INSTITUTE FOR PATIENT- AND FAMILY-CENTERED CARE®

vizient®

Prevalence and functioning of patients and families as educators in hospitals and academic medical centers: A national study

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Table of contents

Executive summary ... 3
Introduction ... 5
Rationale ... 7
Methods ... 9
- Study population ... 9
- Instrument construction, pretesting and data collection ... 9
- Data analysis ... 10

Findings ... 11
- Research question #1 ... 11
- Research question #2 ... 12
- Research question #3 ... 16
- Research question #4 ... 18

Discussion ... 29
Limitations ... 30
Conclusion ... 31
Authors ... 32
References ... 33

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Executive summary

Engaging patients and families across all levels of a health care organization is an approach shown to be associated with better outcomes in quality and the experience of care for patients. Patients and families can do more than give feedback on their episodic experience. They can provide longitudinal and systematic feedback and recommendations to improve quality and safety such as preventing patient falls and hospital readmissions, improving hand-hygiene compliance or medication safety by partnering with health care systems. They can serve in key roles such as members of board level committees and as educators of health care professionals, students and trainees.

The implementation of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey program over a decade ago added the imperative to provide patient- and family-centered, high quality care. Patient- and family-centered care is working *with* patients and families, rather than just working *for* them or doing something *to* them.

In October 2020, Vizient® and the Institute for Patient- and Family-Centered Care® (IPFCC) conducted a survey to understand the prevalence and functioning of patients and families as educators in hospitals and academic medical centers (AMCs). The study population included 67 health care organizations from AMCs, teaching hospitals, community-based hospitals and specialty hospitals (e.g., children's hospitals, cancer centers). For purposes of the study, respondents were grouped into two categories "AMCs" and "non-AMCs" (teaching hospitals, community-based hospitals and specialty hospitals). Highlights from the findings are noted below.

- The survey found that of the 67 total respondents, 54% had involved patients and families when educating staff, clinicians and organizational leaders.
- There are no differences between AMCs and non-AMCs in terms of the likelihood of involving patient and family advisors (PFAs) as educators for staff, clinicians and organizational leaders.
- When it comes to the education of students or trainees (e.g., medical and nursing students, residents, allied health students), 41% of the 46 AMC respondents involved patients and families.
- None of the AMCs scored at the highest range of the index measuring PFA involvement in the education of students and trainees, with most scoring in the lower range.
- AMCs and non-AMCs with longer and deeper experience with PFAs and with patient and family advisory councils (PFACs) are more likely to utilize PFAs in educational programming.
- When it comes to involving PFAs in the education of students or trainees, the size of an AMC is significantly associated with greater likelihood of PFAs involvement (larger AMCs are more likely to involve PFAs in educating students or trainees).

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- The top third of the health care organizations that involve PFAs in hospital educational efforts provide much higher level of support to the PFAs than do the rest of the participants. The different types of support provided include training, evaluations and reimbursement for expenses.

In some exemplary hospitals and health systems, patient and family engagement is considered a strategy within the overall framework of and commitment to patient- and family-centered care. Hospital leaders and staff, as well as PFAs, benefit from training for effective integration of patient and family engagement and the implementation of patient- and family-centered care practices. Once trained, PFAs become effective teachers of practices that facilitate 1) collaborative communication, 2) coordination within teams and across disciplines and settings, and 3) authentic partnerships with patients and families. Traditionally, when hospitals have involved PFAs in education or organizational training/development, the use is almost exclusively in the hospital setting.

This study reveals areas of opportunity to develop the infrastructure to support sustainable and meaningful involvement of PFAs as educators, including:

- dedicating time and resources for a staff member or clinical faculty member to serve as the coordinator or liaison for patient and family faculty;
- increasing efforts to provide specific training for PFAs to serve as patient and family faculty (e.g., storytelling training, presentation skills training);
- increasing efforts to prepare or train hospital leaders, clinicians, staff, and clinical faculty to partner with patient and family faculty, especially in AMCs;
- systematically evaluating educational activities that include PFAs as educators and sharing those results with them;
- acknowledging and rewarding clinical faculty in AMCs for their work in partnering with patient and family faculty; and
- increasing reimbursement and compensation for patient and family faculty.

It also provides a starting place upon which more information and evidence can be built to realize the benefits of engaging PFAs as educators and faculty to teach students, trainees, clinicians, staff and leaders. Their engagement in education is lacking yet vital to support systems of care that are safe, equitable, patient- and family-centered and provide high-quality care at lower costs.

These findings can serve to raise awareness of the possibilities for health care organizations just starting on this journey, and as a call to action for those that are poised to expand the role PFAs play in their institutions.

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Introduction

Issues regarding cost, quality and safety in the United States health care system are well-known, and now, the COVID-19 pandemic has brought to light the long-standing issue of health disparities. The National Academy of Medicine produced two landmark reports, to Err Is Human and Crossing the Quality Chasm, revealing these issues in 1999 and 2001. Additionally, the Agency for Healthcare Research and Quality has reported on health care quality and disparities for 17 years. Its latest report, which includes more than 250 structure, process and outcome measures, shows that although quality of care, along with some health disparities are improving, these issues persist and some are worsening, especially for minority, poor and uninsured populations.[1]

When compared with other countries, the United States health care system underperforms. It is the largest consumer of health services, but ranks last in overall health system performance among 11 nations—Australia, Canada, France, Germany, the Netherlands, New Zealand, Norway, Sweden, Switzerland, the United Kingdom, and the United States—according to The Commonwealth Fund's latest report "Mirror, Mirror on the Wall, 2017".[2] This ranking has not changed since 2004.

Because of these issues, hospitals and health care organizations continually seek tools and resources to help them reduce costs while improving the quality, safety and equity of health care delivery. Additionally, the implementation of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey program over a decade ago added the imperative to provide patient- and family-centered, high quality care. Patient- and family-centered care is working *with* patients and families, rather than just working *for* them or doing something *to* them. HCAHPS survey results are used in the Centers for Medicare and Medicaid Services Value-Based Purchasing program, affecting hospital reimbursement by up to 25%. Although not without its critics, the HCAHPS survey program has had a profound impact on and serves as the foundation for the voice of the customer in providing feedback to the U.S. health care system.

Beyond the HCAHPS survey, patients and families can do more than provide feedback on their experience with each interaction they have with the health care system. They can provide longitudinal and systematic feedback on quality and safety concerns such as patient falls, early mobility of patients, hand hygiene compliance and medication safety by partnering with health care systems. In fact, engaging patients and families has been called the "Blockbuster drug of the century"[3] and patients and families have been referred to as the most underutilized patient safety resource in health care today.

Patient and family engagement (PFE) has been defined as "patients, families, their representatives, and health professionals working in active partnership at various levels across the health care system—direct

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care, organizational design and governance, and policy making—to improve health and health care."[4] Patient engagement has been studied in recent years and evidence suggests that patient engagement can "lead to better health outcomes, contribute to improvements in quality and patient safety, and help control health care costs."[4]

Engaging patients and families across all levels of a health care organization is an approach shown to be associated with better outcomes in quality and the experience of care for patients. In 2018, Vizient and the Institute for Patient- and Family-Centered Care (IPFCC) (funded by the New York State Health Foundation) conducted separate studies that demonstrated a correlation between increased levels of PFE and better outcomes in quality measures including readmissions,[5,6] falls,[5] pressure ulcers,[6] and sepsis[6] as well as "likelihood to recommend" HCAHPS scores.[6] Hospitals that systematically partner with patients and families in quality, safety and operational improvement work—from the point of care to organizational policies and protocols to the governance of the organization—reap the rewards of those efforts. Notably, AMCs are among the top performers when it comes to utilizing engagement as an outcomes improvement strategy in the hospital setting.[5,6]

In some exemplary hospitals and health systems, PFE is considered a strategy within the overall framework of and commitment to patient- and family-centered care. Hospital leaders and staff, as well as patient and family advisors (PFAs), benefit from training for effective integration of PFE and the implementation of patient- and family-centered care practices. Once trained, PFAs become effective teachers of practices that facilitate 1) collaborative communication 2) coordination within teams and across disciplines and settings and 3) authentic partnerships with patients and families. Traditionally, when hospitals have involved PFAs in education or organizational training/development, the use is almost exclusively in the hospital setting.

Over many years, PFAs have been serving as "faculty" in graduate and undergraduate education of students or trainees in medical and other health professions. Yet, little is known about the prevalence of patient and family advisors serving as educators, structures to support these roles or the effect of their involvement. Several small studies and anecdotal examples of the use of PFAs as educators in health care exist, but no broad study regarding this topic was found.

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Rationale

The relationship between clinicians, patients and their family members is foundational to health care. Concepts reflecting a patient- and family-centered care approach—showing respect and empathy; using open, honest, and bi-directional communication; and encouraging shared-decision-making and participation in care are skills that are essential for productive relationships. Often these can be thought of as the "soft skills" of medicine but in fact they are imperative to care quality, safety, equity and experience.[7] The Joint Commission has stated that sentinel events are typically related to human factors, and high on the leading cause list is communication failure.

Medical societies such as the American Academy of Orthopedic Surgeons/American Association of Orthopaedic Surgeons have realized the benefit of improving communications. "Physicians who practice patient-focused communication, show empathy and respect, listen attentively, elicit patients' concerns and calm fears, answer questions honestly, inform and educate patients about treatment options, involve patients in medical care decisions, and demonstrate sensitivity to patients' cultural and ethnic diversity."[8]

Even though practicing patient- and family-centered care is key to build trusting relationships, adequate time in health professional educational curriculum and opportunities to learn, prepare and integrate these skills into practice is lacking. In addition, clinical educators may not feel comfortable or capable to teach these skills. However, there is an approach to education that can address these gaps—integrating patients and families as educators of health care professionals. While the importance of involving patients and families in health professional education seems intuitive as an essential component of promoting patient- and family-centered care, evidence of their involvement is lacking. Yet there is growing support from professional organizations and evidence pointing to the benefits of their inclusion.[9-12]

Patients and families have valuable perspectives to share that contribute in a variety of ways to the instruction and learning of students, trainees and health professionals. For example, they can describe their experience of living with a chronic condition, share the challenges they face in accessing and navigating the health care system, highlight the important role families play in their health and health care and talk about how they may have experienced discrimination, stereotyping or stigma within the health care system. Patients and families can also help students, trainees and health professionals learn how to communicate effectively, build trusting relationships and support partnerships with patients and families in their interactions. Patients and families provide a unique view of the realities of health care and the health care system as well as current challenges such as disparities and inequity. When patients and families serve as faculty for students in medical and other health professions and continuing education for health

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care professionals, they humanize the educational experience and often remind health professionals of the reason they chose healthcare as a career.

Patients and families can serve as educators in a variety of ways, ranging from episodic interactions (e.g., sharing their experiences to a nursing student class, serving as a guest speaker at new employee orientation) to ongoing learning experiences (e.g., offering medical students the opportunity to shadow them over time as they manage their conditions and navigate the health care system) to full partnerships (e.g., patient, family and clinical faculty collaborate to develop educational content and teach learners together).

One barrier to the implementation of patient and family faculty programs is the traditional paradigm—one in which health care professionals function as "experts" and may not see a need to engage patients and families in education or view them as having the knowledge and skills to serve as faculty. Research suggests that it is critical to prepare patients and families so they can assume these roles and be effective as faculty and in collaborating with clinical educators.[13] Clinical educators also need to be prepared to partner with patient and family educators. Patient and family faculty need resources and support to facilitate meaningful and long-term engagement.[14] Evaluation of patient and family faculty programs also needs to be conducted to build an understanding of what resources and infrastructure are necessary to develop and sustain effective programs.

While some patient and family faculty programs have been integrated into the education of students in medical and other health professions and in continuing education within health systems for decades, there is still much to be learned. No study has been found that looked at the prevalence and functioning of these programs in the U.S. Therefore, Vizient and IPFCC collaborated to conduct a national survey to explore the integration of patients and family caregivers in continuing education of health care professionals and undergraduate or graduate students, resident and other interprofessional education.

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Methods

The research team defined the study population, carried out instrument-construction and pre-testing, as well as the data collection and analysis processes as outlined below.

Study population

The study population is based on a list of 193 Vizient members and IPFCC contacts, of which 67 completed the survey instrument for a 35% participation rate. The types of hospitals included in the study population are AMCs (n=46), teaching hospitals (n=7), community-based hospitals (n=4) and specialty hospitals such as children's hospitals and cancer centers (n=10).

For purposes of the study, survey respondents were grouped into two categories "AMCs" (academic medical centers) and "non-AMCs" (teaching hospitals, community-based hospitals and specialty hospitals).

Other demographic information of note about the respondents are the bed size range and the location distribution. The bed sizes, which include hospitals and health systems with multiple facilities, range from 100 to 6,222 with a median of 598 beds. Survey respondents were from urban or suburban locations, 87% and 12% respectively, and span 31 states and the District of Columbia.

Instrument construction, pretesting and data collection

The survey instrument was designed by subject matter experts from Vizient and IPFCC and tested by select Vizient member health care organizations. Aside from basic demographic questions, the survey was divided into three distinct segments:

1. Five general questions about PFA programs that focused on if and how organizations involve patients or family members as advisors or as members of Patient and Family Advisory Council(s) (PFACs).
2. Twenty questions about how organizations involve PFAs as faculty in developing and presenting educational or organizational development programs in the hospital setting (e.g., staff orientation, continuing education) and how they support PFAs in their role as educators.
3. Twenty questions that focused on how academic organizations involve PFAs as Patient and Family Faculty in developing and presenting educational programming in medical education and/or in education of students and trainees in other health professions in the organization (e.g., medical and nursing students, residents, allied health students) and how they support PFAs in their role as educators.

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A link to an electronic survey was sent to specific individuals from the list of 193 Vizient members and IPFCC contacts. These individuals were either Chief Patient Experience Officers or Chief Nursing Officers. Coordinators of patient and family advisory programs were also included. Data collection took place in October and November 2020. Reminders to non-respondents were sent on a regular basis. Both Vizient and IPFCC also communicated about opportunities for organizations to participate in the survey via social media channels (e.g., Twitter, Facebook, LinkedIn). Those efforts did not result in additional survey respondents.

Participants were eligible to respond to more questions if they have PFAs, and those advisors are involved in educating clinicians, staff and leaders, as compared to respondents that did not have PFAs. AMCs associated with schools (e.g., medical and nursing students, residents, allied health students) that provide educational programming for students/trainees and involve PFAs as "faculty" were eligible to answer all of the survey questions.

Data analysis

Data analysis began with a univariate and bivariate analysis of the survey results, categorizing the findings by type of hospital. Indices were constructed to represent the main dependent variables: 1) the extent that hospitals engage patients and family members in education and training of clinicians, staff and administrators and 2) the extent that AMCs engage patients and family members in the education of students and trainees.

The reliability of these indices was assessed using Kronbach's Alpha. Only indices showing a Kronbach's Alpha of .70 were included in analyses. Bivariate analysis between the indices and descriptors of the hospitals were carried out, as well as for each subset of hospitals. Researchers examined the hospitals that were in the top third of respondents in terms of the extent of involvement (EOI) of patients and families as faculty in educational programming. Two key indices were used:

> **EOI – Hospitals:** This index measures the 'extent of involvement' of patients and families as faculty within hospital facilities (e.g., engagement of patient and family as faculty in new employee orientation, various continuing education activities, in development and design of educational or organizational programs).
>
> **EOI – AMC Schools:** This index measures the 'extent of involvement' of patients and families as faculty within medical schools and schools of health professions (e.g., number of patient and family faculty who serve as educators and/or help develop and design courses in which years of schooling students and/or trainees have opportunities to learn from patients and family faculty).

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Researchers sought to address four key questions regarding involvement of PFAs in educating students, trainees, clinicians, staff and leaders.

1. How prevalent is the involvement of PFAs in educational efforts within hospitals? How prevalent is their involvement in educational efforts within AMC schools?
2. What are the characteristics of health care organizations that are most likely to involve PFAs as educators?
3. How do health care organizations support their PFAs when they contribute to educational efforts? What types of support are most likely to be provided?
4. What types of educational activities are health care organizations likely to engage PFAs in, and what are they least likely to engage them in?

Findings

This study examined the degree to which PFAs are integrated into educational programming, specifically the extent to which this occurs 1) in the hospital setting and 2) in AMC schools (e.g., medical and nursing students, residents, allied health students). The four research questions frame the findings as outlined below.

Research question #1

How prevalent is the involvement of PFAs in educational efforts within hospitals? How prevalent is their involvement in educational efforts within AMC schools?

Overall, about 46% of the hospitals in the study population had not involved PFAs in educational efforts at all. There are no differences between AMCs and Non-AMCs in terms of the likelihood of involving PFAs in the hospital setting. However, there is considerable differences in the extent of involvement (EOI) among those hospitals that do utilize PFAs in educational programming (Table 1). The degree of involvement of PFAs in education varies considerably within both categories of hospitals, with scores on the 'extent of involvement index' ranging from 0-24 for hospitals, with 24 being the maximum possible score (Figure 1).

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Table 1.
Extent of Involvement in hospitals

	Overall (n=67)	AMC (n=46)	non-AMC (n=21)
Percent Scoring 0	46%	48%	43%
Mean	6.4	6.1	7.1
SD	7.2	7.1	7.6
Median	4.0	3.5	6.0
Min	0	0	0
Max	24	22	24

Figure 1.
Extent of involvement in hospitals

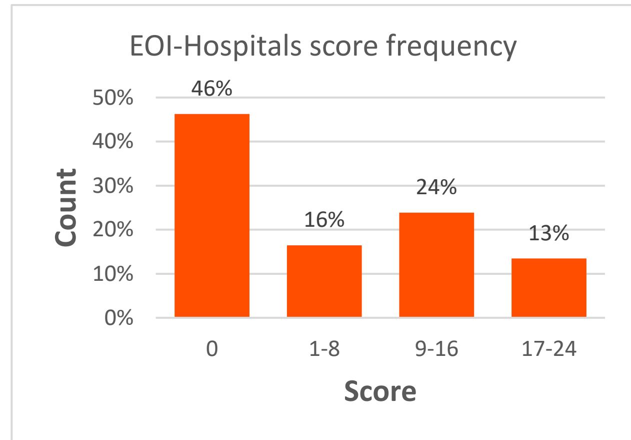
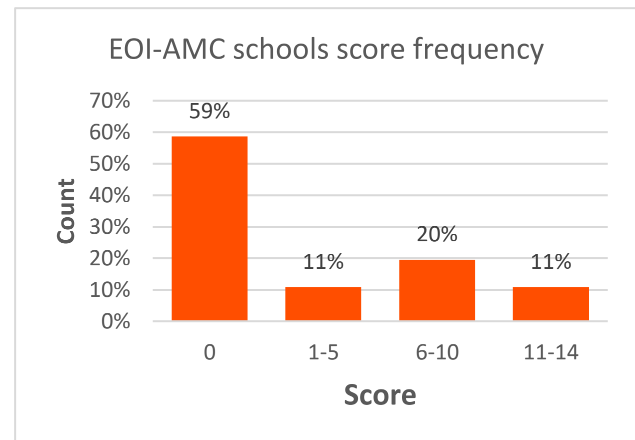


Table 2 shows the 'extent of involvement' in AMC schools. Almost 59% of AMCs do not involve PFAs in the education of students or trainees at all. None of the AMCs scored at the highest range of the index; the maximum score being 18, with most scoring in the lower range of scores (Figure 2).

Table 2.
Extent of Involvement in AMC schools

	AMC (n=46)
Percent Scoring 0	59%
Mean	3.2
SD	4.5
Median	0
Min	0
Max	14

Figure 2.
Extent of involvement in AMC schools



Research question #2

What are the characteristics of health care organization that are most likely to involve PFAs as educators?

Health care organizations with longer and deeper experience with PFAs and with PFACs are more likely to utilize PFAs in educational programming. Table 3 shows the results for the total sample and indicates that organizations with longer established PFACs, a larger number of PFACs and where the PFAs serve

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on more hospital committees are more likely to engage PFAs in educational efforts. This is largely true for AMCs as well as shown in Table 4.

It is interesting to note that most other descriptors of the hospitals were unrelated to whether they engaged PFAs in hospital leader, staff and clinician education. The size of the hospital, the case mix, and the resources of the hospital (as measured by the Medicare/Medicaid mix), are unrelated to PFA involvement in educational programming.

Table 3. EOI-Hospitals Demographic Differences - Overall Sample

Extent of Involvement in hospitals (EOI-Hospitals)			
Variable	**No Involvement (n=31)**	**Some Involvement (n=36)**	**p-value**
Urban	87%	86%	0.99
Med School Affiliation	90%	97%	0.33
Nursing School Affiliation	61%	72%	0.44
Pharmacy School Affiliation	29%	42%	0.32
Other Health Profession School Affiliation	35%	42%	0.61
PFAC Age			
Less than 1 year	3%	0%	*0.04***
1 – 2 years	17%	8%	
3 – 5 years	27%	11%	
6 – 10 years	17%	25%	
Greater than 10 years	37%	56%	
Median Demographic Data			
Number of PFAs	41	123	0.09
Number of PFACs	5	9	*0.04***
Number of Committees PFAs involved in	6	10	*<.0001***
Staffed beds^	851	881	0.91
Discharges^	40,693	45,124	0.72
ER Visits^	34,665	35,447	0.94
Total FTEs^	7,878	9,999	0.28
Number of Affiliated Physicians^	1,850	2,230	0.44
Medicare Case Mix Index (CMI)+	2.14	2.06	0.35

*** Significant at the p<0.05 level*
^Data Source: Definitive Healthcare
+Data Source: American Hospital Directory

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Table 4. EOI-Hospitals Demographic Differences – AMCs

Extent of Involvement in hospitals (EOI-Hospitals) – AMCs			
Variable	**No Involvement (n=22)**	**Some Involvement (n=24)**	**p-value**
Urban	95%	92%	0.99
Med School Affiliation	100%	100%	n/a
Nursing School Affiliation	73%	88%	0.28
Pharmacy School Affiliation	36%	50%	0.35
Other Health Profession School Affiliation	41%	46%	0.74
PFAC Age			
Less than 1 year	5%	0%	0.06
1 – 2 years	23%	4%	
3 – 5 years	18%	13%	
6 – 10 years	18%	29%	
Greater than 10 years	36%	54%	
Median Demographic Data			
Number of PFAs	39	158	0.10
Number of PFACs	5	11	*0.04***
Number of Committees PFAs involved in	7	10	*0.002***
Staffed beds^	754	908	0.40
Discharges^	36,350	45,080	0.32
ER Visits^	29,683	32,963	0.70
Total FTEs^	7,881	9,785	0.22
Number of Affiliated Physicians^	1,864	2,234	0.40
Medicare Case Mix Index (CMI)+	2.26	2.19	0.31

*** Significant at the p<0.05 level*

^Data Source: Definitive Healthcare

+Data Source: American Hospital Directory

The type of affiliation and the location of the hospital (urban/non-urban) is apparently unrelated to whether the hospital engages PFAs as educators. This is true for both AMCs and non-AMCs (Tables 3 and 4). Hospitals that have long standing PFAC's are more likely to involve PFA's in educational activities. (For non-AMC's this relationship does not quite reach statistical significance.)

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However, for AMC schools, both the length and the depth of an AMC's experience with PFAs and PFACs are significant predictors of PFA involvement in educational activities within their affiliated schools. Moreover, the size of the AMC, total FTEs and total # of affiliated physicians, are significantly associated with greater likelihood of PFA involvement in the education of students or trainees in the school setting as shown in Table 5.

Table 5. EOI-AMC Schools Demographic Differences

Extent of Involvement in AMC schools (EOI-AMC Schools)			
Variable	**No Involvement (N = 27)**	**Some Involvement (N = 19)**	**p-value**
Urban	96%	89%	0.56
Med School Affiliation	100%	100%	-
Nursing School Affiliation	85%	74%	0.46
Pharmacy School Affiliation	48%	37%	0.45
Other Health Profession School Affiliation	48%	37%	0.45
PFAC Age			
Less than 1 year	4%	0%	0.002**
1 – 2 years	22%	0%	
3 – 5 years	22%	5%	
6 – 10 years	22%	26%	
Greater than 10 years	30%	68%	
Median Demographic Data			
Number of PFAs	36	191	0.08
Number of PFACs	4	13	0.02**
Number of Committees PFAs involved in	7	11	<.0001**
Staffed beds^	689	1040	0.08
Discharges^	33,254	51,777	0.06
ER Visits^	26,413	38,473	0.15
Total FTEs^	7,254	11,177	0.02**
Number of Affiliated Physicians^	1,650	2,637	0.02**
Medicare Case Mix Index (CMI)+	2.18	2.29	0.14

** Significant at the p<0.05 level

^Data Source: Definitive Healthcare

+Data Source: American Hospital Directory

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Research question #3

How do health care organizations support their PFAs when they contribute to educational efforts? What types of support are most likely to be provided?

The top third of the health care organizations that involve PFAs in hospital educational efforts provide much higher level of support to the PFAs than do the rest of the respondents. Different types of support are provided from training to evaluations to reimbursement for expenses. Tables 6 and 7 show the support for involvement for PFAs in the overall sample and for AMCs respectfully.

Table 6. Support for Involvement – Overall Sample

Survey Questions	All Participants (n=67)	EOI-Hospitals Top Third (n=14)
Is there a staff member or clinical faculty member who serves as the coordinator or liaison for Patient and Family Faculty? (% Yes)	49%	64%
Do PFAs receive specific training to serve as Patient and Family Faculty (e.g., presentation skills training, storytelling training)? (% Yes)	39%	57%
Do organizational leaders, clinicians, and staff receive preparation or training to partner with Patient and Family Faculty? (% Yes)	28%	50%
Are educational programs involving Patient and Family Faculty evaluated for effectiveness or satisfaction? (% Yes)	31%	50%
Are the evaluation results shared with the Patient and Family Faculty? (% Yes)	27%	43%
What compensation do you provide Patient and Family Faculty? (select all that apply) (% Yes)		
Reimbursement for parking	28%	36%
Meals/meal vouchers	27%	21%
We do not provide compensation to our Patient and Family Faculty	13%	29%
Other	16%	21%
Reimbursement for travel/transportation	12%	21%
Gift cards	9%	7%
Monetary stipend or honorarium	8%	14%
Reimbursement for childcare/respite care	6%	21%
Donations made in Patient and Family Faculty name	2%	7%

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The picture for AMC schools is a bit different. The top third of AMCs that involve PFAs in educational efforts for students or trainees, provide only a moderately higher level of support to PFAs than does the total sample.

Table 7. Support for Involvement – AMCs

Survey Questions	Total Sample AMCs (n=46)	EOI-AMC Schools Top Third (n=7)
Is there a staff member or clinical faculty member who serves as the coordinator or liaison for Patient and Family Faculty? (% Yes)	41%	43%
Are there evaluation processes to assess student and trainee perspectives of learning experiences involving Patient and Family Faculty? (% Yes)	20%	29%
Are the evaluation results shared with the Patient and Family Faculty? (% Yes)	20%	29%
Do clinical faculty members receive preparation or training to partner with Patient and Family Faculty in teaching? (% Yes)	13%	29%
Are clinical faculty members given positive recognition for including Patient and Family Faculty in educational sessions? (% Yes)	9%	14%
What compensation do you provide Patient and Family Faculty? (select all that apply) (% Yes)		
Reimbursement for parking	20%	29%
Meals/meal vouchers	17%	14%
Reimbursement for travel/transportation	7%	14%
Other	7%	14%
We do not provide compensation to our Patient and Family Faculty	4%	0%
Monetary stipend or honorarium	4%	14%
Reimbursement for childcare/respite care	4%	29%
Gift cards	2%	14%
Donations made in Patient and Family Faculty name	0%	0%

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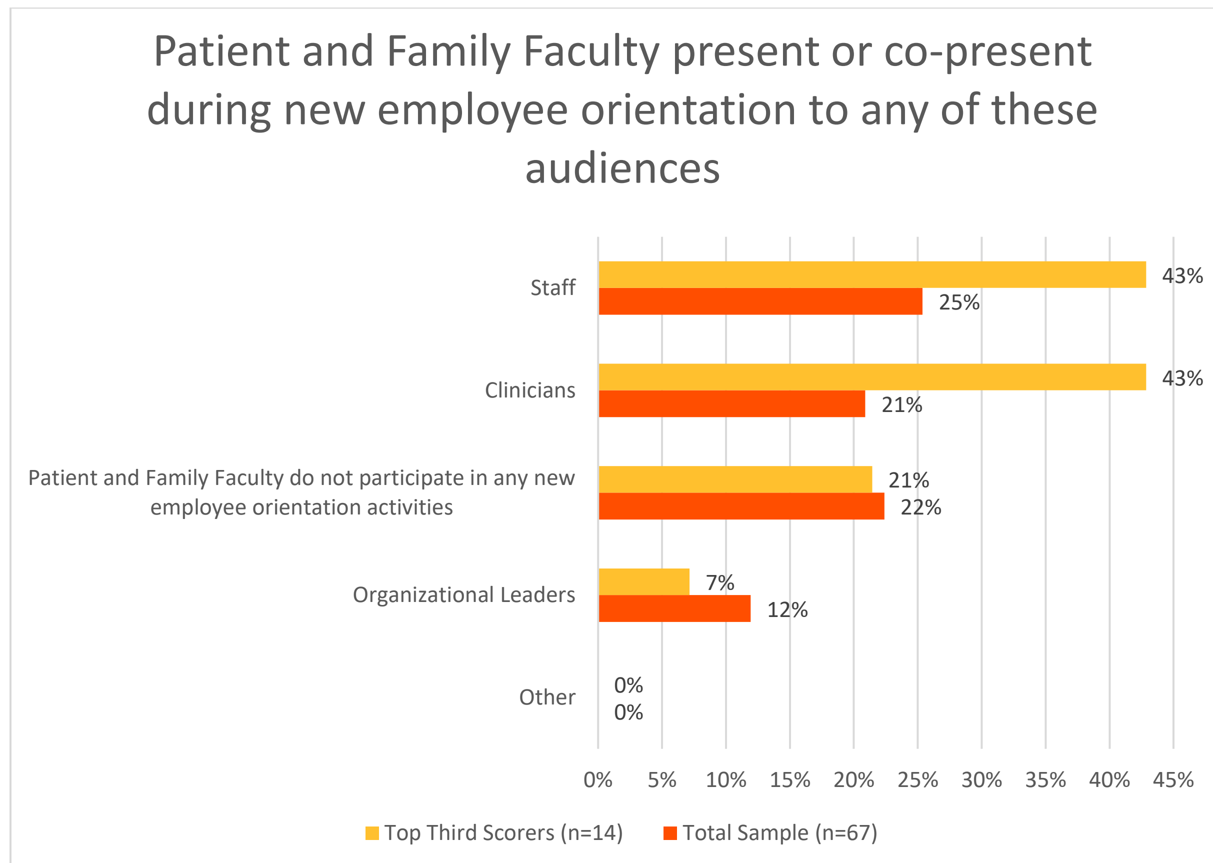
Research question #4

What types of educational activities are health care organizations likely to engage PFAs in, and what are they least likely to engage them in?

Figures 3 to 8 describe the types of activities hospitals (AMCs and non-AMCs) involve PFAs as faculty in developing and presenting educational or organizational development programs (e.g., staff orientation, continuing education) for clinicians, staff and leaders.

Figures 9 to 13 describe the types of activities AMCs involve PFAs as faculty in developing and presenting educational programming in medical education and/or in the education of students and trainees in other health professions in the organization (e.g., medical and nursing students, residents, allied health students).

Figure 3. EOI – Hospitals: Participation in new employee orientation



Top performing organizations utilize patients and families as presenters or co-presenters in new employee orientation for staff and clinicians at a much higher rate than the total sample (43% versus 25% and 21% respectively). When it comes to organizational leaders, the total sample utilizes patients and families as presenters or co-presenters in their orientation at a higher rate than the top third (12% versus

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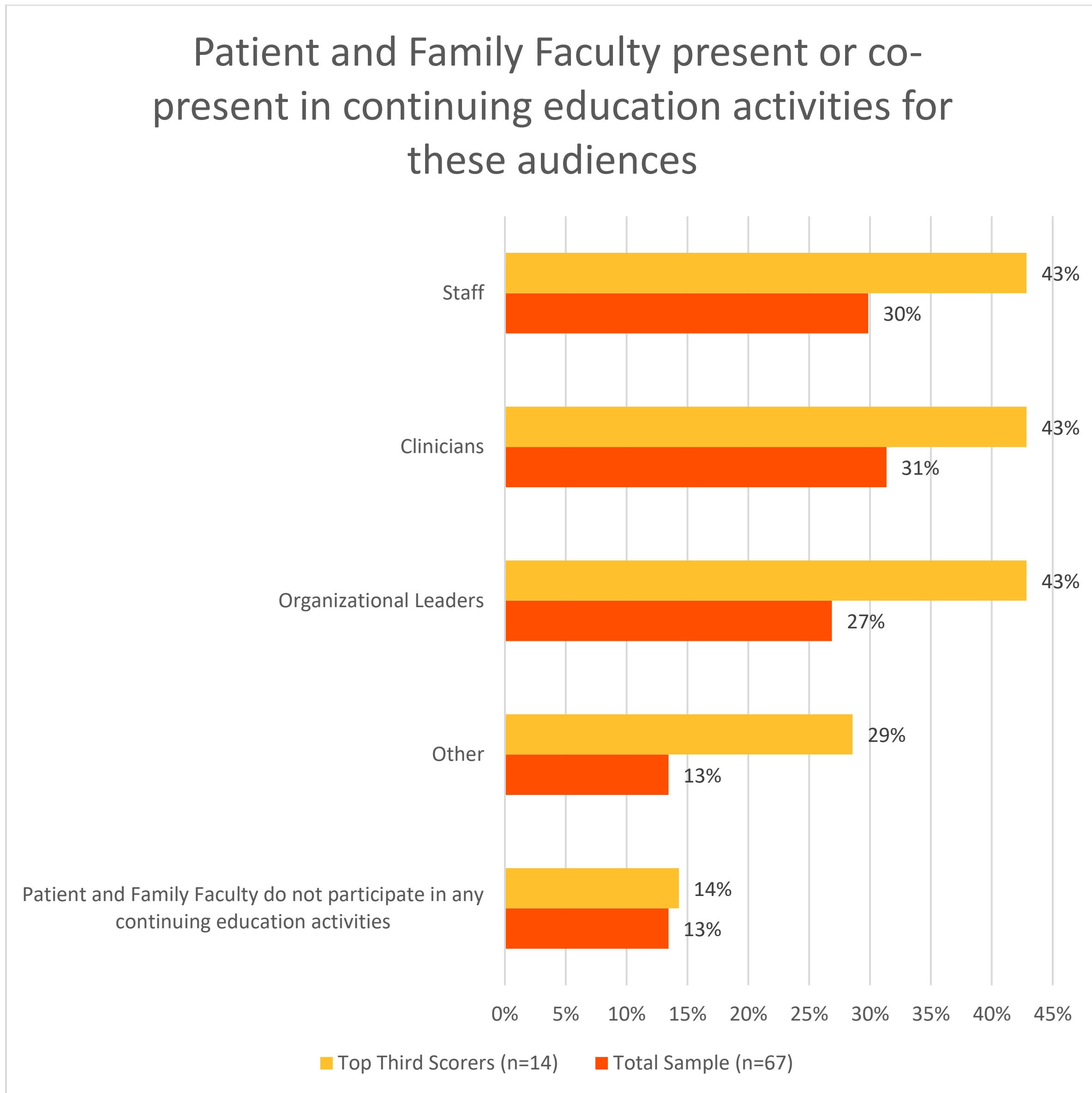
7%). The practice is not yet ubiquitous as approximately one quarter of the participants (21-22%) do not have patients and families as presenters or co-presenters in new employee orientation.

Figure 4: EOI – Hospitals: Participation in continuing education



Top performing organizations utilize patients and families as presenters or co-presenters in continuing education for staff, clinicians and organizational leaders at a much higher rates than the total sample (43% versus 30%, 31% and 27% respectively).

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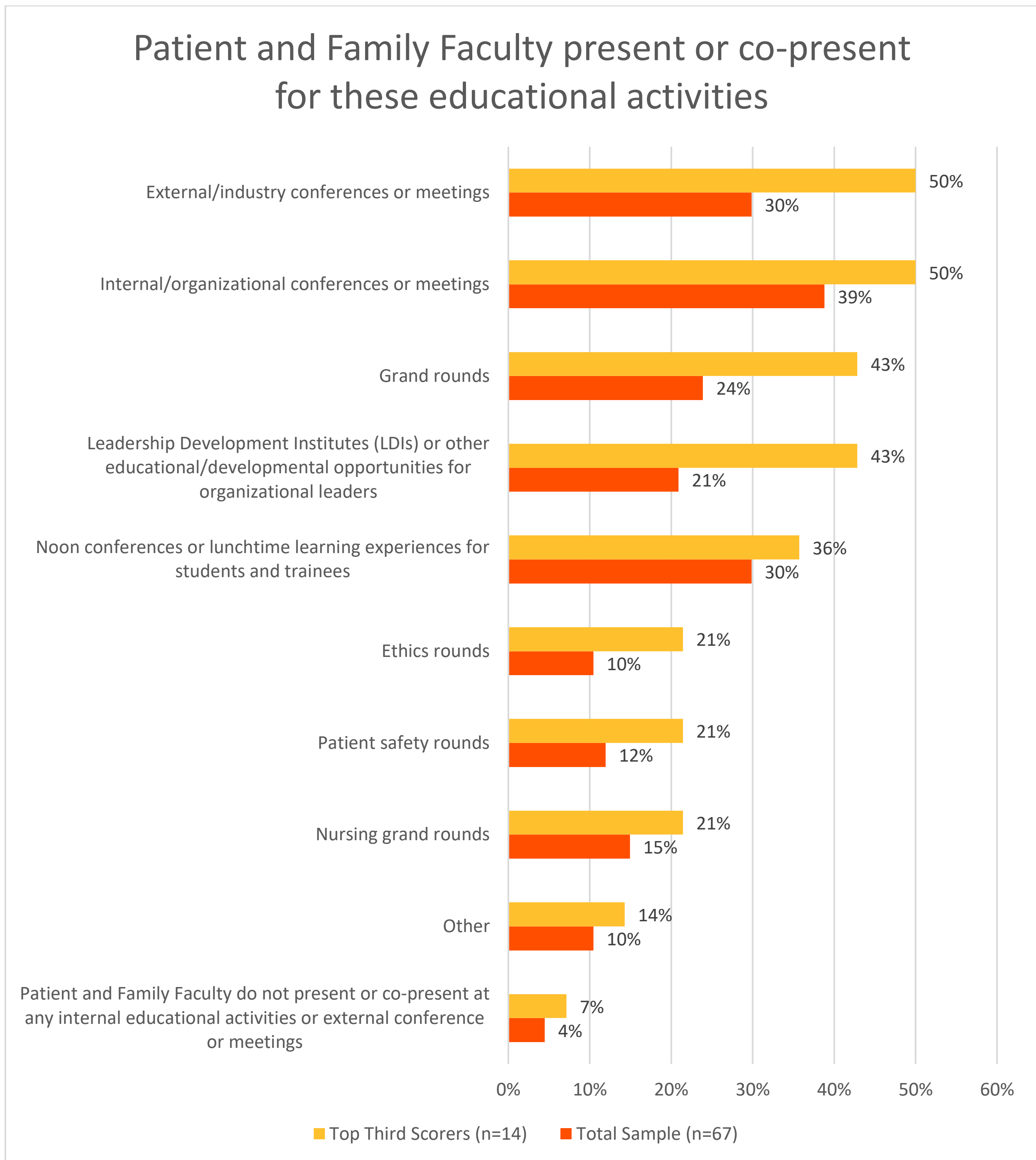
Figure 5. EOI – Hospitals: Presenting in educational activities



In all instances, top performers include patient and family faculty as presenters or co-presenters in many different educational activities at a higher rate than the total sample. PFAs are most likely to present or co-present at conferences and least likely to present on ethics, patient safety or nursing rounds.

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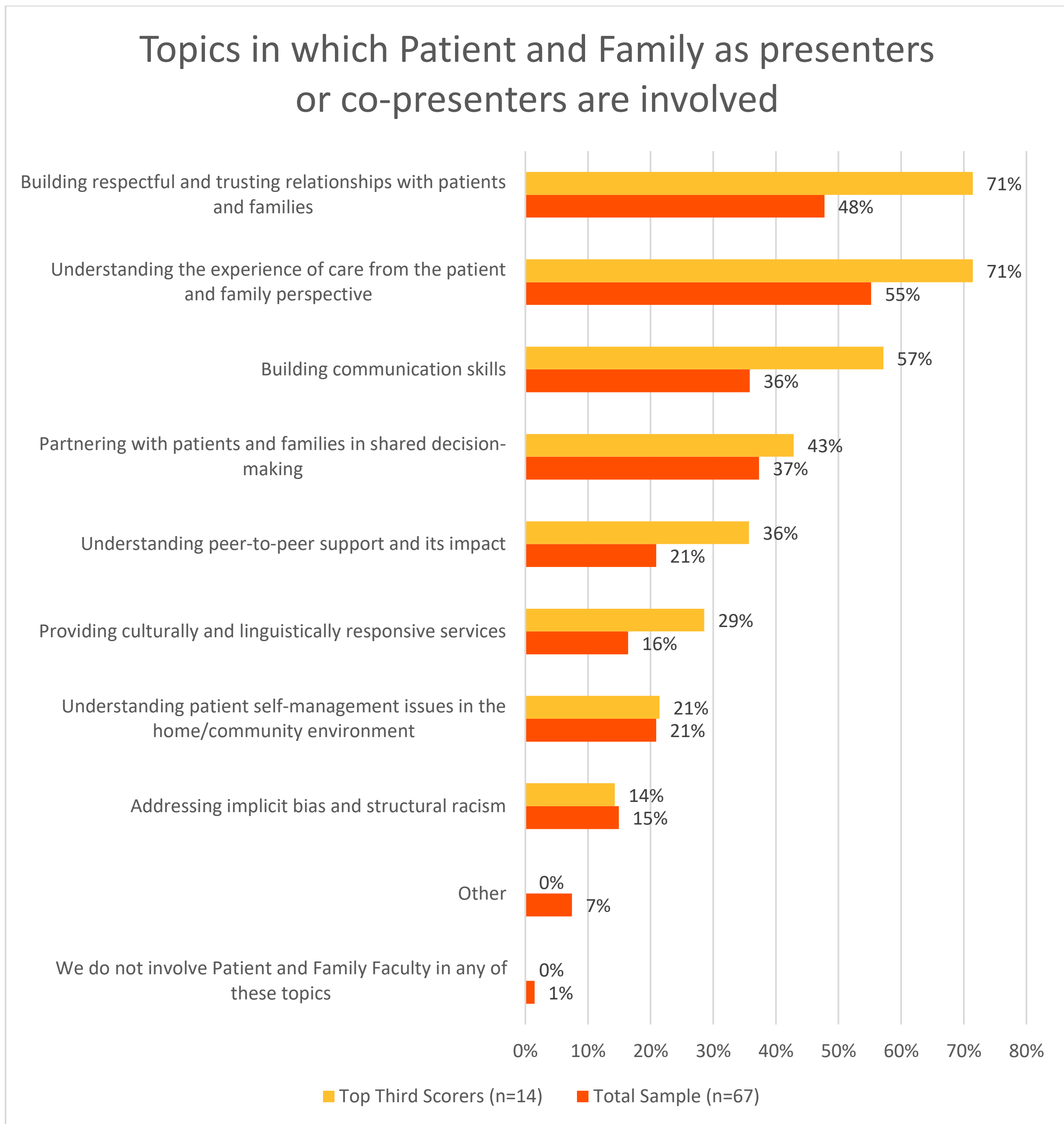
Figure 6. EOI – Hospitals: Topics presented by patients and families



In nearly all instances, top performers involve patients and families as presenters or co-presenters for educational or organizational development programs at a higher rate than the total sample. Building respectful and trusting relationships is the topic PFAs are most likely to present or co-present on, while addressing implicit bias and structural racism is the least likely topic.

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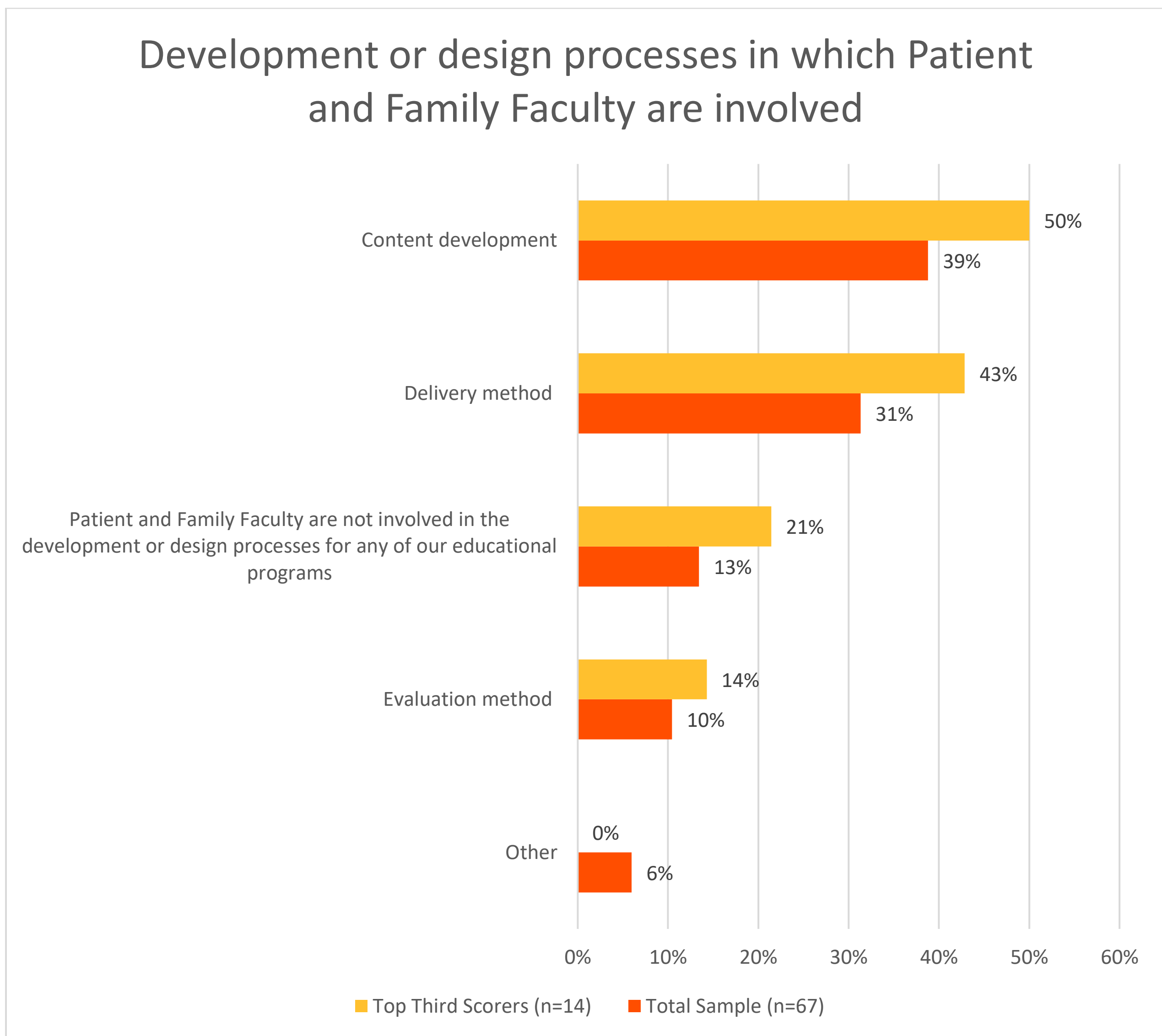
Figure 7. EOI – Hospitals: Involvement in development and design processes



Top performers involve patient and family faculty in content development and delivery method design at a much higher rate than the total sample (50% and 43% versus 39% and 31% respectively). The practice of including patient and family faculty in the development and design processes is still evolving as 21% of top performers and 13% of the total sample do not involve patients and families in these processes. Lastly, patient and family faculty are least involved in the development or design of evaluation methods of educational programs.

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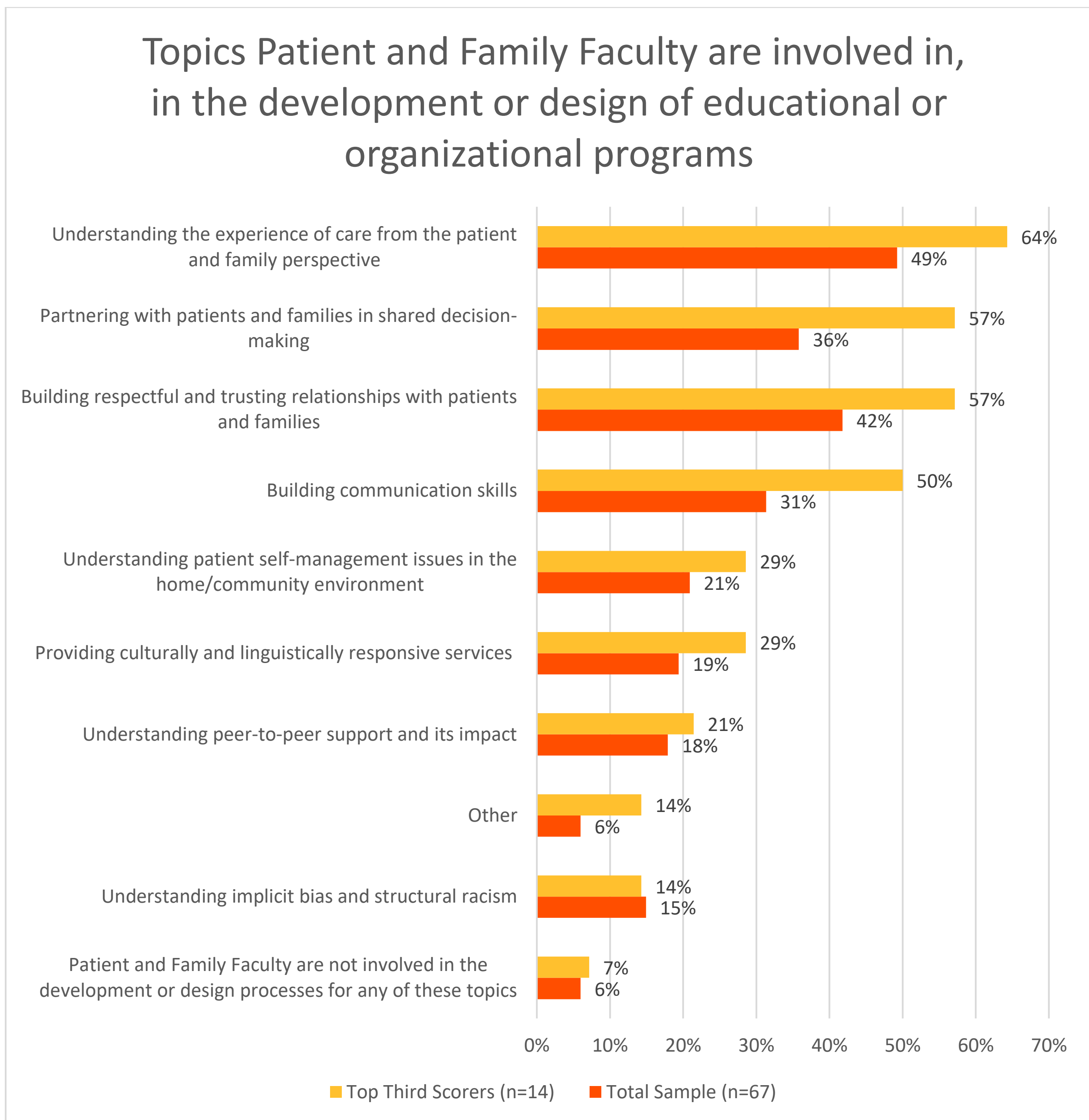
Figure 8. EOI – Hospitals: Involvement in development and design processes by topic



In nearly all instances, top performers involve patient and family in the development or design process for educational or organizational development programs at a higher rate than the total sample. Understanding the experience of care from the patient perspective is the most likely topic PFAs are involved in development or design, while topics such as providing culturally or linguistically responsive services and understanding implicit bias and structural racism are less likely to involve PFAs even among top performers.

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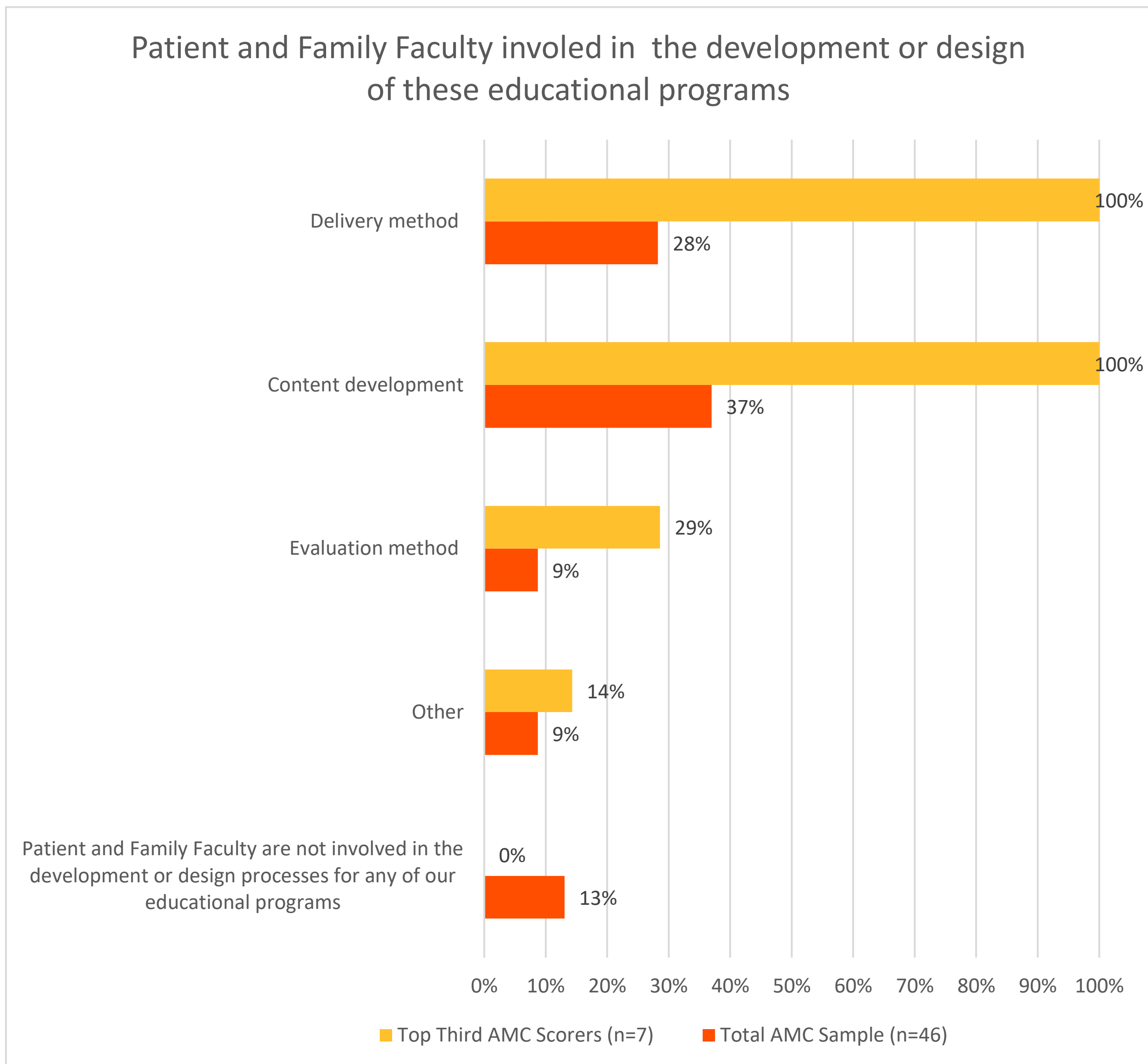
Figure 9: EOI – AMC schools: Involvement in educational development or design



In all instances, AMC top performers involve patient and family faculty in the development or design process of educational programs at a higher rate than the total AMC sample.

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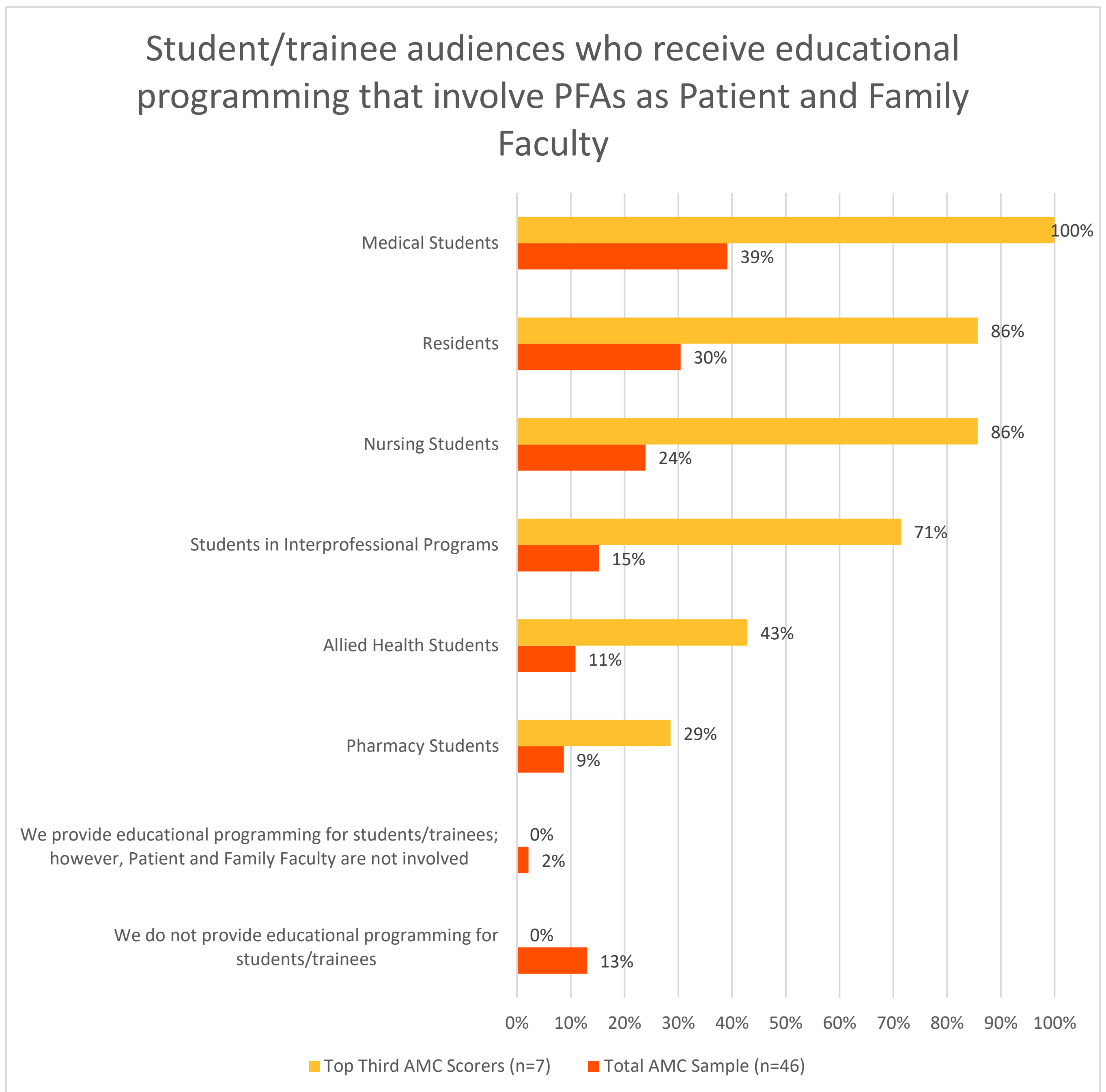
Figure 10. EOI – AMC schools: Types of students/trainees who receive education from PFAs



Top performing AMCs involve patient and family faculty in a broad array of student/trainee educational programming at a much higher rate than the total AMC sample.

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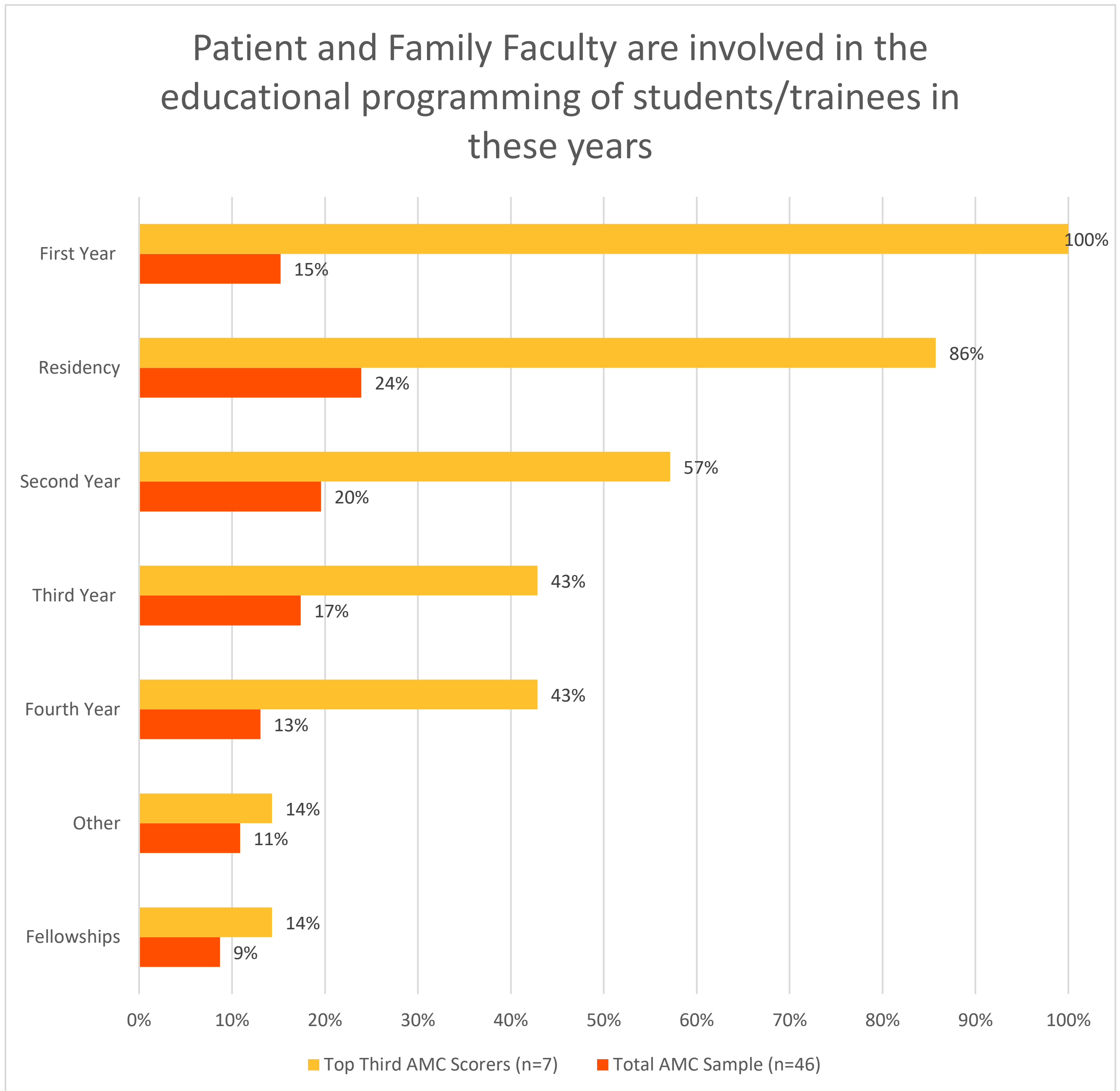
Figure 11. EOI – AMC schools: Years students/trainees receive education from PFAs



Top performing AMCs involve patient and family faculty in each year of student/trainee educational programming at a much higher rate than the total AMC sample.

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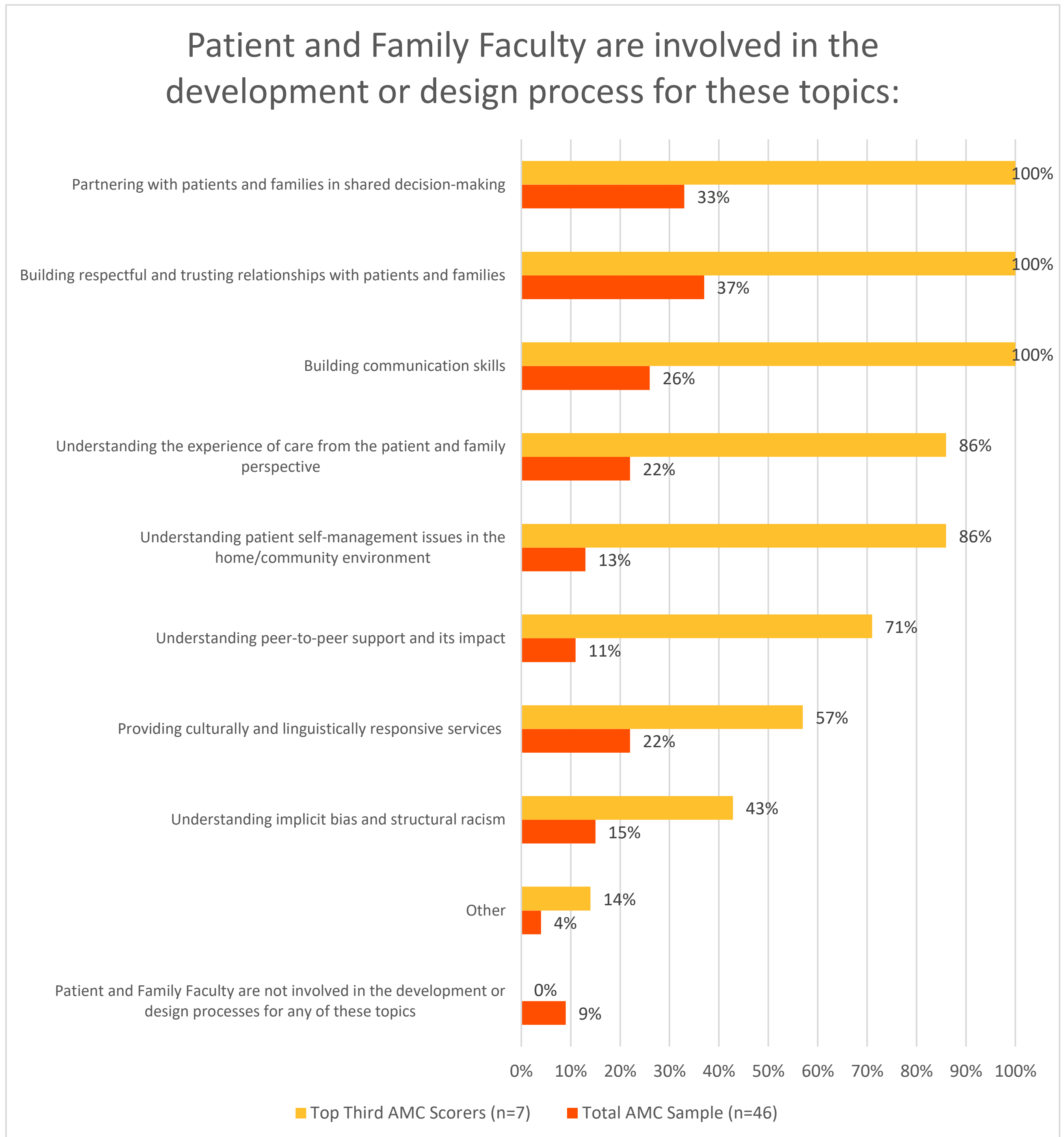
Figure 12. EOI – AMC schools: Involvement in development and design process by topic



In all instances, AMC top performers involve patient and family in the development or design process for educational or organizational development program topics at a higher rate than the total AMC sample.

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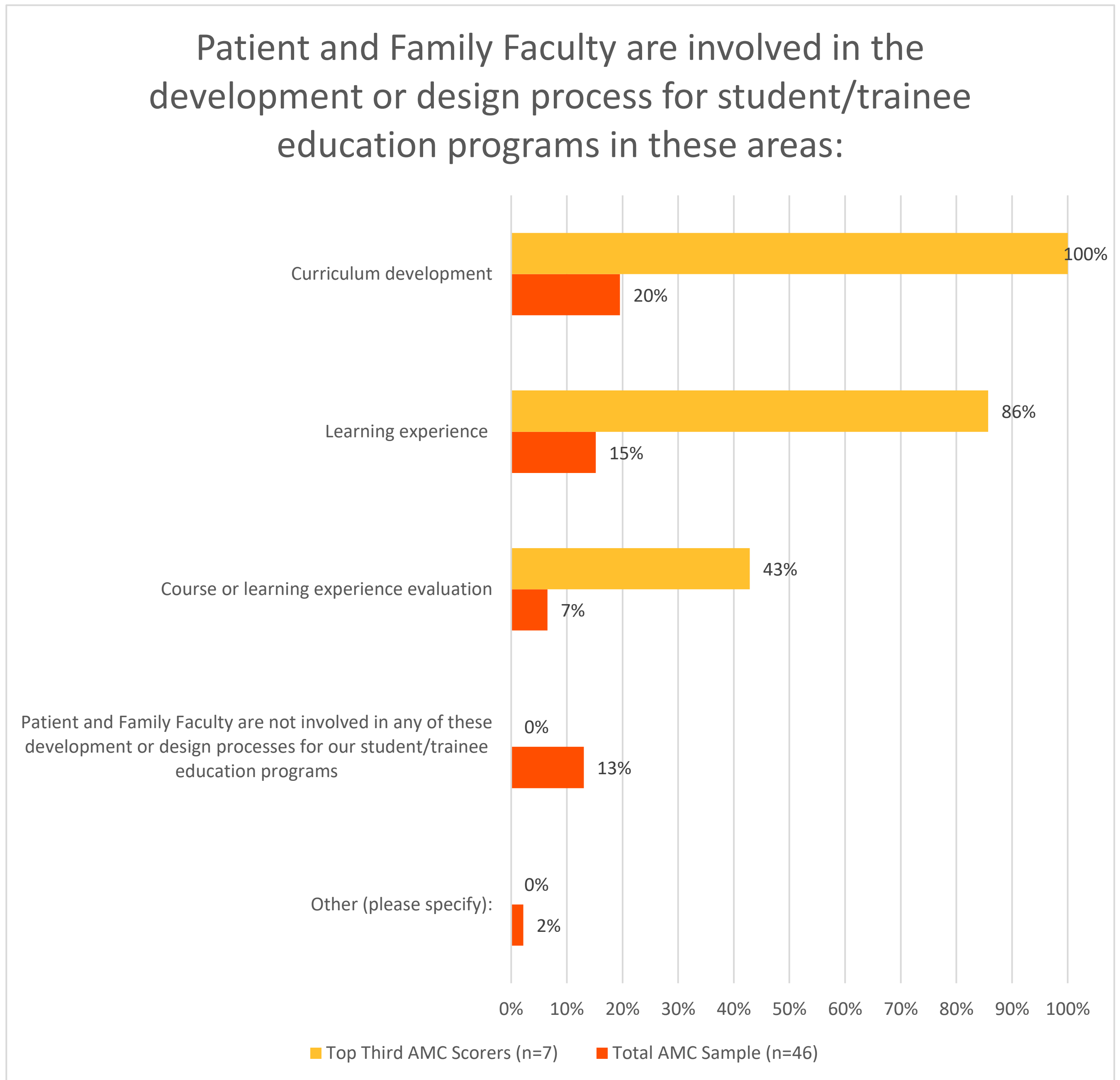
Figure 13. EOI – AMC schools: Involvement in development or design processes



Top performing AMCs involve patient and family faculty in curriculum development, learning experience design and evaluation of courses or learning experience at a much higher rate than the total AMC sample.

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Discussion

Patients and families have valuable perspectives to share that contribute to the instruction and learning of students, trainees and health professionals. What is considered the “soft skills” of medicine (e.g., showing respect and empathy; open, honest, and bi-directional communication; shared-decision-making) are imperative to care quality, safety, equity and experience.[7] In this study, 14 hospitals were identified as top performers from the total sample of 67 participating organizations and seven AMCs were identified as top performers from the 46 participating AMCs. Nearly half of participating hospitals (46%) do not involve PFAs in educational activities and most participating AMCs (59%) do not involve patient and family as faculty in education.

The length of time and the extent to which hospitals and AMCs engage with PFAs on PFACs and on organizational committees (e.g., number of PFACs, number of PFAs involved on committees) was associated with their likelihood to engage them in educational efforts. In other words, the more an organization engages its PFAs, the more likely it is to engage them as educators. The size of the hospital, the case mix and the resources of the hospital (as measured by the Medicare/Medicaid mix), are unrelated to PFA involvement in educational programming. One factor associated specifically with AMCs is the size of the organization. Organizations with more FTEs and affiliated physicians are more likely to engage PFAs in educational activities.

This study reveals areas of opportunity to develop the necessary infrastructure to support sustainability and meaningful involvement of PFAs as educators, including:

- dedicating time and resources for a staff member or clinical faculty member to serve as the coordinator or liaison for Patient and Family Faculty,
- increasing efforts to provide specific training for PFAs to serve as Patient and Family Faculty (e.g., storytelling training, presentation skills training),
- increasing efforts to prepare or train hospital leaders, clinicians, staff and clinical faculty to partner with Patient and Family Faculty, especially in AMCs,
- spreading the integration of PFA’s in new roles and committees throughout the institution.
- systematically evaluating educational activities that include PFAs as educators and sharing those results with them,
- acknowledging and rewarding clinical faculty in AMCs for their work in partnering with patient and family faculty, and
- increasing reimbursement and compensation for patient and family faculty.

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In all instances, top performing hospitals include PFAs as presenters or co-presenters in educational activities and in content development and delivery method design at a higher rate than the total sample.

The practice of involving patients and families as presenters or co-presenters in continuing education activities is more widespread than involving them in new employee orientation. Including patient and families in new employee orientation for staff, clinicians, and leaders demonstrates a true commitment to patient- and family-centered care and patient engagement. Not surprisingly, PFAs are most often asked to share their experiences of care and how to develop trusting relationships with patients and families. Including PFAs in topics related to self-management of chronic conditions, and importantly, diversity, equity and inclusion in hospitals are underutilized.

Top performing AMCs involve PFAs at a much higher rate than the total AMC sample in:

- educating a broad array of student/trainee audiences,
- teaching in each year of students' education, and
- curriculum development, learning experience design and evaluation of courses or learning experiences.

Support for the involvement of PFAs appears minimal, although top performers provide more support to PFAs than the total sample. Most often, PFAs are reimbursed for parking, transportation or childcare/respite care. Very few hospitals and AMCs provide honorariums or stipends to PFAs. Lack of support for the involvement of PFAs impacts the ability to engage individuals who are truly representative of populations served and can effectively teach about their experiences. Providing appropriate support reflects an authentic commitment, level of engagement and acknowledgement of the expertise and value of PFAs as educators. There is much room for improvement to support the involvement of PFAs as educators of students, trainees, clinicians, staff and leaders in the U.S. health care system.

Limitations

This is a cross-sectional study, allowing us to observe relationships as they are reported at one point in time. The response rate of 35% is a limitation of the study, making it harder to generalize the results to all hospitals and AMCs. It is possible that the low response rate actually inflates the rate of PFA involvement in educational programming, as those hospitals that are engaged in these activities may have been more motivated to respond to the survey. If this is the case, then the percentage of hospitals engaging PFAs in educational programming may be over-stated in our results. At the same time, the factors identified as being associated with engaging PFAs in educational programming are likely unaffected by the low

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response rate. It should be noted that the survey was conducted during the COVID-19 pandemic, the hospitals were stretched thin during this crisis and a response rate of 35% might be considered reasonable given all that was occurring during this period.

Conclusion

Until now, little has been known about the prevalence of PFAs serving as educators, structures to support these roles or the effect of their involvement. This study has brought to light top performing organizations from which others can learn as well as foundational evidence to measure in future studies. Awareness is the first step to change. The learnings from this study can assist health care organizations in their efforts to engage PFAs in educational activities. The types of educational activities these organizations are engaging PFAs in and the type of support they are providing to them can serve as a road map for hospitals seeking to develop in this direction. It can give hospitals guidance about where to begin in terms of topics and audiences as well as the types of design and development of educational programming in which they may wish to engage PFAs.

Hospitals that have experience with PFAs, through PFACs and involving them on other committees, are more likely to take the next step of engaging PFAs in educational programming. Once aware of these innovations, other hospitals may come to view the engagement of PFAs in education as a fuller expression of their commitment to engaging PFAs in the work of improving the experience, quality, safety and equity of patient care.

The study might be thought of as a baseline for future studies to track progress in this area and to expand the scope of inquiry. A deeper dive into the impetus for hospitals to move in this direction and the barriers they faced might help other hospitals take on this challenge. Finally, in addition to tracking progress with larger samples, future studies might seek to assess the potential impact of involving PFAs in educational efforts. For example, it would be useful to investigate whether clinicians who are trained with PFA involvement, are more patient-centric in their attitudes and behaviors, as compared to clinicians whose training did not involve PFA input. Other outcomes to assess would include differences in reported patient experiences, health care quality, equity and safety.

Findings reported here raise awareness of the possibilities for hospitals and AMCs that are just starting on this journey, and as a call to action for those which are poised to expand the role that PFAs serve in their institutions.

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About the Institute for Patient- and Family-Centered Care (IPFCC)

IPFCC is a nonprofit organization that has worked since 1992 to advance the understanding and practice of patient- and family-centered care in all settings where individuals and families receive health care and support. IPFCC's work envisions a health care system in which patients and families are meaningful partners in improving health care quality, reducing harm, addressing inequities, and achieving better health outcomes. IPFCC accomplishes its mission through training and technical assistance; educational events; development of resources for the field; and research. IPFCC's work is guided by the core concepts of patient- and family-centered care (PFCC): dignity and respect, information sharing, participation and collaboration. Learn more at www.ipfcc.org.

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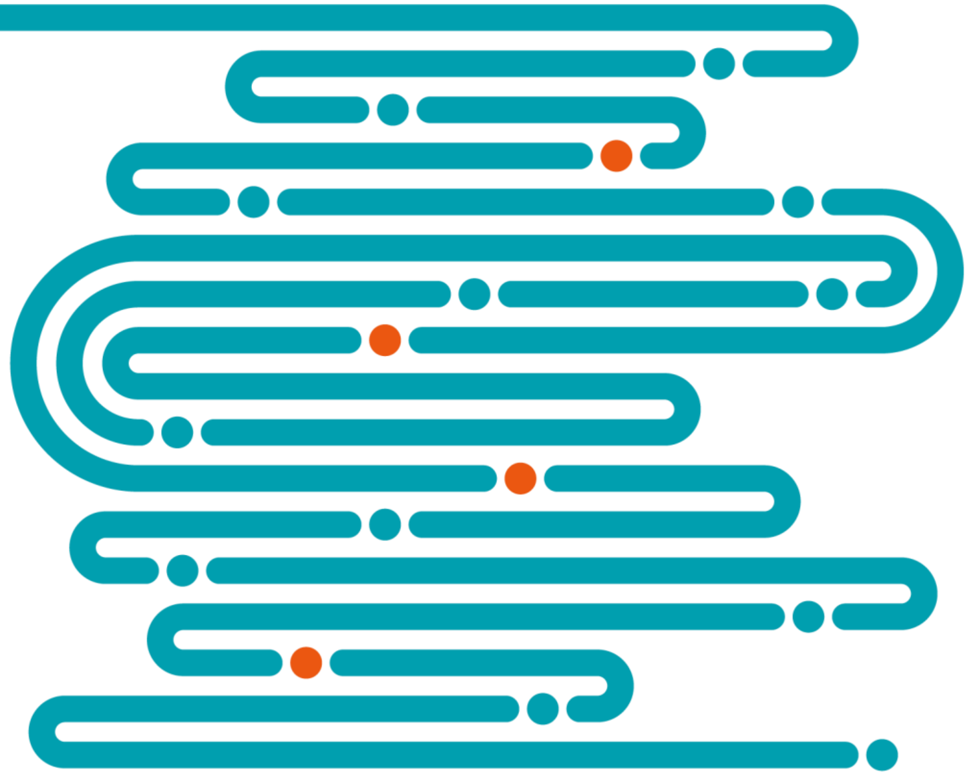

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