Advancing PCC Across the Continuum of Care

White Paper

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Executive Summary

Person-centered care—also referred to as patient-centered care—(PCC) is a complex and multi-dimensional concept that is increasingly recognized as the optimal form of care in all types of health care venues, including primary, acute and long-term care settings (Berwick, 2009; Koren, 2010; Stange et al., 2010). Identifying person-centered care as one of the six determinants of high quality care, the Institute of Medicine (2001) defines it as:

health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences and that patients have the education and support they require to make decisions and participate in their own care.

Despite this definition’s depiction of nearly universal needs and desires that transcend specific patient populations and health care settings, oftentimes discussion of PCC is limited in scope to patient-centered care in acute care environments or person-centered care in long-term care (LTC) settings. In hospitals, patient-centered care largely emphasizes the role of the patient and their loved ones as integral members of the care team who are actively involved in making clinical decisions (Institute for Healthcare Improvement, 2011). In LTC settings, PCC is recognized as supporting personalized care and empowerment of staff while making home environments for residents (Quality Partners of Rhode Island & Nursing Home Quality Improvement Support Center, 2005). While the emphases may vary, fundamentally, these PCC priorities are portable across health care settings. Nonetheless, the tendency to classify PCC barriers, facilitators, best practices and innovations in setting-specific silos may inhibit cross-setting learning and collaboration that could advance PCC across the health care continuum.

With a focus on the users’ experience with health care, Planetree’s Patient-/Resident-Centered Designation Program™ provides a comprehensive framework for defining, implementing and measuring PCC across the continuum of care. Organized around a set of 66 actionable criteria that drive outcomes across eleven PCC dimensions, the program defines PCC through the perspective of the healthcare consumer versus the perspective of the setting where that care is provided. Of the 66 experience- and evidence-based criteria, 51 are transportable, i.e. applicable across the care continuum, effectively establishing a common thread of expectations for any PCC health care experience—regardless of setting.

This paper details the development of the designation program, the only program to assess PCC excellence across the health care continuum, and explores how the program’s inclusive and integrated approach is advancing the practice of PCC by accelerating innovation and inter-organizational, cross-setting learning. Finally, this paper demonstrates how the designation program is positioning organizations for success at a time when PCC has emerged as a national health care priority.
PCC is Increasingly Important Across the Continuum of Care

It can certainly be argued that PCC is a timeless concept. Wasn’t patient-centered care, after all, in essence what Hippocrates trained the first medical students in ancient Greece to provide by listening to the patient? Despite this long history, though, PCC is also extremely timely.

Recent advances in policy, practice and research are compelling health care leaders across the continuum of care to move beyond aspiring to be more patient- or person-centered to taking action to realize that vision. A growing body of evidence is linking adoption of a patient-centered approach to care to improved outcomes, including reduced lengths of stay, avoidable readmissions and emergency department visits, and increases in patient satisfaction and employee engagement (Jarousse, 2011).

The Consumer Assessment of Healthcare Providers and Systems (CAHPS) program is a multi-year initiative of the Agency for Healthcare Research and Quality (AHRQ) to support and promote the assessment of patients' experiences with health care through standardized surveys. In the domestic policy arena, the Centers for Medicare and Medicaid Services (CMS) has elevated patient-centered care and the patient experience as a national health care priority by incorporating the hospital CAHPS survey on performance, known as the Hospital Consumer Assessment of Healthcare Providers and Services (HCAHPS). Through HCAHPS, the patient perception of care will be used as part of the value-based purchasing (VBP) calculations that will influence hospitals’ CMS reimbursements beginning in FY2013 (H.R. 3590--111th Congress). This policy change has effectively transformed patient-centered care from something that is “nice to do” into a financial imperative, and therefore established it as a top priority for hospital executives (Shaw, 2011). Ultimately, the goal to develop CAHPS surveys that can compare results across settings, over time will have a significant impact on how all health care executives evaluate quality experiences and maximize reimbursement.

In the LTC arena, CMS (2005) has directed Quality Improvement Organizations (QIOs) to work with nursing homes to improve organizational culture, and several states include culture change in their pay for performance programs, thus incentivizing person-centered nursing home care (Werner & Konetzka, 2010). A QIO-developed tool called Setting Targets—Achieving Results (STAR) has been utilized by approximately half of the nation’s nursing homes (Baier, Butterfield, Patry, Harris, & Gravenstein, 2009). Users of STAR have set goals around core aspects of PCC, and research shows setting clear and aggressive goals results in heightened performance (Baier, Butterfield, Harris, & Gravenstein, 2008; Baier, Butterfield, Patry, Harris, & Gravenstein, 2009). In addition, over the past several years, CMS has incorporated numerous PCC principles and language into their regulatory guidelines for nursing homes. Given this, PCC can no longer be considered something “nice” to do if resources allow; on the contrary, it is now a CMS imperative.

Beyond setting specific policy levers, a number of other recent national developments are driving PCC culture change. Today, providing integrated care is a national health care priority and public policy supporting the development of accountable care organizations (ACOs) is driving organizations to reconsider opportunities for coordination and collaboration. This applies to the adoption of PCC as well.
Shorter lengths of stays in hospitals and the increasing acuity of patients and residents in skilled nursing and assisted living settings means that for patients and residents to truly experience patient-/resident-centered healthcare, these approaches must be coordinated across the health care continuum.

Other recent drivers of PCC culture change include the development of the Patient Centered Outcomes Research Institute (PCORI), a private-public partnership focused on advancing research to support patient-centered health care, which has begun the process of distributing substantial funds (approximately $3 billion in the decade) to establish core knowledge in the emerging field of patient-centered outcomes research (Washington & Lipstein, 2011). Also, in 2011, the Veteran’s Administration, in partnership with Planetree, established a national Office of Patient-Centered Care and Cultural Transformation (Gaudet, 2011), and also launched a new funding initiative, Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE; United States Department of Veterans Affairs, 2010), which represents an unprecedented effort on behalf of the VA to support the transformation of health care services to be person-centered.

A Complex Concept

Clearly, PCC has emerged as a health care priority across the health care continuum. Nonetheless, providers struggle with how to meet this PCC mandate – not from lack of an aspiration or intention to do so, but more so, from not knowing how to go about doing so.

The relative simplicity of the Institute of Medicine’s definition belies the complexity of PCC. All one need do is consider the term itself—person-centered care—to recognize its inherent complications. Individuals caring for other individuals, individuals caring for themselves, individuals caring for their loved ones—indeed, in few scenarios are the stakes as high and the outcomes so personal. Focusing on its core elements, Epstein and colleagues (2010: 1489) explain that PCC “encapsulates healing relationships grounded in strong communication and trust.” With this emphasis on relationships, communication and trust, implementation of PCC becomes even more daunting.

The multiplicity of individuals involved in PCC (e.g. practitioners, patients and their families) and its various operational elements (e.g. decision-making, education) further contribute to its complexity. Additionally, person-centered care is intrinsically individualized, which moreover complicates its operationalization and execution.

The complexity of PCC and its individualized nature underscore the challenges health care providers face in mapping out a pathway of actionable steps to achieve patient-centeredness. For many health care providers, actualization of PCC requires a shift not merely in operations, but fundamentally in their culture. The shift in the culture of health care organizations from being disease-centered and problem based to being person-centered and promoting of health and wellness entails major changes in operations, strategic planning, resource deployment and the environment of care. How to go about making this substantial culture shift—in other words, how to translate the widely embraced philosophy of PCC into action—has long remained a source of uncertainty for providers. Though no magic bullet exists, evidence does demonstrate the value of an implementation framework, particularly a framework
that is customizable for the organization putting it to use (Caspar, O’Rourke, & Gutman 2009). In the absence of such a framework, efforts to actualize PCC could simply result in superficial strategies (e.g. the addition of amenities) that fail to influence the core relational and interactional aspects of PCC (Epstein & Street, 2011).

An Actionable Framework for Change

A comprehensive program for advancing and assessing PCC excellence across long-term and acute care settings, the Patient-/Resident-Centered Designation Program serves as an implementation framework for the complex and multi-dimensional work of culture change (Frampton, 2009; Guastello, 2010). This is achieved by translating high-level PCC concepts into actionable, attainable and sustainable practices. The program addresses core components of culture change and PCC with explicit organizational performance criteria. The program was developed and is operated by Planetree, Inc., an internationally-recognized leader in developing and implementing PCC practices. The Planetree affiliate network is an international consortium of health care providers committed to implementing the Planetree model of PCC and achieving optimal PCC outcomes while consistently engaging in inter-organizational learning.

An antidote to the trap of equating PCC with surface-level and cosmetic improvements, the program addresses fundamental elements of any PCC culture, including systems for integrating the health care consumers’ perspective in organizational decision-making, engaging medical staff in PCC, empowering staff who work closest with patients and residents to individualize the experience of care, and using data to drive change.

This emphasis on the structure- and process-focused building blocks of culture change (versus a catalogue of isolated PCC practices) positions organizations for change that is sustainable over time. For instance, specific designation criteria, such as those supporting development of active interdisciplinary PCC teams with patient/resident involvement (criteria I.A., I.E. and II.E.) support sustainable change, and thereby overcome shortcomings of other participatory approaches that tend to temporarily engage patients or residents and then wane (Shura, Siders, Dannefer, 2010). As described in the Joint Commission Journal of Quality Improvement, “Planetree’s model differs from other patient-focused care models because of its emphasis on educating patients and making them active partners in the care process” (Blank, Horowitz, Matza, 1995).

The Convergence of Evidence and Experience, Research and Practice

The operational structure of the designation program is organized around a set of 66 experience-based criteria derived from focus groups with patients and long-term care residents which delineated what matters most to them about their health care experiences. Concurrent discussion with leaders from organizations with well-established PCC cultures ascertained the essential practices and processes that were the linchpins for their organizations’ cultural transformations. Informed by this qualitative data, the criteria address PCC implementation priorities as articulated by health care consumers and/or practitioners.
Though the criteria largely originate from focus group findings and interviews, they also incorporate and reflect outcomes data and empirical research—or the evidence-base supporting PCC. With support by The Commonwealth Fund, Planetree, in partnership with My InnerView, the IDEAS Institute and the Brown University Center for Gerontology and Health Care Research, conducted a study to refine the designation criteria and ensure the criteria correlate with findings from research on core aspects and key facilitators of PCC. This project largely validated the experience-based criteria; with few exceptions, the criteria that originated from the experiences and perspectives of patients, residents, family and staff conformed with the evidence base. Gaps that were identified—aspects of PCC not yet represented in the criteria—were addressed through refinements to existing criteria and the addition of new criteria. Importantly, many criteria were recognized by the research team to provide operational guidance and to stimulate implementation of practices that the research literature points to as important without yet establishing a set of “best practices.” Through these progressive criteria, the designation program is moving health care providers to innovate and establish best practices where none have yet been identified.

Ultimately, the Patient-/Resident-Centered Designation Program demonstrates the compatibility of the evidence base and the experience base as drivers and measures of PCC quality. Collectively, informed by both research and practice, these criteria for designation raise the bar for what consumers and staff can expect from a PCC provider. The criteria are organized within 11 person-centered topic domains addressing, for instance, the critical—and transportable—issues of human interactions, family involvement, environmental design and measurement. (See Table 1.)

Table 1

<table>
<thead>
<tr>
<th>Categories</th>
<th>Example of Designation Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Structures and Functions Necessary for Implementation, Development, and Maintenance of Patient-/Resident-Centered Concepts</strong></td>
<td>An ongoing mechanism is in place to solicit meaningful dialogue, input and reactions from patients/residents and families on current practices and new initiatives.</td>
</tr>
<tr>
<td><strong>Human Interactions / Independence, Dignity and Choice</strong></td>
<td>Patients/residents and families are involved in shift-to-shift communication in a manner than meets their individual preferences and needs.</td>
</tr>
<tr>
<td><strong>Promoting Patient/Resident Education, Choice and Responsibility</strong></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>
</tr>
<tr>
<td><strong>Family Involvement</strong></td>
<td>A comprehensive formalized approach for partnering with families in all aspects of the patient’s/resident’s care is developed.</td>
</tr>
<tr>
<td><strong>Dining, Food and Nutrition</strong></td>
<td>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. Patients’/ residents’ person preferences and routines around mealtimes are considered and accommodated to the extent possible.</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>Healing Environment: Architecture and Design</strong></th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Arts Program/meaningful Activities and Entertainment</strong></td>
<td>Arts and entertainment programming and activities are designed with and in response to the interests of patients/residents.</td>
</tr>
<tr>
<td><strong>Spirituality and Diversity</strong></td>
<td>On an individual basis, accommodations are made to integrate patients’/residents’ beliefs into their care and treatment plan upon request.</td>
</tr>
<tr>
<td><strong>Integrative Therapies/Paths to Well-Being</strong></td>
<td>The interests and current utilization patterns of patients and medical staff in the areas of alternative, complementary and integrative healing modalities, is assessed and a plan is developed to address these needs.</td>
</tr>
<tr>
<td><strong>Healthy Communities</strong></td>
<td>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.</td>
</tr>
<tr>
<td><strong>Measurement</strong></td>
<td>Patient experience (both inpatient and outpatient) is regularly assessed using a validated survey instrument and performance exceeds established benchmarks.</td>
</tr>
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**Measuring PCC**

Extenuating the challenge health care leaders face in knowing how to attain the performance goal of becoming person- or patient-centered is the challenge of ascertaining how close an organization is to achieving this desired state. Without a clearly defined target to strive for accompanied by a method for assessing proximity to that goal, efforts to enhance PCC can easily go off-course, especially given the myriad competing priorities jockeying for leaders’ time, stakeholders’ attention, and organizations’ increasingly scarce resources.

Indeed, efforts to evaluate PCC are flourishing. However, these efforts are largely limited in scope to a specific patient population, health care setting or a particular dimension of PCC. For example, instruments have been developed to assess PCC for individuals with dementia (Edvardsson & Innes, 2010; Lann-Wolcott, Medvene, & Williams, 2011; Wisconsin Department of Health and Family Services, 2006), to examine patients’ perceptions of care (Hudon et al., 2011), and to measure empathy in physicians and health care professionals (Hojat et al., 2002). Though each measure is valuable in its own right, these instruments fall short of capturing the complexity and multi-dimensionality of PCC as described above. Accordingly, the lack of a comprehensive approach for measuring PCC progress in a concrete and actionable way has been an impediment to organizations’ success in operationalizing PCC concepts (Frampton et. al., 2010; Frampton et. al. 2008).
Designation serves as a framework not only for implementation, but also for measuring PCC. Outcomes measures are embedded into the criteria, and for acute care hospitals in the U.S., Patient-Centered Hospital Designation is associated with better than average performance on the CMS process of care core measures and all ten publicly-reported domains of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient perception of care survey (Frampton, Guastello, 2010).

A review of quantitative outcomes measures is but one component of the multi-method assessment protocol established for evaluating the presence, progress and sustainability of an applicant site’s PCC culture. The evaluation also incorporates satisfaction survey data and qualitative focus group data, which ensure that assessment of successes and opportunities for improvement are informed by primary stakeholder perspectives. Together, these assessment methods embody a multi-faceted information system to guide and prioritize improvements needed while balancing operational, clinical, and financial considerations. Thus, the need to collect, analyze, and utilize data for continuous improve is underscored by the Center of Medicare Service’s (CMS) goal to establish new regulations relating to Quality Assurance and Performance Improvement (QAPI). The designation criteria can be cross walked with QAPI program’s 5 general elements, lending to healthcare leaders a vital roadmap for achieving CMS compliance and sustaining person-centered excellence.

In the absence of nationally standardized measures that apply across the LTC continuum, at present, thirty LTC communities in the United States and Canada are testing utilization of a LTC-specific multi-method assessment protocol to evaluate PCC in LTC settings over time. This assessment protocol has been developed with equal input from practitioners and researchers. It is inclusive of the Quality Profile, a tool for quantitatively evaluating performance with organization-level data on PCC indicators in three major categories: operations, quality and finance. Unlike other measurement tools, the Quality Profile measures process and outcome indicators that are, by and large, relevant across the LTC continuum, with a small number that are either nursing home or assisted living-specific. The tool is currently in the testing and refinement stage.

**Promoting Innovation by Encouraging Flexibility and Creativity**

By providing a structured framework for implementing and measuring PCC, the designation criteria offer an operational way for establishing PCC performance targets and gauging progress against those targets. Though actionable and measurable, what the criteria are *not* is prescriptive. Importantly, the compendium of designation criteria demonstrate what PCC looks like without dictating how to get there. This enables providers in a variety of settings to discover how universal PCC concepts can be brought to life within the cultural, regulatory and scope of care context of different care venues. Each organization striving for Patient-Resident-Centered Designation individualistically approaches its culture change journey and implements strategies congruent with its distinct realities, including its current financial, cultural and environmental state. By ensuring each organization’s approach to cultural transformation is tailor-able to its distinct needs, Planetree’s Designation Program brings to scale the
advantages of facility-specific change efforts over other culture change models (Caspar, O’Rourke, & Gutman 2009).

This intentionally non-prescriptive framework for culture change is supportive of the program’s aim to not only assess, but also to advance PCC quality across the continuum of care. The flexibility embedded into the criteria leaves ample room for organizations pursuing designation to find innovative approaches for addressing the spirit and intent of the PCC concepts. This positions the designation program to accelerate innovation, thereby advancing PCC.

For instance, criterion III.B. challenges sites to provide a range of easily accessible educational materials that meet the health information needs of patients/residents and families and to provide support to assist individuals in meeting those information needs. Designated sites have developed a number of innovative approaches for meeting the core intent of this requirement. The provision of on-site consumer health resource centers staffed by professional medical librarians is one approach. Another is to engage specialty trained Health Information Ambassador volunteers who work in partnership with a Health Librarian. The volunteers personally and proactively reach out to patients and offer to have a librarian research a health topic for them. The medical librarian then gathers the requested information and provides a written report to the patient or family member. Patient/resident and family member education is enhanced during the care planning process through staff providing disease-specific information, supportive education and connections to community resources and support groups. Loading computers in high-traffic areas with vetted health information Web sites, and ensuring frontline staff are able to access the computers, is another way to ensure access to credible, up-to-date information.

**Transcending Settings of Care and Culture Change Models**

The non-prescriptive nature of the designation criteria has been essential to ensuring the applicability of the program in a variety of health care settings. The criteria are designed to be applicable to all health care providers, irrespective of size, setting or location; however the scope and breadth of the criteria reflect the experiences of sites that have been engaged in an ongoing, focused effort to cultivate a PCC culture over the period of several years.

The program was initially conceived to define and measure patient-centered quality in the acute care hospital environment. Six Planetree hospitals in the United States piloted the criteria and the evaluation process beginning in August 2005. By October 2007, the first five Planetree Designated Patient-Centered Hospitals were recognized. Since that time, 29 sites have been awarded designation, including 17 acute care hospitals (14 in the U.S., 2 in The Netherlands and 1 in Brazil); 1 rehabilitation hospital (in Québec); 1 behavioral health hospital (in the U.S.) and 10 small scale long-term care living communities in The Netherlands. The expansion of the designation program into four countries and in a variety of care settings is a testament to both the universality of the PCC concepts captured in the criteria as well as the broad applicability and adaptability of the criteria to accommodate a variety of cultural and setting-specific nuances.
The program is open to participation by any health care organization; formal affiliation with Planetree is not a requirement. The criteria are designed to be sufficiently flexible to apply to sites on journeys to PCC excellence guided by a variety of culture change models. Planetree affiliates, however, have originated the program. Efforts are currently underway to test the alignment of the program with other culture change models or non-model-based approaches.

Expanding Designation to LTC

Even as ten Dutch LTC communities have been recognized by Planetree as Designated Resident-Centered Communities, a rigorous effort remains underway to further validate that the program, with its origins in acute care settings, fully addresses the complexity and multi-dimensionality of PCC culture change in LTC environments. Thirty diverse North American LTC sites are actively utilizing the designation criteria as a guiding framework for PCC excellence and are testing utilization of a LTC-specific multi-method assessment protocol to evaluate person-centeredness over time. These sites include for-profit and not-for-profit LTC entities, large and small communities, and include nursing homes, assisted living communities, continuing care retirement communities (CCRCs) and Veteran’s Administration (VA) community living centers. True to the program’s aim to share learnings and innovations across the continuum of care, these LTC sites’ experiences with the criteria and the multi-method assessment protocol will inform future refinements to the program more broadly.

Inter-Organizational and Cross-Site Learning Advances PCC

The designation program is designed not only to incentivize sites to attain PCC excellence, but also for the lessons learned along the way to be disseminated in support of other organizations’ culture change journeys. This facilitation of inter-organizational learning promotes innovation and advancement of PCC. Through publication, presentations and informal dialogue, leaders from Designated sites have imparted field-tested practices that address the intent of the criteria (Charmel, 2010; Cliff, 2010; Frampton & Charmel, 2009; Frampton et. al., 2010; Frampton et. al, 2008; Frampton et. al., 2009; Michalak et al., 2010; Spatz, 2009). They have shared innovations related to patient-friendly billing, minimizing noise levels in care areas, involving patient and family advisors in wayfinding improvement efforts, enhancing shift-to-shift communication, enlisting and supporting volunteer “care partners,” engaging members of the medical staff in PCC, and integrating complementary therapy modalities as part of patients’ daily care—to name just a few of the topics on which staff from Designated sites have lent their leadership, wisdom and practical implementation guidance.

The Patient-Centered Care Improvement Guide, released by Planetree and The Picker Institute in 2008, includes numerous policies and implementation tools developed by hospitals as part of their process of preparing to apply for designation, including a PCC Physician Code of Conduct, guidelines for volunteers to use in capturing and recording a patient’s personal story, and sample shared medical record, patient-directed visitation and family presence policies (Frampton et. al, 2008). The free resource has been downloaded from www.patient-centeredcare.org more than 100,000 times, providing significant exposure of these Designated Hospitals’ best practices as a means of supporting other sites in
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developing customized approaches for meeting the designation criteria. The companion Long-Term Care Improvement Guide (www.residentcenteredcare.org) similarly spotlights a variety of innovations from among LTC communities pursuing designation, including a sample policy for resident interview teams and risk agreements, an end-of-life care assessment tool, and pet therapy program guidelines (Frampton et. al, 2010). Accessible at no charge in the public domain, these resources support the aims of the designation program to drive innovation and advancement of PCC.

The potential for doing so is considerably magnified by the inclusivity of the criteria and the diversity of the sites pursuing Patient-/Resident Centered Designation. Because the designation program applies across the continuum of care, opportunities to be exposed to PCC practices and tactics from outside one’s own setting of care are maximized. Designated sites are routinely called upon to share their experiences and their specific approaches through articles, conference presentations, and through peer-to-peer support facilitated by Planetree. For instance, criterion II.H. calls for human resources systems to reflect an organization’s patient-/resident-centered care philosophy. Common approaches for addressing this criterion include incorporating PCC competencies into job descriptions and performance evaluations, and adopting a values-based approach to hiring. A number of LTC communities pursuing designation, however, have raised the bar in what it means to take a person-centered approach to human resources by involving residents in the hiring and evaluation of staff (Tellis-Nayak, 2011). This has motivated their peers working in acute care settings to consider the role that patients and family members may play in selecting and reviewing those who provide their care.

Conversely, LTC providers have benefited from the wisdom and experience of their peers in acute care settings. Criterion III.E. requires that sites have a process to assist patients/residents and families in managing their medical information and coordinating their care among across discrete episodes and settings of care. A number of LTC providers on the pathway to designation have partnered with local hospitals to develop shared resources and portable tools (such as medication lists and health notebooks) for residents to use to keep track of their health care needs both within the long-term care community and when they transition to a different setting of care. These are just two examples of the inter-organizational and cross-setting learning supported through the designation program.

Implications of a PCC Continuum

In our fragmented health care delivery system, continuity and coordination of care are often tenuous. Research demonstrates that uncoordinated and chaotic transitions from one setting of care to another results in high costs and frequent unnecessary readmissions (Mor et al., 2010; Saliba et al., 2000).

The designation program recognizes site-level achievement in PCC. Ultimately, however, by providing a framework for PCC implementation and measurement across the continuum of care, the benefits extend beyond one site. Specific criteria explicitly address the role of a PCC provider in supporting coordinated transitions of care through provision of meaningful discharge/transition instructions provided in a manner that accommodates the patient’s level of understanding (III.C.); development of
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processes to support patients in managing their own health information (III.E.) and cultivation of partnerships with other local healthcare providers to improve cross-site coordination, communication and information exchanges (X.C.).

More globally, though, the program supports more coordinated transitions of care through the incorporation of numerous criteria designed to support patient activation. When equipped with systems and resources that support patients in being active, engaged partners of their professional care providers, patients themselves are best positioned to provide the continuity that is so elusive in our fragmented health care delivery system. Processes that engage patients in discharge planning and assess their comprehension of next steps (III.E); involve patients and family members in care planning (II.P.) and change of shift communication (II.N.), and emphasize that an informed patient is an empowered patient (III.A., III.B) are all embedded into the criteria for designation.

Conclusion

In any patient- or person-centered care delivery model, the primary driver of priorities is the patient or long-term care resident themselves, not the setting where the care is provided. It stands to reason, therefore, that the cornerstones of any PCC culture would be the same in any health care environment, whether an acute care hospital, short-term rehabilitation, or long-term care. This persistent cataloguing of PCC practices, barriers and facilitators by setting is consistent with an industry-wide tendency to view the health care experience from the provider perspective versus the consumer perspective. That paradigm shifts, however, in a PCC culture. The Planetree Patient-/Resident-Centered Designation Program spans these silos, emphasizing the commonalities in PCC care delivery across the continuum of care.

The transportability of the designation program and its associated criteria across care settings is not only an important philosophical distinction of the program, but also a reflection of the current state of the health care industry. The acuity of nursing home and assisted living residents is increasing, and services are consistently being adjusted to meet these changing needs. In today’s health care industry, the rigid siloes that have differentiated acute care settings from long-term care ones are slowly disappearing.

The cross-continuum nature of the program positions the designation framework to accelerate PCC innovation and inter-organizational, cross-setting learning. The criteria challenge sites to elevate aspects of their PCC culture that may generally be considered greater priority in other settings. Acute care sites pursuing designation are challenged to maximize relationship-building and accommodation of patients’ personal routines in spite of the limited amount of time caregivers spend with any one patient. To do so, they are turning to their peers in LTC settings to identify approaches that can be adapted to a shorter length of stay. Taking cues from their peers in acute care hospitals, LTC providers are enhancing efforts to support residents in being informed, empowered health care consumers.

This focus on the patient/resident experience—as opposed to the care venue—is aligned with the emergence of care transitions as a national health care priority. Transitions from one setting of care to another will be enhanced when individuals—really, the only true constants in one’s personal health care
journey—are engaged as partners in their care in acute and long-term care environments, alike. By incorporating criteria related to family involvement, patient engagement in care planning, shared medical records and the like, the designation program effectively establishes a common thread of expectations for the level of patient engagement and activation that occurs in an organization with a culture of PCC. What’s more, data illustrates the impact that such a comprehensive approach to patient engagement and activation can have on reducing avoidable readmissions. A review of CMS’s publicly reported hospital quality data demonstrates that Planetree Designated Patient-Centered Hospitals have lower rates of readmissions than their peers. As CMS moves to a reimbursement model that penalizes hospitals for excessive readmission rates, this field-tested framework for streamlining transitions and preparing patients to confidently and effectively manage their care takes on unprecedented importance.

Beyond establishing this bar of what it means in real terms to be patient- or person-centered, the program provides a concrete framework for reaching that target state, positioning sites to overcome one of the most persistent barriers to the more widespread adoption of PCC and ultimately advancing PCC across the health care continuum.

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To learn more about Planetree and download the designation criteria, go to www.planetree.org.
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