collaboration between service providers and recipients, and enhances community relations (Claes et al., 2010; van Dam et al., 2008). Although person-centred practices are applied in a wide range of settings, they are traditionally used within disability-related services, behavioural health and other social care programmes, to achieve a variety of outcomes.

Person-centred practices use person-centred planning to support the goals and interests of service recipients (Kardell et al., 2020). Sanderson (2000) describes the key components of this as putting the person receiving services at the centre of the process, and including family members and friends to help ensure the plan includes aspects that are important to the person. The process results in a

person-centred plan that reflects what is possible instead of just what is available. Over time, care staff use ongoing listening, learning and reflection to further improve the plan, striving for greater personalisation of services by tailoring them to the individual's wants and needs (Robertson et al., 2006).

With proper application, person-centred practices can help achieve a greater quality of life for recipients of health and social care (Bölenius et al., 2017; Robertson et al., 2005). They have numerous social benefits, including increasing the person's social network, involvement within the community and contact with family and friends (Robertson et al., 2005, 2006; Sanderson et al., 2006). Further benefits have been demonstrated, such as having greater control over life choices, positive changes in scheduled daily activities, and more transitions from institutional to community living settings (Holburn et al., 2004; Robertson et al., 2005, 2006; Sanderson et al., 2006). Along with improved quality of life, people also report greater satisfaction with the care they receive under person-centred practices (Bölenius et al., 2017).

Due to their broad nature, the construct of person-centred practices and related terminology can seem complex to operationalise (Health Innovation Network South London, 2006; van Dam et al., 2008). However, several frameworks and measurement instruments have been developed to model and measure various aspects of person-centredness (White et al., 2008; McCance et al., 2013; Bourne, 2020). Its general aim is to foster relationships based on values of respect and empowerment to facilitate the desired outcomes (van Dam et al., 2008; McCance et al., 2013; Kardell et al., 2020). The instruments used in this study are discussed in the Methods section.

Predictors of person-centred practices

Person-centred workplace

To increase the provision of person-centred care and meet the new HCBS requirements, it is important to create an environment conducive to doing so. Organisational-level implementation offers one way to achieve this goal. A meta-analysis by Chenoweth and colleagues (2019) argues that applying person-centred principles at the organisational level increases the quality of care offered. In addition, Tellis-Nayak (2007) suggest managers who create a person-centred workplace by promoting staff engagement improve care standards. McCance and colleagues (2013) also posit that leadership has an influential role in maintaining a person-centred environment for staff.

A person-centred workplace can be characterised as one whose leadership understands and values the philosophy of person-centred care and incorporates the approach to programme management, offering adequate opportunities for relevant training and education for staff, and using an ongoing feedback loop to facilitate provision of the model (Austrom et al., 2016; Moore et al., 2017; Chenoweth et al., 2019; Hower et al., 2019). Additionally, Alhalal and colleagues (2020) suggest greater structural empowerment (access to information, resources, opportunity and support) among employees in the workplace is associated with an increase in person-centred practices. In short, staff who receive managerial and organisational support are more likely to provide high-quality person-centred care.

Job satisfaction and the person-centred workplace

Numerous studies have documented the positive influence of job satisfaction on work outcomes, including improved engagement and job performance (Fried et al., 2008; Zhang et al., 2020; Ng et al., 2021). This study explores the influence of job satisfaction on person-centred practices and also the role of job satisfaction in the relationship between a person-centred workplace and person-centred practices. Incorporating a person-centred care approach into the workplace is significantly correlated with greater staff job satisfaction (Tellis-Nayak, 2007). Employees can better assist people whom they support in social care when they feel satisfied with their jobs and valued within the organisation. Fidyah and Setiawati (2019) and Sopiah et al. (2021) tested the interaction between organisational culture, job satisfaction and performance, and found organisational culture can positively affect employee

performance through increased job satisfaction. However, few studies are available with regard to person-centred practices and organisational culture. Based on interviews with decision-makers from health and social care organisations, Hower and colleagues (2019) considered individual and organisational determinants affecting the implementation of person-centred practices. They suggest organisations can improve quality and facilitate the implementation of person-centred care by staff members by focusing on their job satisfaction and wellbeing. On the other hand, Dys and colleagues (2022) propose that job satisfaction is an outcome of person-centred practices, rather than a predictor. They argue that organisational structure is significantly associated with person-centred practices and job satisfaction; however, person-centred practices were not shown to predict job satisfaction.

Aims

Addressing gaps in the literature

Even though research has been dedicated to analysing person-centred practices, few such studies have been completed in the US, with a particular shortfall in the Deep South. Adequate evidence exists for the effectiveness of using person-centred practices, but less clear are the interrelationships among person-centred workplaces, job satisfaction and person-centred practices. Understanding these connections is essential to promoting person-centred practices, delivering care in a person-centred way and ultimately improving lives.

The purpose of this study is to examine those interrelationships in the context of employees of healthcare agencies that provide HCBS through a Medicaid waiver in Mississippi. For this research, the authors operationally defined person-centred practices as 'person-centred skill implementation' (that is, implementation of person-centred skills when developing plans for services and support) and 'person-centred process' (integration of person-centredness into developing the plans). Guided by the results of earlier empirical studies, the authors proposed the path model, where the following hypotheses were specified:

- A person-centred workplace would be directly associated with person-centred practices. This hypothesis was based on studies reporting that incorporating a person-centred care approach into the workplace positively influenced the provision of person-centred practices among employees (for example, Tellis-Nayak, 2007; Moore et al., 2017; Chenoweth et al., 2019; Silén et al., 2019; Alhalal et al., 2020).
- A person-centred workplace would be associated with person-centred practices through job satisfaction. Job satisfaction was viewed as a mechanism through which a person-centred workplace influenced practice. This hypothesis was based on the idea that employees can better assist people and engage more in person-centred practices if there is a focus on their own job satisfaction and wellbeing (Hower et al., 2019), and on studies that empirically support the interaction between organisational culture, job satisfaction and work performance (Fidyah and Setiawati, 2019; Sopiah et al., 2021).

The study aimed to shed light on enhancing and promoting person-centredness in the US Deep South and similar communities.

Methods

Design

A survey research design with a purposive sampling procedure was used to collect data from employees of HCBS waiver provider agencies in Mississippi. Although there are five HCBS waivers, only the intellectual disability/developmental disability (IDD/DD) and elderly and disabled (E&D) waiver employees (n = 171) were sampled in this study. The participants were involved in developing plans for services and support for their care recipients – typically persons with intellectual or developmental disabilities or older adults receiving services to support them to continue living in their community rather than in institutions. The participants' job titles included case manager, support coordinator, nurse, direct support provider and social worker. All participants had attended person-centred

thinking workshops conducted by the Mississippi Person Centred Practices Institute within the past three years. The workshops were carried out by certified trainers and addressed core person-centred concepts using curricula developed by the Learning Community for Person Centered Practices, a body that oversees training and certification. Email addresses for potential participants were collected from agency supervisors to ensure a complete list. There were approximately 20 agencies sampled that served persons on the ID/DD or E&D waivers. The sampling frame consisted of approximately 550 employees. Permission to contact participants via email was received from agency administrators.

The online survey was administered using Qualtrics© software (2020) with details anonymised to prevent identifying information being linked to participants. The survey link, along with a brief introduction and explanation, was emailed to all participants in the sampling frame. The full informed consent letter comprised the first section of the survey. The survey consisted of 42 questions and took approximately 10-15 minutes to complete. Most questions were embedded in matrices and contained Likert scale response options. The questions addressed person-centred knowledge, person-centred skill implementation, person-centred organisational practices and job satisfaction, along with demographic information such as job title, years of experience, education level and gender. Two follow-up emails were sent as reminders, after one week and two weeks.

The authors developed the survey, which contained original questions, questions from the validated Brief Index of Affective Job Satisfaction survey (Thompson and Phua, 2012), and questions adapted from the validated Workplace Practices subscale of the Questionnaires of Person-centred Practices in Assisted Living (White et al., 2008). The adapted items were rephrased from second-person questions to first-person statements to measure person-centred workplaces. Questions addressing person-centred skill implementation and person-centred processes (when developing plans for services and support) were developed by the authors and reviewed by certified person-centred trainers. This research received ethical approval from the University of Southern Mississippi institutional review board.

Measures

The person-centred workplace was measured by eight questions adapted from the Workplace Practices measure (23 items) on the Staff PC-PAL from the University of North Carolina Center for Excellence in Assisted Living Questionnaires of Person-Centred Practices in Assisted Living (PC-PAL). Along with other PC-PAL surveys, the Staff PC-PAL survey has been validated to measure person-centredness among staff (White et al., 2008). Participants were asked to rate the extent to which they agreed with statements in their current place of employment on a seven-point scale, from strongly disagree to strongly agree. Two examples of statements are:

1. I've received training that helps me assist the people we serve according to their personal preferences and outcomes/goals
2. I have freedom to try new approaches that I think will improve care or relationships here

Cronbach's alpha (measuring the internal consistency of the survey items) calculated in the current study was .90 (.70 or higher is considered acceptable).

The Brief Index of Affective Job Satisfaction was used to measure job satisfaction. The index contains four items with a five-point Likert scale, from strongly disagree to strongly agree. This measure is comprehensively validated for internal consistency, temporal stability, convergent validity and criterion validity (Thompson and Phua, 2012).

Example statements are:

1. I find real enjoyment in my job
2. I like my job better than the average person

Cronbach's alpha calculated in the current study was .95.

Person-centred skill implementation was measured using a matrix of person-centred skills and asking participants to rate how often they use each skill when developing plans for services and support. The

12 questions were developed by the authors with input from certified person-centred trainers. The questions were reviewed by several employees from HCBS Medicaid waiver providers to ensure face and content validity. The seven-point Likert scale ranged from never (with an option labeled 'I don't know') to always. Examples from the list of skills include:

1. Rituals and routines
2. Communication chart
3. Two-minute drill

Rituals and routines, for instance, is a skill taught to explore what makes people satisfied, content or happy in their everyday lives – such as the importance placed on structured daily routines and the significance of holidays and birthdays. Every skill listed on the survey was addressed in the person-centred thinking workshop, which all participants had attended. Cronbach's alpha calculated in the current study was .90.

The integration of person-centred practices into the planning for services and support process was measured by seven items developed by the authors with input from experts in the field. Participants were asked to rate each statement as they related to developing a services and support plan for care recipients in their agency. The seven-point Likert scale response options ranged from strongly disagree to strongly agree. Examples included:

1. Are non-paid supports (family, friends, peers etc.) included in the development and implementation of the services and support plan?
2. Are the roles and responsibilities of paid supports (case managers, service providers, direct care staff) identified in the plan?

Cronbach's alpha calculated in the current study was .83.

Control variables

Control variables included education and years of experience in their profession. Participants were asked to report their highest level of education on a seven-point scale, ranging from 'high school diploma/GED' to 'doctorate'. Years of experience in their profession were rated on a six-point scale, from 'less than 1 year' to '21 or more years'.

Findings/results

Sample characteristics

A total of 171 respondents participated in the survey. Approximately 95% were female and 5% male. With regard to educational attainment, approximately 49% of respondents had a bachelors degree, followed by masters or equivalent (27%), associate degree (24%), and attendance at some college courses (1%). Table 1 sets out the participants' years of professional experience.

Table 1: Participants' years of experience

Years of experience	Percentage of participants
1-3 years	9%
4-10 years	39%
11-15 years	9%
16-20 years	12%
21+ years	31%

Preliminary and bivariate analyses

Distributions of all variables were screened for normality and outliers. Skewness, a measure of the asymmetry of distribution, and kurtosis, a measure of the peakedness of distribution, are ways in

which a distribution of data deviates from normal (Hair et al., 1998; Ghasemi and Zahedias, 2012). Hair and colleagues (1998) suggest a reference of substantial departure from normality as skewness and kurtosis values greater than +1.96 or less than -1.96. The value of z-score excess of 3.29 was used for referencing outliers (Tabachnick and Fidell, 2001).

Pearson's correlations for continuous variables and Spearman's correlations for ordinal variables were calculated for the association between variables. Bivariate correlations among the study variables are presented in Table 2. At the bivariate level, person-centred workplace was moderately and positively correlated with job satisfaction (r = .42, p <.001) and person-centred processes (r = .45, p <.001). A positive, but weaker correlation was found between person-centred workplace and person-centred skill implementation (r = .30, p <.001). Job satisfaction was positively correlated with person-centred skill implementation (r = .21, p = .013) and person-centred processes (r = .27, p <.001), but the relationships were weak.

Table 2: Correlations between variables

	1	2	3	4	5	6
1. Education	_					
2. Years of experience	**-.18***	_				
3. Person-centred workplace	-.01	-.06	_			
4. Job satisfaction	-.11	.10	**.42****	_		
5. Person-centred skill implementation	.09	-.08	**.30****	**.21***	_	
6. Person-centred processes	**.18***	.00	**.45****	**.27****	**.39****	_

*Notes: *p < 0.05; **p < 0.001; Bold figures: statistically significant correlation*

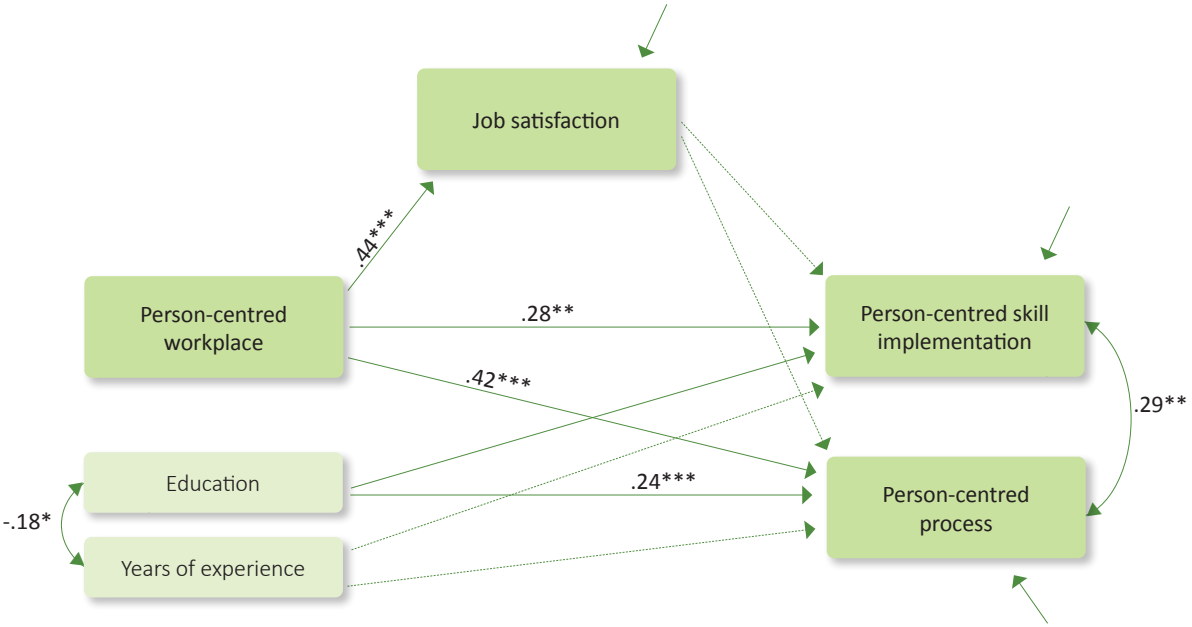
Test of proposed model

The proposed path model was tested with the maximum likelihood method in IBM's structural equation modeling programme AMOS, version 27. Fit indices reflected a good fit between the model and the sample data: $\chi 2(4, N = 171) = 3.40$, p = .493, NFI = .97, CFI = 1.00, RMSE = .00 (90% CI: [.00, .11]), pclose = .68. The individual paths in the model were examined with respect to the hypotheses. The path diagram of the model with the standardised parameter estimates is shown in Figure 1.

A direct relationship between a person-centred workplace and the implementation of person-centred practices was found. After control variables of education and years of experience were taken into account, there was a significant and positive relationship between a person-centred workplace and person-centred skill implementation (β = .28, p = .002), which means those workers who perceived to a larger degree that their workplace environment reflected person-centredness were more likely to implement person-centred skills when developing a plan of services and supports. Likewise, a significant and positive relationship was found between a person-centred workplace and person-centred processes (β = .42, p <.001), which means those workers who perceived to a larger degree that their workplace environment reflected person-centredness were more likely to incorporate person-centred practices when developing a plan of services and supports.

However, an indirect relationship through job satisfaction was not found. While a significant relationship was found between a person-centred workplace and job satisfaction (β = .44, p <.001), neither person-centred skill implementation nor person-centred processes was significantly related to job satisfaction. In this path model, the squared multiple correlation coefficient (R2) for person-centred skill implementation and person-centred process was .13 and .28, respectively.

Figure 1: Parameter estimates for person-centred practice



Discussion

The results reveal relationships between person-centred workplace, job satisfaction and person-centred practices; the principal finding is the strong influence that a person-centred workplace has on both person-centred skill implementation and person-centred processes. Although job satisfaction was significantly correlated to skill implementation in the bivariate analysis, that relationship was not detected in the path model. This further highlights the influence of person-centred workplaces on professionals implementing person-centred skills and incorporating person-centred processes. Another finding related to the variables of education and work experiences. Education was related to a person-centred process but not skill implementation; work experience was related to neither. These findings suggest that greater attainment of education or longer years of work experience do not promise the successful application of person-centred care.

This study's findings covering the influence of a person-centred workplace are consistent with previous studies that focus on the importance of organisational culture. The studies by Chenoweth et al. (2019), Moore et al. (2017) and Tellis-Nayak (2007) all emphasised a remodeling of the workplace culture to better reflect person-centredness and thus lead to greater person-centred care. This study further illustrates the need for this remodeling of the workplace environment, given the significant relationship shown between a person-centred workplace and skill implementation. Conversely, the role of job satisfaction in this study differs from previous studies that suggest it is a predictor for work engagement and job performance (Fried et al., 2008; Fidyah and Setiawati, 2019; Zhang et al., 2020; Sopiah et al., 2021; Ng et al., 2021). In this study, job satisfaction was not found to be a predictor for person-centred practices in the multivariate analysis when accounting for person-centred workplace. This finding highlights the impact of a person-centred workplace, rather than job satisfaction, on person-centred practices such as skill implementation and person-centred processes. This pathway demonstrates the overall importance of developing person-centred workplaces.

Limitations

The limitations of this study must be considered when interpreting the results. It was based on a purposive sampling approach that was not randomly selected. The HCBS Medicaid waivers included were limited to one state and not all of the five waivers from the state participated. Since this study used a cross-sectional design, causality cannot be inferred among the research variables. Future research may consider additional variables to better understand which factors facilitate or discourage

person-centred practices and which operate as mechanisms through which a person-centred workplace affects individual employees' engagement with those practices. Also, future researchers could consider larger sample sizes to analyse these variables on a wider scale. Broadening this research could also be achieved by including a greater number of HCBS Medicaid waivers across multiple states. Furthermore, the construct of person-centred workplace could be broadened to include workplace culture, which requires shared values among all employees.

Conclusion

In the US, person-centred practices are an increasingly important aspect of working with persons with physical and intellectual disabilities and older adults. Policy reforms such as the Medicaid HCBS final rule have driven this movement by mandating person-centred planning among many healthcare agencies (Centers for Medicare and Medicaid Services, 2014b). It is imperative for all levels of organisations to promote person-centred practices to further this transition to person-centred care among all staff members. This study facilitates the discussion of the importance of person-centred workplaces and their influence on a number of variables, including job satisfaction, knowledge of the person-centred process and implementation of person-centred skills. Increasing the understanding of which factors impact the use of person-centred care among organisations and staff members can help advance the transformation of systems of care.

Implications for future practice and research

Organisational policies should include fostering person-centred workplaces. They may achieve greater person-centredness in the workplace by investing in policies that promote greater staff autonomy and by offering consistent person-centred training. Practices to improve person-centred workplaces include establishing regular staff meetings to discuss the needs and preferences of care recipients, and providing enough time and resources for staff members to meet the goals of those they care for. Administrators and leaders could promote these policies by exemplifying person-centredness in their management approach and support of staff members.

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