

Achieving Person and Family Engagement (PFE): Using the Adoption of PFE Metrics as a Lever for Change

## Background

Person and family engagement is created through an active partnership between people receiving care and their families, and those providing care. Engagement builds trusting relationships by honoring the individual’s needs, preferences, values, and strengths. Engaged patients and families participate as partners on the health care team; the team supports engagement with information that helps the person and family to partner on decisions and take action to improve health. Through engagement, patients and families build confidence, skills, and knowledge that translates into health improvements. Person and family engagement also help clinicians to develop more satisfying relationships with patients and families.

Six person and family (PFE) performance metrics that cover three fundamental domains of best PFE practice were chosen by over 25 individuals representing health care professionals, PFE advocates, patients, and families. These metrics are able to be tracked and evaluated over time and were pilot tested by practices to confirm the questions were clear, credible, and easy to answer without undue burden.

 TCPI’s PFE metrics address key strategies that can be adopted by a practice to engage patients and families as partners in decision-making. The metrics address different aspects of engagement.  They work synergistically to promote higher levels of patient activation; this drives improvements in health outcomes and patient experience, and reduces costs. Through improvements on the CMS PFE metrics, practices can meet many quality and reporting requirements as well. The six PFE measures align with the TCPI Phases of Transformation and the PFE Domains.

This guide is intended to help TCPI practices complete the PFE metrics that are part of the Practice Assessment Tool.

Two documents that provide more detailed information on each of the metrics are also available to the practices:

* PFE Program Guide
* PFE Compendium (lists articles, tools, videos, guides for each PFE metric)

# How to Use Response Categories

In development of the measures, a thoughtful approach was taken in creating response categories that take into consideration the variety of practices in TCPI. The goal is that all practices will aim to meet all of the PFE metrics over the course of the TCPI program. There are three exceptions as noted in the response categories below:

* Some practices may have connectivity issues that prevent e-tool use. In that case, a response category of **No (unable to access the internet)** is an available response.
* Recognizing that practices may phase in some of the PFE measures, a response category of **No (but plan to implement in six months)** is available. This information is helpful to PTNs and SANs, so they can provide implementation support for practices.
* When a specialty practice does not have direct contact with patients at the point of care, a response category of **N/A** is available. This choice is only for practices where a practitioner never manages a patient’s care over time or provides care recommendations directly to a patient.

### PFE Metric 1: Support for Patient and Family Voices (Governance)

Are there policies, procedures, and actions taken to support patient and family participation in governance or operational decision-making of the practice (Patient and Family Advisory Councils (PFAC), Practice Improvement Teams, Board Representatives, etc.)?

**Spotlight: Moffitt Cancer Center**

Moffitt’s Patients First strategy has involved patient and family advisors from its inception. Moffitt has an established person and family advisory council (PFAC); organizational leaders such as the Chief Operating Officer and Chief Medical Officer participate each month in this council.

Jamaica Radiology Practicesends a five-question point-of-care text survey after a patient appointment. A designated staff person follows up by phone with those not satisfied with their experience. As a result, patient satisfaction has improved and surprisingly there has been a positive boost in employee morale.

Some ways to meet this metric are:

* The practice has a process in place for including the perspective and active voice of the patient and family (Patient Family Advisor) in the governance of the practice.
* The practice has a Person and Family Advisory Council (PFAC). (Note: for organizations with multiple practices, each practice is *not* required to have a PFAC).
* The organization includes a patient on their board.
* The practice works with external community groups to receive feedback on how to better meet their needs.
* The practice uses surveys and other outreach methods to patients to capture experiential knowledge and feedback.

### PFE Metric 2: Shared Decision-Making (Point of Care)

Does the practice support shared decision-making by training and ensuring that clinical teams integrate patient-identified goals, preferences, outcomes, and concerns into the treatment plan (e.g. those based on the individual’s culture, language, spiritual, social determinants, etc.)?

**Spotlight: The Mayo Clinic**

The Mayo Clinic has created a [Shared Decision Making National Resource Center](http://shareddecisions.mayoclinic.org/). This website provides shared decision making tools, stories of patient experience with shared decision making, as well as implementation resources for putting shared decision making into practice.

[add another practice who has operationalized shared decision making]

Some ways to meet this metric are:

* Practice is using methods to promote and teach shared decision making so that patients (and their families according to patient preference) are authentically part of the care team.
* These tools could include Choosing Wisely materials, decision aids, advanced care planning tools, etc. (Choosing Wisely tools and brochures may be [found here](http://www.choosingwisely.org/)).
* This could also include creating non-medical goals for the patient based on their personal goals (i.e., “I want to walk my daughter down the aisle in six months”). These goals are documented in the medical record as with any other clinical goal and are revisited at subsequent appointments.
* The practice trains clinicians in shared decision making tools and processes.
* Physicians and other clinicians honor patients’ decisions based on shared decision making processes and this is documented after the visit.
* [Maybe find a patient voice to describe this process]

### PFE Metric 3: Patient Activation (Policy and Procedure)

Does the practice utilize a tool to assess and measure patient activation?

**Spotlight: Agency for Health Research and Quality (AHRQ)**

The Agency for Healthcare Research and Quality (AHRQ) has a library of resources ([found here](https://www.ahrq.gov/professionals/prevention-chronic-care/improve/self-mgmt/self/sms_browse.html#tool)) that can be used in training physicians in self-management techniques as well as tools to provide to patients.

[Add a spotlight practice, maybe from Minnesota or Fairview]

Some ways to meet this metric are:

* Practice is using standardized tools that measure a patient’s skills, confidence or knowledge to self-manage their health.
* Examples may include: the Patient Activation Measure (PAM) AHRQ’s Question Builder, motivational interviewing or teach-back techniques to improve patients’ awareness and self-management, etc. (Teach-back techniques from AHRQ may be [found here](https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions/index.html).)
* The practice documents the use of standardized tools in the EMR or using another methodology.
* The practice utilizes data from the patient activation tool to modify their methods of communicating with patients to more effectively assist them in managing their health.

### PFE Metric 4: Active e-Tool (Point of Care)

Does the practice use an e-tool (patient portal or other e-connectivity technology) that is accessible to both patients and clinicians and that shares information such as test results, medication list, vitals, and other information and patient record data?

**Spotlight: The University of Minnesota Physicians**

The University of Minnesota Physicians use MyChart, the patient portal for Epic. MyChart allows patients secure access to their medical records as well as their care team. Patients can schedule appointments, review test results, email the care team, submit prescription renewals and view and print medical information such as visit summaries and health history.

[add another spotlight practice who uses open notes]

Some ways to meet this metric are:

* Practice uses (and makes available to all patients) an e-tool that allows patients to access their medical record and have an easy, direct way to communicate with providers.
* Patients can email their care team and receive information via the patient portal such as test results, visit summaries, prescription renewals, etc.
* Patients can view visit notes using a system such as OpenNotes.
* Practice ensures that patients without the internet can still benefit from electronic communication, such as texting with their patients.

### PFE Metric 5: Health Literacy Survey (Policy and Procedure)

Is a health literacy patient survey being used by the practice (e.g., CAHPS Health Literacy Item Set)?

**Spotlight: The University of Arkansas**

The University of Arkansas has several clinics who utilize the “How to Talk to Your Doctor” handbook. This is a resource made available by the University of Arkansas’ [Center for Health Literacy.](http://healthliteracy.uams.edu/)

Utilizing health literacy best practices, Venice Family Clinic improved their positive response to diabetes outreach letters by 39 percent. The diabetes registry database was used to target patients with A1c values over 9. Letters were personalized, written in Spanish and English, included A1c results in a stoplight format and signed by the patient’s doctor. The new improved letter helped patients understand the action they needed to take and why.

Some ways to meet this metric are:

* The practice systematically addresses health literacy through universal precautions and assessing how well patients understand information provided to help them manage their health.
* The practice has translated information for patients about preparing for tests and examination procedures for those patients who do not speak English (examples may be [found here](https://ethnomed.org/patient-education/tests-procedures-radiology?platform=hootsuite)).
* The practice supplements instructions with appropriate materials (such as videos, models, pictures, etc.)
* Organize information so that the most important points stand out and repeat this information for the patients (using tools such as [Ask Me 3](http://www.npsf.org/?page=askme3) from the National Patient Safety Foundation).
* The Agency for Healthcare Research and Quality (AHRQ) also has a [toolkit](https://www.ahrq.gov/professionals/quality-patient-safety/quality-resources/tools/literacy-toolkit/index.html) with a number of tools and resources that assist in incorporating teach-back and communicating clearly with patients.
* Utilize results from health literacy surveys to revise health brochures and materials to ensure readability and comprehension.

### PFE Metric 6: Medication Management (Policy and Procedure)

Does the clinical team work with the patient and family to support their patient/caregiver management of medications?

**Spotlight: Yale Medical Group**

Yale Medical Group’s Primary Care Center utilizes medication management with their patients. They perform medication reconciliation at each office visit and partner with on-site pharmacists to provide dedicated medication self-management counseling when barriers are identified.

[add another spotlight practice]

Some ways to meet this metric are:

* There is a systematic, standard method in place to evaluate and support patients and their caregivers in medication self-management.
* Utilize explicit, standardized instructions for taking medications using standard time periods for administration (such as those [found here](https://www.ahrq.gov/professionals/quality-patient-safety/pharmhealthlit/prescriptionmed-instr.html)).
* Provide brochures or booklets to patients that will help explain why medications are important and will help them succeed with their care goals (such as the guide [found here](http://www.pcpci.org/file/403)).
* Provide resources to family caregivers who are assisting patients with medication management (such as the podcasts [found here](http://nextstepincare.org/Caregiver_Home/Medication_Management_Guide/videos_about_Medication/)).
* Practice utilizes on-site pharmacists to assist patients with medication management.
* Practice measures results by reviewing health outcomes and medication management self-confidence and knowledge levels data for those who have received medication management education as compared to those who have not.
* Practices use the learnings from the medication management measures results to modify their medication management resources and create more opportunities to involve staff in medication management.

## Continuing the Transformation

Practices are encouraged to consider patient and family engagement as an ongoing strategy for your transformation. We recommend you to think about ongoing ways to increase the depth and quality of engagement on all of the six areas listed above. Clinicians report that engaging patients and families returns the joy in work.