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# **PfP Strategic Vision Roadmap for Person and Family Engagement (PFE)**

**Achieving the PFE Metrics to Improve  
Patient Safety and Health Equity**

*Patient and Family Engagement Contractor for PfP 3.0*

OCTOBER 2017



# **PfP Strategic Vision Roadmap for Person and Family Engagement (PFE): Achieving the PFE Metrics to Improve Patient Safety and Health Equity Second Edition**

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**Patient & Family Engagement Contractor for PfP 3.0**



1000 Thomas Jefferson Street NW  
Washington, DC 20007-3835  
202.403.5000

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## Foreword

In January of 2016, the Patient and Family Engagement Contractor (PFEC), in support of Partnership for Patients (PfP), produced and disseminated the *PfP Strategic Vision Roadmap for Patient and Family Engagement* (also referred to as *The Roadmap*). The first edition was designed to help Hospital Engagement Networks (HENs) and their participating hospitals speak a common language about patient (or person) and family engagement (PFE) and the five PfP PFE metrics. It also provided a set of strategies to assist hospitals in implementing PFE activities to meet the five PFE metrics. In the spring and fall of 2016, two addendums were added to the Roadmap: (1) *Defining the Person and Family Engagement (PFE) Metrics for Improved Measurement: Purpose and Intention of the Five PFE Metrics*, which clarified the metric language, identified the intentions and importance of each metric, and provided guidance to help determine whether a hospital has met the metric and (2) *How Person and Family Engagement Can Help Hospitals Achieve Equity in Health Care Quality and Safety*, which provided guidance on achieving health equity in and through PFE.

PfP is now in its third round of funding (September 2016–September 2019) and has expanded in a variety of ways. HENs are now Hospital Improvement Innovation Networks (HIINs), guiding more than 4,000 hospitals in the continued reduction of hospital-acquired conditions and preventable readmissions. Increasing evidence about the critical role of PFE in improving patient safety and valuable lessons learned about how to implement meaningful PFE activities provide the perfect opportunity to update *The Roadmap*. Our goals for the 2<sup>nd</sup> edition of *The Roadmap* were to: (1) make the document more user-friendly for HIINs and their hospitals; (2) integrate content from the addendums; and (3) update the information so that it reflects the current landscape and language of PfP 3.0. We also have added data and stories from HIINs and hospitals to better illustrate the case for PFE and how to meet the metrics. **This edition of the Roadmap replaces the 1st edition and the addendum on the PFE metrics.** While we have integrated information about health equity into this version of the Roadmap, **we encourage you to continue to refer to the addendum on health equity for more in-depth information.**

We appreciate the many comments, suggestions, and stories that we have received from HIIN leaders and staff, patient advocates, partners, and CMS officers, and have worked to incorporate many of them in this updated version. A special thanks to AIR's Lee Thompson and Emily Kirkwood for their leadership on this revision. We hope it provides clarity and direction for your PFE and patient safety efforts, and we look forward to continuing to assist you in your PFE efforts with the goal of creating safe and patient-centered hospitals across the United States.

Pam Dardess, PFEC Director, American Institutes for Research  
Kouassi Albert Ahondion, COR, Centers for Medicare & Medicaid Services

## Introduction

The Centers for Medicare & Medicaid Services (CMS) has advanced a vision of a safer, more equitable and person-centered healthcare system transformed by meaningful person and family engagement (PFE). The CMS Quality Strategy includes a specific goal to “strengthen person and family engagement as partners in their care.”<sup>1</sup> The CMS PFE Strategic Plan highlights the critical role of PFE in meeting the three broad aims of the National Quality Strategy—Better Care, Healthier People and Communities, and Affordable Care.<sup>2</sup>

### PFE in the Partnership for Patients

CMS’s Partnership for Patients (PfP) is a quality and safety improvement initiative to make hospital care safer, more reliable, and less costly. Within PfP, the **strategic vision of PFE** is that hospitals and other health care providers achieve quality and safety goals by fully engaging patients and their families, determining what matters most to them in every situation, and partnering with them to make improvements to all aspects of care. In this way, PFE helps hospitals incorporate what matters most to patients and families and improves the ability to achieve long-term improvements in quality and safety. Guiding the implementation and adoption of PFE practices in PfP are **five PFE metrics**. The intent of these metrics is to create a culture where patient and family interests and input are sought and included in decisions regarding care, protocols, and hospital operations.

#### PfP 3.0 Goals<sup>3</sup>

By 2019:

- 20 percent reduction in overall patient harm (to 97 Hospital-Acquired Conditions [HACs] per 1,000 discharges)
- 12 percent reduction in 30-day readmissions per 1,000 people

### Purpose of the PfP PFE Roadmap

The purpose of the revised Roadmap is to provide practical guidance to help the Hospital Improvement Innovation Networks (HIINs), hospitals, and other PfP partners achieve a shared vision of PFE and meet the five PFE metrics. The Roadmap contains information about:

- definition and core principles of PFE;
- role of PFE in patient safety;
- the intersection of PFE and health equity;
- definition, intent, and benefits of each PFE metric, as well as tips and resources to help meet each metric and hospital success stories; and
- six PFE strategies to meet the five PFE metrics.

<sup>1</sup> CMS. CMS Quality Strategy, 2016.

<sup>2</sup> CMS. Person and family engagement strategy; 2016 Nov. 22.

<sup>3</sup> Centers for Medicare & Medicaid Services (CMS). Partnership for patients and the hospital improvement innovation networks: continuing forward momentum on reducing patient harm; 2016 Sep. 29.

# PFE in PfP: Definitions and Core Principles

## Definition of PFE in PfP

In PfP, PFE is defined as “persons, families, their representatives, and health professionals (clinicians, staff, and leaders), working in active partnership at various levels—direct/point of care, organizational design, policy, and procedure; organizational governance; and community/policymaking—across the health care system and in collaboration with communities to improve health, health care, and health equity.” This definition draws on established conceptual and behavioral frameworks,<sup>4,5,6</sup> reflects best practices, and acknowledges the multifaceted nature of PFE.

## PFE Core Principles and Defining Elements

The PfP definition of PFE encompasses several core principles and defining elements:

- **PFE involves active partnership.** PFE is about moving toward interactions in which patients and families have shared power, responsibility, and decision-making authority.
- **PFE happens at multiple levels.** Partnership occurs not only at the point of care but also in the development of organizational policies and procedures, in organizational governance, and in the larger community. Achieving the outcomes of PFE is best accomplished when PFE is integrated across each of these levels.
- **PFE is about identifying and responding to patient- and family-identified needs and desired outcomes.** A shift toward PFE means working with patients and families to understand and integrate their goals, preferences, and desired health outcomes into hospital care. Success is defined not just by traditional outcomes (e.g., the resolution of clinical conditions) but also by whether patients achieve *their* desired health outcomes.<sup>7</sup>
- **PFE is a partnership that requires individual *and* system behavior change.** PFE involves structuring systems or care processes to create engagement opportunities (e.g., conducting nurse shift change reports at the bedside), facilitate individual behavior change, and foster engagement across the care continuum.
- **In PFE, “family” is defined broadly and by the individual.** Family members, friends, caregivers, and other care partners (referred to collectively as care partners throughout this document) are a critical component of PFE. The principles of PFE mean that individuals receiving care define the individuals that constitute their “family.”

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<sup>4</sup> Carman K, Dardess P, Maureen M, Sofaer S. Patient and family engagement: a framework for understanding the elements and developing interventions and policies. *Health Aff.* 2013;32(2): 223-23.

<sup>5</sup> Center for Advancing Health. A new definition of patient engagement: What is engagement and why is it important? Washington, DC; 2010 [cited 2015 Nov. 20].

<sup>6</sup> Health Research & Educational Trust. A leadership resource for patient and family engagement strategies. Chicago; 2013 [cited 2015 Nov. 20].

<sup>7</sup> Centers for Medicare & Medicaid Quality Improvement Council Affinity Group. Person and family engagement. Baltimore, MD; 2015 [presented 2015 Nov. 2].

- **PFE must consider the values, preferences, and needs reflected in diverse populations.** Health equity should be strategically integrated in all aspects of quality improvement and PFE. Defined as the “attainment of the highest level of health for all people,”<sup>8</sup> the achievement of health equity requires attending to health disparities, with particular attention to vulnerable populations.<sup>9</sup>
- **PFE is not a “check the box” activity—implementation quality affects results.** While PFE can be advanced through the implementation of specific activities (e.g., the development of a Patient and Family Advisory Council [PFAC]), *how* these activities are implemented is as important as *whether* these activities are implemented. For example, a hospital may have a PFAC that meets infrequently or that largely serves to approve plans as opposed to guiding their development and implementation. In recognition that the quality of PFE implementation affects results, this Roadmap contains six strategies to guide effective implementation of PFE. These strategies address critical elements of effective PFE implementation. Additional information is provided in the “Strategies for PFE Implementation” section of this document.

## The Case for PFE

A growing body of work—captured in the peer-reviewed literature and the experiences of the HIINs and their member institutions—highlights the benefits of PFE, suggesting that successful implementation of PFE practices can contribute to better outcomes. These include:

- **Reductions in hospital-acquired infections and conditions.** Over a 13-month period (January 2015–February 2016), hospitals in the Vizient HIIN that were meeting 4 or 5 of the PfP PFE metrics had lower falls with injury rates than those meeting 3 or fewer of the PfP PFE metrics ( $N = 146$  hospitals). During 2016, the Valley Hospital, a member of the New Jersey Hospital Association (NJHA) HIIN, also saw reductions in falls rates and falls with injury as a result of the implementation of a new teaching tool—developed by a multidisciplinary Falls Task Force including patient and family advisors (PFAs)—to better partner with patients and families about their risk for falls.<sup>10</sup>
- **Reductions in preventable readmissions.** For more than three years (January 2014–March 2017), the Vizient HIIN documented a steady trend in lower 30-Day Potentially-Unplanned Readmission Rates for hospitals that met 4 or 5 of the PfP PFE metrics, compared to those that meet 3 or fewer ( $N = 140$  hospitals). The Minnesota Hospital Association HIIN also found that hospitals meeting 4 or 5 of the PfP PFE metrics had

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<sup>8</sup> U.S. Department of Health and Human Services, Office of Minority Health. National Partnership for Action to End Health Disparities. The National Plan for Action draft as of February 17, 2010 [Internet]. Chapter 1: Introduction.

<sup>9</sup> “Vulnerable populations” encompasses racial and ethnic minorities and individuals who are economically disadvantaged; elderly; rural residents; homeless; un- or under-insured; have no or limited English proficiency; low health literacy; chronic health conditions, poor health status, or mental health issues; children and youth with special healthcare needs; disabled individuals; those at end of life; high-risk mothers and children; members of the LGBTQ community; military veterans; incarcerated persons; and substance users.

<sup>10</sup> The Valley Hospital. Patient and family centered-care: 2016 year-end report. Ridgewood, NJ.



lower rates of potentially preventable readmissions than hospitals meeting 3 or fewer.<sup>11</sup> In addition, a recent study published in the *Journal of the American Geriatrics Society* showed that integrating care partners into discharge planning processes can reduce the risk of an elderly patient being readmitted to the hospital within 90 days by 25 percent and within 180 days by 24 percent.<sup>12</sup>

- **Improved patient experiences and higher Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores.**

Valley Hospital in Ridgewood, NJ (a member of the NJHA HIIN) uses the GetWellNetwork (GWN), an interactive patient/family tool developed and implemented in partnership with PFAs, to provide education at the bedside through the television system. This tool has helped increase hospitals' HCAHPS scores, specifically, communication about medicines, communication with nurses, responsiveness of staff, and the discharge process. In Illinois, St. Alexius Medical Center, a member of the Great Lakes Partners for Patients HIIN, implemented a Patient and Family Advisory Council (PFAC) to address patients' perceptions of care, including pain management. The PFAC developed and piloted a bundle of strategies to improve pain management, resulting in improvements in the hospital's HCAHPS scores, including pain management and overall HCAHPS rating, over a 3-month period (November 2014–March 2015).<sup>13</sup>

- **Improved patient outcomes and reduced length of hospital stay.** Hurley Medical Center's Joint Replacement Center in Flint, Michigan and a member of the Michigan Health & Hospital Association, has seen improved physical therapy outcomes—including earlier mobility and shorter lengths of stay post-surgery—since implementing a new curriculum designed to engage patients throughout the entire care continuum. The curriculum provides patients and family members with in-person educational sessions prior to surgery, resources including a book and video designed by Hurley's patient and family centered care team, pre-admission testing appointments, and personalized outpatient physical therapy programs.<sup>14</sup>

*“As hospitals and health systems commit to collecting data and employing new strategies to improve safety, they need to incorporate patient and family engagement, as it can transform an organization’s culture in important and profound ways. Patients bring a much needed voice and perspective to quality improvement efforts and can help identify additional methods to reduce harm.”*

– Charisse Coulombe, MS, CPHQ,  
Vice President, Health Research  
& Educational Trust, [Guide to Safety Across the Board](#).

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<sup>11</sup> McGann P. Where we are, where we are heading, and how you can “ramp up” your influence on health system transformation—aka “Delivery System Reform—DSR.” Los Angeles: PFCCpartners Patient and Family Advocate Summit 2015 [presented 2015 Oct. 27].

<sup>12</sup> Rodakowski J, Rocco PB, Ortiz M, Folb B., Schultz R., Morton SC, Leathers, SC, Hu L, James AE 3rd. (2017 Apr 3). Caregiver integration during discharge planning for older adults to reduce resource use: a metaanalysis. *J Amer Geriatr Soc*.

<sup>13</sup> Bookout M, Staffileno B., Budzinsky C. (2016). Partnering with a patient and family advisory council to improve patient care experiences with pain management. *Journal of Nursing Administration*; 46(4): 181-86.

<sup>14</sup> National Association of Public Hospitals and Health Systems. Latest Innovations in Patient & Family Engagement: Case Studies from Five Facilities.

- **Reductions in health and health care disparities.** Harborview Medical Center in Seattle, Washington, and a member of the Vizient HIIN, used REaL (race, ethnicity, and language) data to identify disparities and develop programs to address unmet needs of racial and ethnic minorities. Somali and Latino patients who enrolled in a diabetes navigator program—which provides care coordination, coaching, and education—experienced decreases in their blood sugar (hemoglobin A1C) levels after six months.<sup>15</sup>
- **Improved efficiency.** Carolinas Medical Center, a member of the Carolinas Healthcare System HIIN, partnered with patients and families to design the Hospitality Suite, a post-discharge destination designed to ease patients’ transition from hospital stay to home. The suite—which contains refreshments, computers, a TV, charging station and telephone—is open from morning until evening, with rounding by clinical teammates and leaders. In addition to improving the discharge experience for patients, the medical center increased the number of discharges occurring before 12 p.m. over a 2-month period (March 2017–May 2017), resulting in 12 beds that become available for other patients.

## How PFE Intersects with Health Equity

In addressing issues of disparity, it is important to examine the role PFE plays in promoting health equity. Engaging patients and families from diverse cultural, ethnic, or socioeconomic backgrounds is a necessary component for achieving equity in care quality and safety. Equitable application of PFE (i.e., including patients and families from all backgrounds as equal and active partners in their health care) means that every person in the hospital gets the benefit of engagement in improving equity in quality and safety.

*“Equity is no longer a separate initiative, but is equal to quality... it is a strategic imperative.”*

– Institute on Assets & Social Policy, Patient and Family Advisory Councils, 2016, p.1.

Equity in PFE helps ensure that hospitals:

- Consider the needs, perspectives, interests, values, and beliefs of all patients and families, including those from disparate populations in the community.
- Address potential barriers to effective engagement, including implicit biases, cultural or language differences, communication barriers, and limited health literacy.
- Implement actions that reflect what matters most to all patients at each level of hospital care (i.e., direct care/point of contact, hospital policy and procedure, governance, and public and community policy).

When discussing how the PFE strategies and metrics can be applied in ways to help achieve equity in hospital care quality and safety, it is important to have a shared understanding of several core concepts (see exhibit 1). For additional information on how to achieve PFE in equitable ways, see the [Health Equity Roadmap Addendum](#).

<sup>15</sup> Vizient. Equity Enhancement Program Spotlight: Using REAL Data to Reduce Disparities and Improve Quality of Care.

### Exhibit 1: Coming to a Shared Understanding of Key Concepts

Concept	Definition
<b>Vulnerable Populations</b>	“Vulnerable populations” is a term that is used broadly to encompass groups that have a greater likelihood of marginalization or negative health outcomes. Vulnerable populations are often identified as groups including, but not limited to, racial and ethnic minorities; the economically disadvantaged; the elderly; rural residents; the homeless; those who are uninsured or underinsured; individuals with no or limited English proficiency; those with low health literacy; individuals with disabilities, chronic health conditions, or poor health status; high-risk veteran populations such as the homeless or those with serious mental illness; or people who are gay, lesbian, bisexual, or transgender. <sup>16,17,18</sup>
<b>Health and Health Care Disparities</b>	Health and health care disparities are the differences in the access to, delivery of, or quality of health and health care between population groups. <sup>19</sup> Commonly recognized disparities in health include a higher burden of illness, injury, disability, or mortality for a population group relative to another, whereas disparities in health care include differences in insurance coverage, access to care, or quality of care between groups.
<b>Social Determinants of Health</b>	According to the World Health Organization, social determinants of health are “the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life” such as “economic policies and systems, development agendas, social norms, social policies and political systems.” <sup>20</sup>
<b>Diversity and Inclusion</b>	“Diversity” has multiple meanings, but for the purposes of this document, diversity is best defined as “The condition of having or including people from different ethnicities and social backgrounds.” <sup>21</sup> This most often applies to differences in race, ethnicity, gender, gender identity, sexual orientation, age, social class, physical ability or attributes, religious or ethical values systems, national origin, and political beliefs. Inclusion is the practice of engaging a collective mixture of diverse stakeholders whose involvement recognizes the inherent worth and dignity of all people.
<b>Culturally and Linguistically Appropriate Services (CLAS)</b>	CLAS are inclusive of and responsive to the health beliefs, behaviors, needs, and communication styles of its diverse patient population. <sup>22</sup> It is well documented that the provision of services that are culturally and linguistically appropriate encourages greater provider/consumer engagement and collaboration that can help to close the disparities gap in health care outcomes and reduce overall cost of care.

<sup>16</sup> Vulnerable Populations: Who Are They? *Am J Managed Care*. 2006;12(13, Suppl):348-532.

Retrieved from: <http://www.ajmc.com/journals/supplement/2006/2006-11-vol12-n13suppl/nov06-2390ps348-s352>

<sup>17</sup> U.S. Department of Health and Human Services, Health Resources & Services Administration, Office of Health Equity [Internet]. Retrieved from: <http://www.hrsa.gov/about/organization/bureaus/ohe/>

<sup>18</sup> O’Toole, T. P., Pirraglia, P. A., Dosa, D., et al. (2011). Building Care Systems to Improve Access for High-Risk and Vulnerable Veteran Populations. *Journal of General Internal Medicine*, 26(Suppl 2):683-688. doi:10.1007/s11606-011-1818-2.

<sup>19</sup> Kaiser Family Foundation. Disparities in Health and Health Care: Five Key Questions and Answers. August 2016. Retrieved from: <http://files.kff.org/attachment/Issue-Brief-Disparities-in-Health-and-Health-Care-Five-Key-Questions-and-Answers>

<sup>20</sup> World Health Organization. 2016. Social determinants of health. Retrieved from: [http://www.who.int/social\\_determinants/en/](http://www.who.int/social_determinants/en/)

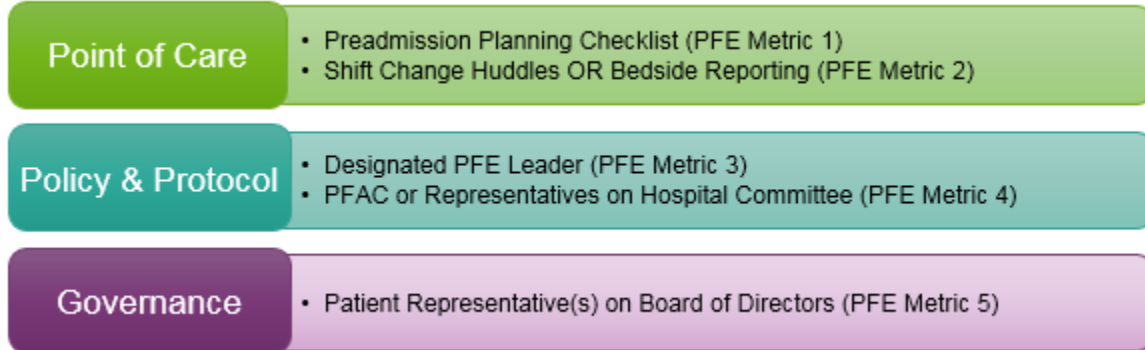
<sup>21</sup> American Heritage Dictionary of the English Language, Fifth Edition. Copyright © 2011 by Houghton Mifflin Harcourt Publishing Company. Published by Houghton Mifflin Harcourt Publishing Company. All rights reserved.

<sup>22</sup> U.S. Department of Health and Human Services, Office of Minority Health. HHS National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care November, 2015 [Internet]. Retrieved from: <https://www.thinkculturalhealth.hhs.gov/clas/what-is-clas>

# About the PfP PFE Metrics

As noted, **five PFE metrics** guide the implementation of PFE within the PfP. The purpose of the five PFE metrics is to ensure that hospitals have, at a minimum, structures and practices that enable active patient and family partnership at three levels of the hospital setting: point of care, policy and protocol, and governance (see exhibit 2).

**Exhibit 2: Partnership for Patients PFE Metrics, by Level of Hospital Setting**



This section provides guidance about the purpose and implementation of the five PFE metrics, including:

<b>What</b>	<ul style="list-style-type: none"> <li>• PfP metric language</li> <li>• Criteria that indicate when a hospital meets the metric</li> <li>• Alternative approaches to meet the metric</li> </ul>
<b>Why</b>	<ul style="list-style-type: none"> <li>• Intent of the metric</li> <li>• Benefits of meeting the metric</li> </ul>
<b>How</b>	<ul style="list-style-type: none"> <li>• Tips to maximize impact of the metric</li> <li>• Resources to meet the metric</li> <li>• An example of how a hospital implemented PFE activities to meet the metric</li> </ul>

In implementing the five PFE metrics, we strongly encourage a focus on the intent of each metric, as described below. Understanding this intent and incorporating the “tips to maximize impact of the metric” can affect the quality of PFE implementation, ensuring that PFE activities support a culture where patient and family interests and input are sought and included at all levels.

## Preadmission Planning Checklist (point of care)

**PfP Metric Language.** Hospital has a physical planning checklist that is discussed with every patient who has a scheduled admission.



**Do We Meet the Metric?** YES, if:

- Hospital has a physical planning checklist for patients with scheduled admissions, AND
- At admission, hospital staff discuss the checklist with patient and family.

### ***Alternative: Hospital has no scheduled admissions***

Hospitals are encouraged to consider and pursue options for achieving the intent of the metric. However, if a hospital does not conduct any scheduled admissions, PFE metric 1 does not apply. HIINs should calculate the percentage of hospitals implementing the metric based only on the hospitals in the HIIN that conduct scheduled admissions.



**Intent of the Metric.** For all scheduled admissions, hospital staff discuss a checklist of items to prepare patients and families for the hospital stay—and invite them to be active partners in their care. The metric focuses on the use of the checklist by admissions staff, an admitting nurse or physician, or other healthcare professional to guide a conversation with patients and families at the earliest point possible before or during their care. Ideally, patients and families also receive a physical copy of the checklist. While there is not a standard checklist that must be used by all hospitals, the checklist should facilitate conversation about topics such as: (1) what patients should expect during their stay (e.g., course of care, pain management); (2) patients' concerns and preferences for their care; (3) potential safety issues (e.g., preadmission medicines, history of infections); and (4) relevant home issues that may affect discharge, such as needs for additional support, transportation, and care coordination.



**Benefits.** When used effectively, the planning checklist is part of a process in which patients and families are encouraged to be active members of the healthcare team by sharing and receiving information, asking questions, and participating in care planning throughout the hospital stay. The planning checklist provides an invitation for patients and families to partner with the clinical care team throughout the stay to help ensure high-quality and safe care and to proactively address issues that may affect readmissions.

The use of a planning checklist can help—

Patients and family members	Clinicians and hospital staff
<ul style="list-style-type: none"> <li>• Clarify expectations about what will happen before, during, and after their hospital stay.</li> <li>• Feel more confident about being active partners in the quality and safety of their care.</li> </ul>	<ul style="list-style-type: none"> <li>• Understand the patient's specific care goals, preferences, needs, and concerns.</li> <li>• Identify the person who will serve as the patient's care partner helping in care and care planning during and after the stay.</li> </ul>

Patients and family members	Clinicians and hospital staff
<ul style="list-style-type: none"> <li>• Get to know the clinicians and staff on their care team and their roles.</li> <li>• Be better prepared to participate in key discussions about their care, including bedside rounding, shift change huddles, and discharge planning meetings.</li> <li>• Share information and ask questions about potential safety issues including those related to discharge planning (e.g., options for continuing care, post-discharge care instructions, and options for accessing community-based resources).</li> </ul>	<ul style="list-style-type: none"> <li>• Invite patients and their care partners to be active members of their healthcare team.</li> <li>• Understand preadmission medication regimens and therapy, allowing for better medication reconciliation and identification of potential medication errors.</li> <li>• Identify and proactively address potential safety issues, risks, and care needs.</li> <li>• Prepare patients and care partners and plan for a safe discharge.</li> </ul>



### Tips to Maximize Impact

- Work with clinicians, hospital staff, and patient/family advisors to ensure the checklist reflects the safety and quality needs and concerns of patients, families, clinicians, and hospital staff.
- Educate clinicians and staff about the benefits of using a checklist and train them on its use, including how to invite patients and families to partner in their care.
- Provide patients and care partners with a copy of the checklist prior to admission, allowing them to identify questions or concerns for discussion with clinicians and staff.
- Inform patients and care partners of any services that will help them participate in the planning checklist discussion (e.g., sign or language interpreters, patient navigators, community partners, peer mentors) and how they can access them.
- Document the conversation with the patient and care partner, and share the information with the entire care team to promote ongoing communication throughout the stay and to improve patient safety.

Appendix table A1 provides suggested activities to meet PFE metric 1.



### PFE Metric 1 Success Story

***Michigan Medicine’s pre-op guidebooks include simple checklists to prepare patients for surgery, helping to reduce hospital readmissions.***

Michigan Medicine, a premier academic medical center and part of the Vizient HIIN, created two pre-op guidebooks to share and discuss with patients prior to surgery: [Preparing and Recovering from My Hip Replacement Surgery](#) and [Preparing and Recovering from My Knee Replacement Surgery](#). The guidebooks include simple “Checklists for Success” that help patients prepare for surgery by providing information on items and over-the-counter medications to purchase, how to get ready the day before the surgery, information to bring to the surgery, recovery planning tips, and more. Patients receive the guidebooks in required pre-op classes and also can get the

guidebooks in clinics, receive them in the mail, or access them online. Michigan Medicine solicited input from staff and patients to develop the guidebooks, asking past and recent patients questions about their pre- and post-surgery experiences—for example, what patients wished they had known prior to surgery, what they wished they had asked during their care, and what did (or did not) work well during their stay. The guidebooks have helped Michigan Medicine reduce readmissions, length of stay, skilled nursing facility admissions, and opioid usage. In addition, the guidebooks have increased patient preparedness, with patients providing feedback that “everybody knows what to do.” To learn more, access the materials from the [July 2017 PFE Learning Event](#), “How to Create Opportunities to Engage with Patients and Families at Admissions and Beyond.”

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#### Resources for PFE Metric 1

- What you need to know before and after surgery (World Health Organization): [http://www.who.int/surgery/publications/patients\\_communication\\_tool.pdf?ua=1](http://www.who.int/surgery/publications/patients_communication_tool.pdf?ua=1)
- Your Guide for Total Knee Replacement Success (AMITA Health): <http://www.alexianbrothershealth.org/upload/docs/Our%20Services/AH%20Knee%20Replacement%20Education%20Booklet.pdf>
- Preparing and Recovering from My Hip Replacement Surgery (Michigan Medicine, University of Michigan): <https://medicine.umich.edu/dept/orthopaedic-surgery/patient-care-services/hip-knee-replacement/patient-surgery-information>
- PFE Metric Learning Modules: Metric 1 (Partnership for Patients): <https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx?CategoryID=836896&EntryID=107954>

For additional resources, please visit the Partnership for Patients Library:  
<https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx>

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## Shift Change Huddles OR Bedside Reporting (point of care)

**PfP Metric Language.** Hospital conducts shift change huddles or bedside reporting with patients and family members in all feasible cases.



**Do We Meet the Metric?** YES, if:

- In as many units as possible, but in a minimum of at least one unit, nurse shift change huddles **OR** clinician reports/rounds occur at the bedside and involve the patient and/or care partners.

### **Alternative: None**

This activity should be possible in all hospital types and structures. However, a hospital may offer alternatives to accommodate patient and care partner participation (e.g., adjust time of shift changes, offer options for care partners to participate via phone or Skype).



**Intent.** The intent of this metric is to include patients and care partners as active participants in as many conversations about their care as possible throughout the hospital stay. They should have the opportunity to question, correct or confirm, and learn more about the next steps in their care as it is discussed between nurses changing shifts and/or clinicians making rounds. Patients and care partners should be encouraged and prompted by clinical staff to be active participants in these meetings to whatever degree they desire and to add to the information being shared between nurses or other clinicians.



**Benefits.** Bedside shift change huddles, bedside reporting, and bedside rounding facilitate the transfer of critical information between staff, patients, and care partners to improve communication, prevent potential safety events and medical errors, improve time management and accountability between nurses—and ultimately, improve patient, family, and nurse staffing satisfaction.

Bedside shift change huddles and bedside reporting with patients and family members can help—

Patients and family members	Clinicians and hospital staff
<ul style="list-style-type: none"> <li>• Hear what has occurred throughout the shift and learn about the next steps in their care.</li> <li>• Ask questions, correct errors, and provide input based on their preference and values.</li> <li>• Increase knowledge of their condition and treatment so that they can participate in their care to the extent they want.</li> <li>• Understand that they are important members of the care team.</li> </ul>	<ul style="list-style-type: none"> <li>• Reinforce teamwork and ensure that every member of the team shares knowledge that contributes to safe and effective care.</li> <li>• Increase patient and family participation, knowledge, and satisfaction.</li> <li>• Create a heightened awareness of individual patient needs that can be proactively addressed throughout the shift.</li> <li>• Improve time management and accountability between nurses.</li> </ul>





## Tips to Maximize Impact

- Collect patient, care partner, clinician, and staff feedback about the shift change huddle or bedside reporting process and use this feedback to refine processes and policies. Ensure that feedback is solicited and obtained from vulnerable populations.
- Involve a multidisciplinary team in shift change huddles to reinforce teamwork and ensure that every member of the team, including the patient and care partner, shares knowledge that contributes to safe and effective patient care.
- Involve the patient and care partner in the entire conversation concerning their care, not just select parts.
- Encourage or prompt the patient and/or care partner to participate in conversations about their care through the hospital stay, to whatever degree they desire.

Appendix table A2 provides suggested activities to meet PFE metric 2.



## PFE Metric 2 Success Story

### *Care team rounds with patients and families promotes patient safety and improves patient satisfaction at Perham Health.*

Perham Health in Perham, Minnesota, a critical access hospital in the Minnesota Hospital Association HIIN, introduced a new model, called “Care Team Rounds,” that involves patients and families at the bedside. A social worker leads the team which includes the charge nurse, nurse leader, patient’s nurse, pharmacy, occupational therapy, and physical therapy. The social worker requests permission from the patient or family each day to conduct the care team rounds. During the rounds, the charge nurse reviews the patient’s admission diagnosis and care in plain language for the patient, family, and care team. The care team asks the patients and family if they have concerns or comments about their care, and uses the time to identify opportunities for improvement, provide updates to the group, and answer questions. Since implementation of care team rounds, Perham Health has noted enhanced communication with patients and families, promotion of safety, improvement of multidisciplinary communication, enriched discharge planning, and improvements in patient satisfaction.

### Resources for PFE Metric 2

- Strategy 3: Nurse bedside shift report, Guide to patient and family engagement in hospital quality and safety (Agency for Healthcare Research and Quality): <http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy3/index.html>
- ISHAPED patient-centered approach to nurse shift change bedside report (Institute for Healthcare Improvement): <http://www.ihl.org/resources/Pages/Tools/ISHAPEDPatientCenteredNurseShiftChangeBedsideReport.aspx>
- PFE Metric Learning Modules: Metric 2 (Partnership for Patients): <https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx?CategoryID=836896&EntryID=107954>

For additional resources, please visit the Partnership for Patients Library:

<https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx>

**PfP Metric Language.** Hospital has a designated individual (or individuals) with leadership responsibility and accountability for PFE.



**Do We Meet the Metric?** YES, if:

- There is a named hospital employee (or employees) responsible for PFE efforts at the hospital either in a full-time position or as a percentage of time within their current position, **AND**
- Appropriate hospital staff and clinicians can identify the person named as responsible for PFE at the hospital.

**Alternative: None**

This activity should be possible in all hospital types and structures.



**Intent.** The intent of this metric is to ensure that PFE efforts are built into the management of hospital operations and given the attention and resources needed to be successful and sustained over time. The hospital should identify at least one staff member who is responsible and accountable for overseeing PFE efforts at the hospital, including identifying, implementing, monitoring, and evaluating PFE activities. Hospitals may also designate multiple individuals within an office or department (e.g., Patient Experience Office, Quality Improvement) as having responsibility for PFE efforts. The person(s) responsible for PFE at the hospital does not need to have a specific title or position or be 100 percent focused on PFE, but all hospital staff should be aware that this person coordinates the hospital’s PFE plans and activities.



**Benefits.** Designating an individual helps integrate the work of PFE into a hospital’s organizational structure, systematize PFE, promote accountability, and ensure continued progress toward a strategic vision of PFE. It also helps establish and sustain a culture of PFE that moves beyond short-term changes to integrate the core principles of PFE throughout the hospital. Finally, it sends a strong signal to hospital leaders, clinicians, staff, patients and care partners, and community members about the hospital’s commitment to partnering with patients and families to provide high-quality and safe care.



**Tips to Maximize Impact**

- To the extent possible, integrate the person/position into an existing office or department that supports patient safety, patient experience, and/or quality improvement initiatives to leverage existing resources.
- Have the person/position with responsibility for PFE report directly to hospital leadership to elevate and reinforce the critical role of PFE in the hospital.

- Associate the following responsibilities with PFE oversight and accountability:
  - Working with hospital leaders—e.g., creating strategic plans for PFE, collaborating with leaders to implement PFE best practices.
  - Identifying, implementing, and overseeing PFE activities—e.g., recruiting, training, and overseeing the work of PFAs and PFACs, reporting accomplishments.
  - Assessing and continually improving PFE performance—e.g., establishing and disseminating short- and long-term PFE goals, developing and assisting with evaluation, monitoring, and feedback activities.
- Develop processes for evaluating the activities and impact of the PFE leader that are inclusive of diverse patient and family participation, input, and feedback.

Appendix table A3 provides suggested activities to meet PFE metric 3.



### **PFE Metric 3 Success Story**

#### ***Evidence-based practices help Barton Healthcare leaders wear multiple hats to promote and support PFE.***

In 2013, the CEO of Barton Healthcare in South Lake Tahoe, California—a member of the Health Services Advisory Group (HSAG) HIIN—asked the hospital’s director of quality improvement to look into starting a PFAC. To get started, the director of quality improvement formed a subgroup with the director of public relations and the patient safety officer. The subgroup members maintained their existing work, volunteering time for the new project due to their belief in the value of PFACs. The subgroup researched evidence-based best practices to build on existing knowledge related to PFACs and to make their business case to leadership. They also utilized existing budgets from various departments to fund the development of the PFAC, including the costs associated with hosting PFAC meetings. Today, Barton Health’s annual PFAC budget of about \$500 covers snacks and supplies for meetings. To learn more, access the materials from the [May 2017 PFE Learning Event](#), “How to Help Hospitals Get Started on the PFE Journey.”

#### **Resources for PFE Metric 3**

- Staff liaison to patient and family advisory councils and other collaborative endeavors (Institute for Patient- and Family-Centered Care): [http://www.ipfcc.org/resources/Staff\\_Liaison.pdf](http://www.ipfcc.org/resources/Staff_Liaison.pdf)
- Working with patients and families as advisors: Implementation handbook (Agency for Healthcare Research and Quality): [https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy1/Strat1\\_Implement\\_Hndbook\\_508\\_v2.pdf](https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf)
- PFE Metric Learning Modules: Metric 3 (Partnership for Patients): <https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx?CategoryID=836896&EntryID=107954>

For additional resources, please visit the Partnership for Patients Library:  
<https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx>

**PfP Metric Language.** Hospital has an active Patient and Family Advisory Council (PFAC) **OR** at least one patient who serves on a patient safety or quality improvement committee or team.



**Do We Meet the Metric?** YES, if:

- Patient and/or family representatives from the community have been formally named as members of a PFAC or other hospital committee, **AND**
- Meetings of the PFAC or other committees with patient and family representatives have been scheduled and conducted.

**Alternative: None**

The two options possible for accomplishing this metric are designed to accommodate hospitals with varying levels of experience working with PFAs. While a PFAC is the recommended best practice, it also is acceptable for a hospital to identify and prepare at least one PFA (and ideally, at least three to four) from the community to serve on an existing hospital committee, such as the hospital’s Patient Experience or Quality Improvement committees.



**Intent.** The intent of this metric is for hospitals to develop formal relationships with PFAs from the local community—who are former patients and represent the patient population—who can provide input and guidance from the patient perspective on hospital operations, policies, procedures, and quality improvement efforts. The relationship may be via a mechanism such as a PFAC or involvement on other hospital committees in which advice, input, and active involvement from patients and family advisors is gathered on a regular basis. Patient representatives on hospital committees should have all the same rights and privileges of all other committee members, and efforts should be made to enable these representatives to share their unique perspective as patients or family members at meetings. Ultimately, this metric confirms that a hospital systematically incorporates patients and care partners as advisors when addressing operations or quality improvement activities.



**Benefits.** Partnering with PFAs at the organizational level brings the perspectives of patients and families directly into the planning, delivery, and evaluation of care. More specifically, PFAs can (1) offer insights into what the hospital does well and areas where change may be needed; (2) help develop priorities and make improvements based on patient- and family-identified needs; and (3) serve as a link between the hospital and the broader community. The long-term benefits of working with PFAs include improvements in overall systems and processes of care, including reduced errors and adverse events, improved health outcomes for patients, and better experiences of care.<sup>23</sup>

<sup>23</sup> Charmel PA, Frampton SB. Building the business case for patient-centered care. *Healthc Financ Manage* 2008;62(3):80–5.



## Tips to Maximize Impact

- Be intentional during the recruitment process—some patients and family members may not be ready or do not have the skill set to serve as PFAs. Utilizing specific processes for referral, application, and interviewing helps identify candidates who are the best fit and allows candidates to self-select out of the process as desired.
- Partner with trusted community groups (e.g., faith communities, social service agencies, advocacy groups) that have deep relationships with the populations underrepresented to assist in recruitment and outreach to PFAC or advisor opportunities.
- Before working with PFAC members or advisors on specific projects, provide a clear description of the project, activities, scope of work, related work that has been done in the past, and how advisor input will be used.
- Help PFAs articulate and tell their stories in a constructive way that highlights opportunities for partnership at all levels of the hospital setting.
- Ask for feedback from and provide feedback to PFAs about the impact of their individual and collective contributions on an ongoing basis so that the experience is meaningful for them.

*“Be brave and share [quality] data... Organizations need to be thoughtful about transparency—and provide the same data to PFAs. PFAs cannot commit to co-design if they are not working with the same data as hospital leaders, clinicians, and staff.”*

– Libby Hoy, Founder/CEO, PFCCpartners

*“Hospitals should follow up with PFAs to share the outcomes of the project and how it will be sustained—PFAs want to feel like contributors and not participants...PFAs want to know that the hospital staff are equally committed to PFE.”*

– Laura Lundquist, PFA, Sutter Health

*“Just do it—start small, be brave, and serve food.”*

– Christine O’Farrell, Director of Quality Management, Barton Healthcare

Appendix table A4 provides suggested activities to meet PFE metric 4.



## PFE Metric 4 Success Story

### ***Maine Coast Memorial Hospital PFAC helps hospital achieve zero falls rate.***

Maine Coast Memorial Hospital (MCMH), a small rural hospital in Ellsworth, Maine and a member of the Vizient HIIN, decided to create a PFAC after hearing about the value that PFACs provided at other hospitals. Specifically, MCMH wanted to address safety and quality issues through its PFAC, referred to as a Patient and Family Partnership Council for Quality and Safety. The PFAC brainstormed potential initiatives at its inaugural meeting and decided to tackle patient falls—falls rates in the medical-surgical unit were above the national average, despite efforts to educate nurses and patients. In addition, MCMH had a multidisciplinary patient falls taskforce that was willing to partner with the PFAC. The PFAC launched the “Catch a Falling Star” program to



identify and address strategies—based on the patient perspective—to reduce and prevent patient falls, including strategies related to signage, which MCMH quickly implemented. The PFAC launched in January 2015 and, in the first quarter of 2015, the hospital experienced a 0.67 percent falls rate and improved to a zero falls rate in the second quarter. The PFAC has supported numerous other hospital initiatives since its successful contributions to efforts to reduce patient falls. To learn more, read the [case study](#), “Patient Safety and Quality Spotlight: Using a Patient and Family Partnership Council for Quality and Safety,” available from Vizient, and access the materials from the [June 2016 PFE Learning Event](#), “Developing and Sustaining Partnerships that Improve Patient Safety.”

#### Resources for PFE Metric 4

- Strategy 1: Working with patients and families as advisors, Guide to patient and family engagement in hospital quality and safety (Agency for Healthcare Research and Quality): <http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/strategy1/index.html>
- How to create and sustain a PFAC toolkit (Partnership for Patients): <http://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx?CategoryID=836879&EntryID=110660>
- Tools to foster collaboration with patient and family advisors (Institute for Patient- and Family-Centered Care): <http://www.ipfcc.org/resources/downloads-tools.html>
- Tips for group leaders on involving patients and families on committees and task forces (Institute for Patient- and Family-Centered Care): <http://www.ipfcc.org/resources/tipsforgroupleaders.pdf>
- PFE Metric Learning Modules: Metric 4 (Partnership for Patients): <https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx?CategoryID=836896&EntryID=107954>

For additional resources, please visit the Partnership for Patients Library:

<https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx>

## Patient Representative(s) on the Board of Directors (governance)

**PfP Metric Language.** Hospital has one or more patient(s) who serve on a governing and/or leadership board as a patient representative.



**Do We Meet the Metric?** YES, if:

- The hospital has at least one position on the board designated for a patient or family member who is appointed to represent that perspective, **OR**
- If a specific board representative is not possible, the hospital has implemented one of the alternatives to the metric to incorporate the perspective of patients and families when making hospital governance decisions (see options below under “Alternative”).
- Hospitals are encouraged to consider and pursue options for achieving the intent of the metric.

### Alternative:

While designating at least one patient representative on the board is the preferred mechanism to ensure co-governance, certain laws, policies, or circumstances may not allow the formation of a patient or family representative seat on the board. In these cases, hospitals are encouraged to pursue alternative options that achieve the intent of this metric and qualify as a “yes” response, including:

- Asking for PFAC input on matters before the board, and incorporating a PFAC report into the board agenda.
- Identifying elected or appointed board members to serve in a specific role, with a written role definition, representing the patient and family voice on all matters before the board.
- Requiring all board members to conduct activities that connect them closer to patients and families, such as visiting actual care units in the hospital two times per year and/or attending two PFAC meetings per year.



**Intent.** The intent of this metric is to ensure that at least one board member with full voting rights and privileges provides the patient and family perspective on all matters before the board, similar to other board members who represent specific interests in the community. While current board members may have had experiences as patients at the hospital (or as family members of patients), the intent is to bring in individuals who do not serve the board in any other professional capacity and whose sole purpose is to be a patient representative and contributor. The goal of this activity is to ensure that the board includes patient and family perspectives when making governance decisions at the hospital.



**Benefits.** Developing a governance structure that supports and exemplifies partnership with patients and family advisors signals and solidifies an organization’s commitment to PFE at the highest level. PFA partnership at this level ensures that governance decisions reflect patients’ and families’ priorities, values, and needs.



### **Tips to Maximize Impact**

- Consider incremental but meaningful steps—for example, establishing a PFAC as a first step toward meeting this metric.
- Thoughtfully recruit PFAs to the board with consideration toward the diversity of the community, personal characteristics, and passion for the hospital’s mission.
- Provide training to the PFA to prepare them to serve effectively on the board.

Appendix table A5 provides suggested activities to meet PFE metric 5.



### **PFE Metric 5 Success Story**

#### ***Patient and family advisors at St. Francis Medical Center are “equal partners” on local governing board.***

As a required condition by the California Attorney General for a merger and acquisition transaction, St. Francis Medical Center (SFMC) in Southeast Los Angeles, a part of Verity Health and a member of the Health Services Advisory Group (HSAG) HIIN, created a local governing board to consult on changes to medical services, community benefit programs, charity care services, collection policies, and capital purchases. The board included community representatives from SFMC’s 30 primary service zip codes, in addition to SFMC staff and representatives from the Los Angeles County Board of Supervisors. PFAs on the board were recruited based on their status as a patient or family member of a patient, as well as their ability to be constructive and match their personal mission with the hospital’s mission to improve care delivery and organizational performance. The PFAs also had to represent the community that the hospital served and be able to speak on behalf of all patients and families, among other criteria. PFAs on the board said they knew they had achieved equal partnership with other board members when people solicited their opinions and felt comfortable meaningfully discussing and challenging their ideas. To learn more, access the materials from the [August 2017 PFE Learning Event](#), “How to Help Hospitals Get Buy-in for PFE at the Governance Level.”

#### **Resources for PFE Metric 5**

- How-to guide: Governance leadership (get boards on board) (Guide from the Institute for Healthcare Improvement): <http://www.ihl.org/resources/pages/tools/howtoguidegovernanceleadership.aspx>
- Guidelines for using patient stories with boards of directors (Institute for Healthcare Improvement): <http://www.ihl.org/resources/pages/Tools/GuidelinesforUsingPatientStorieswithBoardsofDirectors.aspx>
- PFE Metric Learning Modules: Metric 5 (Partnership for Patients): <https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx?CategoryID=836896&EntryID=107954>

For additional resources, please visit the Partnership for Patients Library:  
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# Strategies for PFE Implementation

This section describes **six overarching strategies** that are designed to help hospitals implement PFE practices—including the five PFE metrics—in ways that reflect and operationalize the core PFE principles. While these six PFE strategies can be applied broadly to guide PFE planning and implementation, they are discussed below in the context of meeting the five PFE metrics.

The six strategies<sup>24</sup> are:

1. Organizational partnership
2. Patient and family preparation
3. Clinician and leadership preparation
4. Care, policy, and practice redesign
5. Measurement and research
6. Transparency and accountability

Each strategy is described below, including broad guiding questions to help hospitals understand how to apply the strategy in implementing the PFE metrics and other PFE activities effectively. Appendix A provides more specific guidance about how the six PFE strategies can be applied to support effective implementation of the five PFE metrics. For additional best practices related to implementation and sustainability of PFE, see Appendix B.

## PFE Strategies

### ***PFE strategy 1: Organizational partnership***



Partnering with patients and their families in the design of processes, policies, and facilities helps ensure that hospital systems and structures reflect patient and family perspectives and needs. Organizational partnership creates a clear pathway for infusing patient and family voices and experiences into workflows, organizations, and systems, leading to better experiences and outcomes. Hospitals should strive to include diverse patient, family, and community partners in these organizational partnerships to improve the coordination and equitable delivery of high-quality, safe health care. Diverse partnerships offer multiple perspectives that can help hospitals identify the root causes of safety and quality disparities.<sup>25</sup>

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<sup>24</sup> The strategies listed below are adapted from the “[Roadmap for Patient and Family Engagement in Healthcare: Practice and Research](#)” and include information gathered during interviews with the 17 HENs in PFP 2.0. Developed by AIR, with funding from the Gordon and Betty Moore Foundation, the Roadmap reflects a unified vision for achieving meaningful PFE across the healthcare system and lays out a path to broader PFE by providing specific strategies, that, when implemented, can help achieve the goals of better care experiences, better health, lower costs, and improved safety.

<sup>25</sup> Institute on Assets and Social Policy. (2016). Patient and family advisory councils: Advancing culturally effective patient-centered care. Retrieved from: <https://iasp.brandeis.edu/pdfs/2016/PFAC.pdf>

### **Guiding questions:**

- Have we intentionally included diverse partners on the basis of identified needs to ensure equitable representation by race, ethnicity, language, gender orientation, diagnosis, disability, etc.?
- Does every effort to implement a PFE metric include meaningful input and decision making from patients and family members at the planning, development, implementation, and evaluation phases? Are these engagement efforts truly inclusive?
- How can we make patients and families part of organizational planning and decision making? What mechanisms for organizational partnership exist, and what mechanisms need to be created?
- How can we leverage existing relationships (e.g., hospital volunteers, community stakeholders, former patients) to ensure that our hospital understands and responds to patients' and families' priorities, needs, and concerns?

### ***PFE strategy 2: Patient and family preparation***



Patient and family preparation provides individuals with the skills, confidence, and authority to partner in interactions and healthcare decision making. This includes education and preparation related to their hospital stay, discharge planning, and recovery. It also includes preparation to partner with clinicians, staff, and healthcare leaders to shape how care is organized and delivered more broadly.

### **Guiding questions:**

- What knowledge, information, and skills do patients and their families need to engage effectively before, during, and after their hospital stay to be allies for patient safety? Are there gaps between the information and skills needed and the information and skills they currently have?
- What knowledge, information, and skills do patients and families need to be partners with hospital leaders, clinicians, and staff on committees?
- How might the information and skills needed vary based on the differing needs of our patient and family populations? What are the information, education, and preparation needs of the vulnerable populations we serve, and how will we address them?
- What supports (e.g., sign or language interpreters, patient navigators, or community partners) are needed to allow all patients and their families engage in healthcare decision making?
- How can we better prepare patients and families to share their personal stories to bring about constructive changes in the delivery of care?

### ***PFE strategy 3: Clinician, staff, and leadership preparation***



Preparing clinicians, staff, and hospital leaders to partner with all patients and families (including those that represent vulnerable populations) at all levels of the hospital setting is critical to ensuring that the delivery of care is patient- and family-centered and culturally competent. Hospitals can work to improve care by providing training to reduce barriers and supporting providers in delivering culturally competent, patient-centered care.

#### **Guiding questions:**

- Have our clinicians, staff, and leaders been educated regarding the principles and practices of PFE? How can we help our clinicians, staff, and leaders better understand the perspectives of patients and family members (e.g., via sharing of patient stories)?
- How can we educate providers and leaders on cultural differences in nonverbal communication styles, health beliefs, and the role of family and community?
- What knowledge, information, and skills do our clinicians, staff, and leaders need to partner effectively with patients and families, including members of vulnerable populations?
- What current attitudes, beliefs, or concerns do our clinicians, staff, and leaders have about partnering with patients and families? What attitudes and beliefs do they have about vulnerable populations? How might these affect PFE efforts?

### ***PFE strategy 4: Care, policy, and process redesign***



PFE involves creating an environment in which engagement is expected and welcomed at all levels of the hospital setting. This includes facilitating individual behavior change by providing opportunities for patients and families to engage and be active in their care, creating policies that emphasize patient and family partnership, and implementing care processes that reflect patients' and families' self-identified needs.

#### **Guiding questions:**

- What policies and structures currently inhibit partnership with patients and families at the bedside (e.g., policies that restrict the presence of care partners)?
- How can we redesign processes, policies, and structures to support the PFE metrics? What changes can we make to enhance the interactions between clinicians, staff, patients, and families to address safety and quality issues?
- What changes are needed to support the needs of vulnerable populations (e.g., increased provision of translation services, education materials that use plain language) so they are able to partner effectively at all levels?

## **PFE strategy 5: Measurement and research**



Measurement and research help drive changes in behaviors and processes. Measurement helps identify successes and areas for improvement and build evidence related to best practices. Research can help assess whether, to what extent, and how engagement is occurring and identify outcomes resulting from PFE interventions. Collecting and assessing data also helps hospitals understand their patient population and the nature and extent of disparities affecting the hospital. This information is important to understand how to engage all populations most effectively.

### **Guiding questions:**

- What data are we currently capturing that may provide information about the effect of the PFE efforts on the hospital's patient experience and quality and safety goals? What data are needed that are not being captured?
- What data are important to leaders? Clinicians and staff? Patients and families? The surrounding community? How can we best report and reflect this data to different audiences?
- How can we use race, ethnicity, and language (REaL) data to inform planning and decision making to enhance diversity?
- How can we build in an evaluation component to assess (1) whether each PFE metric is being implemented and (2) the impact of meeting each PFE metric on patients and their families, clinicians, and the hospitals as a whole?

## **PFE strategy 6: Transparency and accountability**



Providing patients and families with transparent information about the performance of the organization in which they are receiving care signals that partnership and openness are an important part of the organization's culture.<sup>26,27</sup> Additionally, consistent and timely access to data and resources can inspire trust and empower clinicians, medical leadership, patients, and families to remain committed to the goal of achieving equitable care.

### **Guiding questions:**

- How can we make data and information transparent to allow patient and family advisors to partner with hospital leaders, clinicians, and staff to improve quality and safety?
- What data can we make available to hospital leaders, clinicians, and staff to help them understand the critical role they play improving quality and safety?
- How are hospital leaders held accountable for implementing and sustaining the PFE metrics?

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<sup>26</sup> Coulter A. Patient engagement—what works? *J Ambul Care Manage.* 2012;35(2):80-89.

<sup>27</sup> Hibbard JH, Greene J, Sofaer S, Firminger K, Hirsch J. An experiment shows that a well-designed report on costs and quality can help consumers choose high-value healthcare. *Health Aff.* 2012;31(3):560-68.

## Conclusion

PFE that is characterized by active partnership with patients and care partners is the cornerstone of improved quality and safety, including reducing hospital readmissions and hospital-acquired conditions. Using evidence-based strategies and practices to implement the five PFE metrics can create changes that promote and sustain PFE over time and improve the quality, safety, and equity of care. Sustaining these metrics and changes over time is reflective of the vision of PFE in PffP—hospitals and other health care providers achieve quality and safety goals by fully engaging patients and their families, determining what matters most to them in every situation, and partnering with them to make improvements to all aspects of care. Building a strong foundation for sustainability requires changing behaviors, attitudes, and values; building systems that encourage and support engagement; and revisiting these systems over time.

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*“To change the culture you have to change the conversations. Involving the patient and family members in decision making fundamentally changes the conversation for the better, whether the issue involves an individual treatment decision or a hospital-wide policy.”*





– Deidre Thomas, MSA, CPHQ, Director, Patient Safety, Carolinas Healthcare System, CMS Partners Meeting, 2017 Jun 28

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# Appendix A. Applying the PFE Strategies to Meet the PFE Metrics in More Meaningful and Equitable Ways

**Table A1: PFE Strategies to Support Effective Implementation of PFE Metric 1: Preadmission Planning Checklist**


PFE strategy	Tactics
 <p><b>Organizational partnership</b></p>	<ul style="list-style-type: none"> <li>● Get feedback from patients and families to better understand how they experience your current admission process. What information would they have liked to have that they did not get? What would have helped them feel more prepared for discharge? What is the best way for patients and families to receive this information (e.g., in person, phone call, mailing)?</li> <li>● Ask patient and family advisors (PFAs), including those that represent vulnerable populations, to review the preadmission planning checklist and processes to suggest improvements that better address patient and family preferences and needs and key safety and quality issues.</li> <li>● Ask PFAs to review other admission materials to provide feedback on how well they support and reinforce the messages of the preadmission discharge planning checklist and address the needs and concerns of patients.</li> <li>● Work with PFAs to develop processes for ensuring that the preadmission planning checklist is used throughout the hospital stay and in the discharge planning process.</li> </ul>
 <p><b>Patient and family preparation</b></p>	<ul style="list-style-type: none"> <li>● Provide patients and family members with information to help them prepare for and understand their hospital stay—for example, what to bring to the hospital; the types of care providers they will be interacting with (attending physicians, residents, interns, physician assistants, nurse practitioners, nurses, nurses' aides, other care staff); how often they will interact with these care providers and in what ways; what routine processes they will experience (e.g., monitoring of vital signs); and any tests or additional procedures associated with their specific admission.</li> <li>● Provide patients and family members with the opportunity to ask questions prior to, during, and after their hospital stay.</li> <li>● Help patients and family members understand what they can do during their hospital stay to be engaged in the quality and safety of care provided, including who to talk to if they have questions or information to share, including how they are feeling.</li> <li>● Educate patients and families about expectations for their active participation during the hospital stay—for example, asking questions, providing clinical care staff with important information about their health, and speaking up when something doesn't feel "right."</li> <li>● Inform patients and families about opportunities for partnership during the hospital stay such as participating in bedside rounds, nurse bedside shift report, discharge planning, and others.</li> <li>● Encourage patients and families to participate in a discussion with admission staff about the preadmission planning checklist and to voice their preferences, concerns, and needs, including those related to language, health literacy and/or cultural beliefs.</li> </ul>



PFE strategy	Tactics
 <p><b>Clinician, staff, and leadership preparation</b></p>	<ul style="list-style-type: none"> <li>• Inform clinicians and staff about the use and purpose of the preadmission planning checklist, including why it is important and how it can help engage patients and families.</li> <li>• Educate clinicians and staff about how the preadmission planning checklist should be discussed and used at various stages during the hospital stay to adjust the care plan as needed to reflect patients’ and families’ preferences, needs, and concerns.</li> <li>• Delineate key roles and responsibilities to ensure accountability for reviewing and discussing the checklist with patients and family members.</li> <li>• Educate providers in exhibiting cultural competence while using the checklist; promote self-awareness of biases and of variation in cultural meanings, stigma, or other cultural sensitivities and avoidance of stereotypes or generalizations.</li> </ul>
 <p><b>Care, policy, and process redesign</b></p>	<ul style="list-style-type: none"> <li>• Examine the process around the use of the preadmission planning checklist. Identify changes that may be needed to ensure that the checklist moves beyond a static document to one that facilitates discussion, is updated throughout the hospital stay, and is incorporated into patients’ records.</li> <li>• Review how the preadmission planning checklist is currently being distributed to all patients—regardless of age, race or ethnicity, language or disability—to determine whether it is reaching all patients and family members at the appropriate time and via a mechanism that is most appropriate for them.</li> <li>• Identify who has responsibility for reviewing the preadmission planning checklist with patients and family members and ensure that this task is integrated with the admission process and workflow.</li> <li>• Identify barriers that may be affecting the ability of specific members of your patient and family population to engage. For example, is there a need for interpreters or language translation services to better improve engagement in the process?</li> </ul>
 <p><b>Measurement and research</b></p>	<ul style="list-style-type: none"> <li>• Collect data about the demographic and socioeconomic status of the hospital’s patient population and the surrounding community to account for and assess potential barriers to use or applicability in the development of the checklist.</li> <li>• Develop plans for collecting and recording information about use of the checklist, including clearly defining what it means to “use” a preadmission planning checklist in a way that reflects the core principles of PFE.</li> <li>• Set specific goals to assess progress against (e.g., to provide and discuss the preadmission planning checklist with 100 percent of patients who have planned admissions).</li> <li>• Collect patient, family, clinician, and staff feedback about the planning checklist and use it to refine the tool and processes related to its use. Ensure that feedback is solicited from vulnerable populations.</li> <li>• Conduct small tests of change to identify the most effective processes for using the preadmission planning checklist.</li> <li>• Develop plans to collect data on how the checklist improves the patient and clinician experience and safety outcomes.</li> </ul>
 <p><b>Transparency and accountability</b></p>	<ul style="list-style-type: none"> <li>• Let patients and families know about the emphasis placed on preadmission planning, why it is important for quality and safety, how it can help facilitate discharge planning and reduce readmissions, and what your hospital is doing to make improvements.</li> <li>• Report data collected about use of the preadmission planning checklist to leaders, clinicians, staff, and patients and families. Capture successes and acknowledge areas for improvement. Stratify data by various patient characteristics (e.g., REaL) to identify any gaps in use that may be present.</li> </ul>

**Table A2: PFE Strategies to Support Effective Implementation of PFE Metric 2: Shift Change Huddles or Bedside Reporting**




PFE strategy	Tactics
 <p><b>Organizational partnership</b></p>	<ul style="list-style-type: none"> <li>● Engage patients and families in the development and implementation of process changes related to shift change huddles, bedside reporting, and/or bedside rounding by asking them to share feedback on current processes, including how patients currently experience shift change. As appropriate, work with patients and families to share their experiences to illustrate why changes are needed, particularly those that are responsive to vulnerable populations.</li> <li>● Work with PFAs to plan and implement shift change huddles, bedside reporting, and/or bedside rounding (e.g., partnering to adapt existing tools and resources to your organization), and involve them in staff training (e.g., participating in role plays or sharing stories).</li> <li>● Ask diverse partners to assess the bedside reporting/shift change processes and suggest improvements to address needs better.</li> <li>● Ask PFAs to participate in monitoring and evaluation efforts to ensure that bedside reporting, shift change huddles, and/or bedside rounding is being implemented in ways that invite and welcome participation from patients and families.</li> </ul>
 <p><b>Patient and family preparation</b></p>	<ul style="list-style-type: none"> <li>● On admission, orient patients and families about what bedside reporting, shift change huddles, and/or bedside rounding are, what will happen, who is involved, and how much time it will take.</li> <li>● Educate patients and families about how they can and should participate in bedside reporting, shift change huddles, and/or bedside rounding, including providing examples of questions to ask, observations to share, and issues to raise.</li> <li>● Inform patients and care partners of any services available at the hospital that will help them participate in bedside reporting (e.g., sign or language interpreters, patient navigators, community partners, peer mentors) and how they can access them.</li> <li>● Educate patients and families about how bedside reporting, shift change huddles, and/or bedside rounding can help address and prevent safety issues during the hospital stay.</li> </ul>
 <p><b>Clinician, staff, and leadership preparation</b></p>	<ul style="list-style-type: none"> <li>● Educate leadership, front-line managers, clinicians, and staff about how bedside reporting, shift change huddles, and/or bedside rounding can help improve safety and quality. Share success stories from other organizations.</li> <li>● Invite leadership to do “walkabouts” to better understand how care is happening “on the floor” and to illustrate why changes are needed.</li> <li>● Educate front-line managers, clinicians, and staff about the critical elements of bedside reporting, shift change huddles, and/or bedside rounding and provide examples of what they look like when implemented effectively.</li> <li>● Identify and directly address concerns that may become barriers to effective implementation of bedside reporting, shift change huddles, and/or bedside rounding (e.g., concerns about how much time it will take, how to share sensitive information, or how to deal with HIPAA concerns).</li> <li>● Provide training opportunities for staff to practice new skills and ask questions, using training mechanisms that are most appropriate for and effective in your environment.</li> <li>● Educate providers and leaders on cultural differences in nonverbal communication styles, health beliefs, and the role of family and community.</li> </ul>






PFE strategy	Tactics
 <p data-bbox="380 282 604 342"><b>Care, policy, and process redesign</b></p>	<ul style="list-style-type: none"> <li>● Develop policies to ensure that bedside reporting, shift change huddles, and/or bedside rounding are “always” events (i.e., every patient, all diagnoses). Clearly specify whether and in what situations it is acceptable to not report at the bedside and what the alternative practice should be in those cases.</li> <li>● Specify who is involved in shift change huddles and bedside reporting (e.g., nurses, nursing assistants, patient, family member [honoring patient’s preferences for family member(s) presence and participation], others) and bedside rounding (e.g., attending physicians, residents, primary nurse, charge nurse, rehabilitation services, dietary team, palliative care).</li> <li>● Specify the critical elements of bedside reporting, shift change huddles, and/or bedside rounding to ensure standardized implementation that truly reflects PFE. For example, critical elements of shift change huddles conducted at the bedside may include: (1) Introduce staff to patients and family members and make a personal connection with patients—for example, by making eye contact and smiling if appropriate; (2) Review the patient’s background, current situation, and plans for the upcoming shift while standing at the patient’s bedside and talking to the patient and family; (3) Conduct a safety check of the room (e.g., to assess fall risk, inspect IV sites); (4) Update white board with information for the upcoming shift; and (5) Ask patient or family member if they have anything to add or have any questions.</li> <li>● Specify tools that should be included as part of bedside reporting, shift change huddles, and/or bedside rounding (e.g., SBAR, check back, checklists).</li> <li>● Assess what changes and resources may be needed to support bedside reporting, shift change huddles, and/or bedside rounding (e.g., staffing changes, changes in timing of shifts, equipment such as mobile workstations, technology that facilitates inclusion of additional members of the care team in bedside reporting).</li> <li>● Provide translation services as needed to facilitate communication during bedside reporting, shift change huddles, and/or bedside rounding.</li> <li>● Implement family presence policies to eliminate barriers to family participation in bedside reporting, shift change huddles, and/or bedside rounding according to patient preference.</li> <li>● Consider processes or technology that could be implemented to support remote attendance by families in bedside reporting, shift change huddles, and/or bedside rounding (e.g., video or audio conferencing, video or audio recording).</li> </ul>




PFE strategy	Tactics
 <p data-bbox="380 285 611 342"><b>Measurement and research</b></p>	<ul data-bbox="646 245 1881 792" style="list-style-type: none"> <li>• Clearly define the behaviors that indicate whether bedside reporting, shift change huddles, and/or bedside rounding is being implemented as intended and in a manner that reflects the core principles of PFE (e.g., specify the critical elements that indicate bedside reporting has occurred in a way that truly includes patients and families; see third bullet above under “Care, policy, and process redesign”).</li> <li>• Set specific performance goals (e.g., have 95 percent of nurses doing shift change huddles at the bedside within 4 months).</li> <li>• Obtain feedback from patients, families, clinicians, and staff about how they experience shift change huddles and bedside reporting, and solicit suggestions for improvement. Ensure that feedback is solicited and obtained from vulnerable populations.</li> <li>• Develop processes for ongoing monitoring (e.g., having PFAs shadow or observe nurses as part of monitoring efforts).</li> <li>• Identify performance data that can help determine whether and how shift change huddles and bedside reporting are affecting outcomes (e.g., HCAHPS scores, employee satisfaction scores, number of days without a safety event).</li> <li>• Develop plans for conducting a pre- and post-implementation evaluation of bedside reporting, shift change huddles, and/or bedside rounding (e.g., collect data to show how much time shift change takes pre- and post-implementation of bedside shift report, look at HCAHPS scores for time periods pre- and post-implementation).</li> <li>• Link monitoring to ensure that processes are occurring as intended with outcome data (e.g., do HCAHPS scores fall when nurses are not implementing all critical elements of bedside shift reporting?).</li> <li>• Collect REaL data to allow examination of health equity issues related to performance data.</li> </ul>
 <p data-bbox="380 854 611 911"><b>Transparency and accountability</b></p>	<ul data-bbox="646 813 1881 992" style="list-style-type: none"> <li>• Report data collected about the conduct of bedside reporting and patient experiences to stakeholders; stratify data by various patient characteristics (e.g., REaL) to identify any gaps that may be present.</li> <li>• Celebrate safety catches and team accomplishments. Share success stories and challenges with leadership, staff, and patients and families.</li> <li>• Let patients and families know about the emphasis placed on bedside reporting, why it is important for quality and safety, and what your hospital is doing to make improvements.</li> </ul>




**Table A3: PFE Strategies to Support Effective Implementation of PFE Metric 3: Designated PFE Leader**

PFE strategy	Tactics
 <p><b>Organizational partnership</b></p>	<ul style="list-style-type: none"> <li>• Develop relationships and partnerships with other health care organizations and stakeholders to engage in peer-to-peer learning, including best practices on how to create and support a position for a designated PFE leader.</li> <li>• Ask patient advocates (employed at the hospital) and PFAs to provide feedback about how PFE could be systematized within the organization, including their perspectives about the best ways to ensure oversight and coordination of policies and procedures that support PFE.</li> <li>• Ask patient advocates and PFAs to help develop a job description for the PFE oversight position and participate in interviewing candidates.</li> <li>• Once the functional area/individual is identified, ask patient advocates and PFAs to provide feedback about how the office, department, or individuals who have responsibility for PFE oversight are functioning from the patient and family perspective. What are the areas of strength? Where is there room for improvement?</li> <li>• Create linkages with community agencies and organizations that support the hospital's vulnerable populations and engage them as experts to help PFE leadership learn about and interact regularly with these diverse populations.</li> </ul>
 <p><b>Patient and family preparation</b></p>	<ul style="list-style-type: none"> <li>• Inform patients and families where responsibility for PFE oversight lies within the organization, provide names and roles of key individuals, and provide information about how to contact and provide feedback to them.</li> <li>• Ensure that PFAC members and advisors know who has responsibility for PFE oversight, including communicating PFAC feedback, work, and accomplishments to hospital leadership. Provide information about how to contact and provide feedback to the office or individuals with responsibility for PFE oversight.</li> <li>• Have the PFE leader conduct PFE rounding to reinforce the importance of their engagement and confirm that communications and education efforts were successfully understood by patients and family members. Consider preparing a PFAC member to participate on these rounds.</li> </ul>
 <p><b>Clinician, staff, and leadership preparation</b></p>	<ul style="list-style-type: none"> <li>• Inform clinicians and staff, including patient advocates, about who is responsible for PFE oversight in the organization, and ensure that clinicians and staff understand the specific roles and responsibilities of individuals with accountability for PFE, including how these individuals will work with and support clinicians and staff.</li> <li>• Educate leadership about how identifying a functional area or individual with responsibility for PFE will benefit the organization, including improving accountability for performance.</li> <li>• Include the PFE leader in organizational discussions and decisions to ensure that his or her valuable insights are heard and considered by those at the top of the organization.</li> <li>• Identify a patient engagement executive and physician sponsor for each entity across the hospital system.</li> <li>• Develop tools, guided by the PFE leader, to help clinicians better implement PFE with vulnerable populations.</li> </ul>





PFE strategy	Tactics
 <p><b>Care, policy, and process redesign</b></p>	<ul style="list-style-type: none"> <li>• Determine where the individual or office with responsibility for PFE oversight will sit within the organizational structure. Who will they report to? Who will report to them? What groups does their work overlap or intersect with? Does their location signal that this is important to leadership?</li> <li>• Identify the specific activities for which the functional area or person has responsibility and develop a clear position description. Is responsibility shared with other offices, groups, or individuals?</li> <li>• Identify mechanisms for touch points and regular communication with hospital leadership.</li> <li>• Plan for distribution of knowledge and responsibilities to ensure sustainability (e.g., ensure that oversight of PFE is not contingent upon the contributions of a single individual).</li> <li>• Create a corporate structure that allows for multiple PFE champions. For example, create subcommittees to address different aspects of PFE (e.g., Patient Education Subcommittee, Staff Education Subcommittee, Patient Experience Subcommittee) and designate leaders for each of these committees. Invite PFAs to serve as members on these committees.</li> <li>• Include staff leader for cultural competency or diversity on PFE leadership team.</li> </ul>
 <p><b>Measurement and research</b></p>	<ul style="list-style-type: none"> <li>• Research where responsibility for PFE is situated within the organizational structure of other hospitals.</li> <li>• Identify processes for assessing the effectiveness of the functional area or person with responsibility for PFE implementation and evaluation (e.g., individual performance evaluation, leadership or board review of functional area). Ensure that these processes are inclusive of diverse patient and family participation, input, and feedback.</li> <li>• Identify metrics that can be used to assess performance of functional area or person based on expectations and job description (e.g., number of PFE initiatives launched and related outcomes; number of PFAs or PFACs established; number of projects, committees, or workgroups that included patients and families; whether PFAs felt prepared to participate).</li> </ul>
 <p><b>Transparency and accountability</b></p>	<ul style="list-style-type: none"> <li>• Create opportunities for visibility where individuals who have responsibility for PFE can interact with clinicians, staff, patients, and the broader community.</li> <li>• Report on evaluation metrics of the PFE leader or functional area's impact on clinical care processes and diverse patient and family experiences.</li> <li>• Share experiences and lessons learned with other hospitals, hospital staff, patients, families, and the community at large.</li> </ul>



**Table A4: PFE Strategies to Support Effective Implementation of PFE Metric 4: PFAC or Representative on Hospital Committee**

PFE strategy	Tactics
 <p><b>Organizational partnership</b></p>	<ul style="list-style-type: none"> <li>• If hospital already has PFAs, solicit suggestions for opportunities to expand PFAC or advisor work (e.g., creating new PFACs, workgroups, or committees; identifying projects with which PFACs can be involved).</li> <li>• Ask existing advisors to assist with recruiting, interviewing, training, and mentoring new advisors.</li> <li>• Explore how to provide advisory opportunities that can meaningfully accommodate language and literacy needs. Consider alternative ways of participating or creating more than one advisory group, if support needs require it (e.g., Spanish-speaking advisory council).</li> </ul>
 <p><b>Patient and family preparation</b></p>	<ul style="list-style-type: none"> <li>• Hold an information session to help former patients and care partners who may be interested in serving as advisors understand the role, responsibilities, time commitments, type of training and support provided, and any compensation available (e.g., reimbursement for travel or child care expenses). Hold information sessions in various areas to expand reach to diverse patients and care partners who may be interested in serving on the PFAC.</li> <li>• Leverage peer-to-peer support programs and connections to help recruit members from vulnerable patient populations to serve on the PFAC.</li> <li>• Partner with the hospital's Volunteer Services Program to select advisors and hold an orientation session to describe expectations, roles, responsibilities, and procedures. Provide training to prepare them to interact confidently with hospital leaders, clinicians, and staff.</li> <li>• If hospital already has advisors, identify existing advisors who can serve as mentors to new advisors during the onboarding process.</li> <li>• Prior to working with PFAC members or advisors on specific projects, provide a clear description of the project, activities, scope of work, related work that has been done in the past, and how advisor input will be used.</li> <li>• Educate advisors about key quality and safety terms, and ensure that plain language is used in all materials and conversations.</li> </ul>
 <p><b>Clinician, staff, and leadership preparation</b></p>	<ul style="list-style-type: none"> <li>• Gather information about clinician, staff, and leadership ideas for changes and improvements.</li> <li>• Talk to hospital leaders about the benefits, importance, and value of working with PFAs or including advisors as members of quality and safety teams. Identify and address attitudes, beliefs, and experiences that may serve as potential barriers to effective partnership with advisors.</li> <li>• Hold small group meetings to encourage clinicians, staff, and leaders to brainstorm ideas for involving PFACs and patients in specific projects.</li> <li>• Identify clinicians and staff who can serve as informal leaders and champions for working with PFAs and PFACs.</li> <li>• Provide training for leaders, clinicians, and staff about how to work effectively with PFAs.</li> <li>• Work with the PFAC to develop training activities for clinicians on culturally competent care.</li> </ul>

PFE strategy	Tactics
 <p><b>Care, policy, and process redesign</b></p>	<ul style="list-style-type: none"> <li>• Identify a staff liaison to oversee and coordinate PFA and PFAC work, including recruiting and training advisors, identifying opportunities for projects; ensuring that PFACs and quality and safety teams are functioning effectively, and reporting to hospital leadership about accomplishments.</li> <li>• Specify eligibility criteria for patient PFAC membership or participation on a quality or safety committee, develop recruitment and interview processes that enable the ongoing identification and selection of effective PFAs, and interview potential candidates to determine match between hospital's needs and patient's interests.</li> <li>• Outline general roles and responsibilities of PFAC members or quality and safety committee members and, with new PFAC members, draft a general mission statement and charter for the PFAC.</li> <li>• Ensure that PFAC education and training materials are available in various communication formats and languages; use plain language and ensure access to sign or language interpreters.</li> <li>• Identify several projects for PFACs to work on or opportunities to bring advisors on to quality and safety teams. Where possible, obtain input from patients, families, staff, and the community to identify priority projects. Determine where priorities align with hospital priorities and where they differ.</li> <li>• Develop a longer-term vision for working with advisors while planning smaller, immediate action steps.</li> <li>• Identify opportunities for extending work with advisors outside of the hospital walls (e.g., as advisors for community health).</li> </ul>
 <p><b>Measurement and research</b></p>	<ul style="list-style-type: none"> <li>• Identify metrics to track accomplishments (e.g., number of advisors recruited, number of active advisors, number and type of efforts in which advisors are involved, examples of work completed, outcomes of projects on which advisors participated).</li> <li>• Review the composition of the PFAC and the advisory program to determine opportunities to ensure the membership reflects all populations served, especially vulnerable populations.</li> <li>• Collect data about PFA experiences (e.g., extent to which they felt prepared to participate, extent to which they felt their input was welcomed, extent to which they felt their participation affected the work and outcomes).</li> <li>• Collect data from clinicians and staff about their experiences working with PFAs (e.g., extent to which they believe advisor input was helpful, extent to which they believe advisor input affected outcomes of the work).</li> <li>• Identify and monitor measures related to specific quality and safety issues or projects on which advisors work.</li> <li>• Collect data to track PFAC activities, experiences, and impact on hospital policies and practices as they relate to equity and disparity issues.</li> </ul>
 <p><b>Transparency and accountability</b></p>	<ul style="list-style-type: none"> <li>• Share data and information equally with advisors.</li> <li>• Encourage chairs of quality and safety committees to model transparency and ownership of quality- and safety-related issues.</li> <li>• Establish feedback procedures. Follow up with PFACs and advisors about how their input was or was not used, and provide clear explanations when input was not used.</li> <li>• Share accomplishments with hospital leadership. Communicate accomplishments publicly in multiple ways (e.g., on the hospital website, in staff trainings, in board meetings, in community meetings).</li> <li>• Share success stories and examples of areas in which PFAC input helped to inform efforts to improve quality and safety, specifically related to disparities and equity.</li> <li>• Share improvements and lessons learned with other hospitals.</li> </ul>

**Table A5: PFE Strategies to Support Effective Implementation of PFE Metric 5: Patient Representative(s) on the Board of Directors**

PFE strategy	Tactics
 <p><b>Organizational partnership</b></p>	<ul style="list-style-type: none"> <li>• Ask PFAs to attend board meetings to share their stories of how they developed into their role as a PFA and their impact on quality and safety to illustrate the value of having one or more patient members on the governing or leadership board.</li> <li>• Work with PFAs and board members to understand potential barriers to effective participation on governing or leadership boards by a patient member.</li> <li>• Include members of vulnerable populations intentionally to ensure that traditionally marginalized voices are heard and represented.</li> </ul>
 <p><b>Patient and family preparation</b></p>	<ul style="list-style-type: none"> <li>• Leverage peer-to-peer support programs and connections to help recruit members from vulnerable patient populations to serve on governing or leadership boards.</li> <li>• Provide training for the patient board member to describe expectations, roles, responsibilities, and procedures.</li> <li>• Identify someone who can serve as a resource for or mentor to the patient member of the governing or leadership board.</li> <li>• Educate patient governing and leadership board members about quality and safety issues, financial terms, PFE, and overall responsibilities of the governing/leadership board. Prepare them to interact effectively at an equal level with other board members.</li> <li>• Provide culturally and linguistically appropriate educational tools, materials, and resources with examples of how to engage as a representative on governing or leadership boards.</li> </ul>
 <p><b>Clinician, staff, and leadership preparation</b></p>	<ul style="list-style-type: none"> <li>• Provide training to hospital board members about quality and safety issues, health equity, and PFE, including orientation for all new board members.</li> <li>• Provide training to hospital board members about how to partner effectively with patient representatives on the board.</li> <li>• Share success stories and effective practices from other hospitals who have worked with patients as members of boards and governing bodies.</li> </ul>
 <p><b>Care, policy, and process redesign</b></p>	<ul style="list-style-type: none"> <li>• Develop role descriptions for patient board members that include qualifications, responsibilities, and expectations.</li> <li>• Develop selection criteria and a vetting process for patient board members to ensure that the patient perspective is represented via the inclusion of individuals who identify themselves as patients first. Ensure that selection criteria include consideration of diversity so that patient board members are representative of the community that the hospital serves.</li> <li>• Identify and address barriers to full and effective participation by patient board members (e.g., ability to travel, timing of meetings, voting rights).</li> <li>• Develop processes for peer-to-peer guidance and mentorship of struggling board members (patients and others).</li> <li>• Include opportunities for education about and review of PFE initiatives and related issues at each board meeting.</li> </ul>

PFE strategy	Tactics
 <p data-bbox="380 285 611 342"><b>Measurement and research</b></p>	<ul data-bbox="642 245 1850 469" style="list-style-type: none"> <li>• Develop metrics to understand how patient member(s) have been included (e.g., percentage of meetings at which patient board member was present, whether patient board member has decision-making authority equal to other members).</li> <li>• Collect data to track representatives' involvement in the activities of the governing board, as well as their experiences and impact on hospital policies and practices.</li> <li>• Conduct self-evaluations and assessments of the board annually. Use the assessments to identify education needs or process improvements.</li> <li>• Identify specific initiatives or system-level measures that can be used to assess board performance relative to PFE.</li> </ul>
 <p data-bbox="380 529 611 586"><b>Transparency and accountability</b></p>	<ul data-bbox="642 488 1850 712" style="list-style-type: none"> <li>• Make public the organization's commitment to include a patient member of the board.</li> <li>• Report on the diversity of board representatives.</li> <li>• Share results of board self-assessments and evaluations, including areas for improvement, with leaders, clinicians, staff, patients, families, and the community.</li> <li>• Share success stories and examples of areas in which representative input helped to inform efforts to improve quality and safety, specifically related to disparities and equity.</li> <li>• Continually develop the board's capability and share best practices with other hospital leaders.</li> </ul>



## Appendix B. Keys to Successful Implementation and Sustainability of Equitable PFE Activities

The following elements describe additional best practices for successful implementation and sustainability of PFE activities.

- **Develop and articulate a clear vision for how PFE activities align with and support organizational priorities.** Grounding PFE work, including the PFE metrics, in the organization’s mission and strategic goals communicates that PFE is everyone’s responsibility, an important part of organizational culture, and more than a short-term, “flavor of the month” initiative. It is also important in signaling that PFE is symbiotic with existing quality improvement processes and safety initiatives.
- **Build systems that facilitate and reward desired behaviors.** Long-term sustainability is facilitated by the establishment of systems that move from PFE as individual behavior change to PFE as organizational change. This could include mandating new processes (e.g., bedside rounding); building prompts into electronic medical records (e.g., including prompts to discuss the PFE metric 1 preadmission planning checklist in the EMR); developing PFE behavior standards related to work, hiring, and performance (e.g., nurse shift report will be conducted at the bedside every time, for all patients); and implementing incentives to reward desired behaviors.
- **Cultivate and encourage visible support from senior leaders.** Leaders help establish an organizational culture of PFE by communicating the organization’s vision for PFE, developing and describing plans of action, communicating how PFE will be integrated into the daily operations of the organization, and providing resources for implementation. They can also model effective partnerships with patients and families, for example, by attending PFAC meetings to better understand patients’ concerns and perspectives.
- **Identify clinician and staff champions.** Identifying and working with clinician and staff champions creates momentum for initiatives and on-the-ground support. Clinician and staff champions can help inform and educate peers, ensure adherence to initiatives, organize staff trainings, provide guidance and support during training, and assist with the monitoring and feedback necessary for sustainability.
- **Structure implementation in phases with accompanying milestones.** Developing timelines that account for the time needed for pre-implementation, initiation, and post-implementation help set realistic expectations. Where possible, it can be helpful to focus on smaller-scale implementation as the gateway to larger-scale rollout (e.g., beginning

### Keys to successful implementation and sustainability of PFE activities

- Develop and articulate a clear vision for how PFE activities align with and support organizational priorities.
- Build systems to facilitate desired behaviors.
- Cultivate and encourage visible support from senior leaders.
- Identify clinician and staff champions.
- Structure implementation in phases with accompanying milestones.
- Identify and address barriers to engagement of patients and families from diverse backgrounds.
- Provide ongoing monitoring, feedback, and coaching.

with implementation of nurse bedside shift report on one unit prior to hospital-wide rollout). At each stage, include milestones that will indicate progress and success.

- **Identify and address barriers to uniform engagement of patients and families from diverse cultural, ethnic, or socioeconomic backgrounds.** Working closely with community and cultural leaders can help hospitals overcome barriers to engagement, such as lack of trust. For example, patients and families from traditionally marginalized communities may be more willing to trust partners who have demonstrated a commitment to and/or success in addressing issues of inequity in underrepresented populations. In addition, collecting data about the demographic and socioeconomic status of the hospital’s patient population and the surrounding community (social determinants) helps hospitals account for and assess potential barriers to engagement at all levels.
- **Provide ongoing monitoring, feedback, and coaching.** Ongoing monitoring and coaching emphasizes that PFE activities are not just short-term changes and helps ensure maintenance of desired behaviors over time. For example, periodic “spot checks” can help ensure that staff continue to use a preadmission planning checklist and discuss it with all patients who have a scheduled admission. Providing non-punitive, constructive feedback to clinicians and staff addresses variations in implementation and reinforces and solidifies positive behaviors.

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#### Recommended Resources for Implementation and Sustainability

- Strategies for leadership: Patient- and family-centered care (American Hospital Association and the Institute for Patient- and Family-Centered Care): <http://www.aha.org/advocacy-issues/quality/strategies-patientcentered.shtml>
- Information to help hospitals get started: Guide to patient and family engagement in hospital quality and safety (Agency for Healthcare Research and Quality): <http://www.ahrq.gov/professionals/systems/hospital/engagingfamilies/howtogetstarted/index.html>
- A leadership resource for patient and family engagement strategies (Health Research & Educational Trust and the Gordon and Betty Moore Foundation): [http://www.hpoe.org/Reports-HPOE/Patient\\_Family\\_Engagement\\_2013.pdf](http://www.hpoe.org/Reports-HPOE/Patient_Family_Engagement_2013.pdf)
- Advancing the practice of patient and family centered care in hospitals: How to get started (Institute for Patient- and Family-Centered Care): [http://www.ipfcc.org/resources/getting\\_started.pdf](http://www.ipfcc.org/resources/getting_started.pdf)
- How Person and Family Engagement Can Help Hospitals Achieve Equity in Health Care Quality and Safety: Health Equity Addendum (Partnership for Patients): <https://www.healthcarecommunities.org/ResourceCenter/PartnershipforPatientsLibrary.aspx?CategoryID=836894&EntryID=107862>

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