Implementation of Patient and Family Advisory Councils in Primary Care Practices in a Large, Integrated Health System

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INTRODUCTION

The role of patient engagement in healthcare is well recognized.[1] While some guidelines exist for development of patient councils,[2] and characteristics of high functioning patient advisory councils have been identified around representative patient sample recruitment, facilitation, accountability, and supportive culture,[3] implementation of patient and family engagement is not well standardized. There has been interest in patient engagement in healthcare research,[4, 5] but there remains a need to describe the process of patient and family involvement in primary care practice including recruitment, goals and expectations, and outcomes of the engagement process. A reporting item tied to reimbursement for The Centers for Medicare and Medicaid Services Comprehensive Primary Care Plus program (CPC+),[6] (Patient and Caregiver Engagement domain), is that Patient and Family Advisory Councils (PFACs) are created with representation of care providers and patients and families from participating primary care practices and that recommendations of the group are integrated into care delivery. We describe the implementation of PFACs across primary care practices to guide care optimization and co-design solutions in a large, integrated healthcare system.

METHODS

The Cleveland Clinic Health System (CCHS) includes 44 primary care practices organized into 10 hubs, with 3–7 practices per hub site. Beginning in April 2017, we integrated primary care practice-specific PFACs into our healthcare partner structure. A steering committee included representation from health system departments including Internal Medicine, Family Medicine, Finance, and the Office of Patient Experience. The PFAC meetings were offered at hub sites, with practices having the option of conducting individual practice site meetings instead of attending at the hub. At each meeting, both employee and patient representation from each practice was required. Practices identified a volunteer clinical lead (physician or advanced practice provider) and a group facilitator for the meetings, which were scheduled for both third and fourth quarters of 2017. Provider facilitators were offered online training materials and suggested topics for the first meeting, with subsequent agendas determined by local facilitators. Patients were recruited using two methods: (1) a survey sent to an established internet panel of active CCHS patients engaged in offering feedback and (2) ideal healthcare partner characteristics were shared and providers responded with nominations. Interested patients were contacted by project staff and requested to become CCHS volunteers including an onboarding process with online application, interview, background check, confidentiality agreement, education modules, and orientation session. No monetary incentive was offered to providers or patients for participation. Patient feedback was systematically elicited by the facilitator through open discussion.

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RESULTS

Forty PFAC meetings were conducted between July and December 2017 and included 151 patients, 100 males and 51 females. Approximately 60% of participating patients were recruited through the survey. Meetings were 90 minutes at the end of the work day with dinner provided. The hub meetings occurred twice in 2017, in third and fourth quarters, with 53 patients attending in both quarters. More than half of the participating primary care practices elected to have meetings at their individual practice site instead of the hub site and also conducted those meetings once per quarter in 2017. In response to a CPC+ program question, most practices reported that the initial patient participants were only "slightly representative" of the full population they serve. Topics discussed at the meetings varied by site and included team-based care, access to care, workflow related to office visits, communication with the office between visits, financial issues, and clinical decisions (Table 1).

Table 1 Themes and Examples of Discussion Topics at Patient and Family Advisory Council Meetings

Theme	Examples
Team-based care	Need for explanation of role of care team members, including physicians, medical assistants, nurses, nurse care coordinators, pharmacists, social workers; need for clarity on how team members work collaboratively to care for the patient
Access to care	Appointment types, wait times for scheduling, visits with primary provider/team vs. urgent access providers, virtual visit: types of concerns appropriate to address in virtual visit, insurance coverage
Workflow related to office visits	Pre-visit test ordering, check-in procedures (automated vs. in-person, information required, privacy during process), need for assistance upon arriving/wheelchair availability
Communication with office between visits	Phone or electronic communication (through electronic medical record), test result reporting, question of option for live chat function for electronic communication
Financial	Need for explanation of medical bills, availability of patient financial advisors in health system to assist with concerns
Clinical decisions	Antibiotics for upper respiratory infections, shared decisions around initiation of new medications and patient concerns to be addressed

DISCUSSION

We implemented PFACs across primary care practices in a large health system. Meeting discussions provided significant insight into patient understanding and concerns around primary care delivery. Most themes did not relate to clinical decisions regarding care but importantly highlighted the need for improved communication with patients about care delivery structure and presented several opportunities for quality improvement. Significant barriers to PFAC implementation included (1) patient recruitment (only 35% of patients participated in both quarters) and (2) availability of providers and patients to travel to meetings. Nonetheless, participants remained engaged and meetings were well attended, representing as essential step to improving relationship-centered care delivery. Continuing with quarterly PFAC meetings, future work will focus on defining specific roles and goals for patient involvement in quality improvement initiatives, ensuring representation reflecting populations served by each practice, and measuring outcomes of PFAC integration into primary care delivery.

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