EXCELLENCE IN PERSON-CENTERED CARE

Planetree Certification

Person-Centered Care Certification™ Program Manual

2017 revision

(with all changes to take effect January 1, 2018 in the United States and January 1, 2019 outside of the United States)

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For Additional Information:
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*This document **replaces** the following two documents (and any earlier iterations):*

- *Planetree Designation Process Manual, 2014-2015*
- *Planetree International Designation Process Manual, 2016-2017*

About Planetree International

Planetree International is a mission based not-for-profit organization that has partnered with over 700 healthcare organizations in 25 countries and across the care continuum to transform how care is delivered. Powered by over 50,000 focus group attendees comprised of patients, families, and staff, and nearly 40 years of experience working with healthcare organizations, the Planetree approach emphasizes the quality of human interactions that occur within healthcare settings, the importance of connecting healthcare personnel to the purpose and meaning of their work, and practical strategies for engaging patients and family members as true partners in care. These elements have been consolidated into the Person-Centered Care Certification Program, which provides organizations with a structured process to guide culture change efforts that yield improvements in clinical, operational and patient experience outcomes. Drawing on this experience, in 2017 Planetree partnered with the National Academy of Medicine to introduce an evidence-based Guiding Framework for Patient and Family Engaged Care, using the certification process as a foundation for sustainable improvement.

Acknowledgements

Planetree International is grateful to all of the healthcare organizations and professionals who have contributed to the development of the Person-Centered Care Certification Program over the years, and in particular as it has evolved from Version 1.0 (Patient-Centered Designation) to Version 2.0 (Person-Centered Care Certification). In particular, we would like to acknowledge the following individuals and groups for their contributions:

- Members of the Designation Advisory Committee who spearheaded the program's multi-year pilot phase
- All those who have served terms on the International Designation Committee and have provided vital guidance in the development and interpretation of the program elements
- Planetree International staff and partners who have implemented the program
- All of the patients, long-term care residents, family members, design professionals and professional caregivers at healthcare organizations across the continuum of care and around the world who have participated in the program, and whose insights over the years have largely informed the criteria that set a standard for excellence in the delivery of person-centered care.

This document, and specifically the revised criteria and measurable elements for Version 2.0 introduced here, were developed as part of a collaborative process spearheaded by the Designation Reconstruction Advisory Council, an international and multi-stakeholder group that included patient and family advocates, healthcare executives, practitioners, Planetree staff, board members and international partners. This group met monthly between September 2016 and February 2017, and provided significant input into the program revisions. Members unanimously endorsed the criteria revisions in March 2017.

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1. Background

In 2001, the landmark Institute of Medicine (IOM) Committee report, *Crossing the Quality Chasm* identified "patient-centeredness" as one of six key determinants of high quality healthcare, alongside safety, effectiveness, efficiency, equity and timeliness. Patient-centered care was defined by the IOM as "care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions." Another widely embraced definition emerged from the World Health Organization: "An approach that consciously adopts the perspectives of individuals, families and communities and sees them as participants as well as beneficiaries of trusted health systems that respond to their needs and preferences in human and holistic ways."

Since then, important strides have been made and have built on one another to accelerate adoption of what is now widely referred to as "person-centered care." (See page 6 for more on this.) The concept has been incorporated into healthcare policy and reimbursement models. It has sparked the interest of researchers who have studied the impact of person-centered approaches on outcomes, and it has fueled the emergence of patient experience officers and patient and family advisors in healthcare centers around the world. Person-centered care also gained prominence in organizations' mission statements, marketing efforts and web sites.

However, in the absence of a common understanding of the critical elements necessary to implement and sustain an organizational culture of person-centered care, person-centeredness remained more of an elusive aspirational state than a concrete goal that could be set, measured and attained.

In 2007, following a multi-year development and testing period, Planetree International introduced the Patient-/Resident-Centered Designation Program to address this gap between aspirations and actions necessary to create a more person-centered healthcare system. The program provides a structured, operational framework for evaluating the systems and processes necessary to sustain organizational culture change. Through a rigorous validation process that engages patients, their families and caregivers, the program recognizes healthcare organizations and providers that have achieved superior levels of practice of person-centered care. The program's framework has been implemented in settings across the continuum of care and in 23 countries worldwide.

In the ten years since the Designation Program was launched, progress has continued toward the goal of creating a more person-centered healthcare system. This work included the January 2017 release of a discussion paper by the National Academy of Medicine (formerly the Institute of Medicine) that introduced a new definition:

> ***"Care planned, delivered, managed, and continuously improved in active partnership with patients and their families (or care partners as defined by the patient) to ensure integration of their health and healthcare goals, preferences, and values. It includes explicit and partnered determination of goals and care options, and it requires ongoing assessment of the care match with patient goals."***

This new definition derives heavily from the IOM's 2001 definition, but is much more explicit in emphasizing the partnership between patients, families and their clinical team. By highlighting "partnered determination of goals and care options," this new definition advances understanding of person-centered care as going beyond working *for* patients and families to working *with* them – not only in designing their care at the personal level and in continuous improvement at the organizational level, but also in defining the outcomes that matter most to them. This is a fundamental shift in the orientation of many healthcare processes and practices.

To recognize this shift, a new term was introduced – patient and family engaged care. For the purposes of this document and throughout the Person-Centered Care Certification Program which aims to provide support for operationalizing these concepts of patient and family engagement, this is the definition Planetree feels best captures the broad range of practices, methods and approaches that encompass a culture of person-centered care.

1.1. Key Program Elements

- ***Criteria*** – The set of standards that delineate the critical elements necessary to implement and sustain an organizational culture of person-centered care. The criteria are intended to provide a level of consistency in what it means to be person-centered, while continuing to promote individuality and innovation in the delivery of care. The criteria are designed to be applicable to any organization across the healthcare continuum, irrespective of size, location or formal affiliation with Planetree.

- ***Validation via Documentation and the Lived Experience*** – Person-Centered Care Certification is conferred based on a variety of factors, including:
    - A written application wherein applicants attest to ways in which their organization's current activities satisfy the intent of the criteria;
    - Review of policy and process documents;
    - Performance on key organizational indicators related to person-centered care; and
    - How those who interface with the organization (patients, family members, staff) assess the person-centered culture.

  Fundamental to the evaluation process are focus groups or interviews with patients (and residents in long-term care settings) and family members, as well as with the organization's personnel. These focus groups and interviews elevate the voices of these key stakeholders as an integral part of the assessment of the organization's person-centered culture. This unique feature of the Person-Centered Care Certification Program ensures that certification is not conferred based solely on documentation, but based on the experiences of real people in real circumstances.

- ***Recognition Tiers*** – In 2011, intermediate recognition tiers were introduced to the program to provide interim opportunities for recognition for organizations working toward the highest level of recognition. The tiers each represent incremental levels of achievement. See page 13 for more on these recognition tiers.

2. Introducing Version 2.0: Person-Centered Care Certification™

Guided by the voices of patient and family partners and healthcare professionals across the continuum, Version 2.0 redesign of the program is being introduced in 2018. This effort signals the most significant improvement effort since the program's launch more than a decade ago. What remains the same, however, are the program's overarching goals, which have guided every decision and improvement effort in its evolution.

2.1. Program Goals

- To define the key elements needed to implement and sustain organizational cultures of person-centered care
- To provide a concrete framework for implementation; and
- To confer external validation and recognition that differentiates healthcare organizations demonstrating superior levels of achievement in person-centered care

2.2. About the Program Redesign Process

The program redesign was guided by the *Designation Reconstruction Advisory Council*, an international and multi-stakeholder group that included patient and family advocates, healthcare executives, practitioners, Planetree staff, board members and international partners. This group met monthly between September 2016 and February 2017, and provided significant input into the program revisions. Members unanimously endorsed the criteria revisions in March 2017. A list of members of this group is listed on page 1 of this manual.

In addition to the members of this advisory group, additional input was solicited during the development phase from a broad population of stakeholders via:

- A public comment period from January-February 2017 to solicit input on the draft criteria revisions
- Staff and International Partner feedback sessions
- Education and feedback sessions with representatives of Designated sites
- Small scale tests to operationally vet proposed process changes.

All of this input significantly influenced the development of Version 2.0 of the Person-Centered Care Certification Program, and Planetree extends its deep appreciation to all those who contributed their time, insights, and perspectives in this important work of defining what it takes to achieve person-centered excellence.

Another important source of guidance for the program redesign effort was the International Society for Quality in Healthcare (ISQua) International Accreditation Programme's (IAP) *Guidelines and Principlse for the Development of Health and Social Care Standrds, 4th Edition (September 2015)* and *Guidelines and Standards for External Evaluation Organisations, 4th Edition (September 2015)*. These standards provided direction for aligning the Person-Centered Care Certification standards and evaluation process with internationally-accepted best practices in external evaluation services.

2.3. Program Redesign Areas of Focus

The program redesign was guided by these four primary improvement strategies:

1. Re-organize and consolidate the criteria to emphasize the most high-leverage changes
2. Introduce a more transparent and logical scoring system for rating organizational performance
3. Promote greater flexibility in how organizations may meet the spirit and intent of the criteria
4. Redistribute performance expectations across the recognition tiers to expand opportunities for organizations to earn recognition for their progress.

2.4. From Patient-Centered Designation to Person-Centered Care Certification

Among the changes being introduced as part of the program redesign is a renaming of the program from the Patient-Centered Designation Program to the Person-Centered Certification Program.

Why Person-Centered?

This fairly subtle shift in terminology from "patient-centered" to "person-centered" is in line with an approach to healthcare that treats individuals as more than a sum of their body parts and medical conditions.

When it comes to how individuals view themselves and how they want to be viewed by others, rarely is "patient" the primary definer of their identity. They are multi-dimensional human beings, whose care should be provided in a holistic may to address their full range of their needs, preferences and experiences. In other words, it is an approach that focuses on the *person* first.

Furthermore, to truly promote health, wellness and holistic care, we must look beyond an individual's health history and their list of complaints and symptoms to consider their experiences *outside* of the healthcare delivery system. Better understanding the social determinants of an individual's health is an integral component of person-centered care.

Finally, adoption of this terminology better captures the inclusiveness of person-centered care. A person-centered culture is not built solely around the patient experience and the needs and preferences of patients, but also must address the experiences and needs of family members, as well as of healthcare professionals.

Why Certification?

The program has been restructured as a *certification* program to minimize confusion in the marketplace created by Planetree's previous use of the term *designation,* which was not widely understood. The term *certification* is more universally recognized for the kind of structured, standards-based quality improvement framework that this program provides.

****Note: Any organization that has been awarded Patient-Centered Designation (or Bronze or Silver-level recognition) will retain that honorific and use of the Version 1.0 badge for the duration of their current term.****

2.5. What is New in Version 2.0?

- The criteria that delineate the critical elements for achieving excellence in person-centered care have been significantly re-organized and consolidated. The new set of criteria narrows in on the most high-leverage, evidence-based changes tied to what matters most to patients, families and healthcare personnel. The revised set includes 26 criteria across five drivers, compared to 66 criteria across 11 domains in Version 1.0 of the program.

- Measurable elements have been associated with each of the criteria. These indicators provide explicit guidance on how an applicant will be measured or rated on each criterion.

- A quantifiable scoring system has been developed to logically and consistently measure achievement. The scoring system is based on numerical points associated with each measurable element.

- The evaluation methodology has been designed to ensure that evidence derived from the "lived experience" (for instance, focus groups, observation, discussion, etc.) continues to be the most heavily weighted component of the certification score.

- The performance levels associated with each recognition tier have been adjusted, with defined scoring ranges corresponding with each. In Version 2.0, the recognition levels are defined by the number of points earned by an applicant site. The levels of recognition are:

    - **Planetree Certified Bronze (96 – 119 points).** *Or at least 60% of the total available points.*

    - **Planetree Certified Silver (120 - 143 points).** *Or 75%-89% of the total available points.*

    - **Planetree Certified Gold (144 points or more).** *Or 90% or more of the total available points*

- The introduction of an online application (available at https://application.planetree.org/) will enhance the applicant experience and reduce the administrative burden of applying.

- A glossary of terms that appear in the criteria and measurable elements has been developed to promote common understanding and interpretation of the terms.

2.6. New Certification Badges

In conjunction with the roll-out of the Person-Centered Care Certification Program, in 2018 new recognition badges will be introduced to reflect the new person-centered certification language adopted in Version 2.0. In addition, to better leverage the badges to communicate to the public what the achievement of Person-Centered Care Certification means, language has been incorporated into the design that conveys the essence of person-centered care in three words: *Quality, Compassion, Partnership*.

2.7. Transition Timeline

- *Transition to Version 2.0 in the United States:* The new criteria and modifications to the evaluation process, including transition to a new on-line self-assessment tool, will take effect in the United States on January 1, 2018.

- *Transition to Version 2.0 Outside of the United States:* The new criteria and modifications to the evaluation process, including transition to a new on-line self-assessment tool, will take effect outside of the United States on January 1, 2019. However, all sites have the option to use the new criteria earlier than that if they choose to do so.

3. Program Terminology

The following terms are used in the program overview. For consistent understanding, they are defined below.

Criteria: The standards organizations are held to. Each of the 26 criteria is broken down into measurable elements which establish a more operational understanding of what it takes to demonstrate that the spirit and intent of the criterion is being met.

Documentation Evidence: Evidence provided in writing as part of the application process.

Drivers: A high level depiction of what it takes to create and maintain a culture of person-centered care. The criteria are organized into 5 drivers:

- Create organizational structures that promote engagement
- Connect values, strategies and action
- Implement practices that promote partnership
- Know what matters
- Use evidence to drive improvement

Lived Experience Evidence: Evidence that can only be acquired from being on-site at an organization and interacting directly with stakeholders. Approaches used to gather this lived experience evidence include focus groups, interviews, meetings and structured observation.

Measurable Elements: An explicit accounting of the operational requirements needed to fully satisfy each criterion. Each measurable element is associated with a numerical point value.

Person-Centered Care: "Care planned, delivered, managed, and continuously improved in active partnership with patients and their families (or care partners as defined by the patient) to ensure integration of their health and healthcare goals, preferences, and values. It includes explicit and partnered determination of goals and care options, and it requires ongoing assessment of the care match with patient goals." (National Academy of Medicine, 2017)

Provisional Score: Points awarded to a site based on the documentation evidence submitted. Points remain provisional until validated through lived experience evidence acquired during the on-site portion of the evaluation process.

4. Person-Centered Care Certification Program Elements

The Person-Centered Certification Program provides a structured, operational framework for evaluating the organizational systems, processes and practices necessary to achieve the aim of *improving quality, patient loyalty and staff engagement by building a continuously learning person-centered organizational culture driven by the voice of patients*. The diagram below depicts this framework.

4.1. Person-Centered Care Drivers

The Person-Centered Care Certification criteria are organized around 5 drivers. These drivers present a high-level depiction of what it takes to create a culture of person-centered care. They include:

1. **Create organizational structures that promote engagement** – *Organizational and physical structures that break down the barriers, both literal and figurative, between healthcare professionals and patients/residents and families*
2. **Connect values, strategies and actions** – *Efforts to create cohesion between what we do, i.e. behaviors and tasks, and why we do it, i.e. values and mission.*
3. **Implement practices that promote partnership** –*Methods, processes and behaviors adopted by teams to guide healthcare interactions that cultivate trust, build reciprocal relationships and improve communication between patients/residents/families and healthcare professionals.*
4. **Know what matters** – *Efforts to deliver individualized, whole person care. Care is personalized according to individual needs, preferences and values, and based on partnered determination of goals.*
5. **Use evidence to drive improvement** – *Organizational capacity to create measurable change.*

4.2. Criteria

The criteria operationalize the guiding principles expressed through the drivers and break them down into their principle components. There are between 4 and 7 criteria associated with each driver, for a total of 26 criteria.

4.3. Measurable Elements

The concepts expressed through the drivers and criteria are further clarified through the measurable elements. Measureable elements are associated with each of the criteria as an explicit accounting of what is required to fully satisfy each criterion. They serve as indicators of how, specifically a site will be measured or rated on each criterion. Each measurable element is associated with numerical points for sites to accrue toward a final score.

4.4. Numerical Points System

Table 1.1 depicts the number of points associated with each criterion, and then with each driver. The total number of points that can be earned is 160. The 160 points are equally distributed among the five drivers; however not all the criteria are weighted the same. Point weights for the criteria range from 2 points to 15 points.

Table 1.1. DRIVER	CRITERION							Grand Total
	1	2	3	4	5	6	7	
1. Create org. structures that promote engagement	6	2	13	7	4			32
2. Connect values, strategies and action	8	7	7	10				32
3. Implement practices that promote partnership	4	4	4	4	3	4	9	32
4. Know what matters	6	7	5	9	5			32
5. Use evidence to drive improvement	2	6	15	3	6			32

How are points earned?

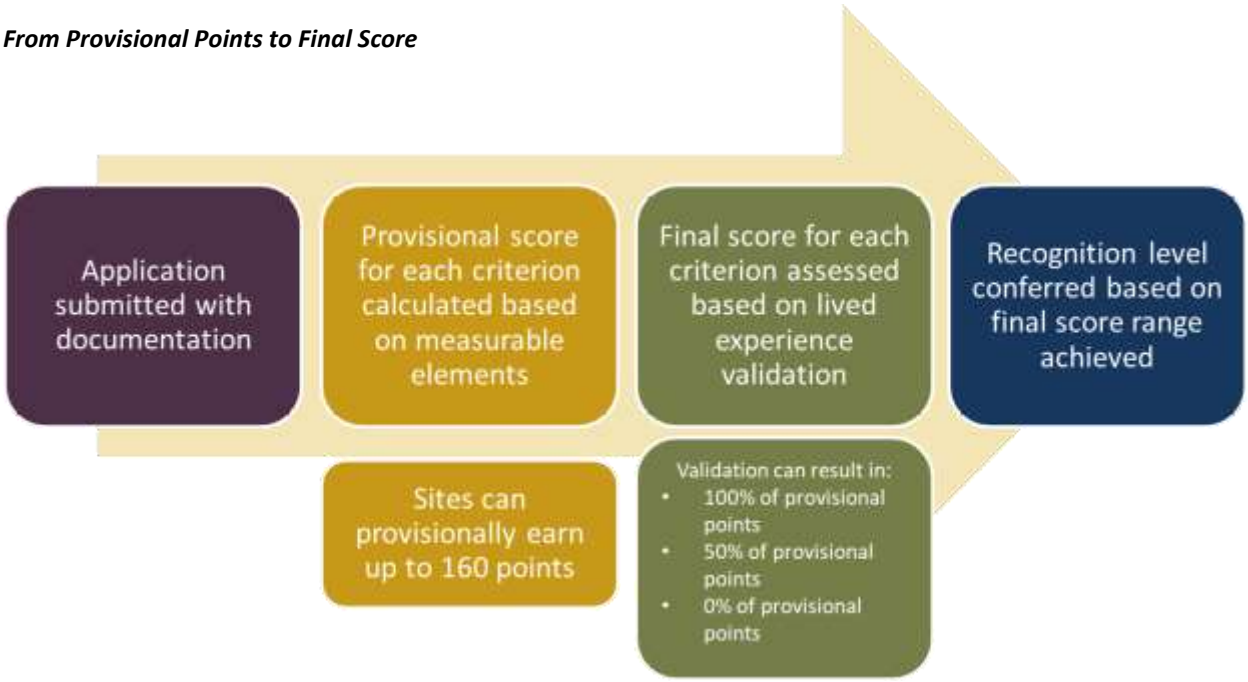
Points are first awarded to an applicant provisionally. These **provisional points** are accrued based on how well the written application and submitted documentation address the measurable elements associated with each criteria.

Upon review of their application by program staff, applicants will be notified of the number of provisional points they have earned. At that time (before the on-site validation visit), the applicant has the opportunity to submit further evidence to earn additional provisional points, leading into the on-site visit.

Points remain provisional until validated through **lived experience evidence** acquired during the on-site portion of the evaluation process. Lived experience evidence is defined as evidence that can only be acquired from being on-site at an organization and interacting directly with stakeholders. Approaches used to gather this lived experience evidence include focus groups, interviews, meetings and structured observation.

As depicted in the figure below, based on observation and discussion with stakeholders during the validation process, for each criterion, an applicant may either earn 100% of its provisional points; 50% of its provisional points or none of its provisional points. This "carry over" process of provisional points to final scoring of the application is applied criterion by criterion.

From Provisional Points to Final Score



The rating scale for lived experience evidence is based on:

- **Frequency and consistency of comment type,** e.g. expressions of satisfaction versus dissatisfaction
- **Specificity of feedback,** e.g. degree to which expressions of (dis)satisfaction are accompanied by personal examples that left an impression (positive or negative)
- **Importance**, e.g. match between satisfaction and prioritization

Table 1.2 below provides guidance into how lived experience evidence is evaluated, and how the ratings are applied:

Table 1.2. Lived Experience Evidence Rating Scale

FULL VALIDATION	Lived experience evaluation strongly validates documentation. Multiple participants per group are able to draw on personal experiences as examples of PCC in action. Extremely limited "outlier" comments or experiences.	100% of documentation points applied.
PARTIAL VALIDATION	Lived experience evaluation is inconclusive, i.e. One of the following occurs: • Participants within the same group share reports of conflicting experiences • Themes from different groups conflict with each other • Discussion evidences variability on the specific topic (between shifts, between units or locations, between weekday/weekend end, etc.) • Limited feedback makes it difficult to validate the application.	50% of documentation points applied
NO VALIDATION	Lived experience strongly contradicts documentation. • A critical mass of site visit participants routinely and consistently attest to experiences that are in conflict with person-centered care. • There is widespread agreement (across groups, across units and locations, etc.) that actual practice contradicts documentation.	0% of documentation points applied

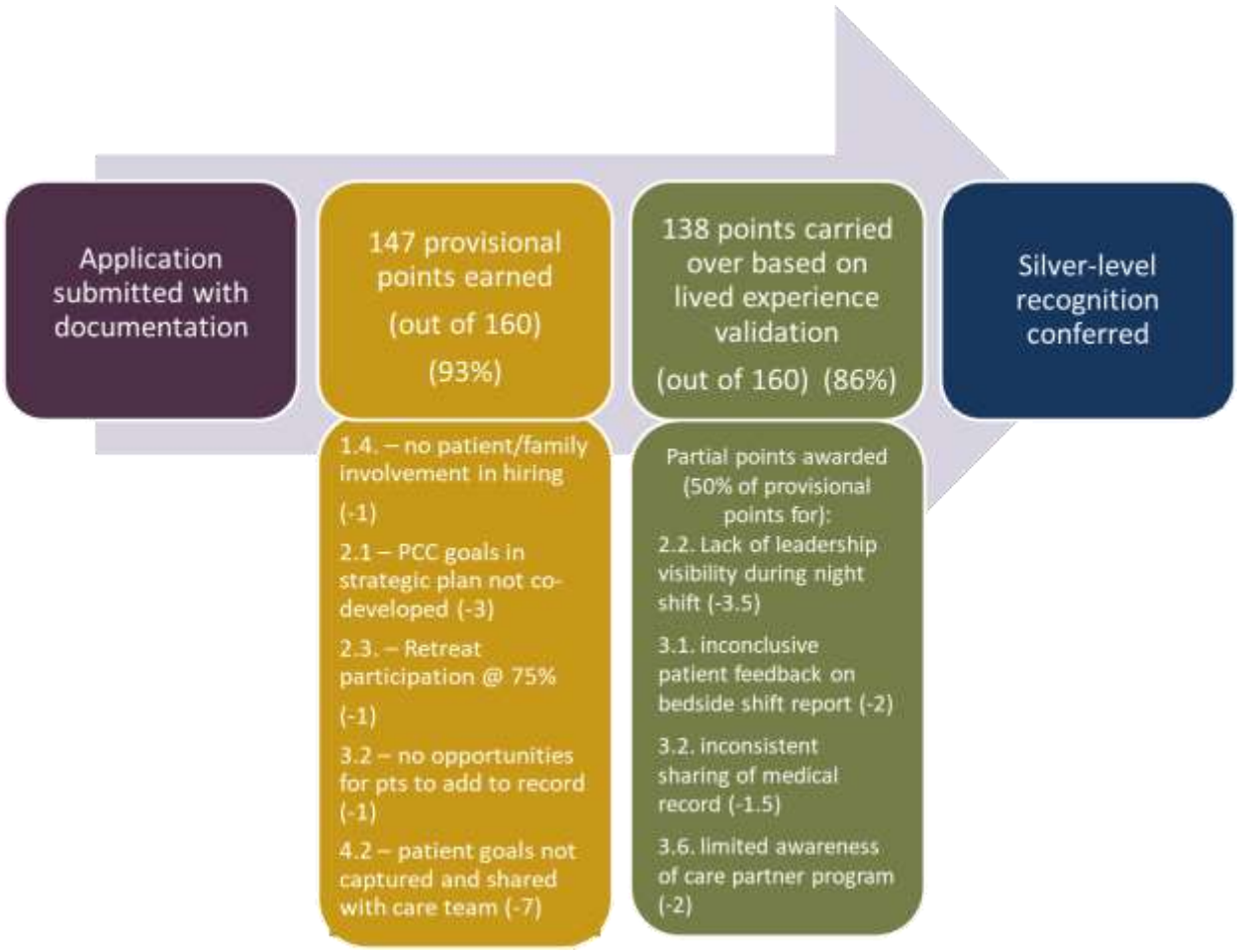
Recognition Levels and Point Range Performance Thresholds

Recognition levels are now defined by the number of points earned by an applicant site:

- **Planetree Certified Bronze (96 – 119 points).** *Or at least 60% of the total available points.*
- **Planetree Certified Silver (120 - 143 points).** *Or 75%-89% of the total available points.*
- **Planetree Certified Gold (144 points or more).** *Or 90% or more of the total available points*

An Example for Clarification

The figure below provides an example of how this scoring process is applied.



5. Process Overview: Step by Step Guide to Applying for Certification

Pre-Work	Applicants are encouraged to prepare to apply for Person-Centered Care Certification by completing a readiness assessment. This assessment may be a self-study (self-assessment) in which a multi-stakeholder team from the applicant organization examines how current activities align with the criteria. Another possibility is to engage Planetree to complete an independent gap analysis. A gap analysis is a multi-day site visit consisting of focus groups with patients/residents, staff and other key constituent groups, as well as observation and a facility walk-through and design assessment. This visit occurs prior to the site applying for certification, and is intended to prepare the organization to apply. At the conclusion of the gap analysis, the organization's leadership team will be provided with a comprehensive report relating their current practices to each of the certification criteria. Recommendations of where additional work may be necessary to meet the criteria will also be included. These self-assessment activities are designed not only to position the applicant for success in the certification program, but also to chart a course for continuous learning and improvement. Also during this preparation phase, applicants have the opportunity to consult with Planetree staff to receive technical assistance about the certification process.
Step One: Complete and Submit the Online Person-Centered Care Certification Application	As of January 1, 2018, applications from U.S.-based organizations for Person-Centered Care Certification will only be accepted via the online tool. (For sites outside of the U.S., application via the online tool will be required as of January 1, 2019). The application can be accessed at www.application.planetree.org. Users will need to set up a user name and password to access the online application. The on-line application includes questions that prompt the user for a narrative response, as well as evidence requirements that prompt the user to upload documents. Narrative responses should be focused, and not excessive. Read the application carefully, as in many cases, documentation may be uploaded as evidence in lieu of submitting a narrative response. The on-line application can be saved and re-visited as often as necessary. Updates and revisions can be made up until the application is submitted. Failure to respond to a question or to upload the requested documentation will result in forfeiture of the associated points. All of the narrative questions and evidence requirements are outlined in Section 7 of this manual to assist applicants in preparing their application. Once all of the responses have been entered and evidence uploaded, submit the application.

Step Two: Application Review	Submitted applications are then reviewed and scored by Planetree staff. A ***provisional score*** will be calculated based on the evidence provided in the application. The provisional score will be communicated to the applicant with an accounting of where points were withheld.
Step Three: Opportunity for Provisional Score Adjustment	Based on the understanding of where and why provisional points were withheld, the applicant will have the opportunity to submit additional documentation and information to increase its provisional score. Additional information and documentation may be supplied until the final day of the on-site validation visit. This supplementary information may influence the provisional score, and the site will be kept apprised of any adjustments to its provisional score as it prepares for the validation visit. All supplementary information must be submitted through the on-line application portal.
Step Four: Schedule the On-Site Validation Visit	Planetree certification staff works with the applicant's identified point person(s) to schedule the on-site validation visit and finalize the schedule for the visit. It will generally take four to six weeks for a visit to be scheduled after the application has been reviewed. The cost, duration and number of evaluators for the validation visit will be determined in advance, based on the size and complexity of the organization. Approximately one month before the visit, the visit schedule is finalized, and the applicant is then responsible for organizing focus groups, per the agreed upon schedule.
Step Five: The On-Site Validation Visit	An evaluation team comes on-site to observe interactions and operations, as well as to conduct a series of focus groups and/or interviews with patients/residents and families, personnel, and members of the medical staff, and patient/resident and family advisors. In addition, they will meet with the leadership team and members of the multidisciplinary steering team guiding person-centered care implementation efforts. The role of the evaluation team is to validate through these qualitative methods that the organization is meeting the needs of its patients/residents and staff. At the completion of the validation visit, the site visit team will provide a debriefing session with leadership to share findings, including an anticipated (but not yet final, definitive) certification score range. Following the site visit, a more detailed written report is provided to the applicant, including pertinent comments from the focus groups and a complete accounting of the number of points earned for each criterion.

Step Six: Application Scoring – From Provisional Score to Final Score	A final certification score is calculated based on based on the extent to which the lived experience evidence validates the submitted documentation. This determination is made by the evaluation team for each criterion. • For "fully validated" criteria, 100% of the provisional points will be awarded. • For "partially validated" criteria, 50% of provisional points will be awarded. • For any criteria where lived experience evidence consistently contradicted the documentation (i.e. "not validated), none of the provisional points will be awarded. The final score is the total of all the points earned. The level of certification conferred is based on the applicant's final total score: • Planetree Certified Bronze (96-119 points) • Planetree Certified Silver (120-143 points) • Planetree Certified Gold (144 points or more)
Step Seven: Conferring of Certification	Certification is conferred by an independent, international committee based on the total number of points earned by a site. The accrual of points will be documented by staff based on findings from the application and on-site evaluation processes. Summaries of sites' performance are circulated for committee validation prior to awarding certification. Applicants can anticipate being notified of their Person-Centered Care Certification status within 6-8 weeks of the on-site validation visit. ***NOTE: Unlike Version 1.0 of the Patient-Centered Designation Program, there is no longer a remediation period after the site visit for applicants to respond to gaps that emerged during the on-site work. Certification is awarded at the level corresponding to the total number of points accrued during the evaluation process.**
Step Eight: Promotion and Celebration	Applicants are encouraged to promote certification to their staff, patients/residents and the local community. Planetree will provide a marketing toolkit to assist in promotion. Planetree will annually announce and recognize all Planetree Certified sites at the Spirit of Planetree Awards Dinner held during the Planetree Annual Conference. Certified sites are encouraged to be represented at the awards ceremony to receive this acknowledgement.
Step Nine: Site Provides Routine Updates to Planetree for Duration of Certification Term	The certification term is three years, during which time Planetree Certified sites are expected to continue to adhere to the criteria and incorporate appropriate policies and procedures as changes are published and made effective from time to time (though not more often than one time a year).

6. The On-Site Validation Visit

To achieve Person-Centered Care Certification, an applicant organization must demonstrate that it has been able to effectively operationalize the person-centered concepts represented in the criteria. It is not sufficient for an organization to demonstrate satisfaction of the criteria on paper; it must be apparent from interacting with stakeholders that the organization lives its commitment to person-centered care daily. Therefore, after reviewing the application materials, Planetree schedules an on-site validation site visit that consists of the following:

- Observation of services and interactions
- Facility walk-through (with direction from the evaluation team of areas to visit)
- Focus groups with patients and patients' families and/or with residents and residents' families
- Focus groups with staff and organization leadership (including leadership from the governing body or board of directors)
- Meeting with patient/resident and family advisors
- Impromptu interviews with current patients/residents
- Focus groups with staff
- Impromptu interviews with staff
- Focus group with medical staff
- Meeting with the group that oversees organization-wide implementation of person-centered practices

Please note that a responsible person from the organization should be on the premises at all times to facilitate the site visit and answer questions for the Planetree team. This person does not, however, attend the focus group sessions.

6.1. Duration

The typical duration of a validation site visit is three to five days, depending on the size and complexity of the organization.

6.2. The Evaluation Team

Evaluation teams typically include two Planetree team members. However, the number of evaluators and the length of the site visit will be determined by Planetree based on information in the application, including the size and complexity of the organization.

6.3. Scheduling Site Visit Dates

Site visit dates are established by the Planetree evaluation team in consultation with the application point person. Planetree must be advised at the time of submission of the application if there are days during the designated time frame that will pose problems for the organization. Examples of such days may include community events, religious holidays and vacation plans.

A draft schedule for the visit will be prepared by Planetree and shared with the application point person in advance of the visit.

6.4. Cancellation and Rescheduling

After consulting with the applicant organization to identify mutually convenient dates for the visit, Planetree will notify the site of the specific site visit dates. This will occur at least 30 calendar days prior to the visit. An organization is considered scheduled for a site visit on the date the notification is sent. The dates established are then considered final. All related nonrefundable travel cancellation expenses will be assessed if an organization requests any change in the scheduled dates of its assessment visit, whether cancellation, postponement, or other date change.

6.5. Note on Focus Group Participation

The involvement of constituents served is essential to any person-centered approach. Focus group feedback, therefore, is a pivotal component of the evaluation process. The use of neutral moderators in safe environments encourages comments of all types -- positive and negative. It is through these groups that the evaluation team can hear firsthand from those being cared for and the team of caregivers about how the site's person-centered approach has made an impact on their personal experiences.

During the site visit, a variety of focus groups will be conducted. The focus groups are one of the primary ways that Planetree validates successful implementation of the criteria and well populated focus groups are essential to a successful site visit. **Each of the patient/resident focus groups must be attended by a minimum of eight (and no more than twelve) randomly selected participants, and each of the employee focus groups must have a minimum of ten (and no more than twelve) randomly selected participants.** It is essential that participants in patient/resident focus groups not have any other relationship with the organization (e.g. as a volunteer, employee, Board member, etc.).

It is the applicant's responsibility to ensure minimum participation levels in each focus group. The applicant's point person recruits focus group participants, confirming their availability to participate in focus groups and/or interviews during the visit. At least three weeks prior to the site visit, the organization must have a plan in place to ensure adequate participation in focus groups.

If the focus groups are not adequate, either because of the number of participants or because the participants have a relationship with the site, Planetree may require a second on-site visit, at the applicant's expense, to conduct additional focus groups before reaching a certification decision. *Tips for recruiting focus group participants are located in Appendix H.*

Representative comments made during the focus groups will be provided to the applicant as part of the final certification report.

6.6. Site Visit Facility Walk-Through

A walk-through of the facility will be incorporated into the site visit. The purpose of this walk-through (which may be broken up and spread out over the course of the visit) is both to:

- Assess the degree to which a healing environment has been established, and
- Provide the opportunity for more spontaneous interaction and discussion with stakeholders throughout the organization.

The applicant should assign a tour guide who is familiar with the layout and function of all patient/resident, family/visitor and staff support areas. However, please note that the evaluation team will identify the specific areas they would like to walk-through (in consultation with the tour guide). These determinations will be guided by

the criteria, information provided in the application, as well as discussion with stakeholders during the visit.

6.7. Debrief Report

Prior to departing, the evaluation team will provide a debriefing session with leadership to present findings from the site visit, as well as preliminary results. A final certification score will not be announced to the team, as decisions require the review of the independent committee that confers certification to be finalized.

7. Person-Centered Care Certification Criteria and Measurable Elements

The following section provides an in-depth look at each of the 26 criteria for Person-Centered Care Certification. For each criteria, you will find:

- **A Statement of Intent** to clarify the purpose of the criteria and why it is a high leverage driver of person-centered excellence.
- **Explanations and Clarifications** to support common understanding of the criteria, its intent and how it will be evaluated.
- **Operational Examples** of how the criteria could be applied in practice. *These examples do not represent the ONLY ways the criteria could be applied. The examples are provided as further guidance for understanding the criteria. Organizations are welcome to present approaches other than those included in the examples if they achieve the intent described.*
- **The Measurable Elements** associated with the criteria that provide an explicit accounting of what is required to fully satisfy each criterion. They serve as indicators of how, specifically a site will be measured or rated on each criterion.
- **An Accounting of How the Criteria will be Scored**, with a breakdown of points associated with each measurable element.
- **A Preview of the Application Questions and Evidence Requirements.** The questions and requirements presented here are for information and preparation purposes only. This is not an application form. All applications for Person-Centered Care Certification must be submitted online using the online application portal.

1.1.	**6 points**
A multi-disciplinary, site-based committee structure oversees and assists with implementation and maintenance of person-centered practices. Active participants include: **• Patients/residents and/or family members*;** **• A mix of non-supervisory and management staff;** **• A mix of clinical and non-clinical staff** **• A senior-level executive champion** **• A senior level clinical champion.** ***patient/resident/family member participants represent "end users" of the services and are not currently employed nor previously employed by the organization.***	

Intent: Implementation of person-centered practices does not fall to one person/position alone. Nor is it limited as a charge to one specific sector or functional department of the organization. A structure is in place to:

- Promote the inclusion of individuals from all key stakeholder groups
- Coordinate and guide person-centered projects and initiatives across the organization
- Spread and scale person-centered initiatives throughout the organization.

Active participation by a senior level executive champion ensures a direct line of communication with senior leadership.

Active participation by a clinical champion ensures that when person-centered initiatives affect clinical processes, all aspects of quality, regulatory and outcome measures are considered.

Explanations and Clarifications:

- *Senior-level executive champion*: Functions as or reports to the highest level of management within the organization.
- *Senior-level clinical champion:* A clinical staff member (from nursing or the medical staff) who functions as or reports to the highest level of management within the organization

Examples

- Person-centered care steering committee, task force or guiding coalition that meets on a regular basis
- Practice improvement team
- System-level person-centered care steering committee, with site-based improvement teams
- Culture change task force

1.1. MEASURABLE ELEMENTS

1.1.1.	Documentation of the group's activities over the past 12 month provides evidence that the structure is well-established and participants meet on a regular basis.	1 point
1.1.2.	Representatives from each of the following sectors have participated in 100% of the 3 most recent meetings: patients/residents/families; non-supervisory staff; management staff; clinical staff; non-clinical staff.	1 point
1.1.3.	The work of this group is aligned with the organization's strategic and operational goals (as established in criterion 2.1)	1 point
1.1.4.	A senior level executive champion has participated in a minimum of 8 of the last 12 meetings.	1 point

1.1.5.	A clinical champion has participated in a minimum of 8 of the last 12 meetings.	1 point
1.1.6.	The current group roster evidences membership mix aligned with criteria.	1 point

1.1. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

1. What entity or structure(s) currently oversees and assists with implementation and maintenance of person-centered practices?

2. Briefly describe the function or charge of this group or structure.

3. How often does the group meet?

4. How many times has the group met over the last 12 months?

***Note: (A group charter, or equivalent, can be uploaded in lieu of responding to questions 1-4 if it addresses the questions.)**

5. Who has been identified as the senior-level executive champion for this group? (Name and title)

6. After reviewing the attendance roster for the last 12 meetings of this group, can you attest to this person's participation in a minimum of 8 of the last 12 meetings? (Yes or No).

7. Who has been identified as the clinical champion for this group? (Name and position)

8. After reviewing the attendance roster for the last 12 meetings of this group, can you attest to this person's participation in a minimum of 8 of the last 12 meetings? (Yes or No).

9. Provide specific examples of how the work of this group over the past year has supported progress toward the organization's broader strategic and operational goals (as documented in criterion 2.1)

1.1. Required Evidence to Upload	**Guidance**
EV1. Attendance rosters to evidence that representatives from each of the following sectors participated in 100% of the 3 most recent meetings (1. patients/ residents/families; 2. non-supervisory staff; 3. management staff; 4. clinical staff; 5. non-clinical staff.	• 3 most recent meetings all should have occurred within 4 months of submitting the application. • One person can represent multiple groups, i.e. a director of nursing is both clinical and management.
EV2. Documentation of the group's activities/ discussion from the 3 most recent meetings as evidence that areas of focus are aligned with organizational priorities (see criterion 2.1)	• 3 most recent meetings all should have occurred within 4 months of submitting the application. • Examples of evidence include meeting minutes, meeting notes, reports/updates to the governing body, etc. that connect the dots between the goals established via criterion 2.1 and the goals and/or activities of this group.
EV3. Current membership roster, with names, job titles and/or roles (i.e. patient, resident or family)	• No one group (i.e. patients/residents/family; non-supervisory staff; management staff; clinical staff; non-clinical staff) should be represented by a single member (i.e. one patient/resident/

	family; one clinical staff person, etc.)
***Optional* Evidence to Upload**	**Guidance**
Team Charter (or equivalent)	A team charter (or equivalent) can be provided in lieu of responding to questions 1-4 if the document addresses the questions posed.

1.2 **An individual (or team) is appointed to guide implementation of activities that advance organizational progress toward person-centered care goals. This individual (or team) functions as or reports directly to a senior executive in the organization.**	**2 points**
Intent: As an organizational priority, person-centered care efforts are allocated the staff resources needed to be successful and sustained over time. The person(s) in this role is not required to have a special title or be 100% focused on person-centered care (they may serve other functions in the organization), but the portion of their time dedicated to person-centered care responsibilities should be sufficient to advance related organizational goals. In addition, all members of the organization should be aware that this is the person (or team) with day-to-day responsibility for managing activities toward person-centered goals. Organizations also have the option of creating an office or department that serves this function (such as Planetree, Patient Experience, or Person and Family Engagement). A reporting structure wherein this role either functions as or reports directly to a senior executive in the organization establishes person-centered care as a leadership priority, promotes alignment between PCC goals and larger organizational goals, and facilitates decision-making and planning when additional authority may be necessary.	
Explanations and Clarifications: *Senior-level executive*: Functions as or reports to the highest level of management within the organization.	
Examples • Director of Person-Centered Care • Chief Experience Officer • Planetree Director • Service Excellence Director	

1.2. MEASURABLE ELEMENTS

1.2.1. A job/role description formalizes expectations and duties for the person and/or team who guides person-centered care implementation.	1 point
1.2.2. The job description and/or organizational chart evidences a reporting relationship within the organization aligned with the criteria.	1 point

1.2. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

10. What is the name and position of the individual(s) appointed to guide person-centered care implementation?

11. How long has this person been in this role?

1.2. Required Evidence to Upload	**Guidance**
EV4. Job/role description	
EV5. If not explicitly stated in the job/role description, provide evidence of the reporting relationship for this role within the organization.	An example of an acceptable form of documentation is an organizational chart.

1.3.	**13 points**
The organization's ongoing improvement structure and process rely on partnerships between leadership, staff and patients/residents/families to identify, prioritize, design and assess person-centered improvement efforts. Stakeholders are educated in improvement methods and are supported in making real time change.	

Intent: The organizational culture is one of continuous learning and improvement. Person-centered improvement efforts are collaborative, and are informed by the voices of leadership, staff and patients/residents/families. Importantly, these structures or processes rely heavily on and emphasize the perspectives of patients/residents/family and community members to provide input and guidance on operations, policies, procedures, and quality improvement efforts. These are true partnerships, and the structure(s) or process(es) support collaboration, relationship-building, and co-creation of goals and solutions.

Explanations and Clarifications:

- *Measurable Improvement*: A discernible and positive difference in achievement toward a specified goal.
- ***Clarification for 1.3.1.*** Review of patient/resident and/or staff survey data does not constitute patient/resident/family or staff involvement.

Examples:

- Patient and Family Advisory Council, Patient and Family Partnership Council or Resident Council
- Practice Improvement Teams that include patients and family members
- Rapid Improvement Events with customary patient/resident/family involvement
- Plan-Do-Study-Act Cycles with customary patient/resident/family involvement
- Integration of patient/resident/family partners as full members on existing teams and committees
- Learning circles for problem-solving and decision-making, with customary patient/resident/family involvement
- QAPI (Quality Assurance and Quality Improvement) initiatives within continuing care settings
- Action teams or project teams with patient/resident/family involvement

1.3. MEASURABLE ELEMENTS

1.3.1. Formalized structures are in place that bring together patients/residents/families with staff and leadership to collaborate on improvement efforts. Formalization of these efforts includes an effective process for recruiting and orienting patient/resident/family partners.	1 point
1.3.2. Education is offered to staff to build competency in improvement work.	1 point
1.3.3. Processes are in place for sharing knowledge derived from improvement projects throughout the organization.	1 point
1.3.4. Within the last 12 months, a minimum of 3 improvement efforts have been implemented with the express involvement of leadership, staff and patients/residents/families, and there is evidence that each of these efforts has yielded measurable improvement.	9 point
1.3.5. Processes are in place to identify improvement priorities for the coming year.	1 point

1.3. Questions Requiring* a Narrative Response

***Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)**

12. What structures, processes and/or actions have been instituted to facilitate the involvement of patients/residents/families in ongoing improvement work?

13. Describe the structure(s), and how they function in order to promote co-production among patients/residents/family, staff and leadership in improvement efforts.

***Note: (A group charter, or equivalent, can be uploaded in lieu of responding to questions 12-13 if it addresses the questions.)**

14. What have been your most successful strategies for recruiting patient/resident and family partners (or advisors)?

15. How are patient/resident and family partners (or advisors) prepared and oriented to the role they will play?

16. How is the knowledge derived from improvement projects shared throughout the organization?

17. How are future improvement priorities established? Specifically, what sources of evidence will the organization consult to inform improvement priorities in the coming year? *(Examples may include any of the data sources identified in criterion 5.2; findings from the qualitative data collection efforts outlined in criterion 5.5, a community health needs assessment, a health literacy assessment, etc.)*

1.3. **Required Evidence to Upload**	**Guidance**
EV6. Current roster of patient/resident/family partners (or advisors)	Patient/resident/family partners are not currently employed nor previously employed by the organization.
EV7. Documentation of education offered to staff over the past 12 months to build competency in improvement work.	Acceptable forms of documentation include list of relevant outside trainings/conferences attended by staff; staff training objectives, slides, workbooks or screen shots of online learning modules.
EV8. 3 completed Partnership Portfolio Worksheets to document 3 specific improvement efforts undertaken within the past 12 months with the express involvement of patients/residents and family partners (or advisors) that have yielded measurable improvement.	**Partnership Portfolio Worksheet Template** When selecting improvement efforts to submit, note that: • At a minimum, two of the three efforts submitted should relate to the patient/resident experience or care • At least one should reference patient/resident/ family involvement in improving a **clinical** practice or process • Not more than one of the three improvement efforts described may be related to the staff experience, in which case there is no requirement for patient/resident/family involvement • Not more than one of the three efforts described should be related to design of the physical environment of care. **However, if a renovation or construction effort has taken place in the last 12 months, it is required that one of the three efforts described focus on how users of the space were involved in the effort.** • At a minimum, one of the three efforts described in the Partnership Portfolio demonstrates the organization's ability to scale an improvement project beyond a small-scale test or pilot. The description should cover the process for spreading the improvement effort.
***Optional* Evidence to Upload**	**Guidance**
Team Charter (or equivalent)	A team charter (or equivalent) can be provided in lieu of responding to questions 12-13 if the document addresses the questions posed.

1.4.	**7 points**
Staff engagement approaches reflect the organization's person-centered care philosophy. There is evidence that person-centered care principles, including caring attitudes and compassionate communication, are integrated into the following: **• Job descriptions** **• Performance evaluation systems** **• Reward and recognition systems** **• New hire screening, selection and orientation.**	

Intent: Person-centered care is understood to be the responsibility of all staff members, regardless of their role in the organization. Staff members are supported in understanding how they are expected to exhibit the values of person-centered care in their role, including the expectation that all staff members will respect and partner with patients/residents and colleagues across disciplines and sectors of the organization. These expectations are established in recruitment and hiring activities, and reinforced through reward and recognition systems and approaches to performance evaluation.

Explanations and Clarifications:

None.

Examples:

- Person-centered care behavioral expectations are explicitly embedded into job descriptions and performance evaluation tools.
- Organizational core values and/or behavioral expectations are co-created by staff and patient/resident/family partners, and reflect the organization's person-centered care philosophy.
- Patient/resident/family partners participate in new hire orientation and onboarding of new staff to personalize the care experience
- Patient/resident/family member feedback utilized in performance evaluations (feedback can be received through surveys, suggestion box, calls or meetings with leadership, etc.)
- **Opportunities for patients/residents and/or families to influence the hiring process (1.4.6.):** Patient/resident family partners identify core person-centered competencies to emphasize during the candidate vetting process (either generally or for specific positions); patient/resident/family partners provide input into interview questions; patient/resident/family interview teams; patient/resident/family completion of behavioral observation sheets, etc.

1.4. MEASURABLE ELEMENTS

1.4.1.	Person-centered care-related competencies/expectations have been formally established for all staff, including those in clinical and non-clinical roles.	1 point
1.4.2.	Recognition and reward systems reinforce person-centered attitudes and behaviors.	1 point
1.4.3.	The onboarding process for new employees includes an introduction to person-centered care concepts.	1 point
1.4.4.	Recruitment and/or hiring processes emphasize the organization's commitment to person-centered care.	1 point
1.4.5.	When patients/residents/family members provide specific feedback about a particular staff member or team (whether positive or negative), there are systems to ensure that feedback is communicated to the relevant staff member(s) and their manager.	1 point

1.4.6.	There are opportunities for patients/residents and/or families to influence the hiring process.	1 point
1.4.7.	Peer-to-peer interviewing is incorporated into the vetting process for potential new employees.	1 point

1.4. Questions Requiring* a Narrative Response

***Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)**

18. Describe (or provide evidence of) processes for holding members of the organization accountable for behaviors and attitudes consistent with the culture of person-centered care. Address all of the following:

- How behavioral expectations are established
- How staff are held accountable for behaviors inconsistent with the culture
- Systems to reward and recognize individuals for attitudes and behaviors that embody the spirit of person-centered care.

***Note: (Behavioral standards and/or documentation of reward and recognition systems can be uploaded in lieu of responding to question 18 if it addresses the questions.)**

19. Describe (or provide evidence of) ways in which the organization's recruitment and hiring practices emphasize the person-centered care culture.

20. What systems are in place to ensure that feedback received by patients/residents/families is consistently communicated to the staff member(s) it pertains to, and their manager(s)?

21. What opportunities have patients/residents/families had to influence hiring processes? *These opportunities may include identifying core person-centered competencies to emphasize during the candidate vetting process (either generally or for specific positions), or could include participation in interviewing processes, etc.).*

22. What opportunities do staff have to provide input into whether candidates for employment in their work areas are a fit with the organizational culture?

1.4. Required Evidence to Upload	**Guidance**
EV9. At least one of the following: • Sample job descriptions (one clinical and one non-clinical) referencing the organization's commitment to person-centered care and/or the position's roles and responsibilities as they pertain to person-centered care; • Sample performance evaluation tools (one clinical and one non-clinical) with standard, explicit evaluative components related to person-centered care; • Documented behavioral standards or core values that reflect the organization's commitment to person-centered care.	If submitting sample job descriptions or performance evaluation tools, provide at least one clinical examples and one non-clinical example.
EV10. Documentation of reward and recognition systems or programs that reinforce person-centered attitudes and behaviors.	Examples of documentation include policies, guidelines, handbooks, etc.
EV11. A copy of your new employee orientation agenda indicating where and how person-centered concepts, initiatives and expectations are shared with new personnel.	
***Optional* Evidence to Upload**	**Guidance**
Sample recruitment materials	
Training materials to prepare individuals to participate in team or peer-to-peer interviews; formalized policy, procedure or protocol for how such interviews occur.	

1.5.	**4 points**
The built environment incorporates elements that support patient/resident and family engagement in their care, including (as appropriate, based on the care setting): • **Minimizing physical barriers to promote communication and compassionate interactions** • **Incorporation of spaces that comfortably accommodate the presence of family and friends** • **Incorporation of elements that support patient/resident education and access to information** • **Barrier-free and convenient access to building(s).** • **Clear and understandable directions for patients/residents and visitors to their destinations** • **Accommodations to preserve patients'/residents' dignity and modesty** • **Access to natural light** • **Promotion of outdoor spaces and opportunities to access them.**	

Intent: The built environment is less institutional, with intentional elements introduced to reduce the stress and anxiety often associated with healthcare environments, as well as to encourage patients/residents/family to participate in care. In planning and design efforts, the organization balances the need for patient/resident safety with the importance of patient/resident comfort, privacy and modesty.

Explanations and Clarifications:

- *Built Environment:* The physical places and spaces created or modified by people that comprise the setting for where individuals receive their healthcare within the organization.

Examples:

- **Environmental elements that minimize physical barriers and promote communication and compassionate interactions:** open nurses' stations; intentional placement of computer screens and placement/height of seating to maximize face-to-face communication; decentralized storage to minimize clutter while ensuring needed items are easily accessible; elimination of overhead paging/ reduction of audible alarms; in long-term care communities, adoption of a neighborhood or household model; in pediatric environments, safe havens (i.e. no medical procedures), such as play areas with child life specialists
- **Environmental elements that comfortably accommodate the presence of family and friends:** overnight accommodations for loved ones in acute and residential care environments; family kitchens; family/friend lounge areas with comfortable seating and positive diversions; extra seating in exam rooms for those accompanying the patient; spaces for children
- **Environmental elements that support access to information:** an on-site consumer health resource library, patient/resident/family access to an existing medical library; information stations in waiting areas with both printed consumer health resources and electronic access to vetted web site with credible and reliable health information; technology in patient rooms positioned and utilized to support interaction and engagement.

- **Measures to ensure patients/residents and visitors are able to easily navigate to their intended destination(s):** signage in reader-friendly language that reflects the primary languages of populations served, incorporation of color coding and symbols into signage, architectural details and artwork serving as destination markers, ambassadors to personally assist individuals finding their way, provision of reader-friendly, patient/resident/visitor-tested handheld maps, involvement of patient/resident/family advisors to develop or refine the navigation scheme.
- **Environmental elements to preserve individuals' dignity and modesty:** private rooms; discrete passageways for transporting patients and residents; privacy accommodations in shared rooms, bathrooms and gowned waiting areas; private consultation areas; policies minimizing instances when patients would be cared for in beds stationed in corridors or hallways; specialty garments to preserve patient modesty
- **Outdoor spaces:** landscaped patios, terraces, courtyards, atria, healing gardens, rooftop gardens, walking paths
- **Measures to incorporate elements of nature into the built environment:** All patient/resident rooms have views to the outdoors; skylights and light wells; indoor plantings, aquariums and terrariums, fountains and water features; artwork featuring nature; interior courtyards and atria that bring nature indoors; views to rooftop gardens

1.5. MEASURABLE ELEMENTS

1.5.1. Within the physical environment, physical barriers have been minimized to promote communication and compassionate interactions (either already in place, or being planned).	0.5 point
1.5.2. Spaces are currently available (or are planned) to comfortably accommodate the presence of family and friends.	0.5 point
1.5.3. There are elements within the built environment that support individuals' access to information (either already in place, or being planned).	0.5 point
1.5.4. Measures have been taken (or are planned) to facilitate convenient access to the building(s).	0.5 point
1.5.5. Measures have been taken (or are planned) to ensure individuals are able to navigate easily to their intended destinations.	0.5 point
1.5.6. Within the physical environment, measures have been taken (or are planned) to preserve individuals' dignity and modesty.	0.5 point
1.5.7. Outdoor spaces are available, accessible and known about.	0.5 point
1.5.8. Elements from nature, including natural light, have been incorporated (or are planned) into the built environment.	0.5 point

1.5. Questions Requiring* a Narrative Response

***Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)**

23. Briefly describe ways in which the design of your space(s) supports person and family engagement. Provide specific examples of design elements in support of each of the following:

- Open communication and compassionate interactions
- Accommodations for family and friends
- Access to information to support informed decision-making and self-management
- Convenient access to care settings
- Individuals' ability to easily navigate to their intended destinations
- The availability and accessibility of outdoor spaces
- Incorporation of elements of nature, including natural light, into the built environment

24. When was your most recent design or renovation project? How did you involve users of the space (patients/residents, staff) in the design process?

1.5. Required Evidence to Upload	**Guidance**
None.	

2.1. **Goals and objectives related to person-centered care are developed in partnership with patients/ residents/families and are integrated into the organization's strategic and/or operational plan.**	**8 points**
Intent: Person-centered care is established as an organizational priority, and influences decision-making at a governance level. True to the values of person-centered care, associated goals and targets are co-created by leadership, staff and patients/resident/family partners.	
Explanations and Clarifications: • *Governing Body:* Highest authority with governance responsibilities. • ***Clarification for 2.1.3:*** If collectively one OR the other of these individuals (PCC executive champion, PCC director) has attended 75% of the meetings, this suffices. In other words, it need not be the PCC director who attends all 75% of the meetings, if in his/her absence, the PCC executive champion participates.	
Examples: • **Person-centered care goals co-development approaches:** involve person-centered care steering team (see criterion 1.1) in developing strategic/operational goals. This group already represents a cross-sectional, multi-stakeholder group; appoint at least one patient/resident/family member as a full voting member of the governing board who provide the patient/resident/family perspective on all matters before the board.	

2.1. MEASURABLE ELEMENTS

2.1.1.	Goals related to person-centered care have been explicitly integrated into the organization's strategic and/or operational plan.	2 point
2.1.2.	Person-centered care goals and priorities are co-developed by leadership, staff and patients/residents/families.	5 points
2.1.3.	The organization's person-centered care executive champion (see criterion 1.1) or the staff member appointed to guide PCC activities (see criterion 1.2) has attended a minimum of 75% of the governing board meetings held in the last 12 months.	1 point

2.1. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

25. How are the voices of these three key stakeholder groups (the governing body, staff and patients/residents/family partners) assimilated into co-developed goals and objectives related to person-centered care? Include in your response any specific systems in place to ensure patient/resident/family partners have a voice in establishing person-centered priorities, as well as any systems in place to ensure a representative cross-section of staff also have a voice in establishing these goals.

26. After reviewing the attendance rosters for all the governing board meetings held over the last 12 months, can you attest that the individual identified in criterion 1.1 as the organizational person-centered care executive champion OR the individual(s) identified in criterion 1.2 as appointed to guide PCC activities has attended a minimum of 75% of those meetings? **(Yes or No)**.

2.1. Required Evidence to Upload	Guidance
EV12. Executive summary of the organization's current strategic or operational plan.	
EV13. A summary update (for instance, a dashboard report) on current progress against goals and objectives.	

2.2. **Leadership interacts regularly with staff from all sectors and at all levels to drive improvement in the organization.**	**7 points**
Intent: Leadership decisions are informed by first-hand interactions with staff closest to the work. All staff have the opportunity to hear directly from leadership about the organizational priorities and operational plans, and have the opportunity to respond with feedback, ideas and questions.	
Explanations and Clarifications: *Leadership:* Those at the highest level of management who oversee the day-to-day tasks of managing the organization. They have the ability to make significant decisions about the organization on their own authority, and hold specific executive powers delegated to them by the governing body.	
Examples: • Leadership Rounds • Walkabouts • Lunch with Leaders • Town Hall Meetings • Open Office Hours • Videotaped and/or streamed town hall forums to allow off site or off shift staff to participate and receive information	

2.2. MEASURABLE ELEMENTS

2.2.1.	Members of the leadership team routinely interact with staff from all sectors of the organization.	3 points
2.2.2.	Practices have been implemented to ensure that these routine interactions between leadership and staff occur as a result of leaders meeting staff where they are at (e.g. leadership rounds, walkabouts, etc.) versus staff coming to leadership.	1 point
2.2.3.	Specific change ideas have been acted upon based on improvement needs and opportunities identified through these leadership practices.	3 points

2.2. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

27. Describe practices adopted by senior leadership to routinely access the perspectives of staff from all sectors of the organization. The description should address:

- Frequency
- Format (e.g. town hall meeting, office hours, leadership rounding, walkabouts).
- Efforts to ensure a broad cross-section of staff across the organization are reached (including different sectors, different shifts, etc.)
- Who among leadership participates?

****Note: for full credit, at least one of the practices described must include leadership meeting staff where they are at (rounding, walkabouts) versus staff coming to leadership (lunch meetings, town hall forums, etc.)**

28. Identify 3 specific change ideas identified over the last 24 months through these leadership practices that have since been implemented (or addressed in some way.)

2.2. Required Evidence to Upload	Guidance
None.	

2.3.	**7 points**
All staff, including employed medical staff, off-shift and support staff, participates in experiences designed to help them personally connect to the concepts of person-centered care and to better understand the perspectives of patients/residents, families and other colleagues. These are offered an ongoing basis to reinforce and revitalize staff engagement in person-centered behaviors and practices.	
Intent: The concepts of person-centered care are continually reinforced through experiences designed to keep all staff sensitized to the experiences of patients/residents and families (as well as their colleagues), and to provide opportunities for the team to rally around a collective purpose and to reflect on their role in person-centered care. These activities are experiential and/or participatory in nature and are sequenced to provide ongoing reinforcement of the concepts.	
Explanations and Clarifications: • "All staff" includes employed medical staff	
Examples: • Person-centered retreats/experiential educational activities • All-employee rallies or assemblies that feature patient/resident/family speakers • Staff discussion groups • A collection of role plays, discussion prompts and reflective exercises routinely incorporated into huddles, staff meetings, etc.	

2.3. MEASURABLE ELEMENTS

2.3.1.	All staff, including employed medical staff, off-shift and support staff, has the opportunity to participate in experiences specifically designed and offered to help them personally connect to the concepts of person-centered care.	1 point
2.3.2.	Measures have been put into place to evaluate these experiences.	1 point
2.3.3.	The concepts from these experiences are reinforced beyond a one-time exposure to the experiential or participatory content, i.e., there are refreshers, follow-up offerings, etc.	1 point
2.3.4.	The percentage of current staff members who have participated in at least one these experiences equals or exceeds 85% (*partial points awarded for lower participation rates.)*	>85% or more: 4 points 50%-84%: 3 points 25-49%: 2 points 10-24%: 1 point < 10%: 0 points

2.3. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

29. Describe (or provide evidence of) specific experiences offered to staff within the past 24 months that reinforce person-centered care concepts, practices and behaviors and encourage them to consider the perspectives of patients/residents/families and other colleagues. For each opportunity identified, please share:

- The main objective(s)
- The format, with an emphasis on the elements of the delivery format that promote interaction, participation and experiential learning
- The audience it is geared toward (e.g. Planetree retreats for all staff, person-centered care physician training for medical staff; etc.)
- Details about frequency/penetration (how often is it offered? How many staff have been exposed to the content, etc.)

***Note: Content documents, e.g. agendas, outlines, slide decks, facilitator guide, etc. can be uploaded in lieu of responding to question 29 if they address the questions.**

30. What measures have been put in place to evaluate these offerings? What sources of evidence or feedback do you draw on to ensure the content is delivering the intended results? *(Examples include program evaluations, pre- and post-tests to measure changes in participants' understanding of the concepts, etc.)*

31. What percentage of current staff members (including employed medical staff) have participated in at least one of the offerings described above?

2.3. Required Evidence to Upload	**Guidance**
None.	
***Optional* Evidence to Upload**	**Guidance**
Training agendas with experiential or participatory aspects of the education highlighted, slides with notes on the experiential and participatory aspects, a compilation of discussion prompts, scenarios for debriefing, etc. that are incorporated into huddles, staff meetings, etc.	

2.4. **The organization partners with other community institutions (e.g. housing authorities, religious institutions, schools, social services, etc.) to address social determinants that may impact individuals' access to care, health and well-being, with an emphasis on vulnerable populations.**	**10 points**
Intent: Numerous factors, including social, economic and environmental ones, work together to shape individuals' access to care, and opportunities and barriers they encounter to engaging in healthy behaviors. For this reason, it is not realistic to expect any one organization or sector to independently be effective in addressing so multifaceted an array of determinants of health. As stewards of population health, person-centered organizations join forces with other community partners to share information, promote healthy behaviors and encourage peer support where people live, work, learn, worship and play.	
Explanations and Clarifications: • *Social Determinants of Health*: The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. (World Health Organization)	
Examples: • **Types of evidence to draw on to identify vulnerable populations (2.4.1.):** census data, a community health needs assessment, etc. • **Examples of potential partnering organizations:** Housing authorities, religious institutions, schools, YMCAs, senior centers, public libraries, social services, etc.	

2.4. MEASURABLE ELEMENTS

2.4.1.	The organization draws on evidence to identify vulnerable populations within its local community or patient population.	1 point
2.4.2.	A minimum of 3 partnerships with different community-based supports have been active within the last 12 months, each with the explicit aim to meet the needs of a vulnerable population.	6 points
2.4.3.	Usage/participation/referral data (or comparable data to demonstrate activity and/or impact) can be provided for each of the 3 examples provided.	3 points

2.4. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

32. How does the organization maintain a current understanding of the vulnerable populations within the local community or your patient population? Specifically, what sources of evidence do you draw on to identify vulnerable populations?

2.4. Required Evidence to Upload	**Guidance**
EV14. 3 completed Healthy Community Portfolio worksheets to identify 3 specific partnerships with different community-based supports active within the last 12 months.	**Healthy Community Portfolio Worksheet Template** The description for each partnership effort should include: • An overview of the partnership activities and goals • How the effort targets a defined vulnerable population. Specifically, the description should identify the vulnerable population(s) targeted and how the partnership helps to address a documented gap in care, access, resources, etc.) • How you evaluate the degree to which the collaboration is achieving its intended results, with supportive data (i.e. usage/participation/referral data)

3.1.	**4 points**
Systems are in place to support the active involvement of patients/residents and families in communication exchanges between members of their care team and across settings of care. This includes (as appropriate to the care setting and based on patient/resident/family preferences) shift-to-shift communication, inter-departmental and interdisciplinary communication, communication across levels and settings of care, and care planning conferences.	

Intent: Patients/residents and family members are not merely *told* they are integral members of their own care team. They are treated as such. They are actively invited to participate in discussions and decisions about their care with the clinical team. Participation in these discussions is not limited to hearing the conversation, but also includes invitations and encouragement to add to the conversation, ask questions, confirm a common understanding and/or learn more about next steps in their care. Furthermore, the expectation is that patients/ residents/family have the opportunity to participate in the entirety of these conversations versus select parts.

Explanations and Clarifications:

- ***Clarification for 3.1.4:*** Applicants are asked to identify process measures used to monitor consistent implementation of the practice(s).

Examples:

- Bedside shift report
- Collaborative care conferences
- Patient/resident/family involvement in care planning meetings
- Multidisciplinary rounds inclusive of the patient/resident
- ***Examples for 3.1.4.:*** rounding, audits to validate completion of the process, staff competency checks, patient/residents surveys on their experience/awareness of the practice, etc.

3.1. MEASURABLE ELEMENTS

3.1.1.	A process(es) has been formalized to facilitate the involvement of patients/residents and families in standard communication exchanges when information about them is being transferred among members of their care team.	1 point
3.1.2.	Staff involved in carrying out these processes have been educated about the practice(s).	1 point
3.1.3.	Reader-friendly materials communicate opportunities for involvement to patients/residents and families.	1 point
3.1.4.	A system is in place to monitor the practices described to ensure that they are working as intended.	1 point

3 Implement practices that promote partnership

3.1. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

33. Describe (or provide evidence of) any practice(s) that have been adopted to include the patient/resident/family caregiver in as many conversations about their care as possible throughout their care encounter. As applicable to your care setting, be sure to address shift-to-shift communication, inter-departmental communication, and care planning communications across care settings and levels of care.

34. How are patients/residents/family caregivers encouraged to actively participate in the discussion (versus merely listening to it)?

***Note: (A policy or procedure document or equivalent, can be uploaded in lieu of responding questions 33-34 if it addresses the questions.)**

35. Describe specific care team communication processes where patients/residents/family caregivers are routinely excluded from the exchange of information (or are privy only to select parts of the communication). Why has the organization placed these limits on their involvement?

36. What quality check systems have been implemented to validate the reliable implementation of the practice(s)? *(Examples include routine audits to validate completion of the process, patient rounding to ask about their experiences with the practice, periodic observation of the practice in action, staff competency checks, etc.)*

37. If necessary (i.e. focus group feedback is conflicting or inconclusive), using the quality check systems described above, could you provide a minimum of 3 months of data to validate the practice is being actively implemented? [Yes/No]

3.1. Required Evidence to Upload	**Guidance**
EV15. An approved policy, procedure, documented workflow or checklist to evidence systems in place to facilitate the involvement of patients/residents/family caregivers in communication exchanges when information about them is being transferred among members of their care team.	Documentation must reflect that the practice(s) have been in place a minimum of six months.
EV16. Evidence of staff education to carry out the documented practice(s).	Examples of acceptable documentation include staff training objectives, slides or workbook or screen shot of online learning modules
EV17. Sample reader-friendly materials provided to patients/residents/family caregivers to communicate opportunities for their involvement in the documented process(s).	

3.2.	**4 points**
A policy and documented process is in place to provide individuals access to their medical record and/or plan of care while they are being treated. They are regularly encouraged to access this information and are supported in understanding and contributing to the documentation. There is evidence that this offer/process to access this information is communicated to every patient/resident.	

Intent: For patients/residents to be engaged as bona fide members of their own care team, it is essential that the rigid division between what information is shared among clinicians and what information is shared with patients/ residents and family members be eliminated. This includes the medical record and care plan (or an equivalent source of information on the patient's/residents' current health status and prognosis, how they are responding to interventions, treatment options, any concerns, and what needs to occur for their treatment plan to yield optimal results.) A collaborative review of the record, with the patient/resident (and family, with patient/resident consent) supported in understanding its contents by a healthcare professional, provides the opportunity for education and sets the stage for more informed decision-making.

Explanations and Clarifications:

- *Shared Medical Record:* Refers to the patients' ability to access their real-time, in-progress personal health information during a care episode, e.g. during a hospitalization and/or treatment.
- ***Clarification for 3.2.4b:*** Applicants are asked to identify process measures used to monitor consistent implementation of the practice(s).

Examples:

- Shared medical record/care plan policy
- Maintenance of care plans in a place that can be easily accessed by all staff to review and share in residential settings.
- eTools, such as a patient portal, that is accessible to both patients and their clinicians with the ability to share real time information such as test results, medication lists, vitals, etc.
- Open Notes
- ***Examples for 3.2.4b.:*** rounding, audits to validate completion of the process, staff competency checks, patient/residents surveys on their experience/awareness of the practice, etc.

3.2. MEASURABLE ELEMENTS

3.2.1a. A process(es) has been formalized to enable patients/residents to access their real time personal health information, including their medical record and/or plan of care.	0.5 point
3.2.1b. A process(es) has been formalized to enable patients/residents to contribute notes, comments and/or questions as part of their medical record and/or plan of care.	0.5 point
3.2.2. Staff involved in carrying out these processes have been educated about the practice(s).	1 point
3.2.3. Reader-friendly materials communicate to patients/residents their ability to access their real-time personal health information, as well as to contribute to these documents.	1 point
3.2.4a. Systems or processes are in place to support achievement of the goal that every patient/ resident is notified of their ability to access their real time personal health information.	0.5 point
3.2.4b. A system is in place to monitor the practices described to ensure that they are working as intended.	0.5 point

3.2. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

38. Describe (or provide evidence of) any practice(s) that have been adopted to provide individuals with real-time access to their personal health information, including the active medical record and/or plan of care (or an equivalent source of information on the diagnosis and plan of care) while they are being treated.

39. Describe (or provide evidence of) any mechanisms in place for patients/residents to document their comments and for the care team to access those comments (with patient/resident permission).

***Note: (A policy or procedure document, or equivalent, can be uploaded in lieu of responding questions 38-39 if it addresses the questions.)**

40. What strategies have you adopted to meet the goal that the opportunity to access their medical record or plan of care is communicated to every patient/resident?

41. What quality check systems have been implemented to validate that the system(s) to respond to individuals' requests to access their real-time health information and/or contribute to the contents are effective? *(Examples include routine audits to validate completion of the process, patient rounding to ask about their experiences with the practice, periodic observation of the practice in action, staff competency checks, etc.)*

42. If necessary (i.e. focus group feedback is conflicting or inconclusive), using the quality check systems described above, could you provide a minimum of 3 months of data to validate the practice is being actively implemented? [Yes/No]

3.2. Required Evidence to Upload	**Guidance**
EV18. An approved policy, procedure, documented workflow or checklist to evidence systems in place for 1.) providing individuals with real-time access to their personal health information, including their medical record and/or plan of care (or an equivalent source of information on the diagnosis and plan of care), and 2.) to facilitate individuals contributing their notes, comments and/or questions to their medical record, in their care plan or as a companion document that is shared with the care team.	Documentation must reflect that the practice(s) have been in place a minimum of six months.
EV19. Evidence of staff education to carry out the documented practice(s).	Examples of acceptable documentation include staff training objectives, slides or workbook or screen shot of online learning modules
EV20. Sample reader-friendly materials provided to patients/residents/family caregivers to communicate opportunities for them to access their real-time personal health information, as well as to contribute comments.	

3.3.	**4 points**
Practices are implemented to assess individuals' preferred learning style, culture and ability to understand the concepts and care requirements associated with managing their health. These assessments are used to provide education (including discharge instructions as applicable) in a manner that accommodates their learning preferences and level of understanding in a culturally and linguistically appropriate way.	

Intent: An underlying principle of person and family engagement is that access to information about their health, treatment options and care plan can empower individuals to participate more actively in their healthcare and make appropriate health decisions. However, this applies only when this information is provided in a way in which the recipient can understand it. Person-centered organizations are equipped with strategies to meet the needs of individuals of varying capacities to process and understand the information conveyed to them. Education and plans of care take into consideration health literacy, preferred language and culture.

Explanations and Clarifications:

- ***Clarification for 3.3.3:*** Applicants are asked to identify process measures used to monitor consistent implementation of the practice(s).

Examples:

- Use of health literacy assessment tools
- Teach back methodology to validate that the patient/resident and/or care partner can not only repeat instructions in their own words, but also describe how those instructions fit into their lifestyle, e.g. "Tell me what you are going to do at home now what we have reviewed this information."
- Availability and accessibility of interpreters
- Adoption of conversational assessment and/or motivational interviewing techniques
- ***Examples for 3.3.3.:*** rounding, audits to validate completion of the process, staff competency checks, patient/residents surveys on their experience/awareness of the practice, etc.

3.3. MEASURABLE ELEMENTS

3.3.1.	A process(es) has been formalized to assess individuals' abilities to understand the concepts and care requirements associated with managing their health. This process(es) should take into consideration an individual's preferred language, health literacy level and preferred learning style.	1 point
3.3.2.	Staff involved in carrying out these processes has been educated about the practice(s).	1 point
3.3.3.	A system is in place to monitor the practices described to ensure that they are working as intended.	1 point
3.3.4a.	Evidence can be provided to demonstrate that these assessments inform individualized approaches to education. At least 3 specific examples of accommodations made to address individuals' documented language, learning style and/or health literacy level can be provided.	0.5 points
3.3.4b.	Education materials are current, reader-friendly, use language patients/residents/families understand and reflect the patient/resident perspective. Samples are provided.	0. 5 points

3.3. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

43. Describe (or provide evidence of) any practice(s) that have been adopted to assess patients'/residents' ability to comprehend information about their health and care provided to them verbally and in writing. The practice(s) should take into consideration an individual's preferred language, health literacy level and preferred learning style.

***Note: (A policy or procedure document, or equivalent, can be uploaded in lieu of responding questions 43 if it addresses the question.)**

44. What quality check systems have been implemented to validate reliable implementation of the practice(s)? *(Examples include routine audits to validate completion of the process, patient rounding to ask about their experiences with the practice, periodic observation of the practice in action, staff competency checks, etc.)*

45. If necessary (i.e. focus group feedback is conflicting or inconclusive), using the quality check systems described above, could you provide a minimum of 3 months of data to validate the practice is being actively implemented? [Yes/No]

46. Provide 3 examples from the past 12 months to demonstrate how the care team has drawn on these assessments to individualize approaches to patient/resident education in culturally and linguistically appropriate ways. Each example should clearly identify specific accommodations made to address individuals' documented learning preferences and/or health literacy levels.

3.3. Required Evidence to Upload	**Guidance**
EV21. Provide as evidence of the practice(s) adopted to assess individuals' health literacy in their preferred language and their preferred learning style, one of the following: • An approved policy or procedure • A health literacy assessment tool • A documented workflow or checklist • A screen shot from the EHR where health literacy level and preferred learning style is documented.	Documentation must reflect that the practice(s) have been in place a minimum of six months.
EV22. Evidence of staff education to carry out the documented practice(s).	Examples of acceptable documentation include staff training objectives, slides or workbook or screen shot of online learning modules
EV23. Provide 3 sample education materials (including discharge instructions, as applicable to the care setting) to demonstrate that materials are current, reader-friendly and reflect the patient/resident perspective.	

3.4.	**4 points**
Practices are implemented to assess and address the social determinants of an individual's health, including those pertaining to accessing care, barriers to self-management and adopting healthy behaviors.	

Intent: Person-centered organizations are equipped to partner with patients/residents and family caregivers to assess and develop a plan to holistically address potential social, behavioral and physical barriers to achieving one's health goals.

Explanations and Clarifications:

- ***Social Determinants of Health*:** The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. (World Health Organization)
- ***Examples of social determinants of health to be considered include***: Availability of resources to meet daily needs (e.g., safe housing and local food markets); socioeconomic conditions; access to educational, economic, and job opportunities; access to healthcare services; availability of community-based resources in support of community living and opportunities for recreational and leisure-time activities; transportation options; public safety; social support; language/Literacy; barriers in the physical environment; and access to mass media and emerging technologies (e.g., cell phones, the Internet, and social media) *(Healthy People 2020)*
- ***Clarification for 3.4.3:*** Applicants are asked to identify process measures used to monitor consistent implementation of the practice(s).

Examples:

- Social needs assessment
- Patient/resident-completed tool to identify goals, strengths challenges and supports
- ***Examples for 3.4.3.:*** rounding, audits to validate completion of the process, staff competency checks, patient/residents surveys on their experience/awareness of the practice, etc.

3.4. MEASURABLE ELEMENTS

3.4.1.	A process(es) has been formalized for assessing the social determinants of an individual's health, with an emphasis on those pertaining to accessing care, barriers to self-management and adopting healthy behaviors.	1 point
3.4.2.	Staff involved in carrying out these processes have been educated about the practice(s).	1 point
3.4.3.	A system is in place to monitor the practices described to ensure that they are working as intended.	1 point
3.4.4.	Evidence can be provided to demonstrate that these assessments inform individualized approaches to care planning. At least 3 specific examples of accommodations made to address individuals' identified barriers or challenges to managing their health can be provided.	1 point

3.4. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

47. Describe (or provide evidence of) any practice(s) in place for assessing individuals' strengths and challenges as they pertain to accessing care, self-management and adopting healthy behaviors.

***Note: (A policy or procedure document or equivalent, can be uploaded in lieu of responding questions 47 if it addresses the questions.)**

48. What quality check systems have been implemented to validate reliable implementation of the practice(s)? *(Examples include routine audits to validate completion of the process, patient rounding to ask about their experiences with the practice, periodic observation of the practice in action, staff competency checks, etc.)*

49. If necessary (i.e. focus group feedback is conflicting or inconclusive), using the quality check systems described above, could you provide a minimum of 3 months of data to validate the practice is being actively implemented? [Yes/No]

50. Provide 3 examples from the past 12 months that demonstrate how the care team has drawn on these assessments to individualize care plans. Each example should clearly identify specific elements included in the care plan to address individuals' identified barriers, challenges or strengths to leverage to enable individuals to better manage their health and/or care partners to support their loved one in managing their health.

3.4. Required Evidence to Upload	**Guidance**
EV24. Provide as evidence of systems for assessing individuals' strengths and challenges as they pertain to accessing care, self-management and adopting healthy behaviors, one of the following: • An approved policy or procedure • An assessment tool • A documented workflow or checklist • A screen shot from the EHR where these strengths and challenges are identified	Documentation must reflect that the practice(s) have been in place a minimum of six months.
EV25. Evidence of staff education to carry out the documented practice(s).	Examples of acceptable documentation include staff training objectives, slides or workbook or screen shot of online learning modules

3.5.	**3 points**
Flexible, 24-hour family and friend presence (visitation) is supported by policy and in practice. Limits to their presence are mutually developed between the patient/resident, their support network and the care team. Limits are based on patient/resident preferences, the treatment plan, agreements with roommates, and safety considerations.	
Intent: Broad, generalized restrictions on who can accompany patients/residents and when during a healthcare episode are eliminated. Any limitations to the presence of family and friends are imposed on a case-by-case basis and in collaboration with the patient/resident, according to personal preferences and in consideration of their healthcare needs. Any clinically-based restrictions on family involvement are explained to the patient/resident and family.	
Explanations and Clarifications: • **Family** refers to those considered by the patient/resident as family.	
Examples: • Patient-/resident-directed visitation, open visitation • Family presence protocols • ***Examples for 3.5.2.*:** public signage, web site copy, patient/resident welcome materials, etc.	

3.5. MEASURABLE ELEMENTS

3.5.1.	Formalized documentation establishes a consistent baseline patient-/resident-directed approach to family/friend presence or visitation across the entirety of the organization with no universal restrictions on loved ones' presence based on age, relation, or time of the visit, i.e. patient/resident-directed visitation. *(In such cases where such universal restrictions may be necessary, a formalized process in in place to maximize flexibility around the presence of family/friends.)*	1 point
3.5.2.	Reader-friendly materials communicate this flexible approach to family/friend presence or visitation.	1 point
3.5.3.	Staff involved in managing preferences around family/friend presence have receiving coaching or education in doing so.	1 point

3.5. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

51. Not including individual preferences, are there any instances where universal restrictions to family/friend presence have been applied (such as during shift report, on certain units, etc.)?

3.5. Required Evidence to Upload	Guidance
EV26. Formalized policy or documentation of the organization's approach to family/friend presence and visitation.	Documentation must reflect that the practice(s) have been in place a minimum of six months. The documentation should establish a consistent baseline patient-/resident-directed approach to family/friend presence or visitation across the entirety of the organization with no universal restrictions on their presence based on age, relation to the patient/resident, or time of day or night.
EV27. Sample reader-friendly materials that communicate this flexible approach to family/friend presence or visitation.	Examples include images of public signage, screen shots from the web site, patient/resident welcoming materials, etc.
EV28. Evidence of staff education to carry out the documented practice(s).	Examples of acceptable documentation include staff training objectives, slides or workbook or screen shot of online learning modules

3.6.	**4 points**
Processes are in place for identifying and partnering with patients/residents and family/ friend caregivers throughout the care encounter to participate in care activities and to enhance their abilities to manage healthcare needs outside of a specific care episode. These care activities include physical care, patient education, and care coordination. The approach is tailored to the treatment plan, patient/resident preference and the family/friend caregivers' abilities.	

Intent: One definition of patient-centered care is providing care that is focused on the individual, *in the context of family and community*, rather than on the disease (World Health Organization, 2010). When care is focused in this way, in consideration of the social determinants of health, healing may be accelerated because the patient/resident, supported by an informed and involved family member(s) or friend(s), is better equipped to effectively manage their health outside of a specific care episode.

Explanations and Clarifications:

- **Family** refers to those considered by the patient/resident as family.
- ***Clarification for 3.6.4:*** Applicants are asked to identify process measures used to monitor consistent implementation of the practice(s).

Examples:

- Care Partner Program
- Use of caregiver assessment tools
- Educational content tailored to family/friend caregiver role
- Provision of tools to family/friend caregiver for tracking changes in their loved one's health status
- On-site caregiver center, equipped with tools and support for family caregivers
- ***Examples for 3.6.4.:*** rounding, audits to validate completion of the process, staff competency checks, patient/resident surveys on their experience/awareness of the practice, etc.

3.6. MEASURABLE ELEMENTS

3.6.1.	A process(es) has been formalized to facilitate the identification, orientation and participation of family/friend caregivers as members of the care team with documented roles and responsibilities (based on individual preferences).	1 point
3.6.2.	Staff involved in carrying out these processes have been educated about the practice(s).	1 point
3.6.3.	Reader-friendly materials communicate opportunities for family/friend caregivers to participate in the patient's/resident's care.	1 point
3.6.4.	A system is in place to monitor the practices described to ensure that they are working as intended.	1 point

3.6. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

52. Describe (or provide evidence of) any practice(s) in place for involving patients'/residents' family or friend caregivers in specific, documented care activities in accordance with individual preferences. This description should address:

- How family/friend caregivers are identified
- How they are oriented to their role, and
- Specific examples of ways family and friend caregivers are encouraged to participate in a range of care activities.

***Note: (A policy or procedure document or equivalent, can be uploaded in lieu of responding questions 52 if it addresses the question.)**

53. What quality check systems have been implemented to validate reliable implementation of the practice(s)? *(Examples include routine audits to validate completion of the process, patient rounding to ask about their experiences with the practice, periodic observation of the practice in action, staff competency checks, etc.)*

54. If necessary (i.e. focus group feedback is conflicting or inconclusive), using the quality check systems described above, could you provide a minimum of 3 months of data to validate the practice is being actively implemented? [Yes/No]

3.6. Required Evidence to Upload	Guidance
EV29. Provide as evidence of systems for involving family/friend caregivers in patient/resident care, one of the following: ○ An approved policy or procedure for family/friend involvement ○ A documented workflow or checklist	Documentation must reflect that the practice(s) have been in place a minimum of six months.
EV30. Evidence of staff education to carry out the documented practice(s).	Examples of acceptable documentation include staff training objectives, slides or workbook or screen shot of online learning modules

EV31. Sample reader-friendly materials provided to patients/residents/family & friend caregivers to communicate opportunities for formalized family/friend caregiver involvement in care activities.	

3.7.	**9 points**
The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each individual, especially for those with chronic conditions and during transitions of care.	

Intent: Improving the coordination among the various settings and care providers along the healthcare continuum can improve patient/resident safety, quality of care, and health outcomes while avoiding significant costs, minimizing inappropriate readmissions, and reducing patient/resident/family frustration, emotional distress and dissatisfaction. By definition, transitions of care involve multiple settings or providers of care. Therefore, collaboration across these care settings is essential.

Explanations and Clarifications:

- ***Transitions of care:*** The transfer of an individual between settings of care, internally within the same setting or to a different setting, and/or to a different team of caregivers, i.e. shift-to-shift transfers.
- ***Examples of potential indicators to measure impact of collaborations across the continuum of care:*** readmission rates, outcomes related to bundled payment programs, and progression in satisfaction scores related to transition confidence.

Examples:

- Discharge/transition summaries are provided to next level of care, and there is accountability for sending and receiving information.
- Health navigators or health coaches
- Integrated technology and coordinated electronic health records that include standardized medication reconciliation elements
- Inter-Continuum Collaboratives

3.7. MEASURABLE ELEMENTS

3.7.1.	A minimum of 3 partnerships between the organization and healthcare organizations at different points across the continuum have been established, and have been active within the last 12 months to improve care coordination and/or transitions of care.	9 points

3.7. Questions Requiring* a Narrative Response

None

3.7. Required Evidence to Upload	Guidance
EV32. Complete 3 Person-Centered Transitions of Care Portfolio Worksheets to document 3 specific collaborative efforts with healthcare organizations at different points across the continuum of care. Each of the efforts should have been active within the past 12 months.	**Person-Centered Transitions of Care Portfolio Worksheet Template** The description for each collaborative effort should include: ○ An overview of the collaboration's activities ○ Its goals as they related to improving care coordination, communication, and/or information exchanges in support of enhanced transitions of care. ○ A description of how you measure the outcomes of the collaboration. Examples include readmission rates, outcomes related to bundled payment programs, and progression in satisfaction scores related to transition confidence.

4.1. **Efforts have been undertaken to promote caring attitudes and compassionate communication. In discussion, stakeholders validate feeling treated with dignity and respect, being listened to and having their concerns taken seriously.**	**6 points**
Intent: In an increasingly complex healthcare delivery system in which concerns about outcomes, productivity and efficiency are often key drivers of decision-making and planning, it is essential to recognize the paramount importance of delivering care with compassion. Compassionate interactions in healthcare encounters establish the basis for a trusting relationship that encourages person and family engagement, and are tied to improved outcomes, faster recovery, a decrease in medical errors and increased satisfaction.	
Explanations and Clarifications: *None.*	
Examples: • Empathy or compassion skills training • Caring touch training • Communication guidelines or behavioral standards that emphasize compassion and caring • Identifying compassion as a core value of the organization, with associated behavioral expectations • Adoption of patient-friendly billing techniques/administrative communication • Snoezelen room/comfort room • No One Dies Alone initiative • Adoption of conversational assessment practices • Speak Up campaign or other mechanism to voice concerns	

4.1. MEASURABLE ELEMENTS

4.1.1.	Performance evaluation tools establish staff's caring attitudes as a critical competency on par with technical skills.	2 points
4.1.2.	Compassion, courtesy and respect have been formally established (via communication standards, specific policies, behavioral guidelines, training, etc.) as explicit expectations for each of the following: o Disclosing adverse events or unanticipated outcomes to those affected, including staff o Billing/collections communications o Responding to complaints or concerns o Caring for patients/residents exhibiting aggression and/or risk to themselves or others o Communication among colleagues	2 points
4.1.3.	Education or coaching to promote caring attitudes and compassionate communication has been provided for staff.	2 points

4.1. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

55. Describe (or provide evidence of) any standard(s), system(s) or process(es) that formally establish expectations for compassionate, courteous and respectful interactions. The description should explicitly address how the standard(s), system(s) or process(es) are incorporated in each of the following:

- Disclosing adverse events or unanticipated outcomes to those affected, including staff
- Billing and collections communications
- Responding to complaints or concerns
- Caring for patients/residents exhibiting aggression and/or risk to themselves or others
- Communication among colleagues

***Note: (Documented communication standards or guidelines can be uploaded in lieu of responding question 55 if they address the questions.)**

4.1. Required Evidence to Upload	**Guidance**
EV33. A sample performance evaluation tool to demonstrate that staff's caring attitudes are established as a critical competency on par with technical skills.	
EV34. Evidence of staff education/coaching to promote caring attitudes and compassionate communication.	Examples of acceptable documentation include staff training objectives, slides or workbook or screen shot of online learning modules
Optional **Evidence to Upload**	**Guidance**
Documented communication standards, specific policies, and/or behavioral guidelines to evidence formalized expectations for compassionate, courteous respectful interactions for each of the following: o Disclosing adverse events or unanticipated outcomes to those affected, including staff o Billing and collections communications o Responding to complaints or concerns o Caring for patients/residents exhibiting aggression and/or risk to themselves or others o Communication among colleagues	Can be provided in lieu of responding to question 55 if the document addresses the questions posed.

4.2.	**7 points**
Patients'/residents' treatment goals are documented and shared with the care team. This documentation is updated as patients'/residents' goals evolve. Care planning processes (including advance care planning) include elements to inform individuals about their care and the options available to them and encourage patient/resident/family involvement in shared decision-making, communicating their treatment goals and ensuring that care plans are aligned with their documented choices and goals.	

Intent: Integrating individuals' self-identified goals, preferences and values into their care plan is the essence of person-centered care. These goals, preferences and values can then be considered alongside clinical knowledge to guide treatment planning and consideration of care options. This level of partnered determination of goals and treatment options cannot occur without care teams first putting in place measures to look beyond "what is the matter" with the patient/resident to understand and document *what matters most* to them. This includes supporting individuals to think through and document their wishes for care if their health declines to a degree where they may lack the capacity to make decisions for themselves.

Explanations and Clarifications:

- *Advance Care Planning:* The process of creating a roadmap for individual healthcare before the need arises for such care. Could include identification of a healthcare proxy, documentation of palliative care and end-of-life care wishes, as well as communication of basic values, goals and decisions that influence healthcare. Advance care plans provide direction to healthcare professionals when a person is not in a position to either make and/or communicate their own healthcare choices.
- *Shared Decision-Making:* the process of interacting with patients who wish to be involved in arriving at an informed, values-based choice among two or more medically reasonable alternatives (Health Affairs, 2004)
- ***Clarification for 4.2.6 and 4.2.7:*** Applicants are asked to identify process measures used to monitor consistent implementation of the practice(s).

Examples:

- Community engagement campaigns to promote documentation of end-of-life and palliative care wishes and preferences, such as The Conversation Project, the Respecting Choices Program, or Five Wishes
- Use of patient decision aids
- Patient Preferences Passport
- Ask Me 3
- Choosing Wisely Campaign
- Communication boards where patient/resident goals are documented
- Collaborative goal setting processes
- Development of shared visit agendas
- Use of Preference for Everyday Living Inventory (or equivalent) tool
- Care cards that document long-term care residents' personal routines and preferences

4.2. MEASURABLE ELEMENTS

4.2.1.	A process(es) has been formalized for working with individuals and their family/friend caregivers to incorporate their personal preferences and/or functional lifestyle goals into care plans.	1 point
4.2.2.	A process(es) has been formalized for working with individuals and their family/friend caregivers to capture preferences and wishes related to end-of-life and palliative care.	1 point
4.2.3.	Shared decision making tools are used to support individuals in differentiating between options available and to clarify how different options align with their personal priorities and values.	1 point
4.2.4.	Reader-friendly materials are provided to support individuals in considering and documenting palliative care and end-of-life goals and wishes.	1 point
4.2.5.	Staff involved in carrying out these processes have been educated about the practice(s).	1 point
4.2.6.	A system is in place to monitor and track alignment of patients'/residents' own goals and preferences with their care plan.	1 point
4.2.7.	A system is in place to monitor and track the percentage of patients/residents with documented end-of-life and palliative care preferences and wishes.	1 point

4.2. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

56. Describe (or provide evidence of) any process(es) in place for working with patients/residents and family caregivers to incorporate personal preferences and goals into the care plan.

57. Describe (or provide evidence of) any process(es) in place for documenting patient/resident/family preferences and wishes related to end-of-life and palliative care.

58. How do teams work to ensure that care plans are aligned with individuals' personal goals and preferences? How is this monitored and tracked?

59a. In the most recent 3-month period for which data is available, what percentage of care plan goals matched patient/resident-expressed goals and preferences?

59b. In the most recent 3-month period for which data is available, what percentage of patients/residents had end-of-life and palliative care preferences documented in their care plan?

4.2. Required Evidence to Upload	Guidance
EV35. Upload at least one of the following: ○ An approved policy or procedure for documenting and sharing patients'/residents' treatment goals in their own words into the care plan ○ A documented workflow or checklist ○ A screen shot of the EHR where patients'/residents' treatment goals are documented in their own words	Documentation must reflect that the practice(s) have been in place a minimum of six months.
EV36. Upload at least one of the following: ○ An approved policy or procedure for documenting patients'/residents' advance care planning preferences ○ A documented workflow or checklist ○ A screen shot of the EHR where advanced care plans are documented.	Documentation must reflect that the practice(s) have been in place a minimum of six months
EV37. Sample reader-friendly shared decision-making tools provided to support individuals in understanding care options available to them and to support them in making informed decisions about their care.	
EV38. Sample reader-friendly materials provided to support individuals in considering and documenting palliative care and end-of-life wishes and goals.	
EV39. Evidence of staff education about the documented process(es).	Examples of acceptable documentation include staff training objectives, slides or workbook or screen shot of online learning modules

4.3. **The special needs of the community's diverse cultural groups are evaluated, documented and addressed in specific and appropriate ways.**	**5 points**
Intent: The needs of diverse populations of patients/residents, families and staff from different cultural backgrounds and belief systems are supported and accommodated. Efforts are made to understand the needs of the hardest-to-reach members of the community.	
Explanations and Clarifications: ○ *Community:* A population of individuals living in the same place OR having a particular characteristic in common. For an organization drawing patients and/or residents from the local area, "community" refers to the geographic service area. For an organization serving individuals with particular needs who may come from diverse geographic areas, "community" refers to the patient population served (and their loved ones). ○ ***Clarification for 4.3.4.:*** Payer source may be used to stratify experience survey data by socioeconomic status.	
Examples: • Tailoring staff education and resources to enhance knowledge about cultural norms/beliefs/traditions prevalent in the community, and updating as these needs evolve. • Specific questions and/or other feedback mechanisms are employed to provide individuals the opportunity to provide feedback related to their cultural experiences. • Translation of materials, signage, surveys, etc. into the primary languages of the community. • Availability of food items that are considered "comfort foods" for the most predominant cultures in the community.	

4.3. MEASURABLE ELEMENTS

4.3.1.	An effort has been undertaken within the last 3 years to assess the cultural and linguistic diversity within the organization's service area or patient population.	2 points
4.3.2.	The findings of that assessment effort have informed changes in practice or services to better meet the diverse needs of the community served.	1 point
4.3.3.	Experience surveys are translated into multiple languages, as appropriate, based on the findings of the cultural and linguistic assessment.	1 point
4.3.4.	Experience survey data is stratified by race, ethnicity, age and socioeconomic status.	1 point

4.3. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

60. Describe (or provide evidence of) any effort(s) undertaken within the last 3 years to assess the cultural and linguistic diversity within the organization's service area. The description should detail:

- The assessment mechanism(s) used and the time period the assessment(s) covers. An example is a community health needs assessment.
- A summary of the findings relative to the cultural and linguistic diversity within the organization's service area.

***Note: (The assessment tool and summary of findings may be uploaded in lieu of responding to question 60.)**

61. How did the evidence collected through the assessment(s) described above inform changes in practice or services to best meet the diverse needs of your community? Identify specific policies and/or practices introduced or adjusted to ensure services appropriate to your community.

62. What languages are patient/resident/family experience surveys translated into? How was the determination made for what languages to translate the surveys?

62a. If experience surveys are not translated into multiple languages, how do you capture the perspectives of patients/residents/family for whom a different language is their primary one?

63. Describe any efforts undertaken to stratify experience data by race, ethnicity, age and socioeconomic status.

63a. How have these efforts to better understand this data informed efforts to reduce healthcare disparities?

4.3. Required Evidence to Upload	**Guidance**
None	
***Optional* Evidence to Upload**	**Guidance**
Copy of community cultural and linguistic needs assessment tool and summary of findings.	Can be upload in lieu of a narrative response to question 60.

4.4.	**9 points***
Systems are in place to document and honor, to the extent possible, patients'/residents' preferences related to: • **Activities of daily living (meals, bathing, grooming, sleep)** • **Scheduling and access** • **Cultural norms and spiritual beliefs** • **Use/interest in a broad range of healing modalities, including those considered complementary to Western or traditional modalities** • **Their personal environment** • **Positive diversions and/or life enrichment activities (including social support)**	
Intent: Person-centered organizations find ways to "systematically personalize" the healthcare experience for each individual. This goes beyond honoring preferences for treatment options, extending as well to maximizing opportunities for individuals to maintain their personal routines, patterns and rhythms of life. Doing so maintains feelings of "normalcy," autonomy and peace of mind at times when people may feel most vulnerable, uneasy and lacking a sense of control.	
Explanations and Clarifications: **Scoring Note:* 8 points are available for element 4.4.1. for all applicants. However, recognizing that the nature of providing care in an acute setting versus an ambulatory setting versus a residential one results in varying levels of both opportunity and significance for addressing these various preference domains, what it takes to earn the full point allowance for this element is different for different settings. The following list breaks down the number of preference domains that need to be sufficiently addressed in order for sites within that setting to earn the 8 total points available. Points will be pro-rated based on the percentage of preference domains sufficiently addressed: • Residential settings: A minimum of 6 preference domains must be sufficiently addressed • Acute care settings: A minimum of 4 preference domains must be sufficiently addressed • Ambulatory settings: A minimum of 2 preference domains must be sufficiently addressed	

Examples:

- **Meal and mealtime accommodations**: on-demand/room service dining; menu of meal options for patients/residents to select from; rounding by chef to understand individuals' personal preferences; dining interview sheets, system to make nutrition counseling referrals for individuals with dietary-sensitive diagnoses, restaurant-, family- or buffet style dining in residential settings, liberalized diets to balance food enjoyment and satisfaction with nourishment and safety
- **Sleep-related accommodations:** sleep menu of items to promote restful sleep; adjustment of administration of procedures/medication to maximize opportunities for uninterrupted rest; nighttime rituals to promote rest
- **Bathing and personal grooming accommodations:** ability to select days/times of day/type of bathing experience; systems that allow for staff to respond to residents' preferences with flexibility and individualization
- **Scheduling and access accommodations:** "after hours" appointments, group visits, telemedicine
- **Complementary therapy accommodations:** holistic and complementary therapies such as massage, aromatherapy, chiropractic care, Reiki, healing touch, etc. are offered on a routine basis for the treatment of sleeplessness, pain, adverse behavioral responses, and decreased appetite; a process is developed for responding to patient requests for in-hospital treatment by the patients'/residents' existing practitioner(s); establishment of a formal integrative or complementary medicine program; evaluation of patients/residents' herbal remedies as part of the medication reconciliation process; system for making referrals to community-based CAM practitioners
- **Opportunities to personalize the environment:** control over lighting and access to daylight, support for patients/residents to bring in items from home to personalize their space, and systems for accommodating preferences related to noise, temperature and visual privacy.
- **Positive diversions and life enrichment activities (including social support):** musical performances, visual arts, crafts activities, animal visitation, bedside reading, access to technology, cognitive fitness activities, intergenerational programming, individualized choices for persons who wish to "self-entertain."
- **Spiritual/cultural accommodations:** spiritual assessments conducted on admission, sacred spaces available for quiet contemplation (and as appropriate, communal worship); worship items available to accommodate the needs of those with different beliefs, e.g. rosary beads, prayer mats, compass, Torah, etc.; menus include comfort food items for predominant cultures in the area

4.4. MEASURABLE ELEMENTS

4.4.1a. Mechanisms are in place to accommodate personal preferences related to meals and mealtime.	8 points
4.4.1b. Mechanisms are in place to accommodate personal preferences related to sleep (e.g. routines, wake times, etc.).	
4.4.1c. Mechanisms are in place to accommodate personal preferences related to bathing and personal grooming.	
4.4.1d. Mechanisms are in place to accommodate personal preferences related to scheduling and access, including appointment availability and options for non-traditional types of appointments or clinical encounters.	

4.4.1e. Mechanisms are in place to accommodate personal preferences related to use of a broad range of healing modalities, including those considered complementary to Western or traditional modalities.	
4.4.1f. Mechanisms are in place to accommodate patient/resident/family preferences related to their personal environment.	
4.4.1g. Mechanisms are in place to accommodate personal preferences related to positive diversions and/or life enrichment activities (including social support).	
4.4.2. Mechanisms are in place to integrate individuals' spiritual beliefs and cultural norms into their care and treatment upon request.	1 point

4.4. Questions Requiring* a Narrative Response

*Requirements for responding to questions 64-70 vary based on the applicants' setting of care.

Residential settings: Must address a minimum of 6 of the 7 questions

Acute care settings: Must address a minimum of 4 of the 7 questions

Ambulatory settings: Must address a minimum of 2 of the 7 questions

***NOTE: All applicants must respond to questions 71-72, regardless of setting *in addition to responding to the minimum requirements established above*. Responding to questions 71 and 72 does not count toward the total number of responses provided for 4.4.**

Meal and Mealtime Accommodations	**64.** How does the care team ascertain individuals' preferences related to meals and meal times? Describe what, if any, mechanisms are in place to accommodate individuals' personal preferences and customary daily habits related to meals and meal times. Provide at least one specific example of how staff has personalized the meal or mealtime experience for one patient/resident.
Sleep-related Accommodations	**65.** How does the care team ascertain individuals' preferences related to sleep? Describe what, if any, mechanisms are in place to accommodate individuals' personal preferences and customary daily habits related to sleep (e.g. routines, wake times, etc.) Provide at least one specific example of how staff has made accommodations to preserve the sleep patterns or routines of one patient/resident.

Bathing and Personal Grooming Accommodations	**66.** How does the care team ascertain individuals' preferences related to bathing and personal grooming? Describe what, if any, mechanisms are in place to accommodate individuals' personal preferences and customary daily habits related to bathing and personal grooming. Provide at least one specific example of how staff accommodated a patient's/resident's personal preferences related to bathing and personal grooming.
Scheduling/Access Accommodations	**67.** Describe what, if any, systems are in place to maximize flexibility in scheduling and access.
Complementary Therapy Accommodations	**68.** How does the care team determine the needs and interests of your patients/residents who wish to have access to complementary/integrative healing modalities, including those considered complementary to Western or traditional modalities? Describe what, if any, systems are in place to accommodate the needs and interests of individuals who wish to have access to a broad range of healing modalities. Provide at least one specific example of how staff addressed the needs of one patient/resident.
Opportunities to Personalize the Environment	**69.** Describe what, if any, opportunities there are for individuals to make choices or maintain control over their physical environment. Provide at least one specific example of how staff accommodated a patient's/resident's personal preferences related to their personal environment.
Positive Diversions and Life Enrichment Activities	**70.** Describe how the organization investigates patients'/residents' interests related to positive diversions and life enrichment activities and how those perspectives have guided the development of the activities or arts and entertainment program. What, if any, systems are in place to provide access for patients/residents/family to positive diversions aligned with their personal preferences and interests?

71. How does the care team ascertain individuals' spiritual beliefs and cultural norms? What mechanisms are in place to integrate individuals' spiritual beliefs and cultural norms into their care and treatment?

72. Provide examples of specific accommodations that have been made to individualize the care plan and care experience to align with a patient's/resident's spiritual beliefs and cultural norms.

4.4. Required Evidence to Upload	Guidance
None	

4.5.	**5 points**
A mechanism is in place to provide staff support services, with an emphasis on: • **Emotional and grief support** • **Health promotion** • **Participation in decisions that impact their functional work area/role** • **Other elements identified by staff as priority areas.**	

Intent: Person-centered organizations strive to not only meet the full range of patient/resident and family needs, but also those of staff. Staff give tremendous amounts of themselves—both physically and emotionally – to this work. Acknowledging and being responsive to the experience of staff, and the multi-faceted demands placed on them every day, is fundamental to person-centeredness. This includes systems and services to encourage employee wellness, provide outlets for stress reduction and promote work-life balance.

Explanations and Clarifications: *None*

Examples:

- **Examples of emotional and grief support for staff:** bereavement/support groups for staff, Schwartz Rounds, employee assistance programs, check-out huddles at end of shift, emotional debriefs after events, Code Lavender
- **Examples of health promotion activities for staff:** employee gyms, fitness classes and/or challenges, walking paths, on-site weight management classes, smoking cessation support, on-site farmers' market/cooking demonstrations to support staff in adopting healthy eating habits, ergonomic assessments of work stations
- **Examples of systems or structures to facilitate staff having a voice in decisions that impact their functional work area or role**: unit-based councils, neighborhood meetings, listening circles, practice improvement teams, consistent assignment or team-based nursing approach
- **Other examples:**
    - Refreshing "off-stage" space is available for staff to decompress
    - Concierge programs (meals-to-go, on-site oil changes/drycleaning pick-up, ticket discounts, etc.)
    - In-house "spa" services for employees (chair massages, aromatherapy, etc.)
    - Healthy food available for staff during all working hours

4.5. MEASURABLE ELEMENTS

4.5.1.	Emotional and grief support is available to staff.	1 point
4.5.2.	Health promotion activities and supports are available to staff.	1 point
4.5.3.	Systems or structures are in place to facilitate staff having a voice in decisions that impact their functional work area or role.	1 point
4.5.4.	There are opportunities for staff to have input into priority areas for staff support services.	1 point
4.5.5.	Systems are in place to evaluate staff's satisfaction with and/or use of support services available.	1 point

4.5. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

73. Describe (or provide evidence of) the availability of emotional and grief support services for staff.

74. Describe (or provide evidence of) the availability of health promotion activities and supports for staff.

75. Describe (or provide evidence of) systems or structures in place to facilitate staff having a voice in decisions that impact their functional work area or role.

***Note: Documentation of staff support services available can be uploaded in lieu of a narrative response to questions 73-75 if the documentation addresses the questions.**

76. How did you ensure that staff priorities informed the development of the organization's staff support services?

77. What systems are in place to evaluate staff's satisfaction with and/or use of support services available?

4.5. Required Evidence to Upload	**Guidance**
None.	
***Optional* Evidence to Upload**	**Guidance**
Documentation of staff support services available.	Examples of acceptable documentation include pages from the employee handbook, policy and procedure documents, promotional brochures, etc. Can be uploaded in lieu of narrative responses to questions 73-75.

5.1. **The organization's improvement strategy and process, as guided by the strategic plan detailed in criterion 2.1 and implemented in accordance with the structures outlined in criterion 1.3, includes regular review of performance data and evaluation of performance against goals or benchmarks.**	**2 points**
Intent: Access to data is an integral part of improvement. Collection and thoughtful examination of performance data provides feedback to all stakeholders that enables them to establish meaningful targets and understand the organization's progress toward those goals. When setting improvement goals, it is important to set expectations with a targeted performance level. These targets clearly communicate expectations, and may also motivate stakeholders to exceed them.	
Explanations and Clarifications: • **Improvement Strategy:** An intentional approach employed to yield progress against established goals.	
Examples: • Performance improvement/quality improvement policy, noting that all stakeholders will have the ability to participate in data reviews, evaluations, and definition of goals.	

5.1. MEASURABLE ELEMENTS

5.1.1.	The organization's improvement strategy includes review of performance data.	0.5 points
5.1.2.	The organization's improvement strategy includes evaluation of performance against either internal goals or external benchmarks.	0.5 points
5.1.3.	Mechanisms are in place for sharing performance against goals or benchmarks across the organization.	0.5 points
5.1.4.	Performance data is used to identify improvement priorities.	0.5 points

5.1. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

78. When goals and priorities are established in the strategic plan (see criterion 2.1), what is the process for setting targets? What benchmarks are used for target-setting?

79. What mechanisms are in place to share performance against goals or benchmarks broadly throughout the organization?

5.1. Required Evidence to Upload	**Guidance**
None	

5.2.	**6 points**
The organization measures or receives quantitative data on: • **Clinical quality performance** • **Patient/resident safety** • **Patient/resident experience of care** • **Staff engagement, staff satisfaction or the staff experience** • **Physician (and other advanced clinicians) engagement, satisfaction or experience** • **The safety culture of the organization**	
Intent: Person-centered care is a multi-dimensional goal. Efforts to measure performance, therefore, must also be multi-dimensional, with data routinely collected to measure overall quality of care, safety, the patient/resident experience and the staff experience.	
Explanations and Clarifications: • ***Physician (and other advance clinicians)***: Those approved and given privileges to provide healthcare to patients in the organization. May include advanced practice registered nurses, physician assistants and others.	
Examples: • CMS Core Measures • Culture of Safety Surveys • Physician/staff/patient/family engagement/satisfaction surveys • Quality Indicators	

5.2. MEASURABLE ELEMENTS

5.2.1.	The organization measures or receives quantitative data on clinical quality and patient/resident safety.	1 point
5.2.2.	The organization has measured or received quantitative data on the patient/resident experience of care within the last **12 months.**	1 point
5.2.3.	The organization has measured or received quantitative data on staff engagement, staff satisfaction or the staff experience within the last **24 months.**	1 point
5.2.4.	The organization has measured or received quantitative data on physician engagement, physician satisfaction or the physician experience within the last **24 months.**	1 point
5.2.5.	A culture of safety survey has been completed within the last **24 months**.	1 point
5.2.6.	Review and analysis of performance on these measures includes consideration of the relationships between the various measures.	1 point

5.2. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

80. For each of the following, indicate 1.) the instrument used to collect data; 2.) the external benchmark used for target-setting; and 3.) how often the data for each is collected:

	Instrument used to collect data	External benchmark used for target-setting	How often the data is collected
Clinical quality			
Patient/Resident Safety			
Patient/Resident Experience of Care			
Staff Engagement, staff satisfaction or staff experience			
Physician (and other advanced clinicians) engagement, satisfaction or experience			
Culture of Safety			

81. When you analyze the findings (including risks and opportunities) from each of these data sources collectively, what have you discovered about the relationship(s) between various measures? Be specific.

5.2. Required Evidence to Upload	**Guidance**
EV40. Summary results from the organization's most recent 12 months of clinical quality and safety performance data.	
EV41. Summary results of the last two years of patient /resident experience of care data. Most recent data should be no more than 12 months old**.**	
EV42. Summary results of the organization's three most recent staff surveys. Most recent data should be no more than 24 months old.	
EV43. Summary results of the organization's most recent physician survey. Data should be no more than 24 months old.	
EV44. Summary results of the organization's most recent safety culture survey. Data should be no more than 24 months old.	

5.3.	**15 points**
Performance data on organizational indicators directly related to the strategic goals identified in criteria 1.3. and 2.1 evidences that changes implemented have improved (or have sustained high performance) across the following domains: • **Clinical quality or safety** • **Patient/resident experience of care** • **Staff and/or physician (and other advanced clinicians) engagement or satisfaction**	
Intent: The organization relies on performance data for continuous learning and to drive improvement in quality and a safety, the patient/resident experience and the staff experience.	
Explanations and Clarifications: • ***Measurable Progress:*** A discernible improvement in achievement toward a specified goal. • ***Clarification on "...organizational indicators directly related to the strategic goals identified in criteria 1.3. and 2.1…":*** Measures selected to report on must explicitly align with goals previously identified as organizational priorities in response to questions for criteria 1.3. and/or 2.1. • ***"Best in class" performance*** will be defined by the organization, based on available benchmarks.	

5.3. MEASURABLE ELEMENTS

5.3.1.	The organization has made measurable progress toward "best in class" performance on one measure of clinical quality or safety that relates directly to the strategic goals identified in criteria 1.3. and 2.1.	5 points
5.3.2.	The organization has made measurable progress toward "best in class" performance on one measure of the patient/resident experience of care that relates directly to the strategic goals identified in criteria 1.3. and 2.1.	5 points
5.3.3.	The organization has made measurable progress toward "best in class" performance on one measure of staff and/or physician engagement that relates directly to the strategic goals identified in criteria 1.3. and 2.1.	5 points

5.3. Questions Requiring* a Narrative Response

None

5.3. Required Evidence to Upload	Guidance
EV45. An Improvement Portfolio is provided that includes evidence of progress toward "best in class" performance across three separate measures (one from each of the following domains: organizational clinical quality or safety; patient/resident experience of care; staff and/or physician engagement or satisfaction).	**Improvement Portfolio Worksheet Template** Elements of each example should include: • A description of the measure and how it directly relates to strategic goals aligned with person-centered priorities • The performance target set, with evidence that this quantitative target is consistent with "best in class" performance • An accounting of the organization's performance on the measure at the time the target was established, i.e. where you started • A description of the plan underway for meeting the established target • Data from the last 12 months to demonstrate measurable progress toward the established target.

5.4. **Performance data on organizational indicators related to efficiency and clinical and service excellence are made available to the public to support consumers in making informed choices.**	**3 points**
Intent: A foundational concept of person-centered care is providing individuals with the information they need to make informed decisions. This not only includes information on their clinical conditions and options, but also extends to information about the places they go to receive their care.	
Explanations and Clarifications: *None*	
Examples: • Publication of performance on the organization's web site, public government sites; community publications, etc. • Posting of performance in public areas on bulletin boards, etc. • **Examples of efficiency measures:** wait times, access to appointments, mean length of stay, readmission rates, etc.	

5.4. MEASURABLE ELEMENTS

5.4.1. Performance data related to clinical quality is publicly reported. Examples include on the organization's web site, public government sites; community publications, etc.	1 point
5.4.2. Performance data related to efficiency is publicly reported.	1 point
5.4.3. Performance data related to service excellence is publicly reported.	1 point

5.4. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

82. What venues are used to publicly report performance data related to clinical quality?

83. What venues are used to publicly report performance data related to efficiency?

84. What venues are used to publicly report performance data related to service excellence?

***Note: (Screen shots or electronic files of the public reporting mechanisms may be uploaded in lieu of responding questions 82-84.)**

5.4. Required Evidence to Upload	**Guidance**
None	
***Optional* Evidence to Upload**	**Guidance**
Screen shots or electronic files of the public reporting mechanisms	Can be uploaded in lieu of narrative responses for questions 82-84.

5.5.	**6 points**
Mechanisms are in place for patients/residents and families to share their experiences, feedback and perspectives – in their own words -- throughout the organization. There is evidence this qualitative data are used to identify, inform and evaluate improvement efforts in the organization.	
Intent: Person-centered improvement begins with the voices of those interact directly with the healthcare organization (patients/residents, families and community members), and relies on the perceptions of these end-users of health care to help identify priorities, drive improvement and evaluate results. Unlike mail and telephone surveys which generate quantitative data on these experiences, mechanisms for capturing these insights *in the person's own words* enhance organizations' ability to more deeply probe and understand their experiences.	
Explanations and Clarifications: • ***Qualitative Data:*** Data that is expressed in language versus in numbers. Can be observed, but not computed. • **Clarification for 5.5.4.:** *Qualitative data referenced should be no more than 18 months old.*	

Examples:

- Focus groups
- Ethnography research
- Elicitation of patient/resident/family narratives
- Community meetings or dialogue days in residential settings

5.5. MEASURABLE ELEMENTS

5.5.1.	The organization uses orchestrated methodologies to regularly gather qualitative information from patients/residents/families and others about their experiences with your organization.	2 points
5.5.2.	Efforts are made, through these methodologies, to access a broad cross section of individuals who represent the population served.	1 point
5.5.3.	Communication channels are in place to share this qualitative data with all stakeholder groups.	1 point
5.5.4.	Themes and trends from these efforts are analyzed and used to identify improvement priorities.	1 point
5.5.5.	Specific changes have been implemented based on insights yielded from this qualitative evidence.	1 point

5.5. Questions Requiring* a Narrative Response

*Required unless otherwise indicated. (In some cases, if available, evidence can be uploaded in lieu of responding to the questions)

85. Describe orchestrated methodology(ies) used to regularly gather qualitative information from patients/residents and families about their experiences with the organization. The description should address:

- Approach(es) taken to capture these voices
- Frequency
- Specific efforts undertaken to ensure a broad cross-section of patients/residents and families are reached.

86. What mechanisms are in place to share this qualitative data broadly throughout the organization?

87. Provide 3 examples of how findings yielded from these voices of the patient/resident/family mechanisms have been used to drive changes in the organization within the past 18 months.

5.5. Required Evidence to Upload	Guidance
EV46. A brief analysis of themes and trends from the most recent effort to collect qualitative data on the experiences of patients/residents/ family.	The data referenced in this analysis should be no more than 18 months old.

8. Program Guidelines and Policies

A. Certification Eligibility

Any organization currently in operation as a healthcare providing organization is eligible to apply for Person-Centered Care Certification. These include, but are not limited to, acute care hospitals, behavioral health hospitals, rehabilitation hospitals, long-term care communities, ambulatory surgery centers, cancer centers, physician offices, community health centers, outpatient care settings, and integrated health systems.

Formal affiliation with Planetree is not a pre-requisite for Person-Centered Care Certification eligibility. As a benefit of membership, however, Planetree affiliates' pricing for certification services differs from that of non-affiliates.

B. Scope of Certification

At this time, Person-Centered Care Certification is not conferred to specific units or care settings within an organization. All care areas of an applicant organization will be assessed during the certification process.

If the applicant organization is a sub-unit of a parent organization, it is eligible to apply for certification independent of the parent organization if:

- ☐ The sub-unit is recognized by patients/residents as a discrete entity and is easily distinguishable from the parent organization (for instance, it is a freestanding building and/or it has a distinct name and recognition apart from its parent organization)
- ☐ The sub-unit is self-sufficient enough to be assessed against every criterion for certification independent of its parent organization
- ☐ On-site leadership has sufficient autonomy to set and change policy to influence the patient/resident experience at the site-level.

C. Multi-Site Organizations

If one application is to cover multiple sites for certification and any one site is operating at a lower level of performance on the criteria than the others, the granting of certification will be dependent on the level at which the weakest site is functioning. An organization may submit more than one application if it wishes to have separate assessments for different facilities or entities that it operates, so long as the separate facilities or entities are eligible in accordance with the criteria outlined above. In separate assessments, each certification decision will be independent and based solely on that individual site visit and assessment.

D. Duration of Term

The certification term (at any tier) is three years.

E. Re-Certification

Planetree Certified sites may choose to apply for re-certification as they approach the completion of the three-year term. The re-certification process is conducted in the same manner as was the original certification assessment, including an application, submission of updated written documentation and a site visit. Organizations interested in achieving a higher level of certification that their current award are welcome to re-apply prior to the completion of their three-year term. However, there are no guarantees that certification at the higher level will be conferred.

F. Changes to the Certification Criteria

Planetree reserves the right to make additions and/or modifications to the Person-Centered Care Certification criteria no more than one time per year. Criteria changes are all approved by the Person-Centered Care Certification Committee and go into effect on January 1st. All additions and changes will be announced at a minimum two months prior.

Organizations whose applications for certification are received prior to January 1st will not be assessed according to the new criteria, regardless of when the application is reviewed by the review committee.

Organizations applying within the calendar year when the criteria changes take effect will be assessed on new criteria, but will have a 12-month grace period within which to fully satisfy the new criteria. In the interim, as part of the evaluation process, sites will be asked to document plans for addressing new criteria. These documented plans will be considered by the evaluators as part of the application review. If the plans for satisfying the criteria appear reasonable, the criteria will be deemed satisfied with the stipulation that the site will document its implementation of those plans within 12 months of being awarded certification.

G. Evaluation of Non-English Speaking Organizations

All Person-Centered Care Certification evaluations conducted by Planetree International are in English. (Partner offices conducting the evaluations will do so in the primary language of their country/region.) Every effort will be made, however, to reduce the burden to non-English speaking organizations. It may be necessary for the organization to provide interpreters to assist during the on-site validation visit.

H. Conferring Certification

Certification at each level will be conferred by an independent, external committee. The role of this committee is to review all Person-Centered Care Certification scoring decisions. To facilitate this external review, summaries of sites' performance will be circulated for committee validation prior to awarding certification.

I. Decision Impartiality

All certification decisions are to be based solely on the performance of the applicant as demonstrated by their application and the on-site visit (versus pre-existing knowledge or prior experience with the site). To preserve this level of impartiality, the following arrangements are in place:

- Planetree staff and contractors are prohibited from participating in the evaluation of an applicant site to which they have provided direct training, coaching or consulting services to the applicant site (either in-person or virtually) within the past three years.
- Planetree staff and contractors will disclose any past or present relationship or employment with applicant organizations. If deemed to have a conflict of interest, they will be prohibited from participating in the evaluation.
- Once the evaluation team is identified, evaluators are restricted from disclosing or discussing details of the evaluation to anyone currently engaged in providing direct training, coaching or consultation to the applicant.
- All application summaries provided to the review committee for final review will be blinded. Any identifying information will be redacted.

J. Appeals

We strive for the certification process to be a transparent one, with decisions clearly substantiated through the final report shared with the applicant. If, however, there is dissatisfaction with the certification decision, including the level of certification awarded, applicants have the opportunity to submit an appeal within 30 days of being notified of the decision. This appeal should be submitted in writing to Planetree International's President and CEO, and should clearly outline the grounds on which the decision is contested. All appeals will be reviewed by the International Certification Committee. Appeals should be addressed to:

Planetree International
130 Division Street
Derby, CT 06418

K. Confidentiality

All information reviewed during the site assessment, as well as patient/resident and employee comments made in focus groups, will be held in strict confidence. Some focus group comments will be shared with the applicant, but will be shared in an anonymous fashion.

L. Communication Regarding Significant Events

It is the responsibility of a site, for the duration of its certification term, to provide information to Planetree on significant events that occur within the organization. The following significant events will automatically trigger a review of the site's certification status, and must be communicated to Planetree within 30 days of their occurrence:

- Involuntary loss of accreditation by a national and/or international accrediting body, including but not limited to The Joint Commission, Joint Commission International (JCI), and others.
- Debarment from participation in federal payer programs
- Uncured bankruptcy, voluntary or involuntary
- Evidence of material misrepresentation
- Failure to maintain a level of performance consistent with the Person-Centered Care Certification criteria
- Voluntary relinquishment of Person-Centered Care Certification

Notice of such significant events must be given in writing and sent to:

Planetree
130 Division Street
Derby, CT 06418

M. Public Information

As a service to healthcare consumers, Planetree will maintain a list on its website of certified organizations. The following information is not deemed confidential and may be made public, unless an organization specifically makes a request in writing to keep this confidential:

1. The name(s) of organization(s) scheduled for certification assessment site visits.
2. Assessment dates, once confirmed with an organization.
3. Certification expiration dates for certified organizations.
4. Which facility(ties) of a multi-facility system are/are not designated.
5. An organization's certification status.

An applicant organization is free to provide copies of its certification report and status to funding agencies.

Appendix A. Glossary of Terms

In order to ensure consistent interpretation of the criteria, this glossary provides definitions of key terms that appear in the criteria and/or the measurable elements.

Advance Care Planning	The process of creating a roadmap for individual healthcare before the need arises for such care. Could include identification of a healthcare proxy, documentation of palliative care and end-of-life care wishes, as well as communication of basic values, goals and decisions that influence healthcare. Advance care plans provide direction to healthcare professionals when a person is not in a position to either make and/or communicate their own healthcare choices.
Built Environment	The physical places and spaces created or modified by people that comprise the setting for where individuals receive their healthcare within the organization.
Community	A population of individuals living in the same place OR having a particular characteristic in common. For an organization drawing patients and/or residents from the local area, "community" refers to the geographic service area. For an organization serving individuals with particular needs who may come from diverse geographic areas, "community" refers to the patient population served (and their loved ones).
Employed Medical Staff	Full- or part-time salaried members of the medical professional staff on the organization's payroll.
Family	Any person who is identified by a patient/resident as part of their personal support network. In other words, those considered "family" by the patient/resident.
Governing Body	Highest authority with governance responsibilities.
Health Literacy	"The degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions." (U.S. Department of Health and Human Services)
Health Promotion	"The process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions." (World Health Organization)
Improvement Strategy	An intentional approach employed to yield progress against established goals.
Leadership	Those at the highest level of management who oversee the day-to-day tasks of managing the organization. They have the ability to make significant decisions about the organization on their own authority, and hold specific executive powers delegated to them by the governing body.

Measurable Progress	A discernible improvement in achievement toward a specified goal.
Off-Shift Staff	Staff who typically work nights, weekends and/or holidays.
Organization (organizational)	Involves the organization as a whole that is being assessed. If the applicant entity is part of a larger system but only the sub-entity is applying for recognition, "organization" refers to the sub-entity, not the entirety of the system.
Patient	In this document, the term patient is used as an overarching term to refer to the end-users of the care and support services provided by the organization in non-residential settings. (In residential settings, the term resident is used.) In certain cases, based on the patient's development stage or age, the term would extend to their guardian as well. This word may be interchanged with the terminology your organization uses to describe users of your services, including client, person, user, etc.
Physicians (other advanced clinicians)	Those approved and given privileges to provide healthcare to patients in the organization. May include advanced practice registered nurses, physician assistants and others.
Policy	A formal and enforceable document that guides staff in the delivery of care.
Qualitative Data	Data that is expressed in language versus in numbers. Can be observed, but not computed.
Quantitative Data	Data that can be measured and expressed numerically.
Resident	Individuals who live in the setting where they are receiving support and services. *In this document, note that "resident" does **not** refer to individuals in the residency stage of graduate medical training.*
Self-management	The ability of a person to deal with all that a chronic illness entails, including symptoms, treatment, physical and social consequences, and lifestyle changes
Senior Executive or Senior-Level	Functions as or reports to the highest level of management within the organization.
Senior-Level Clinical Champion	A clinical staff member (from nursing or the medical staff) who functions as or reports to the highest level of management within the organization
Shared Decision Making	The process of interacting with patients who wish to be involved in arriving at an informed, values-based choice among two or more medically reasonable alternatives (Health Affairs, 2004)

Social Determinants of Health	The conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies and political systems. (World Health Organization)
Staff	Includes permanent employees, temporary employees, medical staff, physicians and volunteers.
Transitions of Care	The transfer of an individual between settings of care, internally within the same setting or to a different setting, and/or to a different team of caregivers, i.e. shift-to-shift transfers
Vulnerable Population	"Those who are made vulnerable by their financial circumstances or place of residence, health, age, personal characteristics, functional or developmental status, ability to communicate effectively, and presence of chronic illness or disability" (AHRQ)

Appendix B. Criteria Breakdown – Sequential

(Printer Friendly)

1.1. A multi-disciplinary, site-based committee structure oversees and assists with implementation and maintenance of person-centered practices. Active participants include: • Patients/residents and/or family members*; • A mix of non-supervisory and management staff; • A mix of clinical and non-clinical staff • A senior-level executive champion • A senior level clinical champion.	6 points
1.2. An individual (or team) is appointed to guide implementation of activities that advance organizational progress toward person-centered care goals. This individual (or team) functions as or reports directly to a senior executive in the organization.	2 points
1.3. The organization's ongoing improvement structure and process rely on partnerships between leadership, staff and patients/residents/families to identify, prioritize, design and assess person-centered improvement efforts. Stakeholders are educated in improvement methods and are supported in making real time change.	13 points
1.4. Staff engagement approaches reflect the organization's person-centered care philosophy. There is evidence that person-centered care principles, including caring attitudes and compassionate communication, are integrated into the following: • Job descriptions • Performance evaluation systems • Reward and recognition systems • New hire screening, selection and orientation.	7 points
1.5. The built environment incorporates elements that support patient/resident and family engagement in their care, including (as appropriate, based on the care setting): • Minimizing physical barriers to promote communication and compassionate interactions • Incorporation of spaces that comfortably accommodate the presence of family and friends • Incorporation of elements that support patient/resident education and access to information • Barrier-free and convenient access to building(s). • Clear and understandable directions for patients/residents and visitors to their destinations • Accommodations to preserve patients'/residents' dignity and modesty • Access to natural light • Promotion of outdoor spaces and opportunities to access them.	4 points
2.1. Goals and objectives related to person-centered care are developed in partnership with patients/ residents/families and are integrated into the organization's strategic and/or operational plan.	8 points
2.2. Leadership interacts regularly with staff from all sectors and at all levels to drive improvement in the organization.	7 points
2.3. All staff, including employed medical staff, off-shift and support staff, participates in experiences designed to help them personally connect to the concepts of person-centered care and to better understand the perspectives of patients/residents, families and other colleagues. These are offered an ongoing basis to reinforce and revitalize staff engagement in person-centered behaviors and practices.	7 points
2.4. The organization partners with other community institutions (e.g. housing authorities, religious institutions, schools, social services, etc.) to address social determinants that may impact individuals' access to care, health and well-being, with an emphasis on vulnerable populations.	10 points

3.1. Systems are in place to support the active involvement of patients/residents and families in communication exchanges between members of their care team and across settings of care. This includes (as appropriate to the care setting and based on patient/resident/family preferences) shift-to-shift communication, inter-departmental and interdisciplinary communication, communication across levels and settings of care, and care planning conferences.	4 points
3.2. A policy and documented process is in place to provide individuals access to their medical record and/or plan of care while they are being treated. They are regularly encouraged to access this information and are supported in understanding and contributing to the documentation. There is evidence that this offer/process to access this information is communicated to every patient/resident.	4 points
3.3. Practices are implemented to assess individuals' preferred learning style, culture and ability to understand the concepts and care requirements associated with managing their health. These assessments are used to provide education (including discharge instructions as applicable) in a manner that accommodates their learning preferences and level of understanding in a culturally and linguistically appropriate way.	4 points
3.4. Practices are implemented to assess and address the social determinants of an individual's health, including those pertaining to accessing care, barriers to self-management and adopting healthy behaviors.	4 points
3.5. Flexible, 24-hour family and friend presence (visitation) is supported by policy and in practice. Limits to their presence are mutually developed between the patient/resident, their support network and the care team. Limits are based on patient/resident preferences, the treatment plan, agreements with roommates, and safety considerations.	3 points
3.6. Processes are in place for identifying and partnering with patients/residents and family/ friend caregivers throughout the care encounter to participate in care activities and to enhance their abilities to manage healthcare needs outside of a specific care episode. These care activities include physical care, patient education, and care coordination. The approach is tailored to the treatment plan, patient/resident preference and the family/friend caregivers' abilities.	4 points
3.7. The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each individual, especially for those with chronic conditions and during transitions of care.	9 points
4.1. Efforts have been undertaken to promote caring attitudes and compassionate communication. In discussion, stakeholders validate feeling treated with dignity and respect, being listened to and having their concerns taken seriously.	6 points
4.2. Patients'/residents' treatment goals are documented and shared with the care team. This documentation is updated as patients'/residents' goals evolve. Care planning processes (including advance care planning) include elements to inform individuals about their care and the options available to them and encourage patient/resident/ family involvement in shared decision-making, communicating their treatment goals and ensuring that care plans are aligned with their documented choices and goals.	7 points
4.3. The special needs of the community's diverse cultural groups are evaluated, documented and addressed in specific and appropriate ways.	5 points
4.4. Systems are in place to document and honor, to the extent possible, patients'/residents' preferences related to: • Activities of daily living (meals, bathing, grooming, sleep) • Scheduling and access • Cultural norms and spiritual beliefs • Use/interest in a broad range of healing modalities, including those considered complementary to Western or traditional modalities • Their personal environment • Positive diversions and/or life enrichment activities (including social support)	9 points

4.5. A mechanism is in place to provide staff support services, with an emphasis on: • Emotional and grief support • Health promotion • Participation in decisions that impact their functional work area/role • Other elements identified by staff as priority areas.	5 points
5.1. The organization's improvement strategy and process, as guided by the strategic plan detailed in criterion 2.1 and implemented in accordance with the structures outlined in criterion 1.3, includes regular review of performance data and evaluation of performance against goals or benchmarks.	2 points
5.2. The organization measures or receives quantitative data on: • Clinical quality performance • Patient/resident safety • Patient/resident experience of care • Staff engagement, staff satisfaction or the staff experience • Physician (and other advanced clinicians) engagement, satisfaction or experience • The safety culture of the organization	6 points
5.3. Performance data on organizational indicators directly related to the strategic goals identified in criteria 1.3. and 2.1 evidences that changes implemented have improved (or have sustained high performance) across the following domains: • Clinical quality or safety • Patient/resident experience of care • Staff and/or physician (and other advanced clinicians) engagement or satisfaction	15 points
5.4. Performance data on organizational indicators related to efficiency and clinical and service excellence are made available to the public to support consumers in making informed choices.	3 points
5.5. Mechanisms are in place for patients/residents and families to share their experiences, feedback and perspectives – in their own words -- throughout the organization. There is evidence this qualitative data are used to identify, inform and evaluate improvement efforts in the organization.	6 points

Appendix C. Criteria Breakdown – By Point Value

(Printer Friendly)

5.3. Performance data on organizational indicators directly related to the strategic goals identified in criteria 1.3. and 2.1 evidences that changes implemented have improved (or have sustained high performance) across the following domains: • Clinical quality or safety • Patient/resident experience of care • Staff and/or physician (and other advanced clinicians) engagement or satisfaction	15 points
1.3 The organization's ongoing improvement structure and process rely on partnerships between leadership, staff and patients/residents/families to identify, prioritize, design and assess person-centered improvement efforts. Stakeholders are educated in improvement methods and are supported in making real time change.	13 points
2.4 The organization partners with other community institutions (e.g. housing authorities, religious institutions, schools, social services, etc.) to address social determinants that may impact individuals' access to care, health and well-being, with an emphasis on vulnerable populations.	10 points
3.7 The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each individual, especially for those with chronic conditions and during transitions of care.	9 points
4.4. Systems are in place to document and honor, to the extent possible, patients'/residents' preferences related to: • Activities of daily living (meals, bathing, grooming, sleep) • Scheduling and access • Cultural norms and spiritual beliefs • Use/interest in a broad range of healing modalities, including those considered complementary to Western or traditional modalities • Their personal environment • Positive diversions and/or life enrichment activities (including social support)	9 points
2.1. Goals and objectives related to person-centered care are developed in partnership with patients/ residents/families and are integrated into the organization's strategic and/or operational plan.	8 points
1.4. Staff engagement approaches reflect the organization's person-centered care philosophy. There is evidence that person-centered care principles, including caring attitudes and compassionate communication, are integrated into the following: • Job descriptions • Performance evaluation systems • Reward and recognition systems • New hire screening, selection and orientation.	7 points
2.1. Leadership interacts regularly with staff from all sectors and at all levels to drive improvement in the organization.	7 points
2.3. All staff, including employed medical staff, off-shift and support staff, participates in experiences designed to help them personally connect to the concepts of person-centered care and to better understand the perspectives of patients/residents, families and other colleagues. These are offered an ongoing basis to reinforce and revitalize staff engagement in person-centered behaviors and practices.	7 points
4.2. Patients'/residents' treatment goals are documented and shared with the care team. This documentation is updated as patients'/residents' goals evolve. Care planning processes (including advance care planning) include elements to inform individuals about their care and the options available to them and encourage patient/resident/family involvement in shared decision-making, communicating their treatment goals and ensuring that care plans are aligned with their documented choices and goals.	7 points

1.1. A multi-disciplinary, site-based committee structure oversees and assists with implementation and maintenance of person-centered practices. Active participants include: • Patients/residents and/or family members*; • A mix of non-supervisory and management staff; • A mix of clinical and non-clinical staff • A senior-level executive champion • A senior level clinical champion.	6 points
4.1. Efforts have been undertaken to promote caring attitudes and compassionate communication. In discussion, stakeholders validate feeling treated with dignity and respect, being listened to and having their concerns taken seriously.	6 points
5.2. The organization measures or receives quantitative data on: • Clinical quality performance • Patient/resident safety • Patient/resident experience of care • Staff engagement, staff satisfaction or the staff experience • Physician (and other advanced clinicians) engagement, satisfaction or experience • The safety culture of the organization	6 points
5.5. Mechanisms are in place for patients/residents and families to share their experiences, feedback and perspectives – in their own words -- throughout the organization. There is evidence this qualitative data are used to identify, inform and evaluate improvement efforts in the organization.	6 points
4.3. The special needs of the community's diverse cultural groups are evaluated, documented and addressed in specific and appropriate ways.	5 points
4.5. A mechanism is in place to provide staff support services, with an emphasis on: • Emotional and grief support • Health promotion • Participation in decisions that impact their functional work area/role • Other elements identified by staff as priority areas.	5 points
1.5. The built environment incorporates elements that support patient/resident and family engagement in their care, including (as appropriate, based on the care setting): • Minimizing physical barriers to promote communication and compassionate interactions • Incorporation of spaces that comfortably accommodate the presence of family and friends • Incorporation of elements that support patient/resident education and access to information • Barrier-free and convenient access to building(s). • Clear and understandable directions for patients/residents and visitors to their destinations • Accommodations to preserve patients'/residents' dignity and modesty • Access to natural light • Promotion of outdoor spaces and opportunities to access them.	4 points
3.1. Systems are in place to support the active involvement of patients/residents and families in communication exchanges between members of their care team and across settings of care. This includes (as appropriate to the care setting and based on patient/resident/family preferences) shift-to-shift communication, inter-departmental and interdisciplinary communication, communication across levels and settings of care, and care planning conferences.	4 points

3.2. A policy and documented process is in place to provide individuals access to their medical record and/or plan of care while they are being treated. They are regularly encouraged to access this information and are supported in understanding and contributing to the documentation. There is evidence that this offer/process to access this information is communicated to every patient/resident.	4 points
3.3. Practices are implemented to assess individuals' preferred learning style, culture and ability to understand the concepts and care requirements associated with managing their health. These assessments are used to provide education (including discharge instructions as applicable) in a manner that accommodates their learning preferences and level of understanding in a culturally and linguistically appropriate way.	4 points
3.4. Practices are implemented to assess and address the social determinants of an individual's health, including those pertaining to accessing care, barriers to self-management and adopting healthy behaviors.	4 points
3.6. Processes are in place for identifying and partnering with patients/residents and family/ friend caregivers throughout the care encounter to participate in care activities and to enhance their abilities to manage healthcare needs outside of a specific care episode. These care activities include physical care, patient education, and care coordination. The approach is tailored to the treatment plan, patient/resident preference and the family/friend caregivers' abilities.	4 points
3.5. Flexible, 24-hour family and friend presence (visitation) is supported by policy and in practice. Limits to their presence are mutually developed between the patient/resident, their support network and the care team. Limits are based on patient/resident preferences, the treatment plan, agreements with roommates, and safety considerations.	3 points
5.4. Performance data on organizational indicators related to efficiency and clinical and service excellence are made available to the public to support consumers in making informed choices.	3 points
1.2. An individual (or team) is appointed to guide implementation of activities that advance organizational progress toward person-centered care goals. This individual (or team) functions as or reports directly to a senior executive in the organization.	2 points
5.1. The organization's improvement strategy and process, as guided by the strategic plan detailed in criterion 2.1 and implemented in accordance with the structures outlined in criterion 1.3, includes regular review of performance data and evaluation of performance against goals or benchmarks.	2 points

Appendix D. Partnership Portfolio Worksheet

Person-Centered Care Certification Partnership Portfolio Worksheet Template	
1. Improvement Opportunity Identified	
2. Using the dropdown menu, how would you characterize the focus of this improvement effort?	
3. What evidence did you draw on to identify this as an opportunity for improvement?	
4. Measure selected to track improvement	
5. Baseline performance on measure	
Date of baseline data	
Baseline performance measurement	*performance measurement must be a percentage rate (e.g. % of patients) or a number (e.g. # of patients)*
6. Performance target set	*must be a rate or number that exceeds that baseline performance measurement provided. A statement that the goal is to improve is not sufficient. The improvement must be quantified.*
7. Actions taken since the collection of baseline data and approximate dates of implementation	
8. Describe the involvement of patients/residents/family members in this improvement project.	
9. Follow-up performance measurement	
Date of follow-up measurement	
Follow-up performance measurement	*follow-up performance measurement must be presented in the same way as the baseline measurement. Charts may be provided, but are not required.*
10. Which description best capture the scale/size of this improvement project? (1. Small scale test of change; 2. Pilot; 3. Large scale intervention)	

Appendix E. Healthy Community Portfolio Worksheet

Person-Centered Care Certification Healthy Communities Portfolio Worksheet Template	
1. Partnering organization(s), with brief description of each	
2. Specific aim of the collaboration.	
3. How long has the partnership been active?	
4. What vulnerable population is targeted by these efforts?	
5. What activities have been implemented via this partnership to address specific needs of that population?	
6. How do you evaluate the degree to which the partnership is achieving the aim defined above?	
7. Performance measurement to demonstrate progress toward the aim.	
Date of performance measurement	
Performance measurement (examples include usage, participation and/or referral data)	

Appendix F. Transitions of Care Portfolio Worksheet

Person-Centered Care Certification Transitions of Care Portfolio Worksheet Template	
1. Partnering organization(s), with an indication of the setting of care each represents.	
2. Specific aim of the partnership.	
3. How long has the partnership been active?	
4. What activities have been implemented via this partnership to achieve that aim?	
5. How do you evaluate the degree to which the partnership is achieving the aim defined above?	
6. Performance measurement to demonstrate progress toward the aim.	
Date of performance measurement	
Performance measurement (Examples include readmission rates, outcomes related to bundled payment programs, and progression in satisfaction scores related to transition confidence, etc.)	

Appendix G. Improvement Portfolio Worksheets

Person-Centered Care Certification Improvement Portfolio Worksheet Template

1. Clinical quality or safety measure selected for improvement.	
2. Related strategic or operational priority, as documented in the organization's strategic or operational plan (criterion 2.1) OR identified as an improvement need through the improvement structures described in criterion 1.3.	
3. Baseline performance on measure	
Date of baseline data	*insert month/year baseline data was collected*
Baseline performance measurement	*performance measurement must be a percentage rate (e.g. % of patients) or a number (e.g. # of patients)*
4. "Best in Class" performance target set	
5. How did you establish the parameters for "best in class" performance on this measure?	
6. Actions taken since the collection of baseline data and approximate dates of implementation.	
7. Follow-up performance measurement	
Date of follow-up measurement	*month/year follow-up measurement was collected. Follow-up data must be from the last 12 months.*
Follow-up performance measurement	*follow-up performance measurement must be presented in the same way as the baseline measurement. Charts may be provided, but are not required.*

Person-Centered Care Certification Improvement Portfolio Worksheet Template

1. Patient/resident/family experience measure selected for improvement.	
2. Related strategic or operational priority, as documented in the organization's strategic or operational plan (criterion 2.1) OR identified as an improvement need through the improvement structures described in criterion 1.3.	
3. Baseline performance on measure	
Date of baseline data	*insert month/year baseline data was collected*
Baseline performance measurement	*performance measurement must be a percentage rate (e.g. % of patients) or a number (e.g. # of patients)*
4. "Best in Class" performance target set	
5. How did you establish the parameters for "best in class" performance on this measure?	
6. Actions taken since the collection of baseline data and approximate dates of implementation.	
7. Follow-up performance measurement	
Date of follow-up measurement	*month/year follow-up measurement was collected. Follow-up data must be from the last 12 months.*
Follow-up performance measurement	*follow-up performance measurement must be presented in the same way as the baseline measurement. Charts may be provided, but are not required.*

Person-Centered Care Certification Improvement Portfolio Worksheet Template

1. Staff and/or physician engagement measure selected for improvement.	
2. Related strategic or operational priority, as documented in the organization's strategic or operational plan (criterion 2.1) OR identified as an improvement need through the improvement structures described in criterion 1.3.	
3. Baseline performance on measure	
Date of baseline data	*insert month/year baseline data was collected*
Baseline performance measurement	*performance measurement must be a percentage rate (e.g. % of patients) or a number (e.g. # of patients)*
4. "Best in Class" performance target set	
5. How did you establish the parameters for "best in class" performance on this measure?	
6. Actions taken since the collection of baseline data and approximate dates of implementation.	
7. Follow-up performance measurement	
Date of follow-up measurement	*month/year follow-up measurement was collected. Follow-up data must be from the last 12 months.*
Follow-up performance measurement	*follow-up performance measurement must be presented in the same way as the baseline measurement. Charts may be provided, but are not required.*

Appendix H. Tips for Recruiting Focus Group Participants

During the on-site validation visit, Planetree will conduct a series of focus groups or listening sessions to obtain information about the applicant's person-centered practices. The focus groups are the primary way that Planetree validates the successful implementation of the criteria and well populated focus groups are essential to a successful site visit. **Each of the patient/ resident focus groups must be attended by a minimum of eight randomly selected participants, and each of the employee focus groups must have a minimum of ten randomly selected participants.** It is essential that participants in patient/resident focus groups not have any other relationship with the organization (e.g. as a volunteer, employee, Board member, etc.). If the focus groups are not adequate, either because of the number of participants or because the participants have a relationship with the organization, Planetree may require a second on-site visit with additional focus groups before reaching a certification decision.

TIPS FOR STAFF FOCUS GROUPS

1. Employees should be invited individually, and their participation should be confirmed, in order to ensure good representation.

    a. It is incumbent upon managers to ensure that their staff can attend the focus groups, and accordingly to determine ways to free their staff during the designated hour time period.

    b. Ideal focus group size ranges from 12-14 participants.

2. To ensure that all employees feel comfortable expressing their opinions,
    a. Each focus group session should be limited to only those invited group members.
    b. Staff is told that their comments are anonymous so we discourage the use of attendance sheets or photographs.
    c. Staff in reporting relationships should not be at the same focus group. Senior staff should not attend the non-supervisory staff or department head focus groups.

3. Include informal leaders from a mix of departments, and in unionized environments, union leadership should always be invited to participate in a non-supervisory focus group.

4. There should be some representation of staff from each department and from all shifts.

5. To ensure optimal participation from staff with diverse perspectives, no staff members should participate in more than one focus group/meeting during the site visit. For instance, employees who participate in the meeting with members of the person-centered care oversight group should be not be included in an additional staff focus group.

6. Ideally, healthy refreshments should be served at each focus group session (coffee, juice, water, nuts, whole grain muffins or bagels, fruit, snacks, popcorn).

7. Focus groups with medical staff and/or board members may be better attended if scheduled as a breakfast, luncheon or dinner meeting.

TIPS FOR PATIENT FOCUS GROUPS:

1. Optimal patient focus group attendance can be difficult to achieve and results may depend on such things as the patient demographics (e.g. age), their recovery status, or the weather. **The ideal size of the focus group is between 10-12 individuals.**

2. Focus groups should be organized around the services received in order to promote dialogue. While ED patients may end up with inpatient experiences, maternity patients could be paired with pediatric patients, but would not be a good mix with oncology visits.

3. Recently discharged patients (within the past three to six months) are generally a good source of information for focus groups. Some methods to solicit attendance are:
    a. Approaching patients at discharge with an invitation
    b. Using discharge lists
    c. Patient advisory group request for names
    d. Patients who write letters of praise or complaint.

4. Plan on inviting approximately five patients for every one participant. For a single focus group of 10-12 participants, contact between 50 to 75 patients.

5. Include family members when appropriate or when they are more likely to attend with this support. Offer maternity patients the option of bringing their babies (having onsite child care is sometimes an incentive)

6. Send an invitation from the organization's leader to "breakfast/lunch/dinner and a discussion session" at the site.
    a. Include mention of an incentive to participate such as a gift certificate to the local mall.
    b. Express the importance of their opinions as you look for ways to enhance their experience at your healthcare center.
    c. Be clear that the session will be facilitated by Planetree and not a representative from the organization.

7. A follow-up to encourage and confirm participation is essential. You may also choose to include a mail back response card in the letter of invitation
    a. ***Three weeks before the scheduled focus group date:*** Send a formal letter to patients inviting their participation and explain in the letter that they will be given a meal and a gift certificate (or some type of incentive) for participating.
    b. ***One week before the scheduled focus group date***: Begin calling invitees randomly until you have confirmations from the maximum number desired for each focus group, plus several extra – ask them to put the date on their calendars.
    c. ***One or two days before the focus group***: Make follow-up reminder phone calls to all confirmed participants.
    d. Mention that they will receive refreshments and a thank-you gift for giving their time.

8. In order to ensure that focus group participants are comfortable offering their unbiased opinion, the patients included in the focus groups must not have any relationship to the healthcare center other than as a patient. Employees, medical staff members, board members, and volunteers who have been patients should not be included in the patient focus groups.

TIPS FOR RESIDENT FOCUS GROUPS:

Resident focus group sessions are most effective when limited to **eight to ten participants**. Due to hearing and other impairments, the smaller the group, the more effective the facilitation and information garnered. It may be helpful to have a microphone set up for the facilitators to utilize.

Please note, if you have short term rehab at your site, an additional resident focus group may be added.

