***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 to 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 support the Practice Transformation Networks (PTNs) and their TCPI practices as they work toward implementation of each PFE strategy reflected in the metric. These questions and their response categories will be integrated in the PAT in June of 2017.

***Understanding the PFE Performance Metrics:***

Each question is listed with its response categories to provide context, the intent of each measure shared, and a few resources that could assist practices in their implementation in these domains. More information can be found *in the TCPI > Documents > Affinity Groups > PFEAG section of www.healthcarecommunities.org.* PFE Resources. A more detailed Compendium listing articles, videos, tools, and guides for each PFE metric is available to PTNs requiring more resources or training.

***A note about 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.

***A note about examples shared below:***

There is no training, tool, or process that is the one and only way to fulfill the aim of implementation of these PFE strategies. Throughout the guide, examples are shared to illustrate practical, concrete ways to engage patients and families as members of their health care team and as improvement partners in practice transformation. The examples below are not meant to be all-inclusive or a complete list. Practices are unique and may find other effective ways to honor the intention of the metrics listed below.

**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.)?**

**Intent**: The intent of this metric is to include the perspective and voice of the patient and family in all aspects of the governance/operation of the practice.

According to the TCPI change package, each practice is strongly encouraged to implement a systematic way for patient and family to serve as advisors to infuse their voices into the policies, procedures, and governance of the practice.

* Practice transformation is accelerated when patients and families serve as valued advisors and improvement partners.
* Patient and Family Advisors (PFA) are well prepared volunteers who can provide the lived experience and share this perspective to inform practice operations and care processes.
* How PFAs serve the practice will depend on the structure and goals that best fit the current practice culture.
* PFAs work in partnership with practice staff and should be considered part of the team.
* PFAs can be included on any practice committee or a PFAC can be created.
* Even in small practices including at least two PFAs is recommended so that diverse voices representing the populations being served are heard.
* Education material that is developed in partnership with PFAs should take the patients’ health literacy into account.

**You’ll meet this metric if:**

* The practice has a process in place for including the perspective and active voice of the patient and family (Patient Family Advisor) in all aspects of the governance of the practice.

**For example:**

1. A Patient Family Advisory council meets regularly and is an active participant in influencing improvements.
2. Practice has a cadre of Patient Family Advisors who participate on committees and work groups.
3. There are Patient Representatives on the Board of Directors.

**Resources**:

Person and Family Advisory Councils

* [Advancing the Practice of Patient- and Family-Centered Care in Primary Care and Other Ambulatory Settings (IPFCC)](http://www.ipfcc.org/pdf/GettingStarted-AmbulatoryCare.pdf)
* [Guide to Creating Patient and Family Advisory Councils](http://www.ipfcc.org/advance/Advisory_Councils.pdf) (IPFCC)
* [Working with Patient and Families as Advisors](http://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf) (AHRQ)
* [Example annual report from a Patient and Family Advisory Council](http://www.ipfcc.org/advance/topics/annual-report-bidmc-2015.pdf)
* [Example year-end report from another Patient and Family Advisory Council](http://www.ipfcc.org/advance/topics/annual-report-bronson-2013.pdf)
* Partnership for Patients (PfP) Strategic Vision Roadmap for Person and Family Engagement (PFE)

Practice Improvement Teams

* [Cambridge Health Alliance’s Practice Improvement Team](http://mcaap.org/wp2013/wp-content/uploads/2015/06/CHA-Practice-Improvement-Team-Toolkit.pdf)
* [Family Practice Group Quality Improvement Team](http://www.fpgcares.com/quality-improvement-team.htm)
* [Module 14: Creating Quality Improvement Teams and QI Plans](http://www.ahrq.gov/professionals/prevention-chronic-care/improve/system/pfhandbook/mod14.html) (AHRQ)

Board Representatives

* [Dana-Farber Cancer Institute](http://www.aha.org/content/00-10/resourceguide.pdf): patients and family members serve on the Board-level Joint Committee on Quality Improvement and Risk Management
* [Community Health Partnership of Illinois](http://www.chpofil.org/our-board-of-directors.html): most of the Board members are also receiving care at their Partnership clinics
* The Tennessee Hospital Association held a workshop on successfully including patient representatives on the hospital board

**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.)?**

**Intent**: The intent of this metric is to ensure that patients (and their families according to patient preference) are authentically part of the care team.

* Shared decision making is a process which provides:
  + A standard method for patients and the healthcare team work together to make care decisions.
  + Patients with accurate and extensive knowledge about their diagnoses and care plan, enabling them to be effective partners in their care.
  + An opportunity to build trust and loyalty to practices as patients feel heard and their thoughts, values, and desires are respected.
  + An increase in both patient and staff satisfaction, as they learn to work as a team.
  + Potential for better follow-through by the patient because they have a greater understanding of the benefits and risks associated with their decisions.
* This process goes beyond the concept of sharing information with a patient and making recommendations for care.
* Shared decision making is a collaborative process and provides patients the opportunity to express their personal values and desires for treatment.
* Many patients will need to be invited and supported to be an active member of the health care team. The initial discussion should determine the best way for each patient and family member to participate.

**You’ll meet this metric if:**

* Practice is using a tool to promote and teach shared decision making in order that patients (and their families according to patient preference) are authentically part of the care team.

**For example:**

1. Practice has begun to train providers and staff on the value of shared decision making.
2. Practice is in the process of developing a process to ensure that every patient is provided an authentic opportunity to share in all decisions regarding their care.
3. Practice determines their own shared decision process and has disseminated to staff.

**Resources:**

Utilizing any of the following shared decision making tools would constitute a “yes” answer:

* [AHRQ Shared Decision Making Resources](https://www.ahrq.gov/professionals/education/curriculum-tools/shareddecisionmaking/index.html)
* [Mayo Clinic Shared Decision Making National Resource Center](http://shareddecisions.mayoclinic.org/decision-aid-information/decision-aids-for-chronic-disease/)
* [Option Grids](http://www.optiongrid.org/)
* [Ottawa Personal Decision Guide](https://decisionaid.ohri.ca/decguide.html)
* [Informed Decision Making](http://www.informedmedicaldecisions.org/shareddecisionmaking.aspx)
* [Ask Me 3: Good Questions for Your Good Health](http://www.npsf.org/?page=askme3)
* [Choosing Wisely: 5 Questions to Ask Your Doctor Before You Get Any Test, Treatment, or Procedure](http://consumerhealthchoices.org/wp-content/uploads/2013/06/CWPosterGeneralSmall.pdf)

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

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

**Intent**: The intent of this metric is to use a standard method to measure a patient’s activation level. Patient activation reflects “an individual’s overall knowledge, skill, and confidence for self- management”. [[1]](#footnote-1)

Tools to measure patient activation can include the [Patient Activation Measure (PAM)\*,](http://www.insigniahealth.com/products/pam-survey) but it can also include other tools that measure a patient’s willingness and capacity to take on the role of managing their own health and health care.

* People with low levels of activation are less likely to be an active partner in their care. This could impact patients’ willingness to seek help when needed, ask questions, follow a treatment plan, or manage their overall health.
* Measurement with a standard tool provides needed information to help the clinical team to customize their approach to supporting an improvement in a patient’s activation level.
* Studies have shown that higher activation improves clinical outcomes, reduces costs, and increases patient satisfaction.
* Highly activated patients are more likely to adopt healthier behaviors as well as more effectively manage chronic or acute conditions.
* TCPI is striving to achieve patient activation through a broader perspective of care management that is aligned with the change package.

**You’ll meet this metric if:**

* Practice is using a standard PAM tool to assess and measure patient activation
* Practice is using any of the other tools listed below to assess and measure patient activation
* Practice has developed their own tool to assess and measure patient activation

**For example:**

1. Practice has implemented and trained staff and providers on motivational interviewing
2. Practice holds classes and groups with the purpose of improving patient activation
3. Practice includes patient family advisors on the planning and implementation of a program to increase patient activation.

**Resources:**

\*Free **access** to the PAM may be available through your local QIN/QIO.

Other tools that measure a patient’s confidence and capacity to take on the role of managing their own health and health care include:

* [Stanford Chronic Disease Self-Efficacy Scales](http://patienteducation.stanford.edu/research/secd32.html)
* [Patient Health Engagement Scale](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4376060/)
* <https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/interventions.html>
* <http://bit.ly/2km87G1> AHRQ Patient Engagement Resources

**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?**

**Intent**: The intent of this metric is to have an electronic tool that allows patients to access their medical record and have an easy, direct way to communicate with providers.

* A patient portal or other e-tools provide patients with a secure online website where they can have 24-hour access to their personal health information. There are many benefits to having this tool available including:
* Provides an easy way for patients to engage in their own healthcare.
* Allows providers to have an efficient and direct method to communicate with patients.
* Questions about care, appointments, prescription refills, and other concerns appear in real time to physicians, nurses, and other care team members
* Delays and inefficiencies are reduced.
* Patients can be assisted during appointments to register onsite as well as being supported on how to use the e-tool. However, this information should not be restricted to patients who have access and the ability to use the e-tool.
* Monitoring registrations and usage will provide important information about who is using the portals and which patients may need more assistance or alternative methods for this level of access.
* Ensure that all patients have access to their healthcare information. Thought should be given to alternatives for patients who may not speak English, have limited technical skills, no access to computers, or possess low health literacy.

**You’ll meet this metric if:**

* 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.

**For example:**

* Practice has a new patient portal and staff assists patients to register either before or after their appointment.
* Practice has a patient portal and has reached out to patients who do not access it by providing alternatives for connecting.
* Practice does not have a patient portal but has set up a system to provide two-way communication between the practice, providers and patients. (e.g. texting or other secure e-mail options)

**Resources:**

1. For more information on e-tools and e-connectivity, visit the [Office of the National Coordinator for Health Information Technology website.](https://www.healthit.gov/providers-professionals/ehr-implementation-steps)
2. Another helpful resource may be found at [OpenNotes](http://www.opennotes.org/).
3. Consider: <https://howsyourhealth.org>

**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)?**

**Intent**: The intent of this metric is to ensure that practices are systematic in addressing health literacy issues.

* It is critical that health information is delivered in a way that is easily understood by patients and their families.
* Ratzan and Parker (2000) define health literacy as “the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate health decisions.”
* Health literacy differs from general literacy as it includes a person’s ability to navigate the healthcare system; share accurate, relevant health history; self-manage chronic disease and medications, and to understand necessary mathematic concepts.
* It is not enough to create education materials that have a low reading level. AHRQ National Healthcare Disparities Report (2007) reported that up to nine out of 10 adults may **lack** the skills needed to manage their health and prevent disease. This means that adults with high literacy levels may still have low health literacy.
* Adults with lower health literacy have worse health care and poorer health outcomes (Berkman et al. 2004).
* Evaluating a patient’s health literacy provides valuable information about how to provide useful and accessible information about their diagnoses and treatment plan.

**Ways to meet this metric:** A health literacy patient survey is being used by the practice to systematically address health literacy issues.

**For example:**

1. The practice surveys patients and families to determine whether the health literacy practices result in patients having a greater understanding of their condition and what information has been shared with them.
2. A process to evaluate a patient preferred language is determined and practice supplies written information in this language.
3. Health literacy is being discussed and taught at staff meetings and other opportunities.
4. Patient/family advisors work with the practice to ensure that the materials developed are easily understood and answer important questions patients determine are important to help them understand and manage their condition or navigation of the health care system.

**Resources:**

* <https://health.gov/communication/literacy/quickguide/quickguide.pdf>
* AHRQ Health Literacy Measurement Tools
* [Health Literacy Tool Shed](http://healthliteracy.bu.edu/all)

**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?**

**Intent**: The intent of this metric is to ensure that all patients and/or their family are being supported to safely manage their medications.

* Medication management is a collaborative process that includes working with patients to reconcile medications, creating an accurate list of current medication being taken, and exploring how medications are being managed in the community environment.
* This patient-centered approach helps to optimize safe, effective, and appropriate drug therapy.
* Patients, especially those with chronic conditions, are often managing most of their care and medications at home. This requires a high-level of understanding of their diagnosis and treatment plan.
* The Institute of Medicine (2003) defines self-management support as “the systematic provision of education and supportive interventions by health care staff to increase patients’ skills and confidence in managing their health problems, including regular assessment of progress and problems, goal setting, and problem-solving support.”
* This collaboration with patients involves the entire health care team working together.

**You’ll meet this metric if:**

* There is a systematic, standard method in place to evaluate and support patients and their caregivers in medication self-management.

**For example:**

1. Practice has regular classes focused on self-management of medications that include the care givers.
2. Peer instructors are used to provide insight on tips to better manage medication
3. Check-ins are a part of each appointment to determine where help or more education is necessary.

**Resources:**

1. [Patient-Centered Primary Care Collaborative’s Integrating Comprehensive Medication Management to Optimize Patient Outcomes](https://www.pcpcc.org/sites/default/files/media/medmanagement.pdf)
2. [Sutter Health: Diabetes Self-Management Tools and Resources](http://www.pamf.org/diabetes/patients/)
3. [Geriatric Medication Management Toolkit](http://www.champ-program.org/page/101/geriatric-medication-management-toolkit)
4. [South West Self-Management Program](http://www.swselfmanagement.ca/smtoolkit/)
5. [Video on Coaching Patients for Successful Self-Management](http://www.chcf.org/publications/2008/08/video-on-coaching-patients-for-successful-selfmanagement)
6. [Video with Techniques for Effective Patient Self-Management](http://www.chcf.org/publications/2006/08/video-with-techniques-for-effective-patient-selfmanagement)
7. [Partnering in Self-Management Support: A Toolkit for Clinicians](http://www.ihi.org/resources/Pages/Tools/SelfManagementToolkitforClinicians.aspx)
8. [Diabetes Literacy and Numeracy Education Toolkit](https://www.mc.vanderbilt.edu/root/vumc.php?site=CDTR&doc=37816)
9. [Million Hearts Medication Adherence Featured Tools](http://millionhearts.hhs.gov/tools-protocols/medication-adherence.html)

1. Hibbard, J. & Minniti, M. (2012). An evidence-based approach to engaging patients. In D. Nash, J, Clarke, A. Skoufalos, & M. Horowitz (Eds.), *Health Care Quality: The Clinician’s Primer* (pp.245-262) American College of Physician Executives. [↑](#footnote-ref-1)