Hospital Roadmap for Person and Family Engagement (PFE):

Achieving the Five PFE Best Practices to Improve Patient Safety and Health Equity

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Introduction

The IPRO HQIC views person and family engagement (PFE) as integral to high-quality, safe, efficient, and effective patient-centered care. 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."**[i] Engaging patients and families from diverse cultural, ethnic, or socioeconomic backgrounds is a necessary component for achieving equity in care quality and safety.

A growing body of work—captured in peer-reviewed literature and the experiences of hospitals and health systems across the United States—highlights the benefits of PFE, suggesting that successful implementation of PFE practices can contribute to better outcomes. These outcomes include:

- Reductions in hospital-acquired infections and conditions including falls with injury;[ii]
- Reductions in preventable 30-day readmissions rates;[iii,iv]
- Improved patient experiences and higher Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores;[v]
- Improved patient outcomes and reduced length of hospital stay;[vi] and
- Reductions in health and health care disparities.[vii]

This PFE Roadmap provides practical guidance to help hospitals implement five PFE best practices:

1. Implementation of a planning checklist for patients who have a planned admission
2. Implementation of a discharge planning checklist
3. Conducting shift change huddles and bedside reporting with patients and families
4. Designation of a PFE leader in the hospital
5. Active Person and Family Engagement Committee or other committees where patients are represented and report to the board

For each PFE best practice, the Roadmap provides the definition and intent, the benefits, tips and resources to help implement the best practice, and a hospital success story. Appendix A provides additional guidance about how to implement and sustain PFE practices.

The Five PFE Best Practices

PFE 1 Implementation of a planning checklist for patients who have a planned admission*

Definition. At least one unit at the hospital has a physical planning checklist that is discussed with every patient prior to or at the time of any scheduled admission (e.g., surgery, procedure, test, delivery). The checklist can be a stand-alone document or integrated into other materials, for example, a patient handbook.

To implement the practice, a hospital must:

- Have a physical planning checklist for patients with scheduled admissions, preferably designed or reviewed by patient and family members, AND
- At or before a scheduled admission, have hospital staff discuss the checklist with patients and/or their care partners.

Hospitals that do not have any planned admissions – including "swing-bed hospitals" – will be exempt from this practice.

What if our hospital has swing beds?

Hospitals with swing beds should evaluate each patient individually to consider how they can best partner with your hospital to ensure a safe stay. In some cases, the stay may be too short to discuss a planning checklist. In other cases, it may be beneficial for the hospital to discuss the checklist – or parts of the checklist – and invite the patient to be a partner in their care. Regardless of the type of hospital, admission status, and length of stay, all hospitals should invite patients to be partners in their care as early in their stay as possible.

Intent of the Practice. The intent of this practice is to establish an active partnership between the patient and the hospital from the very start of inpatient care. The discussion should invite the patient and their designated family caregiver to partner with hospital staff to ensure safe, patient-centered care throughout their stay, and to identify specific needs and preferences that can inform care. The discussion should result in patients and family caregivers feeling comfortable asking questions and actively participating in their care. The practice 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, at a minimum, facilitate conversation about: (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); (4) identification of a family member or friend who is serving as an care partner, and preferences regarding their involvement in care; and (5) 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
• Clarify expectations about what will happen before, during, and after their hospital stay. • Feel more confident about being active partners in the quality and safety of their care. • Get to know the clinicians and staff on their care team and their roles. • Be better prepared to participate in key discussions about their care, including bedside rounding, shift change huddles, and discharge planning meetings. • 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).	• Understand the patient's specific care goals, preferences, needs, and concerns. • Identify the person who will serve as the patient's care partner helping in care and care planning during and after the stay. • Invite patients and their care partners to be active members of their healthcare team. • Understand preadmission medication regimens and therapy, allowing for better medication reconciliation and identification of potential medication errors. • Identify and proactively address potential safety issues, risks, and care needs. • Prepare patients and care partners and plan for a safe discharge.

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.

PFE Practice 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, 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."[viii]

Resources for PFE Practice 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
- Your Guide for Total Knee Replacement Success (AMITA Health): https://www.amitahealth.org/assets/documents/ortho/ah-knee-replacement-education-booklet.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
- Sample Preadmission Planning Checklist (English) – IPRO HQIC Resource Library
- Sample Preadmission Planning Checklist (Spanish) – IPRO HQIC Resource Library

PFE 2 Implementation of a discharge planning checklist

Definition. At least one unit at the hospital has a physical discharge planning checklist that is discussed with every patient prior to discharge. The checklist can be a stand-alone document or integrated into other discharge papers.

To implement the practice, a hospital must:

- Have a physical discharge planning checklist for patients, preferably one that was designed or reviewed by patients and families, AND
- Prior to discharge, have hospital staff discuss the checklist with patients and/or their care partner.

This practice should be possible in all hospitals.

Intent of the Practice. Patients and their care partners should be included as full partners in the discharge planning process so that they understand how to successfully continue their recovery after they leave the hospital. The practice focuses on the use of the checklist by a physician, discharge staff, or other healthcare professional to guide a conversation with patients and care partners about being discharged prior to leaving the hospital. 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 life at home will be like (e.g., foods and activities to avoid); (2) medications (e.g., purpose of each medicine, what and how to take it, and potential side effects); (3) warning signs and problems and who to contact if there is a problem; (4) test results, either explaining them or letting the patient know when they should hear about results and whom to call if they don't get the results; and (5) follow-up appointments, including offering to schedule them.

Benefits

- When used effectively, the discharge planning checklist invites and encourages patients and their care partners to participate in the discharge planning process by sharing and receiving information and asking questions.
- The planning checklist provides an invitation for patients and families to partner with the discharge planning team to reduce complications post-discharge, including adverse drug events and hospital-acquired infections, that can lead to hospital readmissions.[ix]
- Engaging patients and their care partners in discharge planning can also help to reduce their anxiety and increase HCAHPS scores.[x]

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 the discharge planning checklist.
- Provide patients and care partners with a copy of the checklist, ideally 1-2 days prior to discharge, 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 discharge planning checklist discussion (e.g., sign or language interpreters, patient navigators, community partners, peer mentors) and how they can access them.
- Use the teach-back or "show-me" method to check the patients' understanding of the information shared and discussed.

> ***Teach-back method****: Patients and their care partners repeat back – in their own words – what they need to know or do to be sure the clinician or staff explained the information clearly; if needed, the clinician or staff will re-teach the information.*

PFE Practice 2 Success Story

Advocate Trinity Hospital help patients and families prepare to leave the hospital and improves patient experience scores.

Advocate Trinity Hospital in Chicago, IL implemented IDEAL Discharge Planning – which includes discussing a checklist with patients and their care partners – in its 29-bed medical surgical unit as part of a larger effort to reduce hospital readmissions. Trinity provided the *Be Prepared to Go Home Checklist and Booklet* to patients at admission. Nurses and staff encouraged patients and care partners to read the booklet and ask questions throughout their stay. Nurse assistants helped patients write their questions in the booklet. Nurses reviewed the checklist and booklet with patients and family members prior to discharge. They were also required to keep track of key tasks in the discharge planning process in a separate system-wide tool.

All unit staff and nurses were educated about the upcoming changes, and some nurses received a 6-hour training on the new discharge planning process. These nurses then trained other nurses in small, 1-hour group sessions. Once implemented, nurse managers asked patients and families about their experiences participating in the discharge planning process and shared this feedback with the nurses.

Twelve months after the hospital began using the checklist as part of IDEAL Discharge Planning, HCAHPS scores consistently increased, particularly for measures related to discharge and communication with doctors; previously scores related to discharge had

been in the single digits. Nurses were also more aware of patients' needs and concerns related to discharge.[xi]

Resources for PFE Practice 2

- Be Prepared to Go Home Checklist and Booklet, Guide to Patient and Family Engagement in Hospital Quality and Safety (Agency for Healthcare Research and Quality): https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html
- Your Discharge Planning Checklist (Centers for Medicare & Medicaid Services): https://www.medicare.gov/Pubs/pdf/11376-discharge-planning-checklist.pdf
- Use the Teach-Back Method: Tool #5 (Agency for Healthcare Research and Quality): https://www.ahrq.gov/health-literacy/improve/precautions/tool5.html

PFE 3 Conducting shift change huddles and bedside reporting with patients and families

Definition. In at least one unit at the hospital, patients and/or their care partners are included in nurse shift change huddles or conversations with clinicians about their care, treatment, and tests.

To implement the practice, a hospital must:

- Conduct nurse shift change huddles **OR** clinician reports/rounds at the bedside and involve the patient and/or care partners.

This practice should be possible in all hospitals. 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 practice 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.[xii]

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

Patients and family members	Clinicians and hospital staff
• Hear what has occurred throughout the shift and learn about next steps in their care. • Ask questions, correct errors, and provide input based on their preference and values. • Increase knowledge of their condition and treatment so that they can participate in their care to the extent they want. • Understand that they are important members of the care team.	• Reinforce teamwork and ensure that every member of the team shares knowledge that contributes to safe and effective care. • Increase patient and family participation, knowledge, and satisfaction. • Create a heightened awareness of individual patient needs that can be proactively addressed throughout the shift. • Improve time management and accountability between nurses.

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 diverse and under-represented 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.

PFE Practice 3 Success Story

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

Perham Health, a critical access hospital in Perham, Minnesota, 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.[xiii]

Resources for PFE Practice 3

- 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.ihi.org/resources/Pages/Tools/ISHAPEDPatientCenteredNurseShiftChangeBedsideReport.aspx

PFE 4 Designation of a PFE Leader in the Hospital

Definition. At least one person is recognized across all hospital staff and administration as responsible for the leadership, coordination, support, and reporting of PFE activities throughout the hospital.

To implement the practice, a hospital must:

- Assign a hospital employee (or employees) the responsibility for coordinating PFE efforts at the hospital either in a full-time position or as a percentage of time within their current position, **AND**
- Create awareness among hospital staff and clinicians throughout the hospital so that they can identify the person named as responsible for PFE at the hospital.

This practice should be possible in all hospitals.

Intent. The intent of this practice 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 helps establish and sustain a culture of PFE that moves beyond short-term changes to integrate the core principles of PFE throughout the hospital.
- 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.

PFE Practice 4 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 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.[xiv]

Resources for PFE Practice 4

- 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
- 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

PFE 5 PFAC or Representatives on Hospital Committee

Definition. The hospital has at least one active Person and Family Engagement Committee, Patient and Family Advisory Council (PFAC), or other committee (e.g., Patient Safety) with full membership positions for patient or family representatives. These councils or committees should report directly to the Board.

To implement this practice, a hospital must:

- Formally name patient and/or family representatives from the community as members of a PFAC or other hospital committee, **AND**
- Schedule and conduct meetings of the PFAC or other committees with patient and family representatives

This practice can be implemented in one of several ways to accommodate hospitals with varying levels of experience working with patient and family advisors (PFAs) on a PFAC. Hospitals that don't have a PFAC may implement this practice by including a patient or family representative (ideally, at least two 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 practice 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 practice 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. 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 (e.g., pressure ulcers, sepsis and 30-day readmissions), and better experiences of care.[xv,xvi]

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 or representatives. 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 about advisor opportunities.
- Before working with PFAs or representatives on a project, provide a clear description of the project and activities, any related work that has been done in the past, and how their input will be used.
- Help PFAs and representatives 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 and representatives 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

PFE Practice 5 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 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.[xvii]

Resources for PFE Practice 5

- 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
- 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
- The impact of a patient and family engagement council at a critical access hospital (American Institutes for Research): https://www.youtube.com/watch?v=ZTSwCDPo8KE&feature=youtu.be

Appendix A. Keys to Successful Implementation and Sustainability of Equitable PFE Practices

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

Keys to successful implementation and sustainability of PFE practices

- Develop and articulate a clear vision for how PFE aligns 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 engaging patients and families from diverse backgrounds.
- Provide ongoing monitoring, feedback, and coaching to clinicians and staff.

- **Develop and articulate a clear vision for how PFE aligns with and support organizational priorities.** Grounding PFE work, including the five PFE practices, 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 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 with implementation of nurse bedside shift report on one unit prior to hospital-wide rollout). At each stage, include milestones that 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 clinicians and 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.

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
- 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

[i] 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.
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