Person-Centered Care Certification® Criteria with Point Values

1.1. A multi-disciplinary, site-based committee structure oversees and assists with implementation and maintenance of person-centered practices. Active participants include: • Patients/residents and/or family members; • A mix of non-supervisory and management staff; • A mix of clinical and non-clinical staff • A senior-level executive champion • A senior level clinical champion.	6 points
1.2. An individual (or team) is appointed to guide implementation of activities that advance organizational progress toward person-centered care goals. This individual (or team) functions as or reports directly to a senior executive in the organization.	2 points
1.3. The organization's ongoing improvement structure and process rely on partnerships between leadership, staff and patients/residents/families to identify, prioritize, design and assess person-centered improvement efforts. Stakeholders are educated in improvement methods and are supported in making real time change.	13 points
1.4. Staff engagement approaches reflect the organization's person-centered care philosophy. There is evidence that person-centered care principles, including caring attitudes and compassionate communication, are integrated into the following: • Job descriptions • Performance evaluation systems • Reward and recognition systems • New hire screening, selection and orientation.	7 points
1.5. The built environment incorporates elements that support patient/resident and family engagement in their care, including (as appropriate, based on the care setting): • Minimizing physical barriers to promote communication and compassionate interactions • Incorporation of spaces that comfortably accommodate the presence of family and friends • Incorporation of elements that support patient/resident education and access to information • Barrier-free and convenient access to building(s). • Clear and understandable directions for patients/residents and visitors to their destinations • Accommodations to preserve patients'/residents' dignity and modesty • Access to natural light • Promotion of outdoor spaces and opportunities to access them.	4 points
2.1. Goals and objectives related to person-centered care are developed in partnership with patients/residents/families and are integrated into the organization's strategic and/or operational plan.	8 points
2.2. Leadership interacts regularly with staff from all sectors and at all levels to drive improvement in the organization.	7 points
2.3. All staff, including employed medical staff, off-shift and support staff, participates in experiences designed to help them personally connect to the concepts of person-centered care and to better understand the perspectives of patients/residents, families and other colleagues. These are offered an ongoing basis to reinforce and revitalize staff engagement in person-centered behaviors and practices.	7 points
2.4. The organization partners with other community institutions (e.g. housing authorities, religious institutions, schools, social services, etc.) to address social determinants that may impact individuals' access to care, health and well-being, with an emphasis on vulnerable populations.	10 points
3.1. Systems are in place to support the active involvement of patients/residents and families in communication exchanges between members of their care team and across settings of care. This includes (as appropriate to the care setting and based on patient/resident/family preferences) shift-to-shift communication, inter-departmental and interdisciplinary communication, communication across levels and settings of care, and care planning conferences.	4 points
3.2. A policy and documented process is in place to provide individuals access to their medical record and/or plan of care while they are being treated. They are regularly encouraged to access this information and are supported in understanding and contributing to the documentation. There is evidence that this offer/process to access this information is communicated to every patient/resident.	4 points
3.3. Practices are implemented to assess individuals' preferred learning style, culture and ability to understand the concepts and care requirements associated with managing their health. These assessments are used to provide education (including discharge instructions as applicable) in a manner that accommodates their learning preferences and level of understanding in a culturally and linguistically appropriate way.	4 points
3.4. Practices are implemented to assess and address the social determinants of an individual's health, including those pertaining to accessing care, barriers to self-management and adopting healthy behaviors.	4 points
3.5. Flexible, 24-hour family and friend presence (visitation) is supported by policy and in practice. Limits to their presence are mutually developed between the patient/resident, their support network and the care team. Limits are based on patient/resident preferences, the treatment plan, agreements with roommates, and safety considerations.	3 points

Person-Centered Care Certification® Criteria with Point Values, cont'd.

Criterion	Points
3.6. Processes are in place for identifying and partnering with patients/residents and family/ friend caregivers throughout the care encounter to participate in care activities and to enhance their abilities to manage healthcare needs outside of a specific care episode. These care activities include physical care, patient education, and care coordination. The approach is tailored to the treatment plan, patient/resident preference and the family/friend caregivers' abilities.	4 points
3.7. The organization works with other local healthcare providers across the continuum of care to improve care coordination, communication and information exchanges around the needs of each individual, especially for those with chronic conditions and during transitions of care.	9 points
4.1. Efforts have been undertaken to promote caring attitudes and compassionate communication. In discussion, stakeholders validate feeling treated with dignity and respect, being listened to and having their concerns taken seriously.	6 points
4.2. Patients'/residents' treatment goals are documented and shared with the care team. This documentation is updated as patients'/residents' goals evolve. Care planning processes (including advance care planning) include elements to inform individuals about their care and the options available to them and encourage patient/resident/ family involvement in shared decision-making, communicating their treatment goals and ensuring that care plans are aligned with their documented choices and goals.	7 points
4.3. The special needs of the community's diverse cultural groups are evaluated, documented and addressed in specific and appropriate ways.	5 points
4.4. Systems are in place to document and honor, to the extent possible, patients'/residents' preferences related to: • Activities of daily living (meals, bathing, grooming, sleep) • Scheduling and access • Cultural norms and spiritual beliefs • Use/interest in a broad range of healing modalities, including those considered complementary to Western or traditional modalities • Their personal environment • Positive diversions and/or life enrichment activities (including social support)	9 points
4.5. A mechanism is in place to provide staff support services, with an emphasis on: • Emotional and grief support • Health promotion • Participation in decisions that impact their functional work area/role • Other elements identified by staff as priority areas.	5 points
5.1. The organization's improvement strategy and process, as guided by the strategic plan detailed in criterion 2.1 and implemented in accordance with the structures outlined in criterion 1.3, includes regular review of performance data and evaluation of performance against goals or benchmarks.	2 points
5.2. The organization measures or receives quantitative data on: • Clinical quality performance • Patient/resident safety • Patient/resident experience of care • Staff engagement, staff satisfaction or the staff experience • Physician (and other advanced clinicians) engagement, satisfaction or experience • The safety culture of the organization	6 points
5.3. Performance data on organizational indicators directly related to the strategic goals identified in criteria 1.3. and 2.1 evidences that changes implemented have improved (or have sustained high performance) across the following domains: • Clinical quality or safety • Patient/resident experience of care • Staff and/or physician (and other advanced clinicians) engagement or satisfaction	15 points
5.4. Performance data on organizational indicators related to efficiency and clinical and service excellence are made available to the public to support consumers in making informed choices.	3 points
5.5. Mechanisms are in place for patients/residents and families to share their experiences, feedback and perspectives – in their own words -- throughout the organization. There is evidence this qualitative data are used to identify, inform and evaluate improvement efforts in the organization.	6 points