

Getting Off the Ground: Developing an ED Patient and Family Advocacy Council to Improve Patient Experience

Jonathan D. Sonis, MD; Maryfran Hughes, RN MSN NE-BC; Cassie Kraus; Robin Lipkis-Orlando, RN MS NE-BC; Linda Kane, MSW LCSW; Benjamin White, MD FAAEM

Patient experience continues to be a growing area of focus for hospital and emergency department (ED) leaders across the United States.^{1,2} Despite this, existing avenues of obtaining accurate data regarding the most critical drivers of ED patient experience are limited and, importantly, largely missing the perspective of patients and family members themselves.³ While many U.S. EDs employ a post-visit survey tool (i.e., Press Ganey, Healthstream, QDM, and others), survey data may be limited by poor response rates, non-response bias, and restricted by the scope of the responses reported.⁴

To address the critical need for patient and family member input in improving patient experience, Patient and Family Advocacy Councils (PFACs), which include both invited patients and family members and selected staff, have been employed at the hospital and specialty level with increasing frequency over the past decade. In early 2018, recognizing a void of the patient's voice in our own ED patient experience improvement efforts, we set out to create the first-ever ED PFAC at Massachusetts General Hospital.

Planning and Staff Recruitment

The first step in developing the ED PFAC was ensuring that stakeholders from all branches of the department's leadership were supportive of the concept and would be willing to devote time and resources to the project. Early on, the ED Nursing Director, ED Clinical Director, and Executive Director all recognized the value in forming such a council and agreed to participate. Given the need for experience with PFAC formation, we also reached out to and gained the support of the director of our hospital's Office of Patient Advocacy (OPA), who provided not only invaluable expertise and support, but also a source of potential participants.

To create balance within the group, it was decided that the PFAC would be co-chaired by a nurse (ED Nursing Director) and a physician (ED Administrative Fellow) with plans to also include a representative from ED Administration (Administrative Manager for Quality and Process Improvement) and the OPA (Advocacy Representative), as well as the ED Clinical Director.

Patient and Family Recruitment

Based on recommendations from the OPA, we sought to have an approximate one-to-one ratio of patients and family participants to staff participants in our PFAC. Therefore, five patient and family participants were sought out. Three participants were identified by the OPA as they



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had expressed interest in joining a PFAC and had experienced several episodes of care in the ED. Another two participants were identified directly by the PFAC co-chairs through communication following ED visits. Finally, a sixth patient participant who had already expressed long-term interest in supporting ED patient experience improvement efforts was asked to join the group. All participants were interviewed prior to being selected to participate on the council.

First Meeting Logistics

An initial meeting was scheduled for January 2019 after consulting the schedules of each participant. The agenda for the initial PFAC meeting was developed by the co-chairs with assistance and feedback from the OPA with the goal of introducing all participants and providing a general “lay of the land” of the major challenges facing our ED as well as existing solutions. This included a brief explanation of the PFAC's



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development and the importance of patient and family perspective in improving ED patient experience followed by participant

introductions, a brief summary of ED statistics and a demonstration of previous and current patient experience improvement efforts. While a formal agenda was utilized, extensive discussion among participants occurred throughout the meeting.

“ International medical graduates, through their experiences in offshore medical schools, are uniquely qualified to see, treat and serve a rapidly changing patient population. ”

Challenges

A key challenge throughout the planning and recruitment process was ensuring that the resulting group was diverse and as representative as possible of the population served by our ED. In particular, we found it more difficult to recruit younger participants than retirees, who often expressed increased time flexibility compared to their working counterparts. Ongoing recruitment efforts will focus particularly on underrepresented groups.

An additional challenge revolved around management of the meeting itself. Because all participants were eager to share their experiences and personal interests, some group members were more vocal throughout, at times making it challenging for others' voices to be expressed. Moving forward, each meeting will begin with a summary of meeting expectations, including adhering to time limits and avoiding interruption.

Lastly, maintaining momentum and enthusiasm throughout the PFAC group will continue to be a challenge, both for patient and family participants and for staff. We plan to schedule meetings quarterly for the first year in order to continue to build momentum, with the option of decreasing frequency to three times annually in the second year.

While it is too early to determine whether the formation of the ED PFAC will lead to quantitative improvement in ED patient experience, initial feedback has been universally positive, with patients, family members, staff, and departmental leadership enthusiastic about the promise of gaining the patient and family member perspective in our ongoing patient experience efforts. Despite the challenges in providing excellence in patient experience in the ED, this relatively low-effort, low-resource project has the potential to bring significant and longstanding improvement for our patients and their families.⁶⁻⁸ ●

References

1. Emergency Department Patient Experiences with Care (EDPEC) Survey. Accessed via: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/CAHPS/ed.html>, January 2019.
2. HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems. Accessed via: <http://www.hcahponline.org/>, January 2019.
3. Working with patient and families as advisors (Implementation Handbook). Agency for Healthcare Research and Quality. Accessed via: https://www.ahrq.gov/sites/default/files/wysiwyg/professionals/systems/hospital/engagingfamilies/strategy1/Strat1_Implement_Hndbook_508_v2.pdf, January 2019.
4. Tyser AR et al. Evidence of non-response bias in the Press-Ganey patient satisfaction survey. *BMC Health Serv Res*. 2016 Aug 4;16.
5. Massachusetts General Hospital 2017-18 Patient and Family Advisory Council Annual Report. Accessed via: <https://www.massgeneral.org/patientadvisorycouncils/assets/pdf/2017-18-massgeneral-pfac-annual-report.pdf>, January 2019.
6. Welch SJ. Twenty years of patient satisfaction research applied to the emergency department: a qualitative review. *Am J Med Qual*. 2010;25(1):64-72.
7. Pines JM, Iyer S, Disbot M, Hollander JE, Shofer FS, Datner EM. The effect of emergency department crowding on patient satisfaction for admitted patients. *Acad Emerg Med*. 2008;15(9):825-831.
8. Taylor C, Bengler JR. Patient satisfaction in emergency medicine. *Emerg Med J*. 2004;21(5):528-532.



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