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INTRODUCTION:

THE EMERGENCE OF PATIENT-CENTERED CARE AND THE PLANETREE MODEL

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Since the dawn of human time, providing care to the ill, distressed, and injured has been a personal calling. Individuals touched by the suffering of their fellows strove to find ways to relieve pain, provide emotional comfort, and derive spiritual meaning from the often mysterious vicissitudes of the human condition. The shamans, witches and medicine men of our ancestors have been transformed in Western society into our present day nurses, physicians, counselors and chaplains. Specialization in the helping professions has grown tremendously, health care has become a multi-trillion dollar business in the U.S. alone, and patients have become health care consumers.

Consumerism is certainly not a phenomenon limited to health care; it has become a defining characteristic of our social fabric, driving our economy and fundamentally changing the way we do business. Today's consumers expect a different kind of purchasing experience than they did in the past. Whether they are buying coffee or a car, enjoying a movie or visiting the hospital, they expect options tailored to their needs and desires. Common in today's marketplace are a myriad of choices such as six varieties of fresh brewed coffee, eight different flavor shots, cappuccino, mocha latte, iced espresso in small, medium and large sizes, decaffeinated or fat free. Also available are mega-movieplexes with twenty screens, fifteen movie choices, new releases showing every hour on the hour in plush stadium seating with stereo surround sound, purchase your

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tickets in advance at home via the Internet, at credit card kiosks in the lobby, or the old-fashioned way.

Successful businesses in today's consumer-driven society have done a masterful job of identifying what is important to their customers not only about products themselves, but also about the delivery of the products. It's not enough for a hotel to provide an acceptable room to a regular business traveler today. Many hotels keep that traveler's preferences on computer file so that the customer doesn't even have to ask for the non-smoking room at the end of a corridor on the ground floor with Evian stocked in the minifridge when he or she checks in.

While the rest of the world has embraced the consumer revolution and used it to improve service and build customer satisfaction and loyalty, hospitals and health care have been slow to change. We have defined our product too narrowly as a good technical or physical outcome. And while our technology may be state-of-the-art, our delivery has been pathetic. We have lost sight of the primary reason patients come to us. They come not just for medical care, nursing care, and health care, they come to us for *care*.

They come to us at their most vulnerable, looking for support, comfort, and hope. They come to be heard, to be helped, and we make them wait too long in our emergency rooms, seated in uncomfortable, ugly furniture. We isolate them from their loved ones, treat them like children, and withhold information. We require our regular patients with chronic conditions to fill out the same information on the same forms, even though we have asked for this information on numerous previous occasions. We put up glass barriers in our waiting areas and nursing stations so our patients and their families won't disturb

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us while we work. We spend too little time listening and answering questions, and too much time on documentation and filing insurance forms.

Health care often takes the same insensitive approach to dealing with another of its most valuable resources, its employees. Good people with caring hearts enter the health professions to serve patients. Disenchanted with an industry that often puts the bottom line before human needs, nurses in particular are burning out, and fewer young people are choosing health care professions. Coupled with an increase in healthcare utilization, these forces are fueling a labor shortage that threatens to undermine health care for years to come (Advisory Board, 1999).

The vast majority of health care organizations have not kept pace with the consumer revolution. They continue to put technology first. They don't respect the time or the dignity of their patients. They continue to place people in flimsy, open backed gowns while they wheel them past the lobby or the cafeteria on gurnies. The patients stare up at harsh florescent ceiling lights on their way to a one-hour wait in radiology, where they hope they don't run into their neighbor, waiting in the same room, fully clothed, reading out-dated copies of Good Housekeeping.

If one didn't know better, one might think that hospitals set out to design systems that would provide the most sophisticated technical care but deliver the worst possible experience to sick people. This was certainly the impression of one particular patient, Angelica Thieriot, when she was hospitalized in the mid-1970's with a life-threatening condition. Thieriot experienced the classic dysfunctional dichotomy in American medicine, the separation of body from mind. While the best of Western technologic medicine was made available to diagnose and treat her physical symptoms, little attention

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was paid to her emotional, social and spiritual needs. Hospital policies limited the time her family could be by her side to support her. Paternalistic attitudes on the part of providers prevented the sharing of information and explanation to assuage her fears. Austere institutional surroundings did little to comfort her and only served to increase anxiety. Eventually discharged when her symptoms resolved, Thieriot noted that spending time in a hospital was more traumatic than having a life threatening illness.

Within a year, both her son and father-in-law were hospitalized, and Thieriot received a "crash course" in hospitals from the family's perspective. Relegated to distant family waiting areas and the limbo of not knowing what was happening to loved ones, she found the family experience to be as depersonalized and terrifying as her experience as a patient.

THE PLANETREE MODEL

Motivated to action by these events, and by her vision for a more healing hospital experience for patients and families, Thieriot founded Planetree as a non-profit organization in 1978. Taking its name from the sycamore, or planetree, under which Hypocrites taught his students, the organization dedicated itself to radically changing the way health care was delivered. Over the centuries medicine had lost its holistic, patient-centered focus, and Planetree vowed to reclaim that for patients. Everything in the hospital setting was evaluated from the perspective of the patient. Every element of the organization's culture was assessed based on whether it enhanced or detracted from personalizing, demystifying and improving the patient experience. A premium was

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placed on making information available to health care consumers, enabling them to be partners in their care.

Planetree's first step was to establish a consumer health resource center, which opened in 1981 in San Francisco. The center was a place where the lay public had access to medical and health information, as well as in-depth research services. The Resource Center initially offered users a library of over 2,000 health books and medical texts, a clipping file of current medical research, a catalogue of referral groups and agencies, as well as a bookstore. Such a wealth of health information resources was an unheard of luxury at a time when patients were still routinely barred from entering a hospital or medical school library.

The Planetree Health Resource Center became a national model, subsequently helping other organizations establish successful libraries throughout the country. The Center developed a widely used consumer cataloging system known as the Planetree Classification Scheme, which continues to be used by health resource centers around the world.

The History of the Planetree Model

Access to health and medical information was only one aspect of Planetree's vision for personalizing health care. In June of 1985, with funding from The Henry J. Kaiser Family Foundation and The San Francisco Foundation, a major milestone was reached with the opening of the Planetree Model Hospital Unit. The first of five Planetree Model Hospital sites, the 13-bed medical surgical unit at Pacific Presbyterian Medical

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Center in San Francisco, California was like no other hospital unit in existence at that time. This unit was the culmination of years of grass-roots efforts to create a truly new model of care in the hospital setting. Its creation launched one of the most far-reaching experiments in the realm of consumer-responsive, patient-centered care ever attempted in this country.

Using findings from the numerous focus groups with patients, families and staff, the innovative medical surgical unit was designed to offer the latest medical technology in an environment that was comforting and supportive. The 13 bed unit was a pioneering effort to change the way patients experienced hospitals; from impersonal and intimidating institutions to nurturing, healing and educational environments.

Over 70 physicians admitted patients to the Planetree Unit. Each agreed to commit to the philosophy of patient education, participation, and family involvement. Planetree patients had the opportunity to develop direct communication with their doctors in which they were encouraged to ask questions, request information, and participate in their care. This open communication benefited both the patient and physicians in that the prescribed treatment plan continually reflected the patient's own goals.

An atmosphere conducive to healing was created by Planetree's original architect, Roslyn Lindheim. Lindheim, a professor at the University of California at Berkeley, had studied hospitals and therapeutic environments throughout the world and incorporated the most significant aspects into the Model Unit. The result was a remarkable transformation of a typical hospital environment into a physical space that promoted healing, learning and patient participation.

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Standard partitions between patients and staff were removed leaving open and airy workspaces. Soothing colors were chosen and each room was decorated differently to be as individual as the patient who occupied it. A patient lounge was created to be a comfortable place where patients, families and friends could relax, share a meal, or watch a movie. The lounge also served as a satellite resource center providing medical and health information on the unit.

The Planetree Unit included a kitchenette where patients and family members were encouraged to prepare meals or food they'd brought from home. Hungry patients were never told that they would have to wait until hospital staff delivered the next meal. The Planetree kitchenette was stocked with a variety of healthy snack foods including fruit, yogurt, crackers, and herb teas.

Acknowledging that hospitals are often perceived as frightening, unfamiliar places, staff encouraged the patient's family and friends to spend time there as a comfort to the patient, helping to avoid loneliness and isolation. Visiting hours on the Planetree Unit were unrestricted and children were permitted to visit. Family members and friends who wanted to stay overnight were accommodated either in the patient's room or on a sofa bed in the Patient Lounge nearby. Patients were encouraged to wear their own pajamas and display family photo's on conveniently located shelves.

Families were encouraged to participate in the education, physical care and emotional support of the patient. One specific person was designated as a "Care Partner" who became more actively involved in that patient's care. The Care Partner was often the person who would continue to care for the patient after he or she was discharged from the hospital. The Care Partner worked closely with the nurses in a supportive, supervised

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environment to learn whatever skills might be needed. These skills were as simple as helping a patient bathe or dress or as complex as adjusting a portable ventilator. By helping the Care Partner feel comfortable in caring for the patient, the transition home was often easier.

The Model Unit provided a wide variety of educational opportunities for patients, including written materials, audio and videotapes, and personal instruction by the staff. Patients, care partners, family members and friends were invited to make use of the educational resources.

Patients were given information packets specific to their diagnosis and needs. These Packets, provided by the Planetree Health Resource Center, included basic medical information, listings of support groups and other resources that might be helpful after the patient had gone home. In addition, information about complementary therapies, such as massage or stress management, was provided.

The Planetree philosophy stressed that one of the most valuable learning resources available was the patient's own medical chart. Patients were encouraged to read their charts daily, ask questions and discuss findings, and participate in the decisions affecting their care. Patients were also encouraged to keep written records of their experiences and observations in Patient Progress Notes, which became a permanent part of their medical chart if they so desired.

It was the goal of the Planetree Unit not only to help patients get well faster but also to stay well longer, possibly avoiding future hospitalizations. With this in mind, Planetree created a Self-Medication Program enabling appropriate patients to administer their own medications while they were hospitalized. Patients were given fact sheets

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listing uses and possible side effects, and a pharmacist was available to answer questions. The patient gradually assumed more responsibility, taking the medication at the appropriate time and charting that it was taken. This learning process often avoided the problems that occurred when a patient went home with several medications and was unsure what, when, or how much should be taken.

While reducing the stress of hospitalization, the Planetree unit also educated patients about ways to reduce the stress in their daily lives. Volunteers who were specialists in relaxation, visualization and massage offered their services at no charge, helping to make the hospital stay more relaxing and rewarding.

While drawing on the latest technology in Western medicine, the Model Unit attempted also to nurture the healing resources within each patient. Although medicine traditionally draws on the body’s resources to heal, Planetree believed that by incorporating the mind and spirit into this process, healing could take place faster and more completely. In an effort to meet the needs of the whole person (body, mind, and spirit) the Planetree Unit incorporated the arts into its healing environment.

To help meet the human need for beauty, the patient rooms were decorated with photographs of English gardens and artwork on loan from local art museums. Patients were provided with portable cassette players and offered a large selection of musical options and relaxation tapes. Comedy movies were also available, as well as a selection of books on tape.

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Research on the Model Unit

The original Planetree Unit was structured as a three-year demonstration project, serving as a model for hospitals and health care providers throughout the country. As part of the pilot project, the University of Washington agreed to evaluate the impact of the Planetree Unit on the patient experience. The evaluation was also designed to study the level of satisfaction among nurses and doctors on the Planetree Unit, its effect on the quality of patient care, as well as cost effectiveness. Significant findings included increases in patient satisfaction with the environment of the unit, with the technical quality of care provided, and with the education provided. Study results summarized the project as "a successful example of patient-centered hospital care (Martin et al., 1998).

The success of this unique experiment generated a great deal of interest. Four additional model sites were subsequently implemented between 1987 and 1990 to refine the model in diverse settings. These sites included the Samuel's Planetree Unit (cardiac unit) at Beth Israel Medical Center in Manhattan, a 28-bed medical-surgical unit at San Jose Medical Center, Delano Regional Medical Center's large sub-acute patient units, in Delano, California and Mid-Columbia Medical Center, a community hospital in The Dalles, Oregon, the first organization to implement Planetree concepts hospital-wide.

By the early 1990's, hundreds of tour groups from hospitals across the U.S and around the world had visited the Model Sites and worked with the Planetree organization to enhance patient care at their institutions. Managed care was rapidly expanding, hospital budgets were shrinking, the number of beds were declining, and competition for patients was growing. Executive teams were looking for innovative strategies to improve

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patient satisfaction and differentiate their hospitals in an increasingly competitive health care marketplace. One such team from a community hospital in Connecticut believed the Planetree model was the right strategy for them. Pioneering a new relationship with Planetree, Griffin Hospital became the first Planetree Affiliate in 1992. Given this more flexible approach to Planetree implementation, additional hospitals and health systems followed suit, forming what is now known as the Planetree Alliance of Hospitals and Healthcare Organizations. The Alliance is a rapidly growing network of hospitals across the United States and Europe, pioneering innovative solutions to the changing needs of healthcare consumers.

Patient Centered Care and Health Care Consumerism

The story of Planetree mirrors the journey of patient-centered care through the evolution of health care delivery during the last quarter century. From radical idealist philosophy to mainstream business differentiation strategy, patient-centered care has become a well-accepted approach to improving health care quality from the increasingly respected perspective of the patient/consumer. No longer passive recipients, today's educated consumers are a powerful force for change. They are driving a transformation in health care no less profound than that brought about by the technological breakthroughs of the 20th century. The rapid rise in health care consumerism can be traced to several trends. The first has been the steady increase in health care costs. As these costs have risen, so too has the amount consumers are expected to pay out of their own pockets. Employers have shifted more and more of the burden of health care coverage onto employees. In response, individuals have increased both their knowledge and scrutiny of

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how their health care dollar is being spent, demanding new levels of value and service (KPMG, 1998; Press, Ganey, 1999; Trustee, 1998).

At the same time, we've undergone an explosion in the amount of information available in all areas, and in particular on health-related topics. The ease of access to this information provided by the Internet has created an exceptionally well-informed population (AHA News, 1999; Modern Healthcare, 2001; Eng et al., 1998; Ernst & Young, 1998). Combine these trends with the increasingly mobile American population, willing to travel greater distances to get what they want, whether it is a house in the country, a job in the city, or the best patient-care experience in the region, and the result is the new healthcare consumerism.

What do consumers want from the health care system today? They assume they will receive the highest quality technical care. However they also want respect, kindness, privacy, information, autonomy, choices, and inclusion. In addition, they expect healthy, delicious food in a home-like environment, preferably with their family, friends, and pets around them.

While conditions have improved, hospitals have a long way to go in meeting patients' needs. Nothing less than a complete transformation of health care organizational culture is needed. At the heart of this transformation is the need to listen to what patients feel are barriers to their health and healing, and to find ways of removing these barriers (ACHE, 1999; Bezold, 1999; Coile, 2002).

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PART ONE: THE NINE ELEMENTS OF PLANETREE PATIENT-CENTERED CARE

Planetree embarked on this journey to identify and remove barriers with its original model site projects. Through these early initiatives, the nine elements of patient-centered care emerged, and each was adapted over time first by the Model Planetree Hospitals, and later by the many Planetree Affiliate hospitals that followed (Frampton, 2001; Freedman, 2001). Each of these nine elements is described in the first nine chapters of the book, drawing from the experiences and insights of the organizations that have implemented them over the past two decades.

In Chapter One, Laura Gilpin explores human interactions and how they can be shaped to create an organizational culture that is truly healing and patient-centered. She presents numerous strategies employed by Planetree affiliate hospitals that have successfully cultivated the degree of understanding and ownership necessary to change employee beliefs and practices.

Candace Ford and Laura Gilpin present the Planetree model's approach to patient and family education in Chapter Two. Strategies including development of health resource centers, customized patient information packets, bedside collaborative care conferences, patient pathways, self-medication programs, and open medical chart policies are detailed.

In Chapter Three, Susan Edgman-Levitan discusses the strong case for involvement of the patient's social support network, and examples of specific policies and programs that have been implemented to achieve this involvement in heath care settings around the country.

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Cathy Reinke and Carol Ryczek present best practice examples of using nutrition to nurture the soul as well as the body. The symbolic role of food as welcome agent and comfort are explored in the context of the hospital environment. Practical suggestions for changing the image of "hospital food" are offered.

Chaplains Jo Claire Wilson and George Handzo review recent research linking spirituality and health in Chapter Five. They provide a variety of examples of ways in which patient-centered hospitals have addressed the spiritual needs of patients, their families, and employees.

In Chapter Six, Michele Spatz and Dianne Storby explore the role of human touch, and in particular massage, in enhancing the experience of patients, families, and staff. Strategies that have been used successfully for incorporating these largely uninsured services are presented, both for in and out-patient environments.

Roger Ulrich and Laura Gilpin provide a comprehensive, science-grounded review of theory, research and practice relating to how the arts (visual, musical, and theatrical) affect patient outcomes in Chapter Seven. The presentation of evidence-based guidelines for selecting healthcare art in particular will be extremely useful for readers.

In Chapter Eight, David Katz presents a thorough treatment of the state of integrative medicine in both in and outpatient settings. Beginning with a balanced review of both the pros and cons of inclusion of complementary and alternative therapies, he provides a thoughtful examination of a sometimes controversial topic. Specific models and examples from Planetree hospitals that have embraced integrative medicine are presented.

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Well-known for its innovation in the realm of architecture and design, Planetree environmental elements will be explored in Chapter Nine by Bruce Arneill and Karrie Frasca-Beaulieu. Practical approaches to interior and exterior renovation that support patient-centered care are presented in detail. From space utilization to colors and lighting, examples of best practices are offered that stimulate thinking and challenge assumptions about what the hospital's physical environment can offer to patients.

PART TWO: FUTURE DIRECTIONS FOR PATIENT-CENTERED CARE

While the above core elements have stood the test of time, their expression has flourished in a thousand different ways. As employees at hospitals across the country have had the opportunity and responsibility to bring patient-centered care to life in their organizations, a limitless well of creativity has been tapped. Some of their best ideas are presented in the case examples included throughout chapters 1-9, where the core elements are presented in depth. While these ideas took initial root primarily in acute care hospitals, in many cases they have been adapted to outpatient and sub-acute care settings as patient care has continued to shift in this direction.

Chapters 10-16 build on the present foundations of patient-centered care, and take them a step further. What will the truly healing hospital of the future be like? How will it impact larger issues in the communities it serves? Is it economical to deliver this kind of care? Does it impact staff recruitment and retention? How do you acquire the support and participation of medical staff? What role will hospitals play in the continuing evolution of holistic care of our patients' minds, bodies, and spirits? These issues will be explored in the context of transforming the culture of health care, as we know it.

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In Chapter Ten, Patrick Charmel presents the business case for patient-centered care. Drawing from case examples of hospitals that have seen impressive increases in patient and employee satisfaction levels, patient volume increases, and decreases in patient claims, he makes the case for "doing well by doing good".

Steve Horowitz echoes these sentiments in Chapter Eleven, exploring particular benefits to the medical staff of participating in a patient-centered model. Effective strategies for gaining physician support are discussed.

Chapter Twelve presents a wealth of ides for improving nursing staff recruitment and retention. Phyllis Stoneburner and Charlene Honeycutt review present challenges and opportunities of the current and growing health care workforce shortages.

In Chapter Thirteen, Allan Komarek translates the Planetree model from acute to sub-acute and long-term care settings. How do we create the ideal nursing home setting? What could patient-centered care look like to frail elderly rehab patients, or the comatose trauma victim during extended hospital stays?

Chapters Fourteen and Fifteen take us into the not so distant future. Trevor Hancock presents the latest information from the "green" hospitals movement thriving in Canada and Europe, and its early advances in the U.S. Leland Kaiser takes us onto the spiritual frontier in health care, envisioning a bold new path to true mind-body-spirit health care.

Finally in Chapter Sixteen, the editors summarize the challenges and opportunities for further development of patient-centered care in healing health care environments. Looking at today's best practices in combination with emerging trends in

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health care, they suggest where we should focus our attention in order to meet and exceed the needs and desires of our patients, their families, and our staff.

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