Person & Family Engagement

A ROADMAP TO PERSON AND FAMILY ENGAGEMENT

Recommended Policies & Practices for Hospitals

MHA
Michigan Health & Hospital Association

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Developed with guidance from the
MHA Person and Family Engagement Advisory Council

INTRODUCTION: PERSON-AND FAMILY-CENTERED CARE

Person- and Family-centered Care (PFCC) focuses on putting the patient and their caregiver at the center of all decision-making, planning and monitoring of care by empowering them to be active partners in care. Although there is no consistency among institutions in the use of patient vs. person, the term "patient" is often used in a medical and health context. However, we focus on "person" rather than "patient" because it reflects the whole individual and looks beyond the medical and physician condition, to consider their desires, values, lifestyles and social circumstances. It represents the multifaceted nature and core principles of PFCC efforts.

Defined by the Institute for Patient- and Family-Centered Care (IPFCC), PFCC is an approach to the planning, delivery and evaluation of healthcare that is grounded in mutually beneficial partnerships among healthcare staff and patients and caregivers through respect and dignity, information sharing, participation and collaboration[1]. It is through person and family engagement (PFE) strategies, which are designed to foster collaboration between patients, families and clinicians working together toward mutually agreed-upon goals to build a person- and family-centered healthcare system.

PFE relies on **four core concepts**[1] outlined below:

- **Respect and Dignity.** Healthcare staff listen to and honor patient and caregiver perspectives and choices. Patient and caregiver knowledge, values, beliefs and cultural backgrounds are incorporated into the planning and delivery of care.
- **Information Sharing.** Healthcare staff communicate and share complete and unbiased information with patients and caregivers in ways that are affirming and useful. Patients and families receive timely, complete and accurate information to effectively participate in care and decision-making.
- **Participation.** Patients and caregivers are encouraged and supported in participating in care and decision-making at the level they choose.
- **Collaboration.** Patients and caregivers are included on an institution-wide basis. Healthcare leaders collaborate with patients and families in: Policy and program development, implementation and evaluation; in healthcare facility design; and in professional education, as well as in the delivery of care.

A patient can be defined as anyone who is a consumer of the healthcare system, meaning that they receive care from any combination of healthcare professionals, including physicians, nurses, physical therapists and others. Regardless of setting, the IPFCC states that in regard to patient- and family-centered care, patients and families define their "family" and determine how they will participate in care and decision-making. [2]

Prioritizing PFE improves patient care and numerous measures of hospital performance. PFE is an integral part of clinical units' culture. Embracing the implementation of PFE protocols can improve both patient and provider satisfaction, foster better internal and external communication and ultimately lead to healthier people who receive care in a highly reliable system.

PURPOSE OF THE TOOLKIT & HOW TO USE THIS GUIDE

PURPOSE OF THE TOOLKIT

The Michigan Health & Hospital Association (MHA) recognizes the importance of strong partnerships between healthcare providers, patients and families. As a foundational concept, the MHA is committed to partnering with hospitals to help advance person- and family-centered care in Michigan. It is through PFE strategies, which foster collaboration between patients, families and clinicians to move toward mutually agreed-upon goals, that we build a person- and family-centered healthcare system.

In 2017, under the guidance of the MHA Person and Family Engagement Advisory Council, the MHA Keystone Center published the Roadmap to Person and Family Engagement to accelerate the spread of person- and family-centered care. The roadmap includes recommended policies and practices, which build upon the original Centers for Medicare & Medicaid Services (CMS) Partnership for Patients guidelines of that time to improve care quality for patients in hospitals. Today, the Roadmap to Person and Family Engagement has been updated with standardized definitions and changes in policies and practices influenced by the COVID-19 pandemic. This is meant to serve as a resource for healthcare staff and leaders looking to develop or improve person-and family-centered care across their system. The toolkit allows users to assess current structures to identify gaps and opportunities for improvement.

HOW TO USE THE GUIDE

The MHA encourages organizations to utilize this roadmap to assess the current state of hospital implementation of key strategies aimed at building person- and family-centered care. This resource will guide organizations in prioritizing and acting on identified gaps to start – or build upon – person- and family-centered care. Sections of the guide include:

WHY PERSON AND FAMILY ENGAGEMENT (PFE)?

The shift to PFCC can be traced to the Institute of Medicine report[3] that identified the importance of patient-centered care as one of the interrelated factors constituting high-quality care. Due to growing evidence and momentum, PFE efforts have been expanding globally in the past decade, contributing to new norms constituting today's rapidly changing healthcare landscape.

According to the *AHRQ Guide to Patient and Family Engagement*[4], PFE efforts can:

- Improve quality and safety.
- Improve financial performance.
- Improve Consumer Assessment of Healthcare Providers and Systems (CAHPS®) hospital survey scores.
- Improve patient outcomes.
- Enhance market share and competitiveness.
- Increase employee satisfaction and retention.
- Help meet The Joint Commission standards.

IMPROVED QUALITY AND SAFETY

Data suggests that many adverse events in hospitals occur as the result of a breakdown in communication between healthcare team members, the patient and caregiver. By emphasizing effective communication and collaborative decision-making processes, PFE can reduce the risks that lead to adverse events. Research shows that hospitals without visitations saw the most pronounced deficits in their performance with regard to patient ratings of medical staff responsiveness, fall rates and sepsis rates. The findings indicate that the policy to allow visitors, or subjective advocates, lead to sustained higher quality of care. Not only did hospitals in the study see an increase in patient satisfaction, but quality outcomes also improved with a decrease in pressure ulcers from 8.15 to 2.5 percent and a decrease in patient falls from 3.24 to 2.85 falls per patient days.[5]

WHY PERSON AND FAMILY ENGAGEMENT (PFE)?

IMPROVED FINANCIAL PERFORMANCE

PFCC has been shown to improve financial performance through decreased litigation and malpractice claims and lower cost per case due to fewer complications and shorter length of stay. Research indicates malpractice suits are often the result of a difference in expectation between the patient and their caregiver, as well as poor communication between the patient and hospital staff.

The Michigan Model, an approach taken by the University of Michigan Health System (UMHS) since the early 2000s, is based on the concepts of removing barriers to reporting harms, errors and near misses, analyzing what allowed them to happen, communicating proactively and transparently with patients who are harmed and improving timeliness of response. The goal is to improve safety, serve patients better, reduce the emotional toll on clinicians and resolve situations fairly — with litigation as a last resort. The Michigan Model, renamed the CANDOR (Communication and Optimal Resolution) was tested at 14 other hospitals across three health systems. After more than 15 years of using the CANDOR approach, UMHS saw dramatic drops in the number of new lawsuits, the number of malpractice cases that make it to court and the amount paid to compensate patients. At the same time, clinicians across UMHS hospitals and clinics felt more comfortable reporting situations that caused harm, near-misses or that could pose a hazard.[6]

This has allowed faster response to investigate each situation and reduced the chance of harm in the future by changing procedures, equipment and clinical practice. It has also made it possible to offer immediate apologies and compensation to patients when needed.

By making PFCC central to organization's values and polices, healthcare organizations can greatly maximize their resources.

RESEARCH INDICATES MALPRACTICE SUITS ARE OFTEN THE RESULT OF A DIFFERENCE IN EXPECTATION BETWEEN THE PATIENT AND THEIR CAREGIVER, AS WELL AS POOR COMMUNICATION BETWEEN THE PATIENT AND HOSPITAL STAFF.

WHY PERSON AND FAMILY ENGAGEMENT (PFE)?

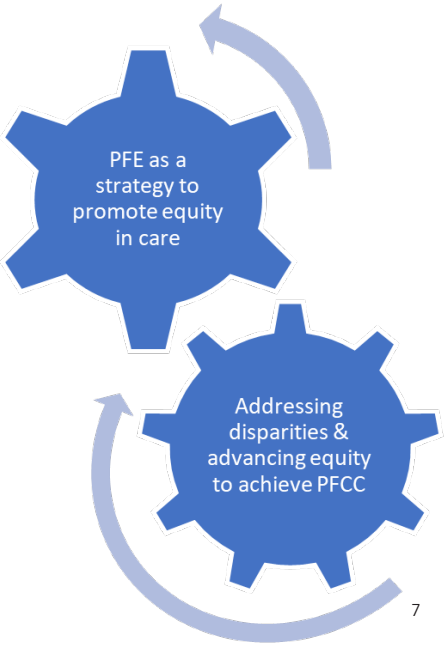
HEALTH EQUITY AND PFE

Health equity is the "attainment of the highest level of health for all people." Achieving health equity requires addressing factors like social determinants of health (SDOH) - the conditions in which people are born, grow, work, live and age - which impact health outcomes and often lead to disparities in health and healthcare. Health disparities refer to differences in health status and access to or availability of facilities and services based on social, economic and environmental conditions.

HEALTH EQUITY MUST BE STRATEGICALLY INTEGRATED INTO ALL ASPECTS OF QUALITY IMPROVEMENT AND PFE; IT IS NOT A SEPARATE AGENDA OR AREA OF FOCUS. BECAUSE NOT ALL PATIENTS AND FAMILIES ARE ALIKE, EFFORTS TO PROMOTE AND SUPPORT PFE MUST CONSIDER THE VALUES, PREFERENCES AND NEEDS TO BE REFLECTED IN DIVERSE POPULATIONS.

To improve the health of all people and truly achieve person-centered care, health systems must strategically integrate health equity into all aspects of system functions, including PFE. PFE can be a critical strategy to help address health and healthcare disparities but requires that health systems look at PFE through the health equity lens. Because not all patients and caregivers are alike, efforts to promote and support PFE must consider the needs, perspectives, interests, values, beliefs and background of diverse populations and work to meaningfully engage with them as equal and active partners in healthcare.

The work of PFE requires co-designing more equitable systems by working with marginalized groups to 1) Develop organizational policies, practices and programs that promote intentional diversity and inclusion; 2) Engage persons and caregivers who truly reflect the communities in which healthcare organizations are located; 3) Use demographic data to inform day-to-day operations and quality improvement work; and 4) Direct systems changes and tailor other organizational change efforts and resources to groups that are most likely to face disparities in their health and healthcare.



7

GLOSSARY OF TERMS

Caregiver or Family: Any relative, partner, friend or neighbor who has a significant personal relationship with and provides a broad range of assistance for another person. These individuals may be primary or secondary caregivers and live with, or separately from, the person receiving care.

Care Recipient: An adult with a chronic illness or disabling condition or an older person who needs ongoing assistance with everyday tasks to function on a daily basis. The person needing assistance may also require primary and acute medical care or rehabilitation services (e.g. occupational, speech and physical therapies).

Healthcare Staff or Formal Caregiver: A provider associated with a formal service system, whether a paid worker or someone from a volunteer organization.

Health Equity: Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential.

Person and Family Advisory Council (PFAC): An organization of current and former patients, family members and caregivers that works together to advance best practices at a hospital or healthcare organization. Through partnership and collaboration with staff, PFACs promote person and family engagement and help establish a culture of person- and family-centered care throughout programs, services and policies.

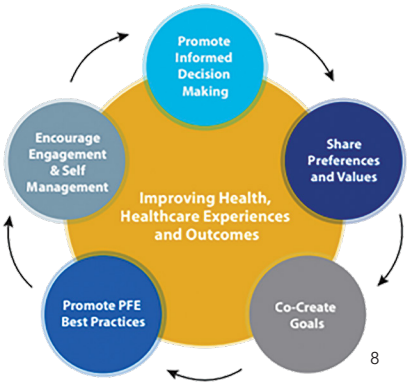
Person- and Family-Centered Care (PFCC): Focuses on putting the patient and their family at the center of all decision-making, planning and monitoring of care and by empowering them to be active partners in their care.

Person and Family Engagement (PFE): Strategies designed to foster a collaboration between patients, families and clinicians working together towards mutually agreed-upon goals that help support building a PFCC health system and culture.

NOTES:

A ROADMAP TO PERSON AND FAMILY ENGAGEMENT

Recommended Policies & Practices for Michigan Hospitals



Person and family engagement goes beyond informed consent. It is about proactive communication and partnered decision-making between healthcare providers, patients and caregivers. It is about building a care relationship that is based on trust and inclusion of an individual's values and beliefs.

1. Prior to admission and prior to discharge, healthcare staff provides and discusses a physical planning checklist & discharge checklist with every patient prior to or at the time of any scheduled admission and at discharge; allowing for questions or comments from the patient or caregiver. The checklist(s) can be a stand-alone document or integrated into other materials, for example, a patient handbook.
2. Hospital conducts shift change huddles and bedside reporting with patients and caregivers in all feasible cases.
3. Hospital has at least one person recognized across all healthcare staff and administration as responsible for the leadership, coordination, support and reporting of PFE activities through the hospital. Person may also operate within other roles in the hospital.
4. Hospital has an active Person & Family Engagement Advisory Council (PFEAC) or at least one former patient that serves on a patient safety or quality improvement committee or team. The PFEAC represents diverse patient populations and makes meetings accessible virtually or other ways to accommodate individuals without the capacity to join in person.
5. Hospital has at least one or more patients who serve as a patient representative on a governing and/or leadership board.
6. Hospital communicates PFE vision and values, supports PFE in all policy programs and services provide the necessary necessary infrastructure and resources for these efforts.
7. The principles of person- and family-centered care, including active PFE, are taught or shared as part of hiring, performance evaluation, orientation and continuing education.
8. There are systems (charting, patient portals, email, phone and patient room resources) and technology in place to facilitate collaboration between patients, caregivers and healthcare staff. Patients and caregivers receive guidance and counsel on decision aids to improve patient-provider shared decision-making.
9. Patients and caregivers are informed at admission of family-initiated rapid response teams (RRT), with a verbal review of guidelines. Patients and caregivers are encouraged to call for RRT if the patient's health changes notably.
10. Patients and caregivers are advised of physician/multidisciplinary rounds and are invited and encouraged to participate to the degree in which they wish to be involved.
11. Caregivers are respected as essential members of the healthcare team with whom to share information and provide support. They are not viewed as visitors and their presence and participation is welcomed (unless medically inappropriate), so long as patient safety isn't compromised.
12. A process has been developed to gather the voice(s) of the patient and caregiver in the root cause analysis of an adverse or near miss event and to engage patient-family advisors in serious safety event reviews.

PURPOSE & RESOURCE(S)

This section provides additional context and resources about the recommended policies and practices outlined on page 8.

1. **Prior to admission and prior to discharge, hospital staff provides and discusses a physical planning checklist and discharge checklist with every patient prior to or at the time of any scheduled admission and at discharge; allowing for questions or comments from the patient or caregiver. The checklist(s) can be a stand-alone document or integrated into other materials, for example, a patient handbook.**

   Purpose: The intent of this practice is to ensure organizations are creating a mechanism and procedure so that patients and caregivers scheduled for admissions are provided a checklist and have an opportunity to talk with hospital staff both prior to and during their admission. The checklist can serve as a list of items and topics for conversation that patients/caregivers can address related to what patients should expect, concerns and preferences for their care, potential safety issues (pre-admission medicines, history of infections, etc.) and any relevant home issues, such as needs for additional support, transportation and care coordination.

   Resource(s):
   - https://www.ahrq.gov/patient-safety/settings/hospital/red/toolkit/index.html
   - https://www.ahrq.gov/patient-safety/patients-families/engagingfamilies/strategy4/index.html

2. **Hospital conducts shift change huddles and bedside reporting with patients and caregivers in all feasible cases.**

   Purpose: As an evidence-based best practice, bedside shift report is a tangible way to ensure that complete and accurate information is shared and that there is a mutual understanding between the care provider, patients and caregivers of the care plan and priorities. The patient and/or caregiver member is able to hear, question, correct, confirm and/or learn more about the next steps in their care as it is discussed between nurses changing shifts or healthcare staff making rounds.

   Patients and/or caregivers should be present during these meetings. They should be encouraged and prompted by the healthcare staff to be active participants to whatever degree they desire and add to the information being shared between the nurses or other healthcare staff discussing their care. Healthcare staff should make an effort to adjust their use of medical jargon, acronyms and other technical language to ensure that the patient and caregiver can easily follow the conversation. If there are language barriers, an interpreter should be present. The patient/caregiver should be part of the entire conversation concerning their care and not just select parts.

   Resource(s):
   - AHRQ: "Nurse Bedside Shift Report"
   - IHI: "ISHAPED Patient-Centered Approach to Nurse Shift Change Bedside Report"

3. **Hospital has at least one person recognized across all healthcare staff and administration as responsible for the leadership, coordination, support and reporting of PFE activities through the hospital. Person may also operate within other roles in the hospital.**

   Purpose: It is critical for the organization 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 to be responsible and accountable for overseeing the implementation and evaluation of the PFE efforts at the hospital. Hospitals may create a role or department (that may have many names such as Patient/Person and Family Engagement, Patient Experience, or Quality Improvement) or identify individual(s) that focuses on PFE. The person responsible for PFE at the hospital does not need to have a special title or position or be solely focused on PFE, but all healthcare staff should be aware that this person manages the hospital's PFE plans and activities. The PFE leader should, at a minimum, identify, implement, monitor and evaluate PFE activities and is likely to coordinate the Patient and Family Engagement Advisory Council (PFEAC).

   Resource(s):
   - Guide to Patient and Family Engagement in Hospital Quality and Safety | Agency for Healthcare Research and Quality (ahrq.gov) : "Supporting Patient and Family Engagement: Best Practices for Hospital Leaders"

4. **Hospital has an active PFEAC or at least one former patient that serves on a patient safety or quality improvement committee or team. The PFEAC represents diverse patient populations and makes meetings accessible virtually or other ways to accommodate individuals without the capacity to join in person.**

   Purpose: The hospital should have a formal relationship with patient and caregivers from the local community who provide input and guidance from the patient perspective on hospital operations, policies, procedures and quality improvement efforts. The relationship may develop through channels such as a PFEAC, which often combines healthcare staff with patient and family representatives.

   An alternative to forming a PFEAC is the inclusion of patients and family advisors on one or more existing hospital committees. These patient representatives 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 caregivers at meetings. The PFEAC or other committees should be formal mechanisms that seek advice, input and active involvement from patients and caregivers on a regular basis.

   Resource(s):
   - Microsoft Word - 00001_CreatingPatientandFamilyAdvisoryCouncils.docx (ipfcc.org)
   - Strategy 1: Working With Patients and Families as Advisors | Agency for Healthcare Research and Quality (ahrq.gov)

5. Hospital has at least one or more patients who serve as a patient representative on a governing and/or leadership board.

Purpose: The intent of this recommendation is to ensure that at least one board member, with full voting rights and privileges, provides the patient and caregiver perspective on all matters before the board, similar to other board members who represent specific interests in the community. Ideally, at least one board member with full voting rights would specifically be appointed for this purpose and with a written role definition as a patient representative. The ultimate goal of this activity is to ensure that the board works with patient and caregiver perspectives when making governance decisions at the hospital.

While designating at least one patient representative on the board is the preferred mechanism to ensure co-governance, there may be barriers that do not allow such roles to be assigned. Until such barriers are removed, the hospital should strive to:

- Ask for PFEAC input on matters before the board and incorporate a PFEAC report into the board agenda.
- Identify elected or appointed board members to serve in a specific role, with a written role definition, as representing the patient and caregiver voice on all matters before the board.
- Strongly encourage all board members to conduct activities that connect them with patients and caregivers, such as visiting actual patient units in the hospital two times per year and/or attending two PFEC meetings per year.

Resource(s):

- How-to Guide: Governance Leadership (Get Boards on Board) | IHI - Institute for Healthcare Improvement
- Improvement Stories | IHI - Institute for Healthcare Improvement

6. Hospital communicates PFE vision and values, supports PFE in all policy programs and services and provides the necessary infrastructure and resources for these efforts.

Purpose: Aligning the hospital's mission and vision statements to support PFE helps ensure that everyone recognizes the importance of these efforts in improving safety and quality of healthcare. Organizations should work to incorporate person- and family-centered care into their hospital's strategic planning, which ensures a clear vision of how PFE fits into organizational processes on a daily, operational basis.

In addition to setting a clear vision of how the organization will work to engage patients and caregivers, hospitals must also define how it will measure and evaluate these efforts, identifying organizational strengths and weakness. Begin by reviewing policies and procedures to ensure they relate to PFE efforts; ensure there are mechanisms for healthcare staff, patients and caregivers to report concerns and failure in engaging patients and caregivers; incorporate processes for acknowledging and correcting engagement failures and define ways to review and improve PFE processes over time. Involve patient and family advisors in the review and development of hospital policies and procedures to ensure the guiding principles and values of PFCC are incorporated. Providing a sound infrastructure and dedicated resources for PFE efforts are also critical aspects in

ensuring suitability of a PFCC culture. Staff will need time to develop, implement, integrate and coordinate various initiatives, such as recruiting, selecting and training patient and caregivers or establishing patient and family advisory councils.

Resource(s):

- Strategy 1: Working with Patients & Families as Advisors (Implementation Handbook) (ahrq.gov)

7. The principles of person-and family-centered care, including active PFE, are taught or shared as part of hiring, performance evaluation, orientation and continuing education.

Purpose: Integrating PFCC principles and active PFE into personnel policies and practices transforms PFE from something that is "nice to do" to something that is expected. The PFCC principles and expectations should be included as part of hiring, training, evaluation and compensation. Ensure that job descriptions emphasize the importance of engaging patients and caregivers and specify standards for incorporating PFCC in job performance for staff both directly and indirectly involved in patient care. Set expectations during the hiring and orientation process and educate new staff on PFCC principles, include PFE in annual performance reviews and tie compensation to PFE. Involve patient and caregivers in new hire interviews and make them part of new employee orientations to set a clear message upfront on the importance of these principles. By using the human resource infrastructure, the organization can further embed PFCC values and principles in the workforce.

Resource(s):

- Strategy 1: Working with Patients & Families as Advisors (Implementation Handbook) (ahrq.gov)

8. There are systems and technology in place to facilitate collaboration between patients, caregivers and healthcare staff. Examples may include charting, patient portals, email contacts, phone and patient room resources. Patients and caregivers receive guidance and counsel on decision aids to improve patient-provider shared decision-making.

Purpose: During the pandemic, many healthcare organizations needed resources to safely connect patients and caregivers in the inpatient and outpatient care settings. When in-person visits were limited or prohibited, technology was a necessary resource in order to support patients, communicate with loved ones, facilitate discharge and care plans and offer virtual outpatient visits. Most hospitals used technology during end-of-life care when caregivers were unable to be in-person. Because of this, there must be an operational commitment to a technology infrastructure among care units to support these needs. Below are recommended policies and procedures for utilizing technology:

Inpatient

- Implement multidisciplinary rounding with care partners to avoid conflicting information and unnecessary calls to the unit floor.
- Utilize technology as part of the patient admission and/or assessment process so that healthcare staff can consult patient advocates and obtain a baseline patient status, particularly if the individual is non-verbal or unconscious.

- Establish patient-provider trust by utilizing digital tools for communicating patient needs, tasks, etc.
- Establish a workflow cadence for sharing information on a patient's status, from admission to discharge.
- Foster communication with tools like care cards that provide contact information for a patient's caregiver.
- Incorporate technology in orientation routines (i.e. night checks) to support patients experiencing anxiety or caregivers who cannot be present.
- Add stations near hospital entrances for those that may not have access to technology at home.
- Offer digital support to families, including language translation tools and how-to's for connecting with patients virtually.
- Identify a team member for technology support and trouble-shooting within a unit.

Outpatient

- Utilize digital tools for scheduling patient visits to avoid longer than necessary wait times.
- Virtually include caregivers during patient visits to address questions, concerns or offer support.

Resource(s):

- https://www.ipfcc.org/bestpractices/covid-19/IPFCC_PFCC_and_COVID.pdf

9. Patients and caregivers are informed at admission of family-initiated rapid response teams (RRT), with a verbal review of guidelines. Patients and caregivers are encouraged to call for RRT if the patient's health changes notably.

Purpose: Family-initiated RRTs give caregivers a powerful tool to quickly call for help whenthe patient's condition is rapidly worsening or a serious new health concern has developed. A RRT is a group of specialized and trained individuals, also known as a medical emergency team, who are called to action to provide immediate assistance when early signs of clinical deterioration are seen in a patient's condition. Allowing patients and caregivers to call a RRT is a significant way hospitals can make patients and caregivers equal partners in safety. Hospitals must ensure these family-initiated RRTs are easy to activate and that patients and families receive educational information and verbal guidelines on when to call the RRT during the admission process. Information about the program should be included in the patient/family handbook and hospitals can also create a poster listing the phone number to summon the RRT. Giving families and caregivers the ability to call for help provides a safety net and ensures they are an active member of the care team.

Resource(s):

- https://www.ihi.org/Topics/RapidResponseTeams/Pages/default.aspx
- https://journals.lww.com/ccmjournal/Abstract/2012/12001/892___Family_Activated_Rapid Response_Team___What.854.aspx
- https://www.myamericannurse.com/family-initiated-rapid-response-team/

10. Patients and families are advised of physician/multidisciplinary rounds and are invited and encouraged to participate to the degree in which they wish to be involved.

Purpose: Engaging patients and caregivers in multidisciplinary rounds conducted at the bedside creates a vehicle for improvement in quality and safety of patient care. Patients and their caregivers best know their needs and can provide valuable insight into the care planning process. It's important that patients and caregivers are prepared and receive information about rounds, such as their purpose and structure, time they are conducted, who will be present and how they can participate.

Oftentimes patients and caregivers can feel overwhelmed by the healthcare experience. Healthcare staff should encourage patients and caregivers to write down questions in advance to prepare for staff rounds. Invite patients and caregivers to fully participate, understanding that choice is important and not all will have the desire to participate. It's critical that each member of the team is identified and their role and responsibilities are explained. Setting the scene occurs daily upon entering the patient room and involves one designated participant introducing key members of the team and encouraging the caregiver to take an active role in clarifying information and contributing to the plan for care. Be sure to also prepare the team to be sensitive when using technical language that may not be understood by the patient and caregiver and also encourage patients to ask questions if there is something that is not completely clear to them.

Resource(s):

- APPLYING PATIENT- AND FAMILY-CENTERED CONCEPTS TO BEDSIDE ROUNDS IN NEWBORN INTENSIVE CARE (ipfcc.org)

11. Caregivers are respected as essential members of the healthcare team with whom to share information and provide support. They are not viewed as visitors and their presence and participation is welcomed (unless medically inappropriate), so long as patient safety isn't compromised.

Purpose: COVID-19 changed the landscape of caregiving, making it more complex and often isolating patient advocates advocates. During the pandemic, visitors and caregivers were banned from healthcare facilities to avoid community spread of the virus. Tragically, these decisions had unintended consequences, even though they were made with the best of intentions.

In the wake of this crisis, many advocates are pushing to have caregivers designated as "essential care partners" at healthcare facilities, as opposed to just visitors. To ensure the care partner role is not understated, these individuals should be provided with the necessary personal protective equipment (PPE) in the case of rising COVID infection rates as to not separate them from the patient.

Resource(s):

- Better Together: Partnering with Families (ipfcc.org)
- We are not visitors: Working together with family caregivers and care partners - The Beryl Institute - Transforming the Human Experience in Healthcare

PURPOSE & RESOURCE(S)

12. A process has been developed to gather the voices of the patient and caregiver in the root cause analysis (RCA) of an adverse or near miss event and to engage patient-family advisors in serious safety event reviews.

Purpose: Patients and caregivers can play a critical role in the process of change. By partnering with them in the adverse event review process, hospitals increase transparency, improve their organization's systems analysis process and empower patients and caregivers to be part of the solution.

There should always be an open line of communication between hospital staff, patients and caregivers. This provides the opportunity for input and sharing of perspectives before, during and after a hospital visit. Start the RCA process by inviting a patient and/or caregiver to tell their story; keep them informed throughout the process and results stage and encourage they participate by providing input and feedback.

Hospitals nationally have also partnered with their patient/caregivers as advisors of the RCA team, providing a critical voice yet having less emotional connection to the event. Having patient/caregivers serve in this role ensures the perspective from the patient/caregiver side, leading to a deeper understating of the root cause, bringing diversity to the team and bringing a perspective that no one else on the safety review team can bring. Caregivers as members of the RCA committee can serve many roles, including:

- Working to identify pieces of the process missing from the patient's perspective.
- Participating in information/data gathering.
- Presenting at all patient/family meetings before and after the RCA.
- Analyzing findings.
- Assisting in the development of action plans and recommendations.
- Acting as an advisor.

Resource(s):

- Communication and Optimal Resolution (CANDOR) Toolkit | Agency for Healthcare Research and Quality (ahrq.gov)

PROCESS FOR COMPLETING ASSESSMENT

HOW TO USE THE PFE ROADMAP ASSESSMENT TOOL

The PFE Roadmap Assessment Tool was developed by the MHA Person & Family Engagement Advisory Council to help identify areas where the healthcare staff can improve person and family engagement. By following the **plan, do, study, act model,** hospital staff can identify and resolve issues.

Plan-Do-Study-Act (PDSA) Methodology

Step 1: Plan
Complete the Person & Family Engagement Assessment to assess your organization's current activity.

Step 2: Evaluate
Analyze the results of the assessment with a cross-functional and multidisciplinary team to determine the current level of implementation. Work to identify and understand gaps, barriers and areas of opportunities within each of the 12 assessment categories.

Step 3: Prioritize
Rank the necessary action items as identified as gaps in the assessment.

- WHY — Develop a clear understanding of the "why," along with a clearly defined problem statement; your organization can develop the business case for this work and get to the drivers and benefits that the initiative is to deliver.
- WHAT — A goal for each action item under the 12 policies and practices.
- HOW — A clearly defined plan of how to achieve, evaluate and monitor the goals.
- WHO — Who will be leading this work? Determine your stakeholders, teams and customers, both internally and externally, depending on the action item(s) you are addressing.
- WHEN — Develop a clearly defined timeline of implementation for each of your identified action items.
- WHERE — Determine where this work will take place — will it be piloted on one unit before being spread organization wide?

Step 4: Act
Act on the identified areas of opportunity and commit to reaching the highest implementation level within each of the 12 recommended policies and practices to build person and family engagement.

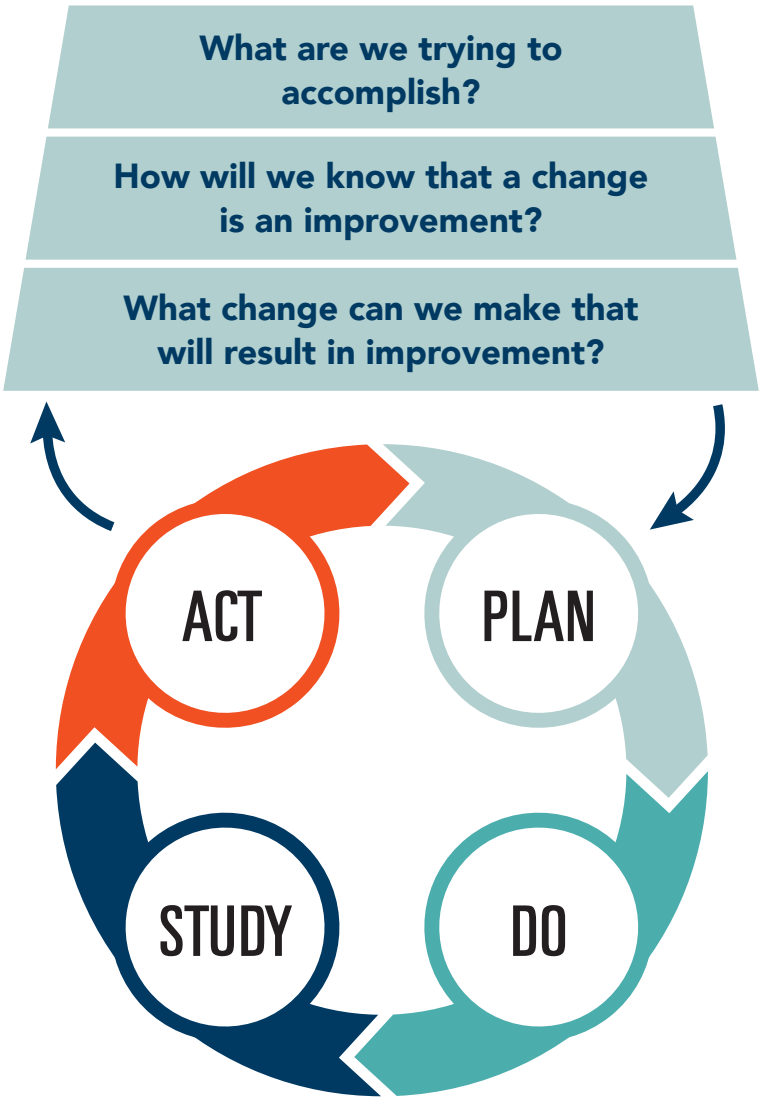
PROCESS FOR COMPLETING ASSESSMENT

Plan-Do-Study-Act (PDSA) Methodology

The PFE Roadmap Assessment Tool can be used through Microsoft Excel to assign a score to each activity with the opportunity to achieve a total of 120 points. The hospital's number on the sliding scale from 1 to 120 helps identify areas of improvement. A higher score indicates more tasks are completed that support improved patient safety and quality through person and family engagement.

The Plan-Do-Study-Act (PDSA) cycle is shorthand for testing a change — by planning it, trying it, observing the results and acting on what is learned. This is the scientific method, used for action-oriented learning.

Model for Improvement



ASSESSMENT OF RECOMMENDED POLICIES AND

LEGEND:

Completed and operational (5) | In progress toward completed/operational (4) | Eliminated due to lack of resources

HOW TO USE:

Under status, enter the number from the legend that correlates with current work being completed under the policy/
of opportunities for improvement. Users should also enter start and end dates and a responsible person to track whe

Recommended Policies and Practices	Status	Start Date	End Date
Prior to admission and prior to discharge, hospital staff provide and discuss a physical planning and discharge checklist (available in various languages) with every patient who has a scheduled admission; allows for questions and comments from the patient or family. The checklist can be a stand-alone document or integrated into other materials.			
Hospital conducts shift change huddles.			
Hospital conducts bedside reporting with patients and family members.			
Hospital has at least one person recognized across all hospital staff and administration as responsible for the leadership, coordination, support and reporting of PFE activities through the hospital. Person may also operate within other roles in the hospital.			
Hospital has an active Person & Family Engagement Advisory Council (PFEAC).			
Hospital has at least one former patient serving on a patient safety or quality improvement committee or team.			
The PFEAC represents diverse populations.			
Meetings can be access virtually or input obtained in other ways for those unable to join in person.			
Hospital has at least one or more patients who serve as a patient representative on a governing and/or leadership board.			
Hospital communicates PFE vision/values.			
Hospital supports PFE in programs and services.			
Hospital provides the necessary infrastructure and resources for PFE efforts.			
The principles of person and family-centered care are taught and shared as part of hiring.			
The principles of person and family-centered care are taught and shared as part of performance evaluation.			
The principles of person and family-centered care are taught and shared as part of orientation.			
The principles of person and family-centered care are taught and shared as part of continuing education.			
There are systems in place to encourage partnerships among patients, families and care providers (examples may include chart, a patient portal in EMR, email, bulletin/whiteboards in patient's room, tablets and other technologies.)			
Patients and caregivers receive guidance and counsel on decision aids to improve patient-provider shared decision-making.			
Patients and caregivers are informed at admission of family-initiated rapid response teams (RRT), with a verbal review of guidelines. Patients and caregivers are encouraged to call for RRT if the patient's health changes notably.			
Patients and caregivers are advised of physician/multidisciplinary rounds.			
Patients and caregivers are invited and encouraged to participate to the degree in which they wish to be involved.			
Caregivers are respected as essential members of the healthcare team with whom to share information and provide support. They are not viewed as visitors and their presence and participation is welcomed (unless medically inappropriate), so long as patient safety isn't compromised			
A process has been developed to gather the voice(s) of the patient and caregiver in the root cause analysis of an adverse or near-miss event.			
A process has been developed to engage patient and caregivers in serious safety event reviews.			
TOTAL SCORE	**0**		

SCORING LEGEND:

99-120
74-98
49-73
24-48

PRACTICES FOR MICHIGAN HOSPITALS FORM

MHA
Michigan Health &
Hospital Association

(3) | Eliminated due to no expertise (2) | No plans (1)

/practice. The report will color code based on the score entered for each activity, allowing the user to identify areas
en specific activities are completed.

Responsible Person	Recommended MHA Roadmap Policies and Practices for Michigan Hospitals
	1. Prior to admission and prior to discharge, healthcare staff provide and discuss a physical planning and discharge checklist (available in various languages) with every patient who has a scheduled admission; allows for questions and comments from the patient or caregiver. The checklist can be a stand-alone document or integrated into other materials.
	2. Hospital conducts shift change huddles and bedside reporting with patients and caregivers.
	2. Hospital conducts shift change huddles and bedside reporting with patients and caregivers.
	3. Hospital has at least one person recognized across all healthcare staff and administration as responsible for the leadership, coordination, support and reporting of PFE activities through the hospital. Person may also operate within other roles in the hospital.
	4. Hospital has an active Person and Family Engagement Advisory Council (PFEAC) or at least one former patient serving on a patient safety or quality improvement committee or team. The PFEAC represents diverse populations and makes meetings accessible virtually or other ways for those unable to join in person.
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	4. Hospital has an active Person and Family Engagement Advisory Council (PFEAC) or at least one former patient serving on a patient safety or quality improvement committee or team. The PFEAC represents diverse populations and makes meetings accessible virtually or other ways for those unable to join in person.
	5. Hospital has at least one or more patients who serve as a patient representative on a governing and/or leadership board.
	6. Hospital communicates PFE vision and values, supports PFE in all policy programs and services and provides the necessary infrastructure and resources for these efforts.
	6. Hospital communicates PFE vision and values, supports PFE in all policy programs and services and provides the necessary infrastructure and resources for these efforts.
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	7. The principles of person and family-centered care are taught and shared as part of hiring, performance evaluation, orientation and continuing education.
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	8. There are systems in place to encourage partnerships among patients, caregivers and healthcare staff (examples may include a chart, a patient portal in EMR, email, bulletin/whiteboards in patient's room, tablets and other technologies). Patients and caregivers receive guidance and counsel on decision aids to improve patient-provider shared decision-making.
	8. There are systems in place to encourage partnerships among patients, caregivers and healthcare staff (examples may include a chart, a patient portal in EMR, email, bulletin/whiteboards in patient's room, tablets and other technologies). Patients and caregivers receive guidance and counsel on decision aids to improve patient-provider shared decision-making.
	9. Patients and caregivers are informed at admission of family-initiated rapid response teams (RRT), with a verbal review of guidelines. Patients and caregivers are encouraged to call for RRT if the patient's health changes notably.
	10. Patients and caregivers are advised of physician/multidisciplinary rounds and are invited and encouraged to participate to the degree in which they wish to be involved.
	10. Patients and caregivers are advised of physician/multidisciplinary rounds and are invited and encouraged to participate to the degree in which they wish to be involved.
	11. Caregivers are respected as essential members of the healthcare team with whom to share information and provide support. They are not viewed as visitors and their presence and participation is welcomed (unless medically inappropriate), so long as patient safety isn't compromised.
	12. A process has been developed to gather the voice(s) of the patient and caregivers in the root cause analysis of an adverse or near miss event and to engage patients and caregivers in serious safety event reviews.
	12. A process has been developed to gather the voice(s) of the patient and caregivers in the root cause analysis of an adverse or near miss event and to engage patients and caregivers in serious safety event reviews.

The sliding scale denotes total points earned for completing the assessment. A higher score indicates more tasks are completed that support improved patient safety and quality within the organization.

Total score maximum is 120 points (completed all policy/practice activities)

REFERENCES

[1] Institute for Patient-and Family-Centered Care. "Advancing the Practice of Patient- and Family-Centered Care." Web. 7 July 2015. <http://www.ipfcc.org/about/pfcc.html>.

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