

# Look to the past to improve our future: Improving quality, safety and equity through community and patient engagement

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**Abstract** Healthcare administrators must ensure delivery of care that is high quality, safe and produces equitable outcomes while balancing business, workforce and community needs. To meet these challenges while guiding their organisations through COVID-19 recovery, administrators can look to a strategy with a strong track record for success: engaging patients, families and communities. This paper focuses on evidence, experience and best practices for improving quality, safety and equity by engaging people, patients, families and communities. Effective patient and family engagement (PFE) and community engagement strategies draw on research and experience across a wide variety of efforts, from nationwide federal programmes such as the Centers for Medicare and Medicaid Services Partnership for Patients initiative to health system- and neighbourhood-level programmes. Research demonstrates that commitment to PFE leads to measurable improvements in quality and safety. Experience shows that engagement, when practiced with attention to diversity, equity and inclusion, can reduce health disparities. Engagement best practices include: making engagement a strategic priority, embedding patients and families with diverse perspectives into improvement efforts, supporting continuous learning by adapting engagement efforts over time, benchmarking progress and measuring disparities. To continue the advances begun before the pandemic, healthcare administrators and leaders must redouble engagement efforts and implement best practices. Administrators can meet the many challenges of the moment by returning to the proven strategy of engaging patients, families and communities to drive integrated quality, safety and equity efforts.

**KEYWORDS:** quality, safety, equity, patient and family engagement, community engagement, improvement, high-reliability organization, HRO

## INTRODUCTION

The task of every healthcare administrator is to ensure that the hospitals and clinics they oversee consistently provide high-quality care to all patients while balancing business, workforce and community needs. Accomplishing this task has always been a major challenge, no time more so than the past several years as hospitals and health systems mobilised in response to the COVID-19 pandemic. From C-suites (or home offices) to intensive care units and laboratories, people working at every level of the healthcare system met the COVID-19 crisis with extraordinary speed, innovation and persistence. Leaders marshalled resources and supported staff to enable this response, while also working through crisis standards of care for patients' many medical needs, not only COVID-19 treatment. Almost overnight, every challenge present

before the pandemic became much more difficult, including preventing patient harm, addressing provider burnout and delivering better care with fewer financial resources.<sup>1</sup> Leading healthcare systems through these challenges was made all the more difficult amid social upheaval due to the murders of George Floyd, Breonna Taylor and Jacob Blake and politicisation of science and public health measures.<sup>2</sup>

As the gradual transition from the crisis phase of pandemic response to a long period of recovery occurs, healthcare system leaders, innovators and policymakers are assessing lessons learned<sup>3</sup> and beginning to envision future possibilities for American healthcare.<sup>4,5</sup> Front and centre among these lessons is the importance of health equity. The stark racial and ethnic disparities in rates of COVID-19 infection, hospitalisation, death and vaccination during the pandemic have

highlighted the imperative for health equity to be a top priority.<sup>6-9</sup> Although for years the ‘forgotten aim’<sup>10</sup> in quality improvement efforts, equity is an essential element of quality, as defined by the seminal *Crossing the Quality Chasm* report (2001).<sup>11</sup> Healthcare’s recent focus on equity adds to the urgency to restart national efforts to improve quality and safety.

Health system leaders who feel this urgency have developed equity strategies, including designating chief health equity officers charged with addressing health disparities within the populations they serve. Others have yet to address health equity in the midst of juggling competing priorities to lead their organisations to a ‘new normal’. However, unless and until all health system leaders approach quality, safety and equity as three equal pillars within an integrated improvement strategy, systems and systemic barriers that have historically perpetuated inequities will continue to be reinforced. Advancing health equity requires recognition that there is no quality or safety without equity and healthcare leaders must prioritise delivering care that is high quality and safe for everyone.

While the challenges that healthcare leaders face are innumerable, there is good news. Evidence and more than a decade of experience point to effective strategies for improving quality, safety and equity. Quality improvement efforts in the decade prior to the pandemic showed significant gains in patient safety<sup>12</sup> and demonstrated that patient, family and community engagement advance quality, safety and equity.<sup>13,14</sup>

As health systems move from the COVID-19 crisis to recovery, they — and patients — will benefit from the learnings and proven methods implemented before the pandemic. Getting back to what works, including engaging diverse patients, families and community members throughout integrated quality, safety and equity efforts, can accelerate improvements. This paper

highlights some of the most important evidence-based engagement strategies that healthcare leaders and administrators can draw on to create an integrated improvement strategy with quality, safety and equity as three equal pillars.

### **CONTINUATION OF QUALITY AND SAFETY GAINS BEGUN BEFORE THE PANDEMIC**

A recent analysis across more than 3,000 hospitals showed that between 2010 and 2019, observed rates of patient safety events decreased significantly among nearly 250,000 patients hospitalised for acute myocardial infarction, heart failure, pneumonia and major surgical procedures.<sup>15</sup> Patients’ relative risk of adverse events remained significantly lower in 2019 compared to 2010 even when adjusting for patient and hospital characteristics. The authors note that this decline in observed patient safety events coincided with the Centers for Medicare & Medicaid Services (CMS) Partnership for Patients programme that focused on hospital safety, patient engagement and eliminating disparities, among other national quality improvement efforts, although the study did not seek to link adverse event rates to these improvement efforts. This analysis highlights the success of widespread and sustained quality improvement and patient safety efforts prior to the pandemic.

### **PFE is essential to improvement efforts**

Experience across more than 4,000 hospitals in the CMS Partnership for Patients programme showed that engaging patients and families throughout quality and safety efforts improved outcomes and patient experience. Patient, or person, and family engagement (PFE) was an important component of the Partnership for Patients model that demonstrated engagement as a framework that went beyond the work of

patient experience and patient satisfaction. PFE fosters partnerships between healthcare leaders, professionals, patients and families to drive clinical outcomes. At its essence, PFE means patients and families are partners in defining, designing, participating in and assessing the care practices and systems that serve them.<sup>16</sup> This assures that practices and systems provide patient- and family-centred care: care that is respectful of and responsive to individual patient preferences, needs and values. PFE occurs at the point of care, at the organisational level and at policy, governance and community levels.<sup>17</sup> Comprehensive quality, safety and equity strategies require PFE at each of these levels. Collaborative engagement with patients and families representing the communities a health system serves ensures that patients' values guide all clinical decisions and communities' needs and priorities drive genuine transformation in attitudes, behaviour and practice.

Within the Partnership for Patients programme, CMS assessed hospitals' engagement efforts using five metrics<sup>18</sup> that focused on engagement at the point of care, in organisational-level policies and protocols and in governance. These metrics assessed hospitals' efforts to prepare patients for planned admissions, include patients in shift-change huddles and bedside rounding, integrate PFE into hospital management operations (eg hiring a dedicated PFE leader), integrate patients and families into advisory committees or councils, and include them on hospitals' governing Boards. Hospitals participating in Partnership for Patients made major gains in implementing PFE practices as measured by these metrics. For example, rates of PFE implementation among participating hospitals increased from between 18 and 34 per cent across the five metrics in January 2017 to between 52 and 84 per cent across the metrics in November 2018.<sup>19</sup>

CMS points to nationwide gains in patient safety during the Partnership for

Patients programme implementation as evidence of the programme's success.<sup>20</sup> The Agency for Healthcare Research and Quality (AHRQ) reported a 17 per cent reduction in hospital-acquired conditions such as pressure ulcers and central-line associated blood-stream infections between 2010 and 2014.<sup>21</sup> This decline coincided with the initial phase of the Partnership for Patients programme, which began in 2011. AHRQ estimated that between 2010 and 2014 this improvement resulted in 2.1m fewer patient harms, 87,000 fewer deaths and approximately US\$20bn in cost-savings.<sup>22,23</sup> These improvements continued in subsequent years as CMS continued to adapt the programme, with an estimated 910,000 fewer hospital-acquired conditions, 20,700 fewer hospital deaths and US\$7.7bn fewer healthcare costs between 2014 and 2017.<sup>24</sup> As noted previously, more recent analyses confirm these improvements in hospital care quality and safety and expands the analysis through 2019.<sup>25</sup>

Research likewise shows that a commitment to PFE leads to measurable improvements in quality and safety. Work within the Vizient Hospital Improvement Innovation Network, or HIIN, demonstrated that when PFE is fully implemented within an organisation, PFE correlates with improvements in clinical outcomes. In 2017, the Patients First project showed a correlation between 98 hospitals' scores on a weighted PFE scoring system and better outcomes on 30-day potentially unplanned readmissions and falls with injury.<sup>26</sup> The weighted scoring system assessed the depth, breadth and intensity of implementation of each of the essential elements of PFE measured by the CMS Partnership for Patients metrics.<sup>27</sup>

More recent experience within a large academic health system with multiple facilities serving rural and urban populations showed that implementing the Integrated PFE Index Assessment, a benchmarking

tool that quantifies PFE implementation and recommends areas for improvement, underscored the opportunities to leverage PFE in continuous improvement efforts. Across more than a dozen hospital campuses within this health system, CEOs, quality and safety officers, medical and nursing directors, and patient experience leaders recognise the importance of PFE, but implementing engagement practices and tracking and measuring how engagement contributes to overall quality, safety and equity goals were not well understood. Measuring PFE implementation is helping these leaders recognise how, for example, engaging patients and families in care planning through inpatient staff rounding and shared decision making can prevent patient safety events like falls and medication errors. Another hospital in this system revised their Sickle Cell Disease treatment guidance after learning through integrated community engagement and equity efforts that stereotypes about patients with Sickle Cell Disease often led to poorly managed pain for this predominantly black population.

A 2018 analysis of 110 hospitals in the state of New York found that hospitals with high-performing Patient and Family Advisory Councils (PFACs), a mechanism for integrating patients and families into organisational management and operations, had statistically significant lower rates of pressure ulcers, sepsis and septic shock, and 30-day hospital-wide readmissions, compared to hospitals with lower-performing PFACs.<sup>28</sup> High-performing PFACs were defined as those scoring in the top 50 per cent of all hospitals within the study on measures of PFAC orientation, committee participation and evaluation. Hospitals with any PFAC (whether high- or low-performing) had better quality and safety outcomes than those with no PFAC. Presence of a PFAC, and especially high-performing PFACs, was also associated with higher Hospital Consumer Assessment of Healthcare Providers Survey scores.

PFE has played an important role in improvement efforts within ambulatory care settings as well as in hospitals. For example, the CMS Transforming Clinical Practices initiative emphasised PFE as an important improvement strategy for the more than 140,000 primary care and specialist providers participating in this four-year effort to prepare ambulatory care practices to successfully participate in value-based payment arrangements.<sup>29</sup>

### **Engaging to advance equity**

Although data on health disparities in the US abound,<sup>30</sup> attention towards addressing those disparities as part of quality and safety improvement efforts has been more limited until recent years. National standards for culturally and linguistically appropriate services provide further guidance demonstrating that diversity, equity and inclusion are essential for delivering<sup>31</sup> high-quality care. These standards include engaging patients, families and the broader communities that health systems serve to understand their diverse needs and values and designing services that align with what matters most to communities. Experience with early phases of the Partnership for Patients programme underscored the importance of PFE as part of health equity efforts, spurring CMS to provide additional guidance on how to apply PFE best practices in ways that work towards more equitable health outcomes.<sup>32</sup>

Community engagement, when practiced with attention to diversity, equity and inclusion, can reduce health disparities and begin addressing long-standing health inequities. Rush University Medical Center in Chicago has demonstrated this through a health equity strategy that emphasises listening to, partnering with and investing in communities<sup>33</sup> as an important component of efforts to improve health outcomes. University of Chicago Medicine also prioritises community engagement

throughout its delivery system, including more than a decade of collaboration with community, ethnic- and faith-based groups to address wide disparities in cancer care among Chicago's most underserved neighbourhoods<sup>34</sup> and extensive community investment and partnership initiatives spanning maternal health, violence recovery and COVID-19 care programmes.<sup>35</sup> The Atrium Health Community Immunity for All programme, recognised by the American Hospital Association in 2021 with the Carolyn Boone Lewis Equity of Care Award,<sup>36</sup> eliminated gaps in COVID-19 testing for African American, black, Hispanic and Latinx community members. Major elements of the programme included collaborations between the health system and 150 community partner organisations and engaging Atrium Health staff and community members as ambassadors who promoted COVID-19 vaccination with their peers.<sup>37</sup>

Experience with the Community Engagement in Early Recognition and Immediate Action in Stroke (CEERIAS) study offers another example<sup>38</sup> of closing health disparities gaps through sustained engagement efforts. Begun in 2014 to address racial disparities in stroke outcomes within Chicago neighbourhoods with majority black populations, this project engaged community members to design and share information within their neighbourhoods about signs, symptoms and local treatment options for stroke. Over three years, the effort significantly increased the use of emergency medical services for suspected stroke within the intervention neighbourhoods, compared to control neighbourhoods. In 2020–2021, a follow-up study (2CEERIAS) adapted this successful community engagement approach to rely primarily on virtual methods during the pandemic.<sup>39</sup> Even after research support ended, community members continue to educate family and neighbours about stroke preparedness more than eight years after the initial study began.

The weight of this experience and evidence shows that engaging patients, families and communities is an essential part of efforts to improve quality and safety while advancing equity.

## GETTING BACK TO WHAT WORKS

To continue the advances begun before the pandemic, healthcare leaders and administrators must redouble engagement efforts and continue, reboot or implement best practices that experience and evidence show to be effective at improving quality, safety and equity of healthcare. Thankfully, both federal organisations<sup>40–42</sup> and philanthropic<sup>43–45</sup> funders have supported development of resources outlining engagement best practice.

Six practices common across these resource guides that are crucial for driving success are outlined as follows.

### **Manage engagement efforts as a strategic priority with board oversight**

Aligning engagement with organisational mission, vision and values drives behaviour across the organisation when leaders integrate engagement throughout personnel management, such as hiring, organisational socialisation and staff performance evaluations.<sup>46</sup> Integrating engagement into organisational development and governance is equally important.<sup>47</sup> Developing and sustaining (or reviving) a PFE programme requires strategic investment to ensure adequate staff time, skills development, organisational socialisation and sustained support for patient and family advisers (PFAs). PFAs are patients and family members who work together with healthcare professionals to improve healthcare by sharing their insights about the experience of care and offering suggestions for improvement.<sup>48</sup> To connect PFE with community engagement, leaders and staff supporting engagement efforts must commit

to seeking out and building relationships with PFAs who bring diverse lived experiences and can represent communities who experience disparities in health outcomes.<sup>49</sup>

### **Embed PFAs with diverse perspectives into improvement efforts that integrate quality, safety and equity goals**

PFE is an equity strategy when health systems build authentic partnerships with patients, families and community members who represent marginalised populations, such as racial and ethnic minorities, persons with disabilities and people who identify as LGBTQ.<sup>50</sup> Marginalised populations have a greater likelihood of negative health outcomes because of social and economic disadvantages arising from systemic racism and exclusionary policies. To tackle long-standing health inequities that stem from systemic and intertwined health, social and economic disadvantages, health systems must build trust and work collaboratively with communities who experience these inequities. An important first step is inviting people who represent communities that experience the poorest quality and safety outcomes to share their priorities. Health systems must listen and build trust, then create opportunities for these community representatives to co-create with leaders, staff and clinicians solutions tailored to their communities' needs and priorities. This includes engaging community members as PFAs in strategic planning and including them within quality improvement advisory groups such as PFACs. Engaging PFAs across the lifecycle of improvement efforts best positions them to contribute meaningfully and avoids delays or rework that often arise when patients and families are not included in early design phases.<sup>51</sup>

### **Support continuous learning by adapting engagement efforts over time to meet evolving organisational and patient needs**

As the past several years have shown, the ability to quickly adapt to changing needs is vital to health systems' success. Identifying and sharing lessons learned as part of engagement efforts build organisational capacity for rapid adaptation to a wide variety of pressures and crises,<sup>52</sup> as became so evident during the pandemic. For example, some health systems that pivoted PFACs to virtual formats found this format lowered barriers to engagement and created opportunities for patients and families to improve vaccination campaigns, pandemic visitation policies and communication related to COVID-19 care.<sup>53</sup> Regular, informal check-ins with PFAs throughout their engagement builds trust, surfaces areas for improving engagement practices and can identify quality, safety or equity concerns ripe for improvement efforts. Creating opportunities for patients and families to speak about the impact they feel as a result of improvement and PFE efforts connects the investments in these practices to the goal of improving lives.

### **Benchmark progress to guide action**

While PFE is a dynamic process built on relationships and teamwork, experience with Partnership for Patients and related efforts has shown that it is possible — and beneficial — to measure engagement efforts. Measures such as the five CMS PFE metrics, or the Integrated PFE Index Assessment tool that expanded on these metrics, provide benchmarks to quantify implementation of evidence-based PFE practices.<sup>54</sup> Benchmarking PFE efforts to best practices allows health systems to identify areas for further integrating PFE and quality improvement efforts and provides essential data for demonstrating the connection



between engagement efforts and quality, safety and equity gains.<sup>55</sup> As increasing numbers of health systems deepen their engagement efforts, health systems will also benefit from understanding how their efforts compare to peer institutions, such as among critical access hospitals or urban medical centres. Furthermore, clearly and consistently communicating how engagement efforts — benchmarked to best practices — are leading to improved outcomes and patient experience can solidify support for continued PFE efforts among staff, board members and PFAs. When measuring PFE, it is important to engage patients and families who bring racial, ethnic and cultural diversity in the process of making sense of data and planning actions to address areas needing improvement.<sup>56</sup>

### **Measure disparities and assess community needs**

The mandate today is clear: quality and safety efforts must address long-standing health disparities. Efforts to advance equity must begin with a clear understanding of disparities. This means health systems must examine their own data to identify gaps in care quality, safety and outcomes by race, ethnicity, language, age, insurance status and other demographic and social factors.<sup>57</sup> Collecting information from patients about their race, ethnicity and language preferences (known as REAL data) and sexual orientation and gender identity (known as SOGI data) is an important first step, as are stratifying outcomes by these characteristics and choosing comparators that will highlight rather than obscure disparities.<sup>58</sup> Understanding social needs within communities served, such as access to affordable food and housing, is likewise important so that health systems can identify where partnerships with local social service providers will best address unmet health and social needs.

Designing data collection processes and interpreting data in partnership with patients, families and communities are essential to ensure that data reflects communities' cultures and provides a complete view of their diverse experiences. Growing recognition of the importance of patient-, family- and community-driven data is driving the adoption of PFE throughout healthcare research and quality measurement efforts.<sup>59–61</sup> Vital to community-centred data use are partnerships with patients and families representing diverse communities. These require long-term commitment to build trust and develop culturally competent engagement skills among staff and leaders.

### **Integrate engagement and equity with principles of high-reliability organisations**

High reliability is another framework often implemented by organisations striving to improve quality and safety.<sup>62,63</sup> To succeed in creating a culture that strives for failure-free operations amid extraordinary complexity and the potential for catastrophic errors, HROs must centre their focus on patients and fully integrate health equity. It is therefore crucial that any healthcare system that is committed to becoming a high-reliability organisation (HRO) commits to achieving health equity. This means the organisational strategic plan should include, explicitly, addressing patient engagement and not merely patient experience as well as health inequity and its root causes. These root causes include implicit bias, structural racism, mistrust and leadership commitment.

Addressing inequity, in an HRO, requires collective mindfulness by leadership and a preoccupation with failure. This means messaging a bold aim such as 'zero inequity' and giving continuous attention to the ways in which inequities arise. In health systems, the HRO principle of sensitivity to operations means asking how root

causes of inequity operate in a system. Sensitivity to operations also demands that organisations collect and stratify REAL and SOGI data. The HRO principle of deference to expertise means that the system leadership seeks out and engages internal and external partners to better understand signals of inequity. The HRO principle of reluctance to simplify guides systems to invest in engagement to better understand and address what matters most to people and their communities. This is particularly important because in an HRO, a culture of safety must be implemented. A culture of safety includes establishing psychological safety, learning from failure and reporting episodes of bias, racism and cultural microaggressions. Lastly, when addressing inequity, the HRO principle of becoming a resilient system requires a focus on equity in all process improvement efforts, including using data to drive change, continuously monitoring for disparities, anticipating the unexpected and keeping the system in a constant state of readiness. The same is so for patient engagement. Patient engagement is not equal to patient experience and patient satisfaction — it is far more extensive and valuable to quality and safety improvement efforts. Organisations must understand these differences and make the connection of their PFE work to quality, safety, equity and HRO activities.

## CONCLUSION

A fundamental learning for improving quality, safety and health equity is activating a system for patient engagement; one that deepens and broadens the work of patient experience. To achieve results delivery systems must expand engagement and equity systems vs traditional patient experience efforts. Experience and evidence show that PFE and community engagement are essential strategies for improving quality and safety while advancing equity. While the intersection of the pandemic, health

disparities, provider burnout and growing cost pressures presents health system leaders with unprecedented challenges, leaders can draw on an extensive bank of experience and evidence as they respond to these challenges. As a new normal emerges out of the COVID-19 crisis, it is essential that health system leaders and administrators return to the strategies that work: engaging patients, families and communities to drive an integrated improvement strategy founded on quality, safety and equity as three equal pillars.

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