Revised 3.2014

PLANETREE DESIGNATION CRITERIA

For Sites Applying for Designation as a Patient-Centered Hospital or a Resident-Centered Community

Integrated Set, revised March 2014 (Revisions (in bold) to take effect January 1, 2015)

The Patient-/Resident-Centered Designation Program was created by Planetree to recognize healthcare providers around the world that have embraced and implemented patient-/resident-centered care in a comprehensive manner. This approach to care is characterized by providers partnering with patients/residents and their family members to identify and satisfy the full range of their needs and preferences. In addition to improving the patient/resident experience, patient-/resident-centered organizations also focus on supporting the professional and personal aspirations of their staff members, who can more effectively care for patients and residents if they are cared for themselves.

Based on the feedback of thousands of patients, residents and healthcare professionals since 1978, Planetree has identified core elements that are essential to practicing patient-/resident- centered care. The Designation Program is based on these core elements, as well as additional elements related to organizational structures and measurement. For each core element, specific criteria have been identified that sites must meet in order to demonstrate that they have implemented that aspect of a patient-/resident-centered approach to care. The following criteria are designed to provide a level of consistency in what it means to be a patient-/resident-centered organization while continuing to promote individuality and innovation in the delivery of care and services.

The designation criteria are designed to be applicable to all healthcare providers. In some cases, however, specific criteria may apply differently in various healthcare settings (acute care, continuing care, behavioral health[1]), and not all criteria apply to all settings. Clarifications for how individual criteria may apply differently in discrete settings (either free-standing facilities or units within a larger setting) are provided within the text. If not otherwise noted, the criteria are applied in the same way across settings.

[1] It is recognized that use of the term "patient" to describe consumers of behavioral health services remains the topic of longstanding debate within the behavioral health community; however, in order to promote parity and in the absence of an all-encompassing term for which there is industry-wide consensus, the word "patient" will be used throughout these criteria to refer to those individuals who receive medical attention, care or treatment. Individual organizations are encouraged to continue using the terminology with which they are most comfortable, and are permitted to replace the word "patient" throughout the criteria with their preferred terminology if they wish to do so.

I. STRUCTURES AND FUNCTIONS NECESSARY FOR IMPLEMENTATION, DEVELOPMENT AND MAINTENANCE OF PATIENT-/RESIDENT-CENTERED CONCEPTS AND PRACTICES

Objectives:

The site's commitment to patient-/resident-centered care extends and is communicated to all levels (governing body, administration, physicians, management, staff, volunteers, patients/residents and families).

Community needs and patient/resident perceptions are incorporated in the planning and implementation of patient-/resident-centered programmatic elements, and their active involvement is encouraged.

All clinical and non-clinical staff, medical staff, and volunteers are involved in the implementation and dissemination of patient-/resident-centered initiatives.

Criteria:

(Revisions (in bold) to take effect January 1, 2015)

I.A: A multi-disciplinary task force, **including patients/residents and family members,** is established to oversee and assist with implementation and maintenance of patient-/resident-centered practices. Active participants on the task force include a mix of non-supervisory and management staff and a combination of clinical and non-clinical staff. The group meets regularly (every 4-6 weeks) on an ongoing basis**.** ~~**In continuing care environments, this task force also includes residents and family members.**~~

I.B: A patient-/resident-centered care coordinator or point person is appointed who is able to commit the time required to champion related activities on an ongoing basis.

I.C: Patient/resident, family and staff focus groups are conducted on-site by Planetree or another qualified, independent vendor periodically (recommended interval is at least every 18 months), and the results are shared at a minimum with senior management, the governing body, and staff.

I.D: Information on patient-/resident-centered care implementation and related clinical, operational and financial metrics is shared with all key organizational stakeholders, including the governing body, at a minimum quarterly. Goals and objectives related to patient-/resident-centered care are adopted as part of the organization's strategic and/or operational plan.

I.E: An ongoing mechanism is in place to solicit input and reactions from patients/residents, families, and the community on current practices and new initiatives, **and to promote partnership between these stakeholders and the organization's leadership and governing body.** This may be achieved via an active patient/resident/ family or community advisory council with regular meetings (at a minimum six times a year) **and access to decision-makers**, or some other effective mechanism to obtain regular input from patients/residents and community. **Participation is representative of the community served.**

I.F: Leadership exemplifies approaches that motivate and inspire others, promote positive morale, mentor and enhance performance of others, recognize the knowledge and decision-making authority of others and model organizational values, as demonstrated in focus groups with staff, employee experience survey results and the adoption of transformational leadership practices.

II. HUMAN INTERACTIONS/INDEPENDENCE DIGNITY AND CHOICE

Objectives:

Staff is supportive and respectful of all patients/residents and their families, and management is supportive and respectful of all staff.

All staff members see themselves as caregivers in a multi-disciplinary team approach.

Staff members are empowered to act as patient/resident advocates and educators.

Decision-making by staff members who provide direct care to patients/residents is supported.

Open and direct communication is demonstrated among all staff and managers.

Continuity of care and accountability for patients/residents is maximized and maintained for the duration of one's care, including during transitions between levels of care.

Staff has input (either unit-based or hospital-wide) in determining how patient-/resident-centered care is delivered.

Care for caregivers is provided in regular and meaningful ways.

Individuals are recognized and acknowledged for their work in creating a patient-/resident-centered environment.

Billing processes are transparent, respectful and responsive to the needs of patients/residents and families.

Systems are in place to maximize the independence, dignity and choice of patients/residents. Patients'/residents' personal preferences are honored, and their customary daily habits and routines are upheld to the extent possible.

The organization balances safety considerations with being supportive of patient/resident empowerment, independence and dignity.

In continuing care environments, residents and family are encouraged to feel a sense of belonging, individuality, ownership and pride in their community.

Criteria:

(Revisions (in bold) to take effect January 1, 2015)

II.A: All staff members of the primary organization being recognized, including off-shift, part-time, and support staff are given an opportunity to participate in a ~~**minimum of eight hours of**~~ patient-/resident-centered staff retreat experience or **a comparable experiential PCC immersion program** ~~**an equivalent**~~, with a minimum concurrent completion rate of 85%. In addition, per diem staff, employed medical staff and other providers (physician assistants, nurse practitioners and clinical nurse specialists) and volunteers are encouraged to participate in a retreat experience.

II.B: Physicians are oriented, regularly educated about, and encouraged to participate in patient-/resident-centered initiatives, **and demonstrate behaviors consistent with the organization's culture of patient-/resident-centered care.** An independently administered physician engagement survey is conducted at least once every **three** years using a validated survey instrument, **and validates physicians' understanding and engagement in that culture.**

II.C: Continuing education to reinforce and revitalize staff engagement in patient-/resident-centered behaviors and practices and build competence around the community's evolving needs is offered on an ongoing basis to all staff in meaningful ways determined by the organization.

II.D: A comprehensive presentation on patient-/resident-centered care concepts, practices and initiatives is provided for all new staff and volunteers as a part of orientation. In continuing care environments, residents and family members are included in a

meaningful way in the new employee orientation program. In addition, the new resident/family orientation includes an introduction of resident-centered care concepts and how those concepts are realized within the community.

II.E: Active teams are in place that address patient-/resident-centered initiatives, and include participation by non-supervisory staff and**~~, as appropriate,~~** patients/residents and families.

II.F: **Formalized processes are in place to promote** continuity, consistency **and accountability in** care delivery, **and which** allow staff the opportunity and responsibility for personalizing care in partnership with each patient/resident.

II.G: A mechanism is in place to provide staff support services that include elements identified by staff as priority areas. Examples include access to support services such as meals-to-go, relaxation and stress reduction programs/services, space to recharge away from patients/residents and families, emotional support such as bereavement services and staff support groups and provision of ergonomic support measures in order to ensure physical well-being of staff and injury prevention.

II.H: Human resource systems, including job descriptions and evaluations, reflect the organization's patient-/resident-centered care philosophy. Other examples include behavioral standards, recruitment and retention efforts, staff selection tools and criteria and conducting team interviews. In continuing care environments, residents play a role in the hiring and evaluation of staff.

II.I: Opportunities, both formal and informal, are provided for staff reward, recognition and celebration. In continuing care environments, recognition and celebration programs integrate residents and family members and extend to their personal milestones, achievements and contributions to the continuing care community.

II.J: Independently administered staff engagement or experience surveys using a validated survey instrument, or other structured staff feedback mechanisms, are conducted at least once every two years.

II.K: **When an adverse clinical event or unanticipated outcome occurs,** a process is in place to provide support to patients/residents, family and staff affected. **This includes a process for full and empathetic disclosure to patients/residents (and family as appropriate).**

II.L: Processes are in place to help patients/residents anticipate the costs of care and assistance is available for those who need to make financial arrangements. Financial communications are concise, clear and respectful.

II.M: The organization has processes in place focusing on keeping patients/residents and staff safe from harm from self and others, and staff is provided education on and demonstrates competency in balancing safety considerations with being supportive of patient/resident empowerment, independence and dignity.

II.N: Effective 24-hour shift-to-shift and inter-departmental communication processes are in place to ensure patients'/residents' individualized needs are evaluated, discussed, and met. Patients/residents and families are involved in shift-to-shift communication in a manner that meets their individual preferences and needs.

II.O: Effective communication mechanisms are in place to engage all staff (including off-site and all shifts) in dialogue about organizational priorities.

II.P: **Staff engage patients/residents, family and/or their advocates in the care planning process. Examples may include use of shared decision making tools, health coaching and collaborative care conferences.** ~~**Processes are in place for integrating patients'/residents' preferred routines and rhythms of daily life into care plans (e.g., accommodations to preserve existing sleep patterns, plans for providing assistance with waking up and going to bed, eating, exercise, etc.). Staff support the engagement of patients/residents and family in the care planning process.**~~

II.Q: The professional development/advancement of staff is supported. Examples include the empowerment of frontline work teams, internal training and promotion tracts (e.g., career ladders), flexible scheduling to enable educational pursuits, an actively utilized tuition reimbursement program, etc.

II.R–*Applies only to continuing care sites*: In continuing care settings, residents are given an opportunity to participate, as appropriate, in a retreat experience or an equivalent to assist with internalizing resident-centered care concepts and to enhance sensitivity to the needs of the entire community. Resident retreats are conducted at a minimum annually.

II.S–*Applies only to continuing care sites*: Residents are provided with the choice of where they are going to live and with whom, with staff input provided as appropriate.

III. PROMOTING PATIENT/RESIDENT EDUCATION, CHOICE AND RESPONSIBILITY

Objectives:

Patients/residents are provided education and access to a wide range of health and medical information, including, as clinically appropriate, having real-time access to the medical record, treatment plan/care plan and other clinical information.

Families are provided education and access to a wide range of health and medical information, including, based on the patients'/residents' preference and consent, details related to diagnoses, the treatment plan and other clinical information.

Patients/residents know that they can participate in the decisions regarding their care and that their decisions will be respected.

Patients/residents are given information about what educational resources are available and know that they may participate at whatever level they are comfortable, while they are residents or either in- or out-patients at the facility.

Patients/residents and family members are involved in the development of the care plan.

Staff is familiar with patient education and community information resources, and will assist patients/residents and families in accessing such resources.

Patients/residents are supported in managing their own healthcare information in order to optimize continuity of care among multiple providers.

Criteria:
(Revisions (in bold) to take effect January 1, 2015)

III.A – *Acute Care and Continuing Care Application*: A policy for sharing clinical information, including the medical record and the care plan, with patients/residents has been approved, staff are educated on this policy and the process for sharing the record and care plan, an effective system is in place to make patients/residents aware that they may review this information, and a process is in place to facilitate patients/residents documenting their comments.

> III.A-*Behavioral Health Application:* In behavioral health settings, decisions about the extent of the clinical information shared and the mechanism used for sharing this information are made on an individualized basis. A range of options are available for sharing such information, including the medical record and the treatment plan, to ensure that patients of varying competency levels have access to information that will help them to understand their symptoms, diagnosis and treatment.

III.B: A range of educational materials, including consumer health, **those designed to accommodate a range of health ~~low~~-**literacy **levels** and culturally appropriate resources, is available for patients/residents and families and is easily accessible to staff. Patients/residents and family members are aware of the collection of resources available and qualified health information professional staff is available to assist them with their health information needs. **The organization has conducted an organizational health literacy assessment and has a plan in place to address deficiencies.**

III.C: Patients/residents are provided with meaningful discharge/transition instructions in a manner that accommodates their level of understanding and in a language that they understand.

~~**III.D: A process is in place to fully and empathetically disclose unanticipated outcomes to patients/residents (and family as appropriate).**~~

Effective January 1, 2015:
Criterion III.D has been retired, and its content has been incorporated into criterion II.K.

III.**D**: The site has a process to assist patients/residents and families in managing their medical information and coordinating their care among multiple physicians, including their admitting physician, primary care provider and appropriate specialists. **An example is providing patient access to personal health information via the organization's electronic patient portal.**

IV. FAMILY INVOLVEMENT

Objectives:

Family members (those who are considered "family" by the patient/resident) know that they are valued members of the patient's/resident's health care team, and, as clinically appropriate, are welcomed and supported to be with the patient/resident whenever the patient/resident wishes.

When mutually agreed upon and clinically appropriate, staff encourages families to participate in the emotional and spiritual support and physical care of the patient/resident.

Staff actively involves patients'/residents' families throughout the care planning process in formal and informal ways.

Any clinically-based restrictions on family involvement are explained to the patient/resident and family.

The organization is mindful of and responsive to the physical and emotional needs of those who are the patient's/resident's support system.

Criteria:

(Revisions (in bold) to take effect January 1, 2015)

IV.A -*Acute Care and Continuing Care Application*: Flexible, 24-hour, patient-/resident-directed family presence is in place, and children are permitted to visit. (Family is as defined by the patient/resident; Exceptions include psychiatric facilities, NICU and in cases of communicable disease.) In continuing care settings, programs are implemented to enhance the visitation experience for both visitors and residents, and appropriate accommodations are made to support visitation as it relates to a variety of resident/family needs, including visitation by a spouse or partner, visitation at the end of life, visits to residents with dementia, etc.

> IV.A-*Behavioral Health Application:* In behavioral health settings, visiting hours are consistent with the patient's treatment plan and flexible to accommodate patient and family visitation preferences. Restrictions to visitation are determined by the treatment plan and patient preferences, and the rationale for any restrictions is clearly communicated to patients and families.

IV.B-*Acute Care and Continuing Care Application*: A comprehensive formalized approach for partnering with families in all aspects of the patient's/resident's care, and tailored to the needs and abilities of the organization and its facility, is developed. An example is a Care Partner Program.

> IV.B-*Behavioral Health Application:* A comprehensive formalized approach to providing families with psychoeducation and, when clinically appropriate, involving them in the patient's care, is developed and tailored to the needs and abilities of the organization and its facility. An example is a Care Partner Program.

IV.C: A process is in place to encourage patients/residents and families to communicate with staff about any concerns related to their care, including any concerns related to patient/resident safety.

IV.D: *Applies only to continuing care sites*: A process aligned with each resident's individual preferences is in place to contact residents' family on a regular basis to communicate progress and/or "positive events."

V. DINING, FOOD AND NUTRITION

Objectives:

Patients/residents, visitors and staff have access to healthy food choices 24-hours/day.

Flexibility in dining options accommodates patients'/residents' personal preferences and routines.

The nutrition program caters to individual needs, including dietary restrictions, in a dignified manner.

Patients/residents direct their dining experience, which seeks to maintain each individual's dignity and, as appropriate, enhance socialization.

Criteria:
(Revisions (in bold) to take effect January 1, 2015)

V.A: A system is in place to provide patients/residents, families and staff with 24-hour access to a variety of fresh, healthy foods and beverages (unless doing so conflicts with the treatment plan). Patients'/residents' personal preferences and routines around mealtimes are considered and accommodated to the extent possible.

V.B.-*Applies only to continuing care and behavioral health sites*: The dining experience maintains patients'/residents' dignity, enhances socialization and supports independence while catering to individual needs. Examples include implementation of a restorative dining program, the provision of finger food, supporting staff and patients/residents in dining together and providing opportunities for patients/residents to assist with meal preparation (ex: table setting, clearing plates, etc.).

VI. HEALING ENVIRONMENT: ARCHITECTURE AND DESIGN

Objectives:

The site creates an environment that is less institutional and more home-like in appearance.

The site balances the need for patient/resident safety with the importance of patient/resident comfort, privacy and modesty.

The environment maximizes opportunities for privacy, intimacy and socialization.

The site and its campus are healing environments, engaging all of the human senses in ways that facilitate the healing process.

The organization considers the experience of the mind, body, and spirit of patients, families, and staff in its planning and design efforts.

Criteria:

(Revisions (in bold) to take effect January 1, 2015)

VI.A: The built environment incorporates evidence-based principles of healing healthcare design and is consistently updated to enhance the safety and security of patients/residents, visitors, and staff. Users of the space are involved in the design process. This may include design teams with stakeholder participation, focus groups with patients/residents, families, physicians and staff, research based on community demography and/or a research basis that supports the continuum of care.

VI.B: Patients/residents have choices or control over their personal environment, including personalization, electrical lighting, access to daylight, noises and sounds, odors, thermal comfort and visual privacy.

VI.C: As plans for future renovations and remodeling are developed, symbolic and real barriers are minimized and open communication and human interactions are prioritized. Examples include implementing principles of universal design, open and collaborative team centers for staff, private consultation areas, family lounges, nourishment centers for family and visitor use and reduction of access-limiting signage.

VI.D. A patient/resident and visitor navigation plan provides a clear and understandable pathway for patients/residents and visitors to their destinations. Patient/resident input informs the navigation plan. Components of the navigation plan may include progressive disclosure, wayfinding that is understandable to a variety of end users regardless of language of origin or physical ability, destination markers, clear sightlines with visual wayfinding markers such as architectural details, pattern or artwork, kiosks and/or the provision of handheld maps. In continuing care settings, signage in resident rooms is kept to a minimum.

VI.E. Physical access to the building is barrier-free, **optimally accessible (employs universality in its design)** and convenient for those served. This may include having **additional accessible** parking adjacent to entrances, offering valet service and/or shuttles to transport visitors to and from the building, and ensuring that wheelchairs **are conveniently located** at entrances sufficient to meet the need **of patients/residents.**

VI.F. The environment is designed to accommodate privacy needs in a culturally appropriate way and provides for patient/resident dignity and modesty, particularly in common areas, check-in/registration, check-out/billing, patient/resident rooms and bathrooms.

VI.G: The organization is able to **demonstrate its commitment to the promotion of holistic community health through environmental stewardship, including sustainable approaches to construction, renovation and ongoing operation and maintenance of the facility as well as encouraging environmentally-friendly practices in staff work (e.g. reduction of interior and exterior pollutants, conservation of resources, preserving green space etc.)**

VI.H. Lighting is provided that is **aesthetically conducive to creating a healing environment and that enhances** staff, patient/resident **and family safety and security throughout premises.**

VI.I: Patients/residents **and staff** have access to nature. Examples include an indoor, outdoor or roof garden.

VI.J– *Applies only to continuing care and behavioral health sites*: Common spaces are available and feature a sense of spaciousness and light. In addition, they satisfy patients'/residents' needs for both private spaces and spaces that support social interaction.

VI.K– *Applies only to continuing care and behavioral health sites*: Protocols are in place for reducing coercive intervention. Examples may include provision of a comfort room, Snoezelen, or low-stimulation environment.

VII. ARTS PROGRAM/MEANINGFUL ACTIVITIES AND ENTERTAINMENT

Objectives:

Patients/residents have access to a variety of arts and entertainment.

Patients/residents are supported in maintaining their personal hobbies and interests.

Staff, patients/residents, and families are engaged and involved in providing meaningful activities and entertainment.

A variety of opportunities exist to support residents' personal, intellectual and professional growth.

The quality of activity programming is emphasized over the quantity of programs offered.

Criteria:
(Revisions (in bold) to take effect January 1, 2015)

VII.A: Arts and entertainment programming and activities are designed with and in response to the interests of patients/residents. In continuing care environments, the array of activities is dynamic, driven by residents' individual interests, and inclusive of family and staff. They also include opportunities for intergenerational interaction and reciprocal learning. The activities program allows for spontaneity and self-directed opportunities for residents, 24-hours a day, 7 days a week.

VII.B–*Applies only to continuing care sites*: A flexible transportation system is provided that enables residents to satisfy personal wishes, to participate in off-site activities and to volunteer.

VIII. SPIRITUALITY AND DIVERSITY

Objectives:

The spiritual needs of patients/residents, families and staff are supported.

The special needs of diverse populations of patients/residents, families and staff from different cultural backgrounds and belief systems are supported and celebrated.

Criteria:
(Revisions (in bold) to take effect January 1, 2015)

VIII.A: A plan is developed and implemented that recognizes the spiritual dimension of patients/residents, families and staff.

VIII.B: ~~**The special needs of the community's diverse cultural groups are investigated, documented and addressed in specific and appropriate ways.**~~ Accommodations are made to integrate **individual** patients'/residents' **cultural norms, needs and** beliefs into their care and treatment plan upon request.

VIII.C.-*Applies only to continuing care sites:* Programs, rituals and ceremonies are regularly offered to celebrate the diversity among all members of the community. An example is holding monthly cultural education events.

IX. INTEGRATIVE THERAPIES/PATHS TO WELL-BEING

Objectives:

The interests of the communities served for evidence-based alternative, complementary and integrative healing modalities are addressed and supported.

Staff members and patients/residents, as clinically appropriate, are provided with caring touch in the heath care environment.

Patients'/residents' wellness needs are approached holistically.

Wellness programs, including chronic disease prevention and management programs, maximize the quality of life for all members of the community.

Criteria:

(Revisions (in bold) to take effect January 1, 2015)

IX.A: **A broad range of healing modalities, including those considered complementary to Western or traditional modalities, are offered to meet the needs of patients/residents. These offerings are based on an assessment of the interests and current utilization patterns of patients/residents and medical staff in such complementary and integrative healing modalities.** Examples could include providing direct services, developing a process for responding to patient/resident requests for in-hospital treatment by the patient's/resident's existing practitioner(s), and evaluation of patients/residents' herbal remedies as part of the medication reconciliation process.

IX.B: A plan for caring touch is developed and implemented as appropriate. (Exceptions include behavioral health patients.) Examples of caring touch include massage, healing touch, therapeutic touch and Reiki. Beyond implementation of formal caring touch programs, patients'/residents' daily care is provided with gentleness.

IX.C: Patients'/residents' **health and** wellness needs are approached holistically **and in consideration of the person's expressed health goals and priorities. Caregivers assess the ability of each patient/resident and family member to self-manage their health care needs, and support is available, as needed, to enhance self-management abilities. Examples include home monitoring, health coach support, programs that support patients/residents family in chronic disease management, stress management, nutrition, etc.**

IX.D - *Applies only to acute care and continuing care sites:* A plan is developed and implemented for providing holistic and dignified end-of-life care. The plan includes clinical care and pain management, meaningful education about advance directives, and psychosocial and spiritual support.

X. HEALTHY COMMUNITIES/ENHANCEMENT OF LIFE'S JOURNEY

Objectives:

Sites extend their activities outside the walls of their organizations in ways that positively impact the health of the communities they serve.

Criteria:
(Revisions (in bold) to take effect January 1, 2015)

X.A: Based on the interests and needs of the community, a plan is developed to improve community health. Examples include provision of direct services, educational information, or referral and collaboration with local agencies.

X.B: The organization facilitates the active involvement of its external community in the life of the internal community. An example is an active volunteer program.

X.C: 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 patient/resident and family, especially during transitions of care.

X.D: *Applies only to continuing care and behavioral health sites:* The goal of sustaining a meaningful life for patients/residents is supported in a manner that is consistent with their physical and mental state and length of stay. Examples include implementation of a life stories program and supporting patients/residents in volunteering.

X.E– *Applies only to behavioral health sites*: Mechanisms are in place to give public voice to and advocate for the importance of behavioral health initiatives and the need for more comprehensive, stigma free and humane approaches to this care.

X.F –*Applies only to continuing care sites:* The move-in process is managed to maximize connections within the community and to minimize the stress associated with the transition.

XI. MEASUREMENT

Objectives:

Data is gathered to measure overall quality of care, patient/resident safety, and the patient/resident experience and is used to enhance quality and safety, and to improve the patient/resident experience.

Criteria:
(Revisions (in bold) to take effect January 1, 2015)

XI.A-*Acute Care Application*: Patient experience (both inpatient and outpatient) is regularly assessed using a validated survey instrument, which includes the HCAHPS questions. HCAHPS performance for the most recent 12 months for which data is available satisfies each of the following:

- The hospital's aggregate performance on the eight composite questions exceeds the national aggregate performance. (Aggregate score can be calculated by averaging mode-adjusted top box scores for the eight questions; scores will be rounded to the nearest whole percentage point.)

- Performance on each publicly reported category falls no lower than seven percentage points below the national average.

- Performance on the overall rating question exceeds the national average.

XI.A-*Behavioral Health Application:* Patients' perspectives of care (both inpatient and outpatient) are regularly assessed using a validated survey instrument.

XI.B-*Acute Care Application*: The hospital monitors and reports its performance on the full set of CMS Quality Measures to CMS, and shares data on all available indicators with Planetree. The hospital's performance for the most recent twelve month period for which data is available exceeds the "National Average" performance as reported on the U.S. Department of Health and Human Services Hospital Compare web site on 75% of the indicators for which the hospital has more than 25 eligible patients for the 12 month period (an n of >25).

XI.B-*Behavioral Health Application:* The hospital monitors and reports its performance on appropriate quality measures and provides benchmarks for comparison purposes. The hospital meets or exceeds benchmarks. Sites accredited by The Joint Commission may submit their ORYX Performance Measure Report, with both the control chart to demonstrate internal trending and the comparison chart to demonstrate performance that meets or exceeds benchmarks to satisfy the criteria.

XI.C: The organization regularly solicits information from staff about safety concerns and uses the information generated to improve safety practices in the organization. The organization has a process for encouraging staff to report quality and safety issues. A survey is conducted to assess its safety culture at a minimum once every two years.

XI.D– ~~***Applies only to Continuing Care Settings***~~**: Staff and patient/resident/family members are actively involved in the design, ongoing assessment and communication of performance improvement efforts. The organization consistently utilizes data to identify and prioritize improvement over time.**

