Patient Engagement – Quality Improvement


Healthcare organizations face growing pressures to increase patient-centred care and to involve patients more in organizational decisions. Yet many providers worry that such involvement requires additional time and resources and do not see patients as capable of contributing meaningfully to decisions. This article discusses three efforts in four organizations to engage patients in quality improvement efforts. McGill University Health Centre, Saskatoon Health Region, and Vancouver Coastal and Fraser Health Regions all engaged patients in quality improvement and system redesign initiatives that were successful in improving care processes, outcomes, and patient experience measures. Patient involvement in redesigning care may provide a way to demonstrate the value of patients' experiences and inputs into problem-solving, building support for their involvement in other areas. Further study of these cases and a broader survey of organizational experiences with patient involvement may help elucidate the factors that support greater patient engagement.


Introduction Infection in our immunocompromised patients is the second leading cause of death, according to the Centers for Disease Control and Prevention (CDC). In an effort to improve quality of care, engage patients in their own care, and reduce morbidity and mortality secondary to infection, the Network designed a joint quality improvement/patient engagement activity to decrease bloodstream infection (BSI) rates. Methods Dialysis facilities were ranked utilizing 2014 National Healthcare Safety Network (NHSN) data. Selection included 20% of Network 13 facilities (n = 58) with the highest BSI rates, which captured 31% of the patient population. Findings Statistically significant (P < 0.001) improvement was reached in the reduction of BSIs; increasing patient engagement in the infection control process; and, correct completion of hand hygiene audits. Significant (P < 0.01) improvement was reached in correct completion of cannulation audits. There was also improvement in the catheter audits, but results were not significant. Discussion Involving patients in the infection control process contributed to our successful outcomes and could be replicated to meet the needs of the end stage renal disease community as a whole.


Efforts to ensure effective participation of patients in healthcare are called by many names—patient centredness, patient engagement, patient experience. Improvement initiatives in this domain often resemble the efforts of manufacturers to engage consumers in designing and marketing products. Services, however, are fundamentally different than products; unlike goods, services are always 'coproduced'. Failure to recognise this unique character of a service and its implications may limit our success in partnering with patients to improve health care. We trace a partial history of the coproduction concept, present a model of healthcare service coproduction and explore its application as a design principle in three healthcare service delivery innovations. We use the principle to examine the roles, relationships and aims of this interdependent work. We explore the principle's implications and challenges for health professional development, for service delivery system design and for understanding and measuring benefit in healthcare services.

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Purpose: The purpose of this paper is to describe the processes and results of implementing and evaluating the Releasing Time to Care™ (RTC™) model in a 45-bed Neurosciences unit in a tertiary care hospital in Saskatchewan province of western Canada.
Design/methodology/approach: Organizational restructuring in healthcare systems has impacted the ability of clinical registered nurses (CRNs) in participation and in influencing the decision making that affect the delivery and outcomes of patient-centered care. At the same time, CRNs’ work has intensified because of increases in patient acuity, technological advances, complexity of care provided to patient families and communities, in addition to the intensifying demands put on by an aging population and dwindling resources. The work reported in this paper shows that significant improvements have been made based on the current needs and the change is forever imminent. Establishing solid people connections and networking opportunities proved valuable for current and future exchange of information and knowledge translation. Findings: Model implementation resulted in positive narrative and empirical data including: improved patient safety, staff engagement, leadership opportunities and an affirmative shift in organizational culture. Improved patient safety was evidenced by a reduction in falls and decreased medication errors. Originality/value: The paper focuses on including the clinical nurse in organizational and system change towards improving patient-centered quality care. Neurosciences 6300 at Royal University Hospital (RUH) in Saskatoon, was viewed as an RTC™ champion and one of the first to implement and complete the 11-module toolkit. © Emerald Group Publishing Limited.


UNLABELLED: Article-at-a-Glance Background: The lack of patient engagement in quality improvement is concerning. As part of an enterprisewide initiative to redesign primary care at UW Health, interdisciplinary primary care teams received training in patient engagement.

METHODS: Organizational stakeholders held a structured discussion and used nominal group technique to identify the key components critical to fostering a culture of patient engagement and critical lessons learned. These findings were augmented and illustrated by review of transcripts of two focus groups held with clinic managers and 69 interviews with individual microsystem team members.

RESULTS: From late 2009 to 2014, 47 (81%) of 58 teams have engaged patients in various stages of practice improvement projects. Organizational components identified as critical to fostering a culture of patient engagement were alignment of the organization's vision that guided the redesign with national priorities, readily available external experts, involvement of all care team members in patient engagement, integration within an existing continuous improvement team development program, and an intervention deliberately matched to organizational readiness. Critical lessons learned were the need to embed patient engagement into current improvement activities, designate a neutral point person(s) or group to navigate organizational complexities, commit resources to support patient engagement activities, and plan for sustained team-patient interactions.

CONCLUSIONS: Current national health care policy and local market pressures are compelling partnering with patients in efforts to improve the value of the health care delivery system. The UW Health experience may be useful for organizations seeking to introduce or strengthen the patient role in designing delivery system improvements.


Encouraging patients and consumers to use data and other information in choosing health care providers is an important way to enhance patient engagement and improve the quality of care. The growing use of technology, including smart phones and near-ubiquitous Internet access, provides consumers with easy access to websites that collect and report assessments and ratings of providers, primarily physicians and hospitals. In addition to new technology, recent laws and changes in society and the delivery of care are laying the foundation for greater use by consumers of provider performance report cards. Such use could be accelerated if the shortcomings of current report card efforts were addressed. Recommendations include making online report cards easier to use and more understandable, engaging, substantive, and relevant to consumers' health and medical concerns and choices.

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**OBJECTIVE:** A key component of the Aligning Forces for Quality (AF4Q) program was engaging consumers in their health and healthcare. We examined the extent to which the alliances embraced 4 areas of consumer engagement: self-management, consumer friendliness of reports of healthcare provider quality, involvement of consumers in alliance governance, and the integration of consumers into quality improvement teams.

**METHODS:** We used a largely qualitative approach. The evaluation team conducted 1100 in-depth interviews with alliance stakeholders. Two authors reviewed the consumer engagement data for each alliance to assess its level of embrace in the 4 consumer engagement areas. For consumer friendliness of public reporting websites, we also assessed alliance public reports for reading level, technical language, and evaluable displays. Population-level effects were also examined for self-management and public reporting.

**RESULTS:** Consumer engagement was new to most alliances, and few had staff with consumer engagement expertise or existing consumer constituencies. For each area of consumer engagement, some alliances enthusiastically embraced the work, other alliances made a concerted but limited effort to develop programs, and a third group of alliances did the minimum work required. Integrating consumers into governance was the area most often embraced, followed by making public reports consumer friendly. Two alliances strongly embraced both self-management and integrating patients into quality improvement efforts. The AF4Q program did not have greater population level effects from self-management or public reporting than were those observed in a national comparison sample.

**CONCLUSION:** The AF4Q program sparked a few alliances to develop robust consumer engagement programming, while most alliances tried consumer engagement efforts for the first time and developed an appreciation for integrating consumer perspectives into their work.


Both payment reform and patient engagement are key elements of health care reform. Yet the question of how incentivizing primary care providers (PCPs) on quality outcomes affects the degree to which PCPs are supportive of patient activation and patient self-management has received little attention. In this mixed-methods study, we use in-depth interviews and survey data from PCPs working in a Pioneer Accountable Care Organization that implemented a compensation model in which a large percentage of PCP salary is based on quality performance. We assess how much PCPs report focusing their efforts on supporting patient activation and self-management, and whether or not they become frustrated with patients who do not change their behaviors. The findings suggest that most PCPs do not see the value in investing their own efforts in supporting patient self-management and activation. Most PCPs saw patient behavior as a major obstacle to improving quality and many were frustrated that patient behaviors affected their compensation.

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This paper highlights the relationship between the Fundamentals of Care Framework, patient safety and quality improvement by describing a more holistic view of patient engagement across the healthcare system. By creating reliable and resilient healthcare organizations that enhance nurses' capacity to engage in relational care and vigilance, healthcare agencies can effectively achieve safety and quality aims. Integral to this is the nurse-patient relationship, whereby nurses know patient preferences for care and recognize when patients are deteriorating to prevent harm within the context of care environments.

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**INTRODUCTION:** Ambulatory practices that actively partner with patients and families in quality improvement (QI) report benefits such as better patient/family interactions with physicians and staff, and patient empowerment. However, creating effective patient/family partnerships for ambulatory care improvement is not yet routine. The objective of this paper is
to provide practices with concrete evidence about meaningfully involving patients and families in QI activities.

METHODS: Review of literature published from 2000-2015 and a focus group conducted in 2014 with practice advisors.

RESULTS: Thirty articles discussed 26 studies or examples of patient/family partnerships in ambulatory care QI. Patient and family partnership mechanisms included QI committees and advisory councils. Facilitators included process transparency, mechanisms for acting on patient/family input, and compensation. Challenges for practices included uncertainty about how best to involve patients and families in QI. Several studies found that patient/family partnership was a catalyst for improvement and reported that partnerships resulted in process improvements. Focus group results were concordant.

CONCLUSION: This paper describes emergent mechanisms and processes that ambulatory care practices use to partner with patients and families in QI including outcomes, facilitators, and challenges.

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Health care organizations have focused considerable effort and resources on improving patient safety and health care quality. Yet, despite these efforts, patients continue to experience harm events within our institutions. Family engagement is a powerful and often untapped resource to improve the quality and safety of organizations. While the value patients and families bring as partners in improving the safety and quality of health care is implicitly recognized, the adoption of structures to actively involve health care consumers has been slow, particularly in organizational or overall system work. Patients and families can stimulate and drive improved health care services through their involvement at the clinical/point of care, policy/design, and governance levels of the organization. For successful implementation, organization leaders must establish family engagement as a system-level priority. Roles to support the development of a family engagement program, methods to evaluate the level of family engagement, and strategies to enhance and sustain family engagement are described. Although there is limited evidence-based knowledge related to the best practices for family engagement, opportunities exist to drive the family engagement agenda at a regional and national level through participation in networks such as the Centers for Medicare & Medicaid Services Partnership for Patients campaign Hospital Engagement Networks.


CONTEXT: There is a strong interest in the Veterans Administration (VA) Health-care System in promoting patient engagement to improve patient care.

METHODS: We solicited expert opinion using an online expert panel system with a modified Delphi structure called ExpertLens<sup>TM</sup>. Experts reviewed, rated and discussed eight scenarios, representing four patient engagement roles in designing and improving VA outpatient care (consultant, implementation advisor, equal stakeholder and lead stakeholder) and two VA levels (local and regional). Rating criteria included desirability, feasibility, patient ability, physician/staff acceptance and impact on patient-centredness and care quality. Data were analysed using the RAND/UCLA Appropriateness Method for determining consensus.

FINDINGS: Experts rated consulting with patients at the local level as the most desirable and feasible patient engagement approach. Engagement at the local level was considered more desirable than engagement at the regional level. Being an equal stakeholder at the local level received the highest ratings on the patient-centredness and care quality criteria.

CONCLUSIONS: Our findings illustrate expert opinion about different approaches to patient engagement and highlight the benefits and challenges posed by each. Although experts rated local consultations with patients on an as-needed basis as most desirable and feasible, they rated being an equal stakeholder at the local level as having the highest potential impact on patient-centredness and care quality. This result highlights a perceived discrepancy between what is most desirable and what is potentially most effective, but suggests that routine local engagement of patients as equal stakeholders may be a desirable first step for promoting high-quality, patient-centred care.

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Kushner, C. and D. Davis (2014). "Improving safety: engaging with patients and families makes a difference!" Healthcare Quarterly 17 Spec No: 41-44.

Following a brief review of the history and context for patient and family member involvement in healthcare safety improvements, a variety of tools and mechanisms for patient engagement will be offered along with specific examples from Patients for Patient Safety Canada (a patient-led program of the Canadian Patient Safety Institute) to illustrate the impact of involving patients and family members in safety work. Barriers and facilitators to patient engagement in safety will also be examined.


Patient engagement has become a primary care research and practice priority. Little guidance exists, however, on how best to engage patients in primary care practice improvement, or how to measure the impact of their engagement. We present an overview of group concept mapping as a method for engaging patients in primary care practice improvement. We detail the group concept mapping process as a tool for use in primary care practice improvement, research, and evaluation, and we present resources to enable researchers and practice leaders to use this tool in practice improvement. To illustrate the method, we present a practice-based quality improvement project conducted with patients and staff at a large urban academic primary care practice.

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The energy of patients and members of the public worldwide who care about improving health is a huge, but still largely unrecognized and untapped, resource. The aim of patient engagement is to shift the clinical paradigm from determining "what is the matter?" to discovering "what matters to you?" This article presents four case studies from around the world that highlight the proven and potential abilities of increased patient engagement to improve health outcomes and reduce costs, while extending the reach of treatment and diagnostic programs into the community. The cases are an online mental health community in the United Kingdom, a genetic screening program in the United Arab Emirates, a World Health Organization checklist for new mothers, and a hospital-based patient engagement initiative in the United States. Evidence from these and similar endeavors suggests that closer collaboration on the part of patients, families, health care providers, health care systems, and policy makers at multiple levels could help diverse nations provide more effective and population-appropriate health care with fewer resources.

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Primary care practices are increasingly asked to engage patients in improving care delivery. We report early experiences with Patient and Family Advisory Councils (PFACs) from interviews of patients and practice staff in the Comprehensive Primary Care initiative, and identify ways to improve PFACs. Patients and practice staff report PFACs help practices elicit patient feedback and, in response, improve care delivery. Nonetheless, there are areas for refinement, including recruiting more diverse patients, providing an orientation to members, overcoming reticence of some patients to raise issues, and increasing transparency by sharing progress with PFAC members and patients in the practice more generally. © 2016 Wolters Kluwer Health, Inc.


RATIONALE: National quality improvement initiatives emphasize building partnerships between patients and providers by promoting patient engagement through communication, shared decision-making, and self-care skills. Efforts to promote patient engagement are especially important for people with asthma. To cultivate effective partnerships in asthma care, patients and providers may benefit from understanding each other's values and
perceptions regarding treatment goals, shared decision-making, and barriers to optimal care and outcomes.

OBJECTIVES: We conducted a survey study to assess and compare asthma patient and provider perceptions of factors that are associated with effective partnerships and patient engagement.

METHODS: Surveys were administered to adult patients with poorly controlled asthma (n = 328) and their physicians (n = 40) before they participated in collaborative learning sessions held in 40 specialty practices across the United States. The surveys included items for both groups to report their asthma-related treatment goals and perceptions about information needs and knowledge, shared decision-making, and barriers to medication adherence.

RESULTS: Providers rated their knowledge about different aspects of their patients’ health status (scale: 1 = poor knowledge, 5 = excellent knowledge). The lowest percentages of 4-5 ratings were for knowledge about patients’ financial status (29%), adherence (42%), lifestyle (46%), and workplace situation (46%). The highest percentages of 4-5 ratings were for knowledge about patients’ exacerbation history (75%), smoking status (76%), hospitalization history (79%), and comorbidities (79%). The percentages of patients and providers, respectively, who indicated the following treatment goals as important differed significantly: preventing exacerbations (62% and 83%, P = 0.01); preventing emergency department visits (44% and 76%, P < 0.01); and improving ability to perform daily activities (69% and 48%, P < 0.01). However, there were no significant differences in percentages of provider-reported goals and goals that providers estimated their patients would indicate as important. Disconnects were also observed for perceived barriers to asthma medication adherence.

CONCLUSIONS: The observed disconnects in patient-provider perceptions may inform strategies for cultivating effective partnerships and patient engagement, to improve care quality and outcomes for people with asthma.


OBJECTIVE: The Robert Wood Johnson Foundation’s (RWJF’s) Aligning Forces for Quality (AF4Q) program was the largest privately funded, community-based quality improvement initiative to date, providing funds and technical assistance (TA) to 16 multi-stakeholder alliances located throughout the United States. This article describes the AF4Q initiative’s underlying theory of change, its evolution over time, and the key activities undertaken by alliances.

STUDY DESIGN: Descriptive overview of a multi-site, community-based quality improvement initiative.

METHODS: We summarized information from program documents, program meetings, observation of alliance activities, and interviews with RWJF staff, TA providers, and AF4Q alliance stakeholders.

RESULTS: The AF4Q program was a dynamic initiative, expanding and evolving over time. The underlying theory of change was based on the notion that an aligned, multi-stakeholder approach is superior to independent siloed efforts by stakeholders. Participating alliances developed or strengthened programming to varying degrees in 5 main programmatic areas: (1) measurement and public reporting of healthcare quality, patient experience, cost, and efficiency for ambulatory physician practices and hospitals; (2) efforts to engage consumers in health, healthcare, and alliance governance (consumer engagement); (3) adoption and spread of effective strategies to improve care delivery; (4) advancing healthcare equity; and (5) integration of alliance activities with payment reform initiatives.

CONCLUSION: The AF4Q initiative was an ambitious program affecting multiple leverage points in the healthcare system. AF4Q alliances were provided a similar set of expectations, and given financial support and access to substantial TA. There was considerable variation in how alliances addressed the AF4Q programmatic areas, given differences in their composition, market structure, and history.


CONTEXT AND OBJECTIVE: Patient advisory councils (PACs) are a strategy for primary care clinics to engage patients in practice improvement. However, there is scant research on how PACs function. This study aimed to understand how PACs are organized and identify common challenges and perceived benefits of high-functioning PACs.
SETTING AND POPULATION: Key informants identified 8 primary care clinics in California with high-functioning PACs. Leaders from each of the 8 clinics nominated 1 clinic staff member and 1 PAC patient member to be interviewed.

STUDY DESIGN: Semistructured, one-on-one interviews were conducted at each clinic site or by phone. Interviews were dual-coded using modified grounded theory. Common themes were identified that would be pertinent to the development of future best practices for running PACs.

RESULTS: Common characteristics of high-functioning PACs included careful attention to participant recruitment, facilitation strategies guiding diverse personalities toward a common purpose, and assigning accountability for practice improvement projects. Interviewees identified a variety of positive outcomes that ranged from tangible improvements to the waiting area to a more patient-centered staff culture.

CONCLUSIONS: PACs show potential for promoting patient-centered practice improvements in primary care. Lessons learned from high-functioning PACs can inform a common set of strategies to assist practices in creating and sustaining effective advisory councils.

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Search Strategy

Database: Ovid MEDLINE(R) Epub Ahead of Print, In-Process & Other Non-Indexed Citations, Ovid MEDLINE(R) Daily, Ovid MEDLINE and Versions(R) (adapted for PsycInfo, Cochrane, and Scopus)

Search Strategy:

1  ((patient* or customer* or consumer* or family) adj2 engagement).mp. [mp=title, abstract, original title, name of substance word, subject heading word, keyword heading word, protocol supplementary concept word, rare disease supplementary concept word, unique identifier, synonyms] (2169)
2  *Quality Improvement/ (7370)
3  "quality improv*".mp. (35157)
4  2 or 3 (35157)
5  1 and 4 (148)
6  limit 5 to (english language and yr="2007 -Current") (142)

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