Introduction
Developed and operated by Planetree, the International Person-Centered Designation Program® is the only program of its kind to formally recognize excellence in person-centered care across the care continuum. The program is organized around three tiers: Bronze, Silver and Gold, each representing incremental levels of achievement.

The 2017 revision to the Designation Program introduces a new organizing framework for the criteria. The original Designation criteria were organized around eleven core dimensions of patient-centered care that aligned with the traditional Planetree components of care (human interactions; promoting patient education, choice and responsibility; family involvement; dining, food and nutrition; healing environment; healthy communities.) This revised set are organized into five primary drivers that establish a high-level framework of what it take to create an effective and lasting culture of person-centered care. These drivers are:

![Diagram of five primary drivers]

Within each of these drivers, there are between 4 and 7 criteria that operationalize the larger concept by breaking it down into its principle components. These criteria will be the standards against which healthcare organizations applying for Designation (or one of the intermediate recognition tiers) are evaluated.

Those familiar with the original Person-Centered Designation Criteria will note a significant reduction in the number of criteria, from more than 60 down to 26. This reduction in the number of criteria is a result of efforts to consolidate the concepts and narrow them down to the most high-leverage person-centered changes.

In revising the criteria, effort has been made to:

- Emphasize concepts that align with patient and family caregiver priorities
- Emphasize the relationships between the criteria, i.e. how they work together to create a culture of person-centered care
- Use language that is clear, concise, logical and makes sense to patients and family caregivers
- Use language and concepts that apply across healthcare settings and in diverse cultures.
### Proposed Criteria Revisions, 2017

<table>
<thead>
<tr>
<th>Create organizational structure that promotes engagement</th>
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</table>
| 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.  
*patient/resident/family member participants are not currently employed nor previously employed by the organization. |
| 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. |
| 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. |
| 1.4. Employee engagement approaches reflect the organization’s person-centered care philosophy. There is evidence that PCC principles, including caring attitudes and compassionate communication, are integrated into the following:  
- Job descriptions  
- Performance evaluation systems  
- Reward and recognition systems  
- New employee orientation. |
| 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 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. |

<table>
<thead>
<tr>
<th>Connect values, strategies and action</th>
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<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>2.2. Leadership has adopted practices to systematically engage all parts of the organization, and to create access for all staff to interact with the leadership team.</td>
</tr>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>
### Implement practices that promote partnership

3.1. Routines have been implemented to support the active involvement of patients/residents and families in standard communication exchanges when information about them is being transferred 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 communication, communication across levels and settings of care, and care planning conferences.

3.2. A policy and documented process is in place to offer and provide individuals access to their record and plan of care while they are being treated, and they are supported in understanding and contributing to the information contained within. There is evidence that this offer/ process to access is communicated to every patient/resident.

3.3. Practices are implemented to assess individuals’ preferred learning style 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 language that they understand.

3.4. Practices are implemented to assess and address individuals’ obstacles and opportunities pertaining to accessing care, barriers to self-management and adopting healthy behaviors.

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.

3.6. 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.

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.

### Know what matters

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.

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 encourage patient/resident/family involvement in making informed decisions about their care, communicating their treatment goals and ensuring that care plans are aligned with their documented choices and goals.

4.3. The special needs of the community’s diverse cultural groups are investigated, documented and addressed in specific and appropriate ways.

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)

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.
<table>
<thead>
<tr>
<th>Use evidence to drive improvement</th>
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</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>5.2. 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.</td>
</tr>
<tr>
<td>5.3. The organization measures or receives quantitative data on:</td>
</tr>
<tr>
<td>- Clinical quality performance</td>
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<tr>
<td>- Patient/resident safety</td>
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<tr>
<td>- Patient/resident experience of care</td>
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<tr>
<td>- Staff engagement, staff satisfaction or the staff experience</td>
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<tr>
<td>- Physician engagement, physician satisfaction or the physician experience</td>
</tr>
<tr>
<td>- The safety culture of the organization</td>
</tr>
<tr>
<td>5.4. 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:</td>
</tr>
<tr>
<td>- Clinical quality or safety</td>
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<tr>
<td>- Patient/resident experience of care</td>
</tr>
<tr>
<td>- Staff and/or physician engagement or satisfaction</td>
</tr>
<tr>
<td>5.5. 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 health care choices.</td>
</tr>
</tbody>
</table>
### Background: Derivation of Revised Criteria from Current Designation Criteria – High Level

<table>
<thead>
<tr>
<th>Original Designation Criteria Sections</th>
<th>Proposed New Criteria (language of criteria has been edited down for space)</th>
</tr>
</thead>
</table>
| STRUCTURES AND FUNCTIONS NECESSARY FOR IMPLEMENTATION, DEVELOPMENT AND MAINTENANCE OF PATIENT-RESIDENT- CENTERED CONCEPTS AND PRACTICES | 1.1. Multidisciplinary PCC oversight group.  
1.2. Individual (or team) appointed to coordinate PCC activities, and functions as or reports to senior executive.  
1.3. Improvement structure/process relies on partnerships between leadership, staff and patients/families to identify, prioritize, design, assess improvement efforts.  
2.1. PCC goals co-developed with patients/families and integrated into strategic plan.  
2.2. Leadership practices to systematically engage all parts of the organization, and to create access for all staff to interact with the leadership team. |
| HUMAN INTERACTIONS/INDEPENDENCE DIGNITY AND CHOICE | 1.4. Employee engagement approaches reflect the organization’s person-centered care philosophy.  
2.3. PCC experiences offered on ongoing basis for all staff  
4.1. Efforts have been undertaken to promote caring attitudes and compassionate communication.  
4.5. A mechanism is in place to provide staff support services.  
5.2. Mechanisms for patients/families to share their experiences – in their own words. Evidence this qualitative data informs QI efforts. |
| PROMOTING PATIENT/RESIDENT EDUCATION, CHOICE AND RESPONSIBILITY | 3.1. Routines to facilitate patients'/families’ active involvement in standard communication exchanges when information about them is being transferred among members of their care team and across care settings.  
3.2. Patients have access to their record and plan of care while they are being treated.  
3.3. Individualized health literacy assessments & patient education/discharge instructions provided in a way patients/families can understand.  
4.2. Care planning processes (including advance care planning) include elements aimed at ensuring care plans are aligned with patients’ documented choices and goals. |
| FAMILY INVOLVEMENT | 3.5. Flexible, 24-hour family and friend presence is supported by policy and in practice.  
3.6. Processes for identifying and partnering with patients and family/friend caregivers to participate in care and enhance their abilities to manage healthcare needs outside of a specific care episode. |
| HEALING ENVIRONMENT: ARCHITECTURE AND DESIGN | 1.5. The built environment incorporates elements that support patient/family engagement in their care. |
| DINING, FOOD AND NUTRITION | 4.3. Systems are in place to document patients’ preferences related to ADLs, cultural norms & spiritual beliefs, CAM, end-of-life care, social support. |
| ARTS PROGRAM/MEANINGFUL ACTIVITIES & ENTERTAINMENT |  |
| INTEGRATIVE THERAPIES/ PATHS TO WELL-BEING |  |
| SPIRITUALITY AND DIVERSITY | 4.3. The special needs of the community’s diverse cultural groups are investigated, documented and addressed in specific and appropriate ways. |
| HEALTHY COMMUNITIES/ENHANCEMENT OF LIFE’S JOURNEY | 2.4. Linkages with other community institutions to address social determinants of health.  
3.4. Practices are implemented to assess and address individuals’ obstacles and opportunities pertaining to accessing care, barriers to self-management and adopting healthy behaviors.  
3.7. Collaboration with healthcare providers across the continuum to improve care |
### Coordination

Coordination.

### Measurement

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<tbody>
<tr>
<td><strong>MEASUREMENT</strong></td>
<td><strong>5.1.</strong> Improvement strategy/process includes regular review of performance data and evaluation of performance against goals or benchmarks</td>
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<td></td>
<td><strong>5.3.</strong> Performance data on clinical quality, patient experience, staff and physician engagement and safety is measured or received.</td>
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<tr>
<td></td>
<td><strong>5.4.</strong> Performance data evidences demonstrable improvement (or sustained high performance) in patient/resident experience, staff engagement and clinical quality/safety.</td>
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<td><strong>5.4.</strong> Performance data is made available to consumers.</td>
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## Background: Derivation of Revised Criteria from Current Domestic Designation Criteria

<table>
<thead>
<tr>
<th>Original Criteria</th>
<th>Proposed New Criteria</th>
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<tbody>
<tr>
<td><strong>I. STRUCTURES AND FUNCTIONS NECESSARY FOR IMPLEMENTATION, DEVELOPMENT AND MAINTENANCE OF PATIENT-/RESIDENT-CENTERED CONCEPTS AND PRACTICES</strong></td>
<td><strong>II. PROPOSED NEW CRITERIA</strong></td>
</tr>
</tbody>
</table>
| 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. | 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.  

*patient/resident/family member participants are not currently employed nor previously employed by the organization. |
| 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. | 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. |
| 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. | 5.2 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. |
| 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. | 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. |
| 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. | 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.  

*See also II.E.* |
<table>
<thead>
<tr>
<th>I.F:</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.2.</td>
<td>Leadership has adopted practices to systematically engage all parts of the organization, and to create access for all staff to interact with the leadership team.</td>
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| II. HUMAN INTERACTIONS/INDEPENDENCE DIGNITY AND CHOICE |
| --- | --- |
| 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 patient-/resident-centered staff retreat experience or a comparable experiential PCC immersion program, 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. |
| 2.2. | Leadership has adopted practices to systematically engage all parts of the organization, and to create access for all staff to interact with the leadership team. |
| 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. See also II.C. |
| 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 person-/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. |
| 5.3. | 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 engagement, physician satisfaction or the physician experience  
• The safety culture of the organization  
See also II.J., XI.A., XI.B., XI.C. |
| 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. |
| 2.3. | All staff, including employed medical staff, off-shift and support staff, participates in experiential exercises 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. See also II.C. |
| 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. |
| 1.4. | Employee engagement approaches reflect the organization’s person-centered care philosophy. There is evidence that PCC principles, including caring attitudes and compassionate communication, are integrated into the following:  
• Job descriptions  
• Performance evaluation systems  
• Reward and recognition systems  
• New employee orientation  
See also II.I. |
**II.E:** Active teams are in place that address patient-/resident-centered initiatives, and include participation by non-supervisory staff and patients/residents and families.

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.  

See also I.E.

**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.

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)

See also I.E.

**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.

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.

See also V.A., V.B., VI.B., VII.A, VIII.A, VIII.B., IX.A

**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.

1.4. Employee engagement approaches reflect the organization’s person-centered care philosophy. There is evidence that PCC principles, including caring attitudes and compassionate communication, are integrated into the following:
- Job descriptions
- Performance evaluation systems
- Reward and recognition systems
- New employee orientation

See also II.D.

**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.
<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
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<tbody>
<tr>
<td>II.J</td>
<td>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.</td>
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</tbody>
</table>
| 5.3 | 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 engagement, physician satisfaction or the physician experience  
  - The safety culture of the organization  
  See also II.B., XI.A., XI.B., XI.C. |
| 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). |
| 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.  
  See also II.O., IX.B., VI.K., IX.D., IX.D. |
| 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. |
| 3.1 | Routines have been implemented to support the active involvement of patients/residents and families in standard communication exchanges when information about them is being transferred 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 communication, communication across levels and settings of care, and care planning conferences. |
| II.O | Effective communication mechanisms are in place to engage all staff (including off-site and all shifts) in dialogue about organizational priorities. |
| 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.  
  See also II.K-IX.M., VI.K., IX.B., IX.D. |
| 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. |
| 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 encourage patient/resident/family involvement in making informed decisions about their care, communicating their treatment goals and ensuring that care plans are aligned with their documented choices and goals.  
  See also IX.D. |
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<thead>
<tr>
<th>Section</th>
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<tbody>
<tr>
<td>II.Q.</td>
<td>The professional development/advancement of staff is supported. Examples include the empowerment of frontline work teams, internal training and promotion tracks (e.g., career ladders), flexible scheduling to enable educational pursuits, an actively utilized tuition reimbursement program, etc.</td>
</tr>
<tr>
<td>II.R.</td>
<td>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.</td>
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<tr>
<td>II.S.</td>
<td>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.</td>
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<tr>
<td>III.</td>
<td>PROMOTING PATIENT/RESIDENT EDUCATION, CHOICE AND RESPONSIBILITY</td>
</tr>
<tr>
<td>III.A.</td>
<td>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.</td>
</tr>
<tr>
<td>III.B.</td>
<td>A range of educational materials, including consumer health, those designed to accommodate a range of health 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.</td>
</tr>
<tr>
<td>III.C.</td>
<td>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.</td>
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### 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

<table>
<thead>
<tr>
<th><strong>IV.A</strong> - Acute Care and Continuing Care Application</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>IV.B</strong> - Acute Care and Continuing Care Application</td>
<td>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. <em>See also IX.C.</em></td>
</tr>
<tr>
<td><strong>IV.B</strong> - Behavioral Health Application</td>
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<tr>
<td><strong>IV.C</strong></td>
<td>Retired. Concept is absorbed in other criteria.</td>
</tr>
<tr>
<td><strong>IV.D</strong> - Applies only to continuing care sites</td>
<td>Retired. Concept is absorbed in other criteria.</td>
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Retired. Concept is absorbed in other criteria.
### V. DINING, FOOD AND NUTRITION

**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

**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.

Reframed to focus more explicitly on incorporation of elements into the built environment to facilitate patient and family engagement. Users’ of space involvement in design processes captured in partnership criteria.

**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.

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)

*See also II.F., VI.B., VII.A, VIII.A-B., IX.A.*

**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.

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 accommodate the presence of family and friends
- Incorporation of elements that support patient/resident education and access to information

*See also II.F., V.A-B., VII.A, VIII.A-B., IX.A.*
### 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.

- 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.

### 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.

1.5, cont’d.

Retired. Outside the scope of focus of the program.

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.

See also II.K-II.M., IX.B., IX.D.
### VII. ARTS PROGRAM/MEANINGFUL ACTIVITIES AND ENTERTAINMENT

**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.

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)**
  
  *See also II.F., V.A-B., VI.B., VII.A-B., IX.A.*

**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.

Retired. Concept is absorbed in other criteria.

### VIII. SPIRITUALITY AND DIVERSITY

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

4.3. The special needs of the community’s diverse cultural groups are investigated, documented and addressed in specific and appropriate ways.

**VIII.B:** Accommodations are made to integrate individual patients'/residents’ cultural norms, needs and beliefs into their care and treatment plan upon request.

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)**
  
  *See also II.F., V.A-B., VI.B., VII.A-B., IX.A.*

**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.

Retired. Concept is absorbed in other criteria.

### IX. INTEGRATIVE THERAPIES/PATHS TO WELL-BEING

**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

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**
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.

| IX.B | complementary to Western or traditional modalities  
|      | • Their personal environment  
|      | • Positive diversions and/or life enrichment activities (including social support)  
|      | See also II.F., V.A-B., VI.B., VII.A, VIII.A-B. |
| IX.C | 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.  
|      | See also II.K-M, II.O., VI.K., IX.D. |
| IX.D | 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.  
|      | See also II.K-M, II.O., IX.B. |
|      | 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 encourage patient/resident/family involvement in making informed decisions about their care, communicating their treatment goals and ensuring that care plans are aligned with their documented choices and goals.  
|      | See also II.P. |

**X. HEALTHY COMMUNITIES/ENHANCEMENT OF LIFE’S JOURNEY**

**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.

<p>| X.A | 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. |
| X.B | Retired. |</p>
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<tr>
<th>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.</th>
<th>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.</th>
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<tr>
<td>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.</td>
<td>Retired. Concept is absorbed in other criteria.</td>
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<td>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.</td>
<td>Retired. Concept is absorbed in other criteria.</td>
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<td>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.</td>
<td>Retired. Concept is absorbed in other criteria.</td>
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**XI. MEASUREMENT**

**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 nine composite questions exceeds the national aggregate performance. (Aggregate score can be calculated by averaging mode-adjusted top box scores for the nine 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 5.3. The organization measures or receives quantitative data on:
- Clinical quality performance
- Patient/resident safety
- Patient/resident experience of care
- Staff and/or physician engagement or satisfaction
- Physician engagement, physician satisfaction or the physician experience
- The safety culture of the organization

See also II.B., II.I.

AND

5.4. 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 engagement or satisfaction
| 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: 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. |

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.

5.5. 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 health care choices.