As the spread of Covid-19 continues to have impact on communities around the world, Planetree International will continue to adjust the Person-Centered Care Certification process to support the evolving needs of applicant sites and to ensure the criteria remain aligned with the most current knowledge.

Has the Certification evaluation process changed?

The Certification evaluation process begins with submission of an online application, which can be accessed at https://application.planetree.org/. This is followed by a lived experience assessment, which occurs within 12 months of the application submission. These two components of the process are unchanged. However, we have made some logistical adjustments to accommodate needs for physical distancing and travel restrictions.

At this time, the lived experience assessment phase of the Certification evaluation will be conducted either entirely remotely or using a hybrid model that combines in-person and remote evaluation methodologies. Planetree staff participating remotely will interact with leadership, staff, patients/residents and families using videoconferencing technology and mobile cameras. Based on safety considerations and travel limitations, the Planetree team will work closely with your site visit point of contact to determine the appropriate format for your lived experience assessment. In addition, information technology (IT) points of contact from Planetree and your organization will work closely together to prepare you for a successful assessment.

To learn more about this virtual certification process, please contact Christy Davies, Director of Certification at cdavies@planetree.org.
Have the Criteria Changed?

The Person-Centered Care Certification Program is organized around a set of evidence-based criteria that provide the structure and direction needed to serve as a road map to excellence in person-centered care, while also being versatile so as to be relevant in a variety of settings and in changing times, including a post Covid-19 world.

In other words, no, the criteria themselves have not changed.

They remain as relevant as ever. However, the ways your team meets these broadly defined goals may very well take new and innovative forms. And we welcome that!

A Note on the Evidence-Base

The Person-Centered Care Certification Program aligns with the National Academy of Medicine’s Guiding Framework for Patient and Family Engaged Care. This framework draws on empirical evidence to demonstrate how a range of patient, family, staff and community engagement strategies work together to create better health, better care, lower costs and better cultures. A pandemic does not negate this evidence, but it may require modification to existing practices to develop new approaches that balance safety and risk with the benefits of person-centered care.

A Reminder

This document is intended as a companion piece to the Person-Centered Care Certification Program Manual (available at https://www.planetree.org/certification-resources/person-centered-care-certification-program-manual). We invite you to use this document to guide your teams in applying the broadly defined goals of the criteria to the current reality. You will find clarification on the intent for a number of the Certification criteria in light of current events, as well as some practical recommendations.

(Note: this document only covers the criteria more significantly impacted by the pandemic. However, all 26 of the criteria remain in effect.)

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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.

**Guidance on Intent:**

This criterion establishes the practice of co-design as an instrumental element of person-centered care. Co-design is defined as “the act of collaborating with patients, families, and caregivers as equal partners in designing healthcare activities that affect quality of care and experience.”2 A growing body of evidence demonstrates that co-design leads to improved patient experience, staff engagement, quality and safety.3-4

This standard does not require that collaboration occurs in person or within the walls of the organization. Nor does it require that a group of patient/resident and family partners meet in the same place at the same time. Virtual engagement of these partners absolutely fulfills the intent of this criteria. In fact, many organizations have found that shifting to virtual engagement has broadened participation because the barriers faced by some to attend meetings in person have been removed.

**Recommendations:**

1. Resist the urge to suspend the involvement of patient/resident/family partners until in-person meetings can resume. Instead, invite their input into how continued involvement can best be supported.

2. Similarly, do not suspend their involvement until the health system returns to “business as usual.” Instead, engage your partners in supporting the priorities of the moment, including the ideas that follow. Keep in mind, the goal is not just information-sharing and education, but involvement and partnership. While it is understandable patient/resident/family partners may have questions about Covid-19 responses, meetings that are limited to updates from staff on Covid-19 do not constitute engagement.

3. Partner with patients/residents/families on efforts to restore consumer confidence in the healthcare system and to reassure consumers that they can safely get the healthcare they need. What are the key messages they would want to hear? What is the information that would help them to feel more safe and secure? What could be done during the healthcare interaction to further build assurance?

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4. Invite their expertise in what it is like to be a patient/resident or family member at this time. Were there any gaps in care, coordination or communication they can help you to identify?

5. Engage partners in discussions about potential changes to policy and practice as circumstances change to better understand the implications of those changes on the human experience of care.

6. Ask partners to review communications about changes to policy and practice to vet language and tone.

7. Invite partners to participate in telemedicine simulations and provide feedback on those interactions.

8. People with the most complex health and social needs are often the most intense users of health system resources. To create a healthcare system that works for all, we must prioritize partnering with those who have the most complex needs. Partner with community-based organizations to engage those who have been most immediately affected by health inequities to better understand their realities and co-design approaches that will work for them.
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.

**Guidance on Intent:**

The “as appropriate, based on the care setting” qualifier in this criterion will be applied during this time, in particular as it relates to “minimizing physical barriers to promote communication and compassionate interactions.” Physical barriers (for instance, transparent screens or partitions) installed in accordance with CDC⁵ or WHO⁶ recommendations to promote physical distancing and minimize patients’ contact with others and reduce droplet transmission are recognized as an important safety precaution.

**Recommendations:**

1. Don’t limit your view of the “built environment” to only bricks and mortar structures. Consider other ways that patients/residents and families engage with their care team. This may include your patient portal, telemedicine platforms, your website, apps and other virtual means of connection. **Is access to these virtual spaces “barrier free and convenient?”** Have they been designed to promote connectivity and collaboration? **Can users easily find their way to the information they are seeking virtually?** Evidence demonstrates the need for a purposeful approach for designing and testing these virtual engagement environments to proactively address usability, functionality and overall experience, as well as to support relationship-building and foster compassionate care.⁷⁻⁸

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2. The erection of physical barriers can also create a psychological barrier to partnership. Furthermore, at a time when individuals may be feeling particularly vulnerable and in need of compassion and connection, these barriers may unintentionally make them feel further disconnected. In light of this, be particularly mindful of wording on signage. Does it convey warmth and caring or is it cold and sterile? In addition, put in place measures to ensure that barriers don’t compromise responsiveness.

3. Numerous studies have demonstrated that access to nature contributes to patients’ well-being, reduces stress and can accelerate recovery. Guidance from CMS and other agencies indicates that utilizing outdoor venues for visitation where social distancing can be enforced may be a safe way to support visitation and combat isolation during Covid-19. Given this, now more than ever, the availability of outdoor spaces like landscaped patios, terraces, courtyards, atria, healing gardens, rooftop gardens and walking paths can make a tremendous difference for patients/residents, families and staff. Review your policies and practices around use of these outdoor spaces with a goal of maximizing access. In particular, consider how these spaces can be used to support in-person visitation in a safe and responsible manner.

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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.

Guidance on Intent:

The intent of this criteria is that the concept of person-centered care – and what that means for your organization and your community – is continually reinforced and revitalized for all staff. This takes on even greater importance at this time when staff may be reeling from the experience of the pandemic and reflecting on the impact on themselves both personally and professionally.

Based on consistent patterns witnessed among those who have experienced a range of disasters and crises, researchers have mapped the phases of emotional responses to disaster.13 These findings can help leaders to anticipate and prepare for shifts in attitudes and behaviors in the aftermath of the Covid-19 outbreak – from a sense of solidarity and collective purpose to possible disillusionment, moral distress, apathy and dis-engagement. Staff may struggle to reconcile the “way things used to be” with this “new normal.” They may be feeling discouraged. Hope and trust may be dwindling. This “disillusionment phase” is generally the longest of these disaster phases, but with the right types of support delivered at the right time in the right ways, teams can be ushered into the “reconstruction phase,” a time of acceptance, adjustment and rebuilding.

Finding ways to support your teams in processing their experiences and reinforcing how the person-centered care vision shapes the organization’s strategies, practices and responses to future events can help to tether their experiences to this collective purpose. During these moments of rapid change and uncertainty, the steadfastness of this collective purpose can be a stabilizing force. In fact, a reconnecting to purpose session for all staff could be a valuable element of your post-Covid support for staff.

There is considerable flexibility in how this intent can be achieved. These experiences should be more than lectures about person-centered care. They should inspire reflection and perspective taking. They can be built into existing processes like team meetings, town hall forums, recognition events and virtual gatherings.

Recommendations:

1. Suspending all person-centered care staff development and education “until further notice” suggests to staff that person-centered care is not a priority and not relevant at precisely the time when teams should be considering how to most effectively respond to community needs in a person-centered way. However, at the same time, we must recognize that staff may be feeling

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emotionally, psychologically and physically drained. Proceeding as if nothing has changed risks completely discrediting what you’re trying to accomplish. Instead, in collaboration with a representative cross-section of staff, consider what will be most meaningful to staff at this time.

2. For maximum reach and flexibility, develop the sessions or activities in a way that allows for both in-person and virtual delivery:

3. Capture and share stories of patients/residents, families, community members and staff members personally affected by Covid-19. What was most important to them during those experiences? What moments stand out as most meaningful? Why? Stories like these can leave an incredibly powerful imprint on our brains that influences future behaviors. What can the team take away from these stories as guiding principles moving forward?

4. Stories like these and reflective exercises may trigger extreme reactions among staff who are feeling the burden of trauma as a result of their experiences. Be prepared to support staff with information on how to access additional support as needed.

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.

Guidance on Intent:

It is well documented that miscommunication between care team members during transfers of care (or hand-offs) is a leading cause of medical errors.\(^\text{15}\) Patients/residents and family caregivers serve as an essential source of continuity during these hand-offs. Because of this, involving them in communication exchanges is an important quality and safety measure. Indeed, the absence of family caregiver engagement in these hand-offs, as well as critical activities like discharge planning and education, has been linked to poor care coordination and increased likelihood of medical errors.\(^\text{16}\) Furthermore, experience shows that when the patient and their family caregiver have the opportunity to discuss the daily plan of care with the multidisciplinary team, patient experience scores improve.\(^\text{17}\) Knowing these benefits, it is incumbent on teams to preserve opportunities for patients and family caregivers to be actively involved in their care. Taking recommended precautions to limit the spread of infection should protect patients/residents and allow for rounding and bedside shift change to proceed. Limiting the number of team members and/or residents in acute care environments may be indicated. Continue to honor patient/resident preferences about the extent to which they want to be involved.

Recommendations:

1. Establish a process wherein Care Partners (family caregivers) are supported in being physically present with their loved one during important exchanges of information, e.g. shift report, care conferences, patient education and discharge planning.

2. In cases where the Care Partner is unable to be physically present (due to health status, availability, etc.), provide the option for virtual participation in these exchanges.

3. If virtual participation is not possible, ensure timely check-ins with the Care Partner after the rounds or meeting. These should occur at a minimum daily, which has been shown to increase family caregivers’ satisfaction with care and their perceptions of how well their information needs were met.\(^\text{18}\)


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.

Guidance on Intent:

It has been well-established that family presence and participation in a loved one’s care have a positive impact on healthcare outcomes and the care experience. Nonetheless, in an effort to minimize risk and control exposure to Covid-19, healthcare leaders and authorities around the world have restricted family presence. For some individuals, however, the potential for harm due to restrictions to family presence may, in fact, outweigh the risk of the virus. This particularly applies in cases of patients with communication challenges, individuals who are cognitively impaired and/or those at risk of delirium (including, notably, patients on ventilators), which has been associated with increased morbidity and longer lengths of stay.

The unintended consequences of these restrictive family presence policies extend beyond patients, residents and families. They have also resulted in great emotional and practical burdens on staff. A person-centered approach to family presence (visitation) is safe, responsible, and compassionate. Restrictions are regularly reassessed and adjusted based on current factual evidence as conditions evolve – with the aim of maximally supporting patients’/residents’ human need for familial support during times of crisis. Furthermore, it distinguishes between supporting the presence of Care Partners versus supporting casual visitation. For more, see the Guidelines for Preserving Family Presence In Challenging Times.

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Recommendations:

Planetree International has identified the following elements as the “Gold Standard in Family Presence” at this time:

1. Alignment with the evidence-based guidance of the World Health Organization*, which includes support of visitation by essential visitors/caregivers, defined as “parents, spouses, other family members or friends without formal healthcare training” for all patients (including patients who are positive for Covid-19). 27

2. Direct and active involvement of patients/residents and families in determining what “essential support” means to them.

3. Active involvement of direct caregivers who will be responsible for implementing and enforcing the family presence policy in developing the policy.

4. Flexibility for family to visit at times that are most convenient for them and takes into consideration work schedules and other realities of their daily lives that may impact availability.

5. Essential family caregivers/Care Partners are supported in being physically present during important exchanges of information, e.g. shift report, care conferences, patient education and discharge planning.

6. A formal process is established for considering case-by-case exceptions to restrictions in a timely and collaborative way. A standardized protocol is developed to promote consistent, equitable and unbiased determinations.

7. Clear communication within the visitation/family presence policy and public-facing communications of current restrictions to visitation, generalized exceptions to those restrictions and the process and criteria for making case-by-case exceptions, including contact information for institutional decision-makers to whom families and staff may appeal to for an exception.

8. Collaboration with other health centers in the region to support a consistent approach to visitation within a local community in order to minimize confusion and mixed messages. It is expected that Gold Certified sites would, at a minimum, be as supportive of visitation as the most flexible comparable site in the region. As exemplars of person-centered care, however, it is more appropriate that Gold Certified sites would be the leader in their region in supporting families’ presence.

*If any of the above conflict with documented state, region, country or city mandates, the site works to maximize meaningful access and connection to family within the limitations imposed and advocates on their behalf to encourage needed changes and updates to such regional mandates so that safe, timely, compassionate and reasonable approaches to visitation are supported. When restrictions are eased, the site actively works toward these Gold Standard practices as quickly as possible.

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.

**Guidance on Intent:**

As welcomed members of the care team, Care Partners advocate for a loved one’s needs and support them in managing their health, healthcare, long-term care and overall well-being. Care Partners are distinct from casual “visitors.” Because they know their loved one best, they are uniquely attuned to subtle changes in their behavior or status. This makes the presence of Care Partners an important strategy for reducing the risk of preventable harm. In addition, Care Partners are a vital source of continuity that support successful transitions of care. When family presence during a care episode is limited, they may have less of an understanding of their loved one’s plan of care, who to contact with questions, symptoms to be aware of, and care management needs. Without Care Partner involvement, patients may be at risk for readmission or avoidable harm.  

**Recommendations:**

1. See recommendations for 3.1. (page 9)

2. Ensure Care Partners know who to contact with questions and concerns that may arise post-discharge and that Care Partners’ contact information is captured and accessible by all members of the care team.

3. Pictorial, written and video demonstrations of care tasks that will need to be completed by the Care Partner can help build their confidence and competence remotely.

4. Offer live or recorded condition- or disease-specific webinars for Care Partners to provide education and support on how to help manage their loved one’s care.

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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.

**Guidance on Intent:**

Compassionate interactions in healthcare encounters establish the basis for a trusting relationship that encourages person and family engagement. Compassion has been tied to improved outcomes, faster recovery, a decrease in medical errors and increased satisfaction.29-34

The extraordinary circumstances of these last several months – the Covid-19 pandemic, unprecedented political turmoil and outcries for social justice and racial equality – have only the elevated the need for greater empathy. A recent National Academy of Medicine discussion paper identified empathy as “a key health care professional training strategy that can lead to cultural shift, reduce bias, improve patient care, and enhance patient satisfaction.”35 But caregivers’ ability to make caring visible in every interaction can be challenging when they are physically covered by PPE, and when, in many cases, the interaction is occurring through a computer monitor.36-37 These circumstances may require caregivers to build new skill sets for conveying caring verbally and non-verbally and in ways that are culturally informed and responsive.

**Recommendations:**

1. Use this tool to coach caregivers in communicating caring messages applicable to Covid-19.

2. Offer coaching to care teams on skills for preserving relationship-centered caring in telemedicine interactions.

3. Engage patient/family partners to participate in telemedicine simulations to provide feedback on the interactions.


4. When face masks and other PPE create a barrier to connection between patients/residents and their caregivers, consider ways to help patients/residents “see” the caregiver behind the mask and build familiarity with the members of their care team. Caregivers should introduce themselves and their role each time they see the patient/resident or family to help compensate for the fact that there are fewer visual references to distinguish between each member of the care team. In addition, caregivers could display a photo of themselves. Selecting a photo that conveys warmth and caring can help to humanize the members of the care team and reassure patients/residents they are in good hands.

5. Face masks may create barriers to communication, particularly for those with hearing impairment. To address this, include a question on admission to assess whether there is a need for any assistive devices.

6. Enhance existing communication training with implicit bias assessment and training, as well as cultural responsiveness training. These sessions can help to bridge cultural and language differences between care team members and patients in a way that builds trust, improves patient care and enhances the patient/resident experience.
4.3. The special needs of the community’s diverse cultural groups are evaluated, documented and addressed in specific and appropriate ways.

Guidance on Intent:

This criterion examines efforts undertaken by healthcare systems to understand and address conditions that create disparities in health and in healthcare. The stresses to the healthcare system and to social conditions caused by Covid-19 may have exacerbated disparities\(^{38-40}\) – but they certainly did not create or cause them. Consider this criterion a call to action to continuously monitor quality of care throughout the health system – but in particular as it relates to the current pandemic – with respect to important demographic characteristics where disparities in care are often experienced, e.g. race/ethnicity, gender identity, socioeconomic status, etc.

Recommendations:

1. Develop a formalized plan to reduce documented health disparities that have come to light throughout the pandemic.

2. Partner with patients, families, community health workers and community-based organizations to understand and address factors that contribute to those disparities.


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.

**Guidance on Intent:**

As person-centered organizations, our commitment is not only to patients, families and our community, but to the healthcare workers who give tremendous amounts of themselves—both physically and emotionally—to this work. Our healthcare workforce has been under tremendous strain, striving to deliver safe, quality, compassionate care. Acknowledging and being responsive to the experience of staff, and the multi-faceted demands placed on them during these unprecedented times, is fundamental to person-centeredness.

**Recommendations:**

1. Create space for staff to acknowledge, share and process the full range of emotions that may be experiencing. Provide a range of options—virtual and in-person, group sessions and one-on-one, as well as opportunities for spontaneous support and more structured programs.

2. In addition to employee assistance programs (EAPs), make pastoral care or chaplaincy support available to staff (either virtually or in person).

3. Listen to staff about what will be most meaningful to them in terms of support and recognition.

4. Plan for a long-term approach to supporting staff through the aftermath of the pandemic.

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Looking For Additional Resources?

- Visit [https://www.planetree.org/person-centered-pandemic-resources](https://www.planetree.org/person-centered-pandemic-resources) for a growing collection of resources to help you maintain your person-centered care culture during these challenging times.

- Download the Person-Centered Care Certification Program Manual at [https://planetree.org/person-centered-care-certification-program-manual/](https://planetree.org/person-centered-care-certification-program-manual/). This comprehensive program manual is a must-have reference for any team pursuing Person-Centered Care Certification. It provides an in-depth look at each of the criteria, along with a step-by-step overview of the application process.