


# Leveraging an Ambulatory Patient and Family Advisory Council to Improve Patient Experience Scores

Journal of Patient Experience  
Volume 8:1-3  
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DOI: 10.1177/23743735211039316  
journals.sagepub.com/home/jpx  


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## Abstract

Reports have shown that ambulatory primary care practices that include patients and families in their quality improvement efforts have many benefits including better relationships and interactions with patients. In this paper, we describe our experience of involving our patients, family, and staff who are members of or Patient and Family Advisory Council (PFAC) in our quality improvement efforts related to patient experience. For a year, members of the PFAC suggested creative implementations to our office policies and workflow to improve satisfaction scores on the Clinician and Group Consumer Assessment of Health care Providers and Systems survey in key areas: information about delays, wait times in clinic, and convenience of appointments.

## Keywords

HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems), outpatient satisfaction data, patient advisory councils, team communication, wait times, patient feedback, community engagement, clinician–patient relationship

## Introduction

Stony Brook Primary Care is an academic faculty practice affiliated with the Renaissance SUNY Stony Brook School of Medicine and located in East Setauket, New York, a suburb of Long Island (1). It is a Patient-Centered Medical Home (PCMH) where medical students, residents, and fellows do their outpatient internal medicine training. One of the tenants of PCMH is patient and family engagement in shared medical decision-making, quality improvement (QI) efforts, and care management. Our Patient and Family Advisory Council (PFAC) was created with the belief that patients and families provide the most accurate feedback about their patient experience. It has been shown that engaged patients have better health outcomes, higher adherence to care plans, improved patient experience, and lower health costs (2).

## Methods

After a review of policy documents published by the Agency for Health care Research and Quality about PFAC (3), we designated a nurse, office manager, and physician to be the leaders of the council. The leaders recruited office staff and physicians to be members. Recruitment of families and

patients was done by casting a broad net through phone calls, email, office flyers, and newsletters to invite those who best represented our diverse practice demographics. Our nurse manager reached out to ~25 patients and eventually eight patients agreed to serve on the council with an equal number of staff and physicians. It is estimated that ~2 h a week by the leaders of the council was dedicated to preparation for meetings, communication, and follow-up of action steps. Communication between meetings was primarily done through email. We chose members who could work constructively and did not include individuals who had conditions that would make it difficult for them to attend or participate in meetings. We aimed to have 60 to 90 min meetings on a quarterly basis with two agenda items and time allotted for open discussion. The first agenda item focuses on the patient experience with attention to the Clinician and Group Consumer Assessment of Healthcare Providers and

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Systems (CG-CAHPS) survey and suggestion box, which is kept in the waiting room of the office. The second agenda is an open discussion to obtain feedback about patient educational materials or new practice delivery ideas. Some of the positive outcomes of PFAC have included the creation of a mission statement for our practice, constructive and innovative ideas about improving daily workflow, enhancing communication, increasing appointment access for patients, and decreasing waiting room times. We have also obtained feedback about health care topics of interest and incorporate them into our quarterly newsletter. It has been shown that wait time has a significant impact on patient experience. Several studies have documented the negative association with increased waiting time and how it impacts patient experience in primary care(4–6). This was strongly confirmed in our meetings with the group. Based on our open discussions, review of the suggestion box, and CG-CAHPS survey, the advisory council targeted three areas that they felt improvement would increase patient experience: the convenience of office hours and information about delays and wait time at the clinic. During our meetings, the members suggested specific implementation of new policy changes each quarter to help improve patient experience scores.

## Results

For one year, July 2018–July 2019, we implemented on a quarterly basis the following Plan, Do, Study Act (PDSA) interventions (see Table 1):

- July to September: baseline
- October to December: first PDSA
- January to March: second PDSA
- April to June: third PDSA

**Table 1.** CG CAHPS Survey/July 2018–July 2019/Responses for the Highest Possible Category for the Survey—“Very Good” or “Always” Responses.

	July to September: baseline	October to December: first PDSA	January to March: second PDSA	April to June: third PDSA
Number of surveys returned	551	487	582	601
Convenience of office hours (%)	71	69	80.2	87
Information about delays (%)	52.4	69.3	84.9	91
Wait time at clinic (%)	56	69.5	87.2	88

Abbreviations: CG-CAHPS, Clinician and Group Consumer Assessment of Healthcare Providers and Systems; PDSA: Plan, Do, Study Act.

## Convenience of Office Hours

PDSA intervention

1. Expand office hours to include more weekend visits
2. Expand office hours to include more evening visits
3. Offer more home-based visits

## Wait Time at Clinic and Information About Delays

PDSA intervention

1. Train hospital volunteers to assist with check in and orientation of patients arriving at the office.
2. Cross-train front desk receptionist to be assigned as waiting room concierge who notified patients of physician delays and assistance with paperwork/check-in.
3. Creation of a waiting room notification board that indicated wait times for the physicians seeing patients that day.

## Discussion

The approach to the creation of a PFAC started with a small leadership group. The literature highlights the need for an administrative manager to keep the PFAC valuable and productive (7). A robust PFAC requires communication with the members through email, text, phone calls, and assignments and goals for each meeting. We were able to include our members to be part of our QI efforts and tied these efforts to our PCMH goals. We focused on improvement efforts that would lead to improved patient experience and were able to implement small changes and monitor our progress. With the involvement of an engaged PFAC, we were able to create meaningful change in our office policies, create new workflows in our office and improve our patient satisfaction scores. Despite the initial resistance to allowing patients to voice their opinions, most staff found that participation in the PFAC to be a gratifying experience. The patient/family members were enthusiastic about being instrumental in the creation of official policies and procedures for our office. They also got an inside view of the challenges involved with staffing and learned to understand the administrative frustrations we all shared about health care delivery. Additionally, the office staff understood the wishes of our patients and were more empathetic about their concerns. This led to a more positive office environment with the emphasis on working together as a team. The practice of primary care is rapidly changing and having engaged patients and staff as partners in your PFAC is a powerful and low-cost way to involve patients in QI efforts to enhance the patient experience and health outcomes. This study took place in 2018–2019 before the height of the COVID-19 public health emergency. The pandemic restrictions obviously affected all primary care practices greatly and this included the need to pivot quickly to telehealth and strict office measures to ensure safety. For example, we were not able to

have a full waiting room or have a waiting room concierge. Additionally, many of our physicians were redeployed to work at the hospital. We were not surprised to find that our patient experience scores showed a decline for the measures we were monitoring during this time. We also had to pivot our meetings for the PFAC and QI committees to be virtual and learned that despite this our patients did appreciate that we never closed our practice and were able to provide care through telehealth and telemonitoring. As we return to normal, we hope to resume our in-person PFAC meetings and continue our important patient experience work.

## Limitations

The creation of a PFAC requires several leaders within a practice to be successful. It requires time away from clinical activities and dedicated patient/family members who will be willing participants. The CG-CAHPS survey was a useful tool to track our progress but ensuring that all patients can answer the survey is a factor. Patients who do not have email or do not bother to mail back the survey may be a factor in the results. Other ways of tracking patient satisfaction should be considered including patient interviews. Ensuring that a representative group of patients/families join as members can be a challenge due to psychosocial factors such as working hours, lack of transportation, or communication challenges. In addition, making sure that new members are added to the group is vital to generate new ideas and discussion.

## Author's Note

Ethical approval is not applicable for this article. This article does not contain any studies with human or animal subjects. There are no human subjects in this article and informed consent is not applicable.


## Declaration of Conflicting Interests

The author declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

## Funding

The author received no financial support for the research, authorship, and/or publication of this article.

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